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Pepperdine University
Graduate School of Education and Psychology

ENHANCING COGNITIVE BEHAVIORAL TREATMENT FOR CHILDHOOD
ANXIETY DISORDERS: A PARENT MANUAL

A clinical dissertation submitted in partial satisfaction of the requirements for the
degree of Doctor of Psychology

by

Anna L. Lock

June 2011

Drew Erhardt, Ph.D.- Dissertation Chairperson

This clinical dissertation, written by

Anna Lock

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

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DEDICATION

This dissertation is dedicated to my family and friends who supported and encouraged me through this process.

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I would like to recognize my dissertation chairperson, Dr. Drew Erhardt, for his dedication and support through this dissertation process as well as throughout graduate school. His commitment to this project as well as to my professional development and growth have been truly appreciated. I also would like to thank my committee persons, Drs. Joanne Hedgespeth and Carol Falender, for their interest in and support of the development of this project.

I would like to thank the authors of the treatment manuals I used during this project: Drs. Philip Kendall and Kristina Hedtke of *Cognitive-Behavioral Therapy for Anxious Children: A Therapist Manual*, Drs. Wendy Silverman and William Kurtines of *Anxiety and Phobic Disorders: A Pragmatic Approach*, and Dr. Bruce Chorpita of *Modular Cognitive Behavioral Therapy for Child Anxiety Disorders*. Their brilliant manuals have been vital to the development of this project and their commitment to the well being of children with anxiety disorders has been inspiring.

I would like to thank my family and friends for their support through this process. I would especially like to thank my parents, Joshua and Joanne Lock, for teaching me the value of education and determination. Their support and encouragement has motivated me to pursue my dreams. Finally, I would like to thank my fiancé, Pablo Noguera. I am truly grateful for his unconditional love and support.

VITA

ANNA LEAH LOCK

EDUCATION

- 08/07-present PEPPERDINE UNIVERISTY, GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY**, Los Angeles, CA
Doctoral Student in APA-Accredited Clinical Psychology program.
- Expected graduation date: 05/2011
 - Dissertation Title: Enhancing Cognitive Behavioral Therapy for child anxiety: A manual for parents. Dissertation Chair: Drew Erhardt, Ph.D.
 - Competency exam passed with distinction: 06/2009
- 08/05-05/06 HARVARD UNIVERSITY, GRADUATE SCHOOL OF EDUCATION**
Cambridge, MA
Masters of Education in Human Development and Psychology
- 08/00-05/04 WAKE FOREST UNIVERSITY**
Winston-Salem, North Carolina
Bachelors of Arts in Psychology, Minor in Sociology

CLINICAL EXPERIENCE

- 08/10-present UNIVERSITY OF SOUTHERN CALIFORNIA, STUDENT COUNSELING SERVICES**, Los Angeles, CA
Intern. Providing psychotherapy, outreach, crisis, and case management to undergraduate and graduate students in this APA-accredited university counseling center. *Supervisor:* Kelly Greco, Psy.D.
- Providing individual therapy using Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Time-Limited Dynamic Psychotherapy (TLDP)
 - Providing group psychotherapy on CBT for Anxiety Disorders, dealing with grief and loss, and developing and maintaining healthy relationships
 - Serving as the liaison to student veterans; providing workshops on transitioning from military life to civilian life; advocating for enhanced veteran services on campus as a member of the Student Veterans Committee
 - Providing individual peer supervision to a practicum student focusing on the development of clinical skills, theoretical skills, conceptualization, and treatment planning
 - Participating in weekly training seminars on working with culturally diverse individuals, evidence-based treatment practices, and treatment of specific Axis I and Axis II disorders
 - Collaborating with the counseling center's director to develop a protocol for assisting clients presenting with sexual assault
 - Serving as an member of the Faculty and Staff Ally Program
- 08/09- 07/10 VETERAN'S AFFAIRS, SEPULVEDA AMBULATORY CARE CENTER**, Sepulveda, CA
Pre-Intern. Conducted intakes and provided psychotherapy to adult veterans in this ambulatory care center.
- *1st rotation:* Chemical Dependency Treatment Unit (4 months).
Supervisor: Silvia Boris, PhD

- Co-facilitated groups on substance abuse recovery and maintenance as well as a sobriety group for victims of childhood trauma; developed and facilitated an emotions management group using Dialectical Behavioral Therapy (DBT).
- Providing individual therapy to patients with substance use and other co-occurring disorders
- *2nd rotation:* Outpatient Mental Health (4 months). *Supervisors:* Steven Ganzell, PhD and David Schafer, PsyD
 - Co-facilitated a group treating veterans with PTSD using Cognitive Processing Therapy (CPT); co-facilitated a Combat Remorse process group using imaginal exposure
 - Providing individual therapy to patients with PTSD using CPT, ACT
- *3rd rotation:* Partial Hospitalization Program. *Supervisors:* Fredrick Martin, PsyD and David Schafer, PsyD
 - Co-facilitated a group treating veterans with severe mental illness using ACT
 - Providing individual therapy to patients with severe mental illness and PTSD using CBT, CPT, and ACT.
- Participated in weekly, year-long seminars for neuropsychology and psychodiagnostic assessments; conducted test batteries and developed integrative reports
- Received weekly training on clinical issues including termination, recovery, boundary-setting, multicultural issues, obesity, and working with elderly veterans

08/09-07/10

PEPPERDINE UNIVERSITY, GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY, Los Angeles, CA

Peer Supervisor. Selected to provide peer supervision to second-year doctoral students conducting cognitive and emotional assessment batteries. *Supervisor:* Carolyn Keatinge, Ph.D.

- Provided individual peer supervision focusing on the development of assessment skills and effective report writing
- Taught students how to use various assessment tools including WAIS-IV, Rotters Sentence Completion Test, TAT, Bender Gestalt Test of Visual Motor Integration, MMPI-2, Woodcock Johnson Third Edition, Test of Cognitive Abilities, Woodcock Johnson Third Edition, Test of Achievement, Nelson Denny Reading Test, VMI, and Brown Attention Deficit Disorder Scale
- Participated in weekly supervision in order to enhance supervisory skills

07/09-07/10

PEPPERDINE UNIVERSITY, GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY, Los Angeles, CA

Peer Supervisor. Selected to provide peer supervision to first-year doctoral students conducting CBT and Psychodynamic therapy at the West Los Angeles Psychological and Educational Clinic. *Supervisor:* Aaron Aviera, Ph.D.

- Provided individual peer supervision focusing on the development of clinical skills, theoretical skills, conceptualization, and treatment planning
- Participated in weekly case conference meetings with first-year clinic therapists
- Received weekly supervision to enhance supervisory skills

08/08-07/09

UNIVERSITY OF SOUTHERN CALIFORNIA, STUDENT

COUNSELING SERVICES, Los Angeles, CA

Practicum Therapist. Provided psychotherapy in a university student counseling center. *Supervisors:* Kelly Greco, Psy.D, Robert Briones, Psy.D,

- Provided short and long-term individual therapy to undergraduate and graduate students focusing on symptom reduction and/or acceptance and the development of healthy coping skills
- Conducted intake interviews and developed treatment plans including referrals to outside community settings as well as on-campus resources
- Served as a process observer for group psychotherapy sessions, providing co-therapists with feedback on group dynamic and process
- Attended weekly trainings on multicultural issues, group psychotherapy, psychiatric consultation as well as specific trainings on working with special populations including ADHD, eating disorders and rape survivors

07/07-07/10

PEPPERDINE UNIVERSITY WEST LOS ANGELES COUNSELING CLINIC, Los Angeles, CA

PsyD Student Pre-intern. Provided short and long-term psychotherapy in a university-based community counseling clinic. *Supervisor:* Joan Rosenberg, Ph.D.

- Provided individual, couples, and family therapy
- Integrated cognitive behavioral and psychodynamic techniques to address the unique needs of each client
- Administered assessment measures on coping skills, spirituality, stages of change, depression, and anxiety

06/06-06/07

MCLEAN HOSPITAL/FRANCISCAN HOSPITAL FOR CHILDREN, CHILD AND ADOLESCENT INPATIENT PSYCHIATRIC UNIT, Brighton, MA

Mental Health Counselor. Provided inpatient counseling to children and adolescents in a locked psychiatric unit in a hospital setting *Director:* Ralph Buonopane, Ph.D

- Provided group psychotherapy to children between the ages of 3 and 19
- Conducted daily assessments evaluating patient current functioning and progress
- Participated in interdisciplinary treatment teams consisting of doctors, nurses, social workers, counselors, families and the patient

01/05-05/05

PENN STATE CHILDREN'S HOSPITAL, HERSHEY MEDICAL CENTER, ADOLESCENT PSYCHIATRIC UNIT, Hershey, PA

Assistant to medical staff. Assisted with inpatient treatment plans for patients on this locked psychiatric unit in a hospital setting.

- Assisted in the provision of group psychotherapy, recreational therapy, and problem solving training
- Shadowed psychiatrists, social workers and counselors in evaluation, individual and group therapy

01/03-06/03

IN HOME CARE, Robertson, Queensland, Australia

Applied Behavioral Therapist. Provided one-on-one behavioral therapy to a child with autism from Sri Lanka

- Designed and conducted multiple weekly tutorial sessions using Applied Behavioral Analysis techniques, working on both educational and social development of a child aged 6/7
- Collected and analyzed data for child's progress

09/00-05/01

AUTISM RESEARCH CENTER, Winston-Salem, North Carolina

Applied Behavioral Therapist. Provided one-on-one behavioral therapy to a child with autism. *Supervisor:* Cassie Gulden

- Trained as a therapist for children with autism using Applied Behavioral Analysis
- Organized and conducted multiple weekly tutorial sessions using the ABA technique, working on both education and social development of a child aged 4/5
- Collected and analyzed data for child's progress

TEACHING ASSISTANT EXPERIENCE

09/08-05/10

PEPPERDINE UNIVERSITY, GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY, Los Angeles, CA

Teaching Assistant. Assisted Carolyn Keatinge, Ph.D. for four semesters with doctoral level assessment courses.

- Assisted for two semesters with a doctoral level cognitive assessment course (tests included: WISC-IV, WAIS-III/IV, RAVLT, COWAT (FAS), Trailmaking, BGVM-II, WRAT-4, VMI); also assisted two semesters with a doctoral level personality assessment course (tests included: MMPI-2, Rorschach Inkblot Test, HTP, Incomplete Sentences, and TAT); assisted for one semester in an assessment course integrating cognitive and personality assessment
- Taught training workshops to doctoral level students on the administration of the WISC-IV, WAIS-III/IV, and Rorschach
- Evaluated and provided feedback on cognitive assessment, personality assessment and integrative batteries and worksheets

RESEARCH EXPERIENCE

12/05-07/08

CAMBRIDGE HEALTH ALLIANCE, FAMILY PATHWAYS PROJECT, Cambridge, MA

Research Assistant. Assisted Karlen Lyons-Ruth, Ph.D on her research on intersubjectivity and attachment.

- Conducted a literature review on intersubjectivity and attachment; synthesized literature in order to expand on current knowledge through our research
- Analyzed video data to identify function and dysfunction aspects of parent-child interactions in the Strange Situation
- Designed coding system to be used to capture parent-child interactions
- Conducted reliability coding and data collection using designed coding system
- Participated in data analysis to prepare information for write up and submission for publication

09/05-06/06

HARVARD UNIVERSITY, FACULTY OF ARTS AND SCIENCES, LAB OF DEVELOPMENTAL STUDIES, Cambridge, MA

Research Assistant. Assisted Peggy Li, Ph.D in the developmental lab in her research in the area of spatial understanding and language development in children.

- Conducted a literature review in the areas of the development of spatial understanding and language development
- Designed and constructed study to be implemented, including the development of scripts and test design
- Recruited participants and implemented study in school and community based settings

08/04-12/04

UNIVERSITY OF QUEENSLAND, COGNITIVE DEVELOPMENT UNIT, St. Lucia, Queensland, Australia

Research Assistant. Assisted Mark Nielsen, Ph.D in his research in the area of the development of cognitive abilities in children.

- Recruited participants and informed parents on research purpose, procedures, and results
- Conducted in-lab research for participants in studies of self-concept and learning behaviors; recorded and coded data for analysis

PRESENTATIONS AND OUTREACH

- *Acceptance and Commitment Therapy for Anxiety Disorders* (2010, November). Presented on the theory and practice of ACT for anxiety disorders to a group of psychology interns.
- *Theory and Practice of Acceptance and Commitment Therapy* (2010, November). Presented on the theory and practice of ACT to practicum students, social work interns, and marriage and family therapy interns.
- *Mindfulness-Based Stress Reduction (MBSR) workshop* (2010, November). Co-facilitated a workshop on MBSR.
- *Making the Transition from Military Life to Civilian Life workshop* (2010, October). Developed and conducted a three-part workshop for student veterans. Addressed issues related to the adjustment from military life to civilian life/university life.
- *Dealing with Grief and Loss* (2009, March)
Conducted an outreach presentation to members of a fraternity following a fatal accident involving a fellow fraternity member. Topics of discussion including coping with loss and common reactions to traumatic events. Counseling center resources were also discussed.
- *Managing Difficult Students* (2008, December). Conducted an outreach presentation to resident advisors in a university setting. Discussed techniques for managing conflict on residential floors and for facilitating coordination between the student, the university and the counseling center.
- *The Effects of Graduate School on Relationships* (2008, May). Community outreach presentation given to a Group Psychotherapy class in the Masters of Arts Psychology program at Pepperdine University.

CONFERENCES AND TRAININGS ATTENDED

11/10

ASSOCIATION FOR BEHAVIORAL AND COGNITIVE THERAPIES
San Francisco, CA

- Attended symposiums and discussions related to treatment anxiety and trauma-related disorders (CPT, PE, ACT, CBT)

07/10

ACCEPTANCE AND COMMITMENT THERAPY TRAINING

- Completed 16 hours of training on the theory and practice of ACT

07/10

MEDICAL UNIVERSITY OF SOUTH CAROLINA; A WEB-BASED LEARNING COURSE FOR COGNITIVE PROCESSING THERAPY: CPT-Web

- Completed a web-based learning course on CPT; received session-by-session instructions on how to conduct CPT for military and combat-related PTSD

- 08/08** **MEDICAL UNIVERISTY OF SOUTH CAROLINA, ONLINE TRAINING COURSE FOR TRAUMA-FOCUSED COGNITIVE-BEHAVIORAL THERAPY**
- Completed an online training course on the theory and application of cognitive-behavioral therapy to individuals who have experience a range of traumatic experiences
- 05/09** **LOS ANGELES COUNTY PSYCHOLOGICAL ASSOCIATION**
Los Angeles, CA
- Attended a conference on using motivational interviewing to engage patients in treatment
- 04/09** **INSTITUTE FOR THE ADVANCEMENT OF HUMAN BEHAVIOR,**
Sherman Oaks, CA
- Attended a two day conference on the frontiers of trauma treatment; Learned therapeutic techniques for treating Posttraumatic Stress Disorder
- 04/09** **THE RENFREW CENTER FOUNDATION FOR EATING DISORDERS,**
online presentation
- Online interactive seminar on eating disorders recovery and the college student population; learned therapeutic techniques for treating a range of eating disorders
- 10/07** **PEPPERDINE UNIVERISTY'S GRADUATE SCHOOL OF EDUCATION AND PSYCHOLOGY,** Los Angeles, CA
- Attended a conference on multicultural issues impacting the community; discussed the ethnic variables impacting immigrant populations including Mexican, Middle Eastern, and Vietnamese populations

HONORS AND AWARDS

10/08-present **Psi Chi Honor Society in Psychology**

PROFESSIONAL AFFILIATIONS

07/07-present **American Psychological Association,** Student Affiliate

10/08-present **Los Angeles County Psychological Association,** Student Affiliate

04/10-present **International Society for Traumatic Stress Studies,** Student Affiliate

04/10-present **Association for Behavioral and Cognitive Therapies,** Student Affiliate

ABSTRACT

Anxiety disorders are among the most common psychiatric disorders affecting children and adolescents. In the past several decades, great advances have been made in the treatment of these disorders. While many psychopharmacological and psychotherapeutic treatments exist, Cognitive Behavioral Therapy (CBT) is currently the treatment approach with the most empirical support. Based on a large evidence-base, several CBT manuals have been developed for the treatment of anxiety disorders in children. While research on incorporating parents into these treatments is mixed, parent involvement is widely recommended in these treatments as well as in unmanualized CBT treatment. Although some self-help books and manual-specific guides for parents exist, there is no current manual that provides parents with information and guidance to facilitate their involvement in both manualized and unmanualized CBT for child anxiety disorders.

The current project involved the development of a manual for parents whose children (ages 8-13 years) are involved in CBT treatment for Separation Anxiety Disorder, Generalized Anxiety Disorder, Specific Phobia, and Social Phobia. The resulting manual was informed by a review of the literature on child anxiety, CBT treatments for anxiety, and the roles parents may play in CBT. The manual consists of introductory psychoeducation on anxiety and CBT followed by six chapters on the major components of CBT for anxiety. In addition to descriptions of these components, each chapter includes instructions on how parents can be involved to facilitate their child's treatment.

Following a discussion of strengths, limitations, and potential modifications to the current manual, plans for evaluating the efficacy of the manual as well as disseminating it to parents are described.

Introduction and Literature Review

Anxiety disorders are among the most common psychiatric disorders affecting children and adolescents (Albano, Chorpita, & Barlow, 1996; Costello & Angold, 1995). However, they are often challenging to diagnose due to the difficulty of distinguishing normative anxiety from clinically significant levels of anxious symptoms that might merit treatment (Albano et al., 1996; Kazdin & Weisz, 2003). Anxiety is defined as, “the apprehensive anticipation of future danger or misfortune accompanied by a feeling of dysphoria or somatic symptoms of tension” (American Psychiatric Association [APA], 1994, p.764). It is a universal occurrence that serves an adaptive function of alerting individuals to threatening situations. Thus, it is normative for children beginning in infancy to manifest a variety of fears that follow a somewhat predictable trajectory that tends to reflect the common developmental tasks of a specific age range. During the early childhood years, anxiety often relates to the immediate environment (e.g., fear of strangers and separation from attachment figures) whereas older children and adolescents tend to have fears related to anticipated events and social situations (e.g., failure, rejection, criticism). Such normative fears tend to be present cross-nationally and cross-culturally (Gullone, 2000). Although anxiety is a normal occurrence for all individuals (Kendall & Suveg, 2006), it is generally considered pathological when it is more severe and/or prolonged than expected, and causes significant distress that interferes with daily functioning (Albano, et al., 1996; Kendall & Suveg, 2006).

Anxiety Disorders & Description of Common Features

There is a wide range of diagnosable anxiety disorders, many of which can be seen as severe and distressful extensions of normative childhood fears. The current

edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000) identifies nine principal anxiety disorders, distinguished largely by the focus of the individual's anxiety. These include Panic Disorder, Agoraphobia, Generalized Anxiety Disorder (GAD), Separation-Anxiety Disorder (SAD)¹, Obsessive-Compulsive Disorder (OCD), Specific Phobia, Social Phobia, Posttraumatic Stress Disorder, and Acute Stress Disorder. The anxiety disorders most commonly diagnosed in children include Separation Anxiety Disorder and Generalized Anxiety Disorder (Cartwright-Hatton, McNicol, & Doubleday, 2006; Hammerness et al., 2008).

Although a description of the symptoms of each of these disorders is beyond the scope of this review, anxiety disorders tend to share several common cognitive, behavioral, physiological, and emotional features that are worth noting. Cognitive features include rumination or excessive worry, thinking that both focuses on and overestimates the likelihood of danger or threats (though the specific focus of concern varies by disorder; Kendall & Suveg, 2006) anxious self-statements (e.g., involving one's inability to cope; Kendall & Treadwell, 2007), and the tendency to interpret neutral stimuli as threatening (Barrett, Rapee, Dadds, & Ryan, 1996; Puliafico & Kendall, 2006). The most common and important behavioral component of anxiety involves avoidant behavior (Kendall & Suveg, 2006) in both ambiguous situations (Barrett et al., 1996) and those related to threatening stimuli (Monk et al., 2006). However, clinging, freezing, agitation, and restlessness can also be considered behavioral features of anxiety in youth. Anxiety is also associated with heightened physiological responses including increased

¹ Although the DSM-IV-TR places SAD in a section of the manual entitled "Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence," it is clearly an anxiety disorder and warrants inclusion here.

heart rate, increased skin conductance, higher cortisol levels, and hyperarousal (Greaves-Lord et al., 2007; Schiefelbein & Susman, 2006; Weems, Zakem, Costa, Cannon, & Watts, 2005). Emotional features include not only dysphoric affective states such as anxiousness and nervousness but also difficulty with emotional regulation (Southam-Gerow & Kendall, 2000). The expression of anxiety in children across these affective, behavioral, cognitive, and somatic domains may be specific to a situation or may be generalized across many situations (Kendall & Suveg, 2006).

Epidemiology

Prevalence and sex differences. Estimates of the prevalence of anxiety disorders in youth have varied widely, depending in part on the nature of the sample and the methodology employed. For instance, a review of the international literature found that the prevalence estimates of anxiety disorders in children 12 years and younger ranged from 2.6% in to 41.2% (Cartwright-Hatton et al., 2006). Southam-Gerow and Chorpita (2007) conclude, based on their review of the epidemiological studies, found that the lifetime prevalence of anxiety disorders in youth ranges from 6-15%. A more recent study has indicated that prevalence ranges from 10-20% (Kendall, Furr, & Podell, 2010). Although the prevalence of anxiety disorders in males and females tends to be similar in pre-adolescence, females have been found to be at greater risk of developing an anxiety disorder in adolescence and beyond (Craske, 1999). Moreover, once females develop an anxiety disorder, it is more likely to persist over time than for males (Costello, Mustillo, Erkanil, Keeler, & Angold, 2003).

Onset, course, and outcome. The average age of onset of anxiety disorders in children varies by disorder. However, trends related to onset are evident that, in some

cases, mirror more normative anxieties in specific age ranges. For example, the onset of Separation Anxiety Disorder and Specific Phobia tends to be early (average age of onset 7 years), Generalized Anxiety Disorder and Obsessive Compulsive Disorder tend to develop in middle childhood (9-12 years), and Social Phobia tends to develop in adolescence (age 12 and older). Panic Disorder tends to be associated with the latest age of onset (approximately 15 years; Albano & Kendall, 2002; Morris & March, 2004).

Once anxiety disorders develop, they tend to have a chronic course, especially if left untreated (Craske, 1999; Pine, Cohen, Gurley, Brook, & Ma, 1998). Furthermore, anxiety disorders are associated with impaired functioning in several areas. With respect to social functioning, anxiety has been found to be associated with negative social expectations, low social competence, and high levels of social anxiety (Chansky & Kendall, 1997; Wood, 2006). Additionally, anxious children tend to have a negative perception of how they will be viewed and accepted by others, thus further adversely affecting their social functioning (Chanskey & Kendall, 1997). Anxiety has also been found to negatively affect academic functioning, possibly due to the fact that attention to anxiety-creating stimuli may decrease the child's ability to attend to academic information (Wood, 2006; King & Ollendick, 1989).

Comorbid disorders. A child diagnosed with an anxiety disorder has a high risk of being diagnosed with one or more additional anxiety disorders (Verduin & Kendall, 2003), with separation anxiety disorder, social phobia, and generalized anxiety disorder being the three most common co-existing anxiety disorders (Brady & Kendall, 1992). Moreover, anxious disorders in children tend to co-occur with other emotional and behavioral disorders at high rates. The most common comorbidities for children with

anxiety disorders are depression (Albano, et al., 1996; Costello & Angold, 1995) and externalizing disorders (Verduin & Kendall, 2003). An association between anxiety disorders and substance abuse has also been found (Falk, Yi, & Hilton, 2008; Kendall, Safford, Flannery-Schroeder, & Webb, 2004). Although the developmental progression of co-morbid disorders tends to vary, anxiety has been found to generally precede the development of depression in children (Albano et al., 1996).

Biopsychosocial Factors Implicated in Childhood Anxiety Disorders

There are a number of factors that have been found to influence the development, maintenance, and exacerbation of child anxiety. Recent theorizing has focused on what is commonly referred to as the “triple-vulnerability” model of anxiety development (Albano Chorpita, & Barlow, 2003; Barlow, 2000; Southam-Gerow & Chorpita, 2007). This model posits interactions between three factors as being central in the development of clinically significant anxiety: (a) a genetically transmitted biological diathesis towards anxiety; (b) a generalized psychological vulnerability toward anxiety, characterized by a lack of perceived control and heightened perceptions of danger; and (c) a specific psychological vulnerability, thought to emerge from early learning experiences that focus anxiety on particular circumstances. As noted by Craske (1999) and others, the exact relationship between these psychosocial and biological factors (including temperament) remains unknown but they are widely believed to interact in a dynamic, cyclical fashion that can result in both a generally elevated risk for anxiety and the emergence of a specific anxiety disorder (Albano et al., 2003; Barlow, 2000). Among the variety of psychosocial factors (e.g., conditioning, information processing, coping strategies) that have been implicated in the second and third components of the “triple vulnerability”

model, considerable attention has been devoted to the potential role of the family environment and, in particular, parenting variables (Barrett, et al., 1996; Chorpita, Albano, & Barlow, 1996; McClure, Brennan, Hammen, & Le Brocque, 2001; Rapee, 1997; Southam-Gerow & Chorpita, 2007; Wood, McLeod, Sigman, Hwang, & Chu, 2003). Because they are of the most relevance to the current proposal, these family factors will be the focus of the remainder of this section.

Genetic and social learning contributions to intergenerational transmission.

As noted above, anxiety disorders are currently thought to develop from a combination of genetic and psychological factors, with the latter often being related to specific life experiences. Multiple lines of evidence point to an intergenerational transmission of anxiety (Albano et al., 2003; Cooper, Fearn, Willetts, Seabrook, & Parkinson, 2006; Southam-Gerow & Chorpita, 2007). One mechanism underlying this intergenerational transmission is genetic, with heritable factors estimated to contribute 30-50 percent of the variance in anxiety (Barlow, 2000). Characteristics often associated with anxiety, including nervousness, emotionality, neuroticism, negative affect, and behavioral inhibition, have been found to have a genetic component (Barlow, 2000) as has a general predisposition towards high levels of anxiety (Craske, 1999; Eley et al., 2003). Moreover, parents of anxious children are more likely to suffer from anxious (as well as depressed) symptoms themselves (Ginsburg, Silverman, & Kurtines, 1995; Krain & Kendall, 2000; McClure et al, 2001). It is important to note that, although genetic contributions exist, they appear to contribute to the development of anxiety in non-specific ways (Craske, 1999) and tend to be strongly influenced by non-genetic factors (Barlow, 2000).

In addition to genetic transmission, social learning factors may explain how children can acquire anxious behaviors from their parents. Social learning factors include modeling and informational transmission (Drake & Kearney, 2008; Suveg, Zeman, Flannery-Schroeder, & Cassano, 2005). These factors appear more likely to be implicated in the transmission of anxiety if parents themselves have symptoms of psychopathology such as anxiety and depression (Suveg et al., 2005). The role of vicarious learning via modeling and informational transmission are supported by Craske's (1999) model of anxiety which draws from extant literature to identify possible pathways through which parent behaviors may contribute to the development and maintenance of anxiety in children. Vicarious learning includes modeling of fear responses to certain stimuli while informational transmission refers to the delivery of threatening information about specific objects or experiences (Craske, 1999). Corresponding to the third component of the aforementioned *triple vulnerability* model, the specific content of vicarious learning may lead to a psychological vulnerability to develop a particular anxiety disorder (Barlow, 2000).

It is important to bear in mind the often dynamic relationships and reciprocal influences among the various factors that may contribute to anxiety disorders in youth. For example, although parental symptomatology clearly impacts children, it is also the case that anxious children can influence parental behaviors in maladaptive ways that, in some instances, might exacerbate their children's anxiety. For example, anxious and non-anxious mothers with anxious children both tend to catastrophize in anxious situations, indicating that even in the absence of their own anxious symptoms, parents may be

developing a biased perception of reality because of their child's anxious reactions (Moore, Whaley, & Sigman, 2004).

Family functioning. In addition to the transmission of anxious behaviors through modeling and information provided by family members, there are numerous other family- and parenting-related factors that appear to play a role in the intergenerational transmission of anxiety. Poor family functioning and family discord have been found to be associated with higher rates of child anxiety and worse child functioning (Hughes, Hedtke, & Kendall, 2008; Kashani et al., 1990). Additionally, a lack of familial support and cohesion, limited participation in extracurricular activities, poor child management skills, and poor problem solving skills have also been found to be common in families of anxious children (Ginsburg et al., 1995; Chorpita, Brown, & Barlow, 1998). However, due to the concurrent as opposed to longitudinal methodologies employed in these studies, the exact relationship between these factors and child anxiety remains unclear. It is possible that the negative family functioning is a cause of the child's anxiety, a response to it, or both (Cooper et al., 2006). However, regardless of whether family factors precede or follow the emergence of clinically significant anxiety, once present, they seem to play a significant role in maintaining and exacerbating anxious symptoms.

Parenting style. In addition to more general family factors, specific characteristics of parenting have been implicated in child anxiety (Dumas & LaFreniere, 1993; Gerlsma, Emmelkamp, & Arrindell, 1990; McLeod, Wood, & Weisz, 2007). Parents of anxious children have been found to be less affectionate, less warm, less likely to grant autonomy, and more likely to catastrophize situations than parents of non-anxious children (Gerlsma et al, 1990; Moore et al., 2004; Whaley, Pinto, & Sigman,

1999; Wood et al., 2003). High levels of parental control have also been associated with many child anxiety disorders (Chorpita et al., 1998; Gerlsma et al, 1990; Ginsburg et al., 1995; Hughes et al., 2008; McLeod et al., 2007). High degrees of parental control have been found to undermine children's perceptions of their own ability to control situations and, thus predict feelings of uncontrollability and higher levels of anxiety (Barlow, 2000; Chorpita et al., 1998). The reduced perception of control experienced by children with highly controlling parents appears to contribute to the generalized psychological vulnerability towards anxiety identified as the second component of the previously discussed *triple vulnerability* model (Albano et al., 2003; Barlow, 2000).

Numerous aspects of parenting style can serve to maintain or exacerbate child anxiety. For instance, parents of anxious children and, in particular, those who are anxious themselves, have been found to devote considerable time to discussing the potential threats in ambiguous situations and to be prone to misinterpret ambiguous cues as threatening, resulting in the reinforcement of escape or avoidant tendencies in ambiguous situations (Albano, Detweller, & Logsdon-Conradsen, 1999; Barrett et al., 1996). Furthermore, it has been found that, during family discussions, parents of anxious children may play a role in the development of avoidant problem-solving strategies, thus increasing the likelihood that avoidant solutions will be used in anxiety-producing situations (Barrett et al, 1996; Barrett & Shortt, 2003). In a phenomenon that has been referred to as the "protection trap" (Silverman & Kurtines, 1996), parents' efforts to protect their children from distress through behaviors such as colluding with or actively encouraging avoidance of anxiety-provoking situations, providing frequent reassurance and promoting an excessive degree of cautiousness can serve to ultimately exacerbate

anxiety in their children who are less likely to both tolerate distressing emotions and reap the benefits of confronting anxiety-provoking situations. Furthermore, numerous components of parental over-involvement, including the aforementioned excessive control, direction of their children's speech, and provision of unsolicited help in anxious situations have been found to be present in parents of anxious children (Gar & Hudson, 2008). Although the intent of these behaviors is to protect the child from things that may be uncomfortable or distressing, the parents are often inadvertently maintaining or exacerbating the child's anxiety by reinforcing the child's avoidance of feared stimuli, maintaining the child's intolerance of uncertainty, and negatively reinforcing the child's reliance on their parents for reassurance (Ginsburg et al., 1995).

CBT Treatment for Child Anxiety

Since the early 1980's, a great deal of work has been devoted to the development of treatments for childhood anxiety disorders and research examining the efficacy of those treatments. These efforts have advanced to the point that there is now a range of pharmacological, behavioral, and cognitive treatment strategies that have been shown to improve anxious symptoms in children. A number of psychopharmacological treatments that have been found to be effective in reducing anxious symptoms in adults have more recently been evaluated for their effects on children. Although still quite limited, this research has generally led to the identification of selective serotonin reuptake inhibitors (SSRIs) as the first choice drug treatment for children with anxiety disorders (Rosenberg, Banerjee, Ivey, & Lorch, 2003). Results from the few randomized control trials conducted to date indicate that SSRIs are more effective than placebo in treating a broad range of child anxiety disorders including Obsessive Compulsive Disorder (OCD), Social

Phobia (SoP), Generalized Anxiety Disorder (GAD), Separation Anxiety Disorder (SAD), and Post Traumatic Stress Disorder (PTSD; Reinblatt & Riddle, 2007). Although efficacy data exist for some other medications, including tricyclics, they are generally considered to be "second-line" agents as compared with the SSRIs due to their less-favorable side effect profiles (Reinblatt & Riddle, 2007). Although studies directly comparing pharmacotherapy with other active treatments such as CBT are limited for anxious youth, existing studies suggest that a combination of CBT and medications tend to be more effective than either treatment used alone (Walkup et al., 2008; Compton, Kratochvil, & March, 2007). Other clinical researchers and integrated treatment models have support the idea of combining such treatments in order to increase the likelihood of decreasing anxiety symptoms and also suggest that the combination and sequencing of these treatments be considered on a case by case basis (see, for example, Keeton & Ginsburg, 2008).

Despite the widespread use of SSRI's for anxious youth and their promising efficacy data, CBT has become the treatment of choice for treating child anxiety (Albano & Kendall, 2002; Ginsburg & Kingery, 2007; In-Albon & Schnieder, 2006; Rosenberg et al, 2003). CBT is a multi-component treatment that invariably involves exposure along with a variety of other psychoeducational, cognitive (e.g., cognitive restructuring, self-statement training, relapse prevention), and behavioral (e.g., somatic management skills training, modeling) strategies (Albano & Kendall, 2002). Reviews of psychological treatments for anxiety disorders in children have concluded that CBT is the only psychosocial treatment for children and adolescents with anxiety disorders that has substantial evidence supporting its efficacy (Barrett & Ollendick, 2004; Cartwright-

Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Ginsburg & Kingery, 2007; Silverman, Pina, & Viswesvaran, 2008). In fact, even current practice parameters for the treatment of child anxiety developed by and for child and adolescent psychiatrists recommend that psychotherapy, specifically CBT, be considered as part of treatment due to the fact that it has the most empirically supported evidence (American Academy of Child and Adolescent Psychiatry [AACAP], 2007). In addition to the evidence-base and practice guidelines, consumer preference and satisfaction considerations support CBT as the first-line treatment for childhood anxiety as parents of anxious children have been found to prefer psychological treatment to medications (Brown, Deacon, Abramowitz, Damman, & Whiteside, 2007). Although speculative, it is certainly possible that parental concerns regarding potential side effects of medications and the unknown effects of long-term pharmacotherapy for children may contribute to this preference for psychosocial treatments.

Theoretical model. The Cognitive Behavioral Model views anxiety as a normal and expected emotion that consists of biological, behavioral and psychological components. Normative anxiety protects an individual by alerting him or her to danger and eliciting adaptive behaviors to avoid stress or negative experiences (Albano & Kendall, 2002). The cognitive-behavioral theory of anxiety comprises a tripartite model including physiological, cognitive and behavioral elements (Barlow, 2002). The physiological element originates in the autonomic nervous system which, when activated, prepares the individual to protect or defend itself via fight, flight, or freezing. Typical physiologic reactions associated with this process that are commonly recognized components of anxiety include increased heart rate, respiration and muscle tension as

well as sweating and changes in blood pressure (Grisel, Rasmussen, & Sperry, 2006). The cognitive element involves narrowing attention towards threatening cues and the behavioral element involves actions and reactions that aid in avoidance.

Although anxiety is a normal occurrence for all individuals, it is generally considered pathological when it is more severe and/or prolonged than expected and causes significant distress that interferes with daily functioning (Albano et al., 1996; Kendall & Suveg, 2006). When anxiety exceeds normative levels, cognitive biases such as overestimating the likelihood of negative events and underestimating one's ability to cope are activated and result in heightened subjective distress. Over time, these biases may become more pervasive and can develop into deeply held beliefs or schemas about ones self, the world and the future that are biased towards threat and danger (Barlow, 2002). These negative schemas result in distorted informational processing, trigger maladaptive physiological, behavioral, and affective responses and subsequently can result in the development, maintenance, and exacerbation of anxiety (Barlow, 2002). For example, a child fearful of public speaking who is required to give an oral presentation in class may think, "I'm going to mess up" or "I can't handle this." These negative thoughts, arising from the child's negatively biased schemas, may result in physiological responses such as increased heart rate, sweating, or shortness of breath. These reactions, coupled with the child's anxious thoughts and feelings, may lead to maladaptive behaviors such as running out of class or forgetting his speech. As a result of this negative experience, the child's anxiety regarding public speaking is reinforced making it more likely that he will respond to such events with anxiety in the future. As demonstrated in this example, the cognitive, physiological, and behavioral components of anxiety interact in ways that

maintain or exacerbate anxiety. It is for this reason that the different elements of CBT are typically geared towards addressing each of these components (Barlow, 2002).

Proliferation of manualized treatment. The cognitive-behavioral model of anxiety has spurred the development of a wide variety of cognitive-behavioral based therapies for children, comprised of treatment strategies that target the cognitive, physiological and behavioral components of anxiety. Such interventions have been developed in academic centers and have resulted in manualized-based treatments (e.g., Barrett, 2004; Chorpita, 2007; Kendall & Hedtke, 2006; Silverman & Kurtines, 1996). While manualized treatments are commonly utilized in the context of university-based treatment and clinic-research settings, such treatments have also been found to be transferable to clinical practice (Van Ingen, Freiheit, & Vye, 2009). Despite this transferability, the use of these manuals in clinical practice has been limited due to lack of access to the manuals themselves or to the training required to implement them (AACAP, 2007). Further, although the use of manualized treatments in clinical settings is growing, many practicing clinicians struggle with “translating” the implementation of such manuals into the various settings in which they practice (Kendall & Biedas, 2007; Vos et al., 2005). Even when manuals are available and practitioners are appropriately trained in using them, the unique circumstances or needs of individual clients often require flexibility in the application of such treatments (AACAP, 2007). Despite these challenges in formally incorporating manualized treatments into routine practice, it is worth noting that many of the common treatment components included in manualized interventions are recommended to be used by community-based clinicians who treat anxious children (AACAP, 2007).

Review of the outcome literature. Many of the clinical researchers who developed manualized treatments for child anxiety have gone on to conduct research evaluating the efficacy of their programs. The first randomized clinical trial examining the efficacy of manualized CBT for child anxiety was conducted in 1994 by Philip Kendall (Kendall, 1994). Using an adaptation of his “Coping Cat” manual for treating child anxiety, Kendall (1994) found that the group that received the manualized treatment improved significantly more than a wait-list control group. Specifically, 64% of the treatment group no longer met criteria for an anxiety disorder following treatment compared with only one member of the control group (n=20). Since this initial study, many more randomized clinical trials have supported the efficacy of CBT treatment for child anxiety (e.g., Barrett, Dadds, & Rapee, 1996; Flannery-Schroeder & Kendall, 2000; Kendall et al., 1997; Kendall, Panichelli-Mindel, Sugerman, & Callahan, 1997; Silverman et al., 1999). With respect to the results of these trials, the percentage of participants who no longer meet criteria for an anxiety disorder following CBT generally falls between 60% and 80% (Ginsburg & Kingery, 2007). Specific areas of improvement resulting from CBT treatment include anxious symptoms, school functioning, and social functioning (Wood, 2006). Improvements have also been found in the child’s ability to face feared situations (Kendall et al, 1997) as well as in an increased ability to cope with stress (Flannery-Schroeder & Kendall, 2000). Furthermore, these improvements appear to be durable as follow up studies have shown the gains associated with these treatments persist for as long as 6 years (Barrett, Duffy, Rapee, & Dadds, 2001). In addition to confirming the general efficacy of these treatments, a recent review of the outcome studies pertaining to CBT treatments for children concluded that such treatments are

similarly effective whether delivered in an individual or group format (Silverman et al., 2008).

Treatment Description of CBT for Child Anxiety

Structure and format of CBT. There is variability across manualized CBT programs for child anxiety with respect to the treatment components included as well as how they are sequenced. However, the general format of such treatments is often very similar. CBT programs are structured in the sense that the general intervention components that are administered over the course of the treatment are pre-specified although tailoring the application of these components to the needs and circumstances of the individual client is expected (Chorpita, 2007; Ginsburg & Kingery, 2007; Silverman & Kurtines, 1996). Programs often divide the components of treatment into distinct segments, although there is variability across programs with respect to the nature and sequencing of these segments. Despite this variability, segments tend to include a psychoeducation stage, a skill building stage, an exposure or application stage, and a review/relapse prevention stage (e.g., Kendall & Hedtke, 2006; Silverman & Kurtines, 1996). Wendy Silverman and William Kurtine's *Transfer of Control* approach to treatment provides an example of such a structure. This program consists of a 10-12 week treatment that is broken down into three weeks of education, five to six weeks of application, and the remaining weeks for relapse prevention. In addition to the overall structure of treatment, CBT programs also tend to use workbooks or handouts that provide an overarching structure for therapy, a structure for individual sessions, and written and visual means for the child to learn and practice important skills (Chorpita, 2007; Kendall & Hedtke, 2006).

Just as CBT programs tend to follow a similar structure, the sessions within the programs also tend to share a similar format. For example, CBT sessions generally begin with a review of previously assigned homework followed by the lesson for the day (e.g., introducing, teaching, and practicing a new skill) before concluding with the assignment of new homework (see, for example, Kendall & Hedtke, 2006). Other session components that can be included in a CBT session include a weekly rating of the child's mood or anxiety and setting an agenda for the session (Chorpita, 2007). These programs also vary with respect to the length of particular lessons. For example, whereas Kendall's Coping Cat manual aims to have the therapist complete one lesson per session, Chorpita's Modular CBT may extend one lesson over several sessions (Chorpita, 2007; Kendall & Hedtke, 2006).

CBT manuals for child anxiety have a strong focus on skill building. As a result, the therapist takes an active role as a coach and teacher (Ginsburg & Kingery, 2007) of cognitive, behavioral and affective skills that will help the child to alter interacting thoughts, emotions, and behaviors that contribute to the maintenance and exacerbation of anxiety (Kendall, Aschenbrand, & Hudson, 2003). A collaborative model of therapy is promoted from the outset. The child is taught at the beginning of treatment that therapy involves teamwork, including not only the child and therapist but also ideally the parents, thus allowing the child to realize that he or she is not alone in working towards managing anxiety (Ginsburg & Kingery, 2007).

As is consistent with a skills-building approach, homework represents an important component in manualized CBT for child anxiety. Homework provides the opportunity for the child to rehearse and master the skills taught in session, to generalize

this work to various “real-world” settings and to appreciate how he or she can make a difference in his or her own life. Treatment programs typically include homework assignments in which the child is instructed to attend to anxiety-provoking situations and to practice implementing learned skills (e.g., as in Coping Cat, implementing the FEAR plan outside of session; Kendall & Hedtke, 2006). Although child clients are encouraged to capitalize on the opportunity to practice target skills during naturally-occurring anxiety-provoking situations during the week, they are also assigned exposure tasks in which they confront previously agreed-upon stimuli or situations that elicit anxiety (Chorpita, 2007; Silverman & Kurtines, 1996). In addition, self-monitoring and daily diaries are often assigned to monitor anxious thoughts and track the child’s reactions to anxiety-provoking situations (Silverman & Kurtines, 1996). Practicing various relaxation techniques initially taught during sessions is another common component of homework in these programs (Kendall & Hedtke, 2006; Silverman & Kurtines, 1996).

Motivating young children to practice target skills and to willingly experience the inevitable discomfort associated with exposure exercises can be challenging. Thus, although contingency management strategies are typically not used to shape anxious symptoms directly, they are commonly used to encourage participation and effort in order to support and facilitate various components of treatment. More specifically, contingency management is often used to motivate children to practice target skills being taught in session (e.g., deep breathing), to face feared stimuli during both within-session and homework-based exposure work, and to help them to see that these skills can be applied in real world situations. Contingency management typically involves the therapist working collaboratively with the parent (and, perhaps, the child as well) to generate a list

of tangible and activity rewards that the child can work towards earning by practicing target skills and facing feared situations. Treatment manuals typically specify that rewards (or tokens such as stickers or points that can be accrued and eventually exchanged for items from the reward list) should be dispensed contingent upon the child's effort rather than his or her actual success with a given task (Ginsburg & Kingery, 2007). For example, Contingency contracts, specifying the specific exposure or approach task that the child will participate in, when it will occur, and how the task will be rewarded, can also be helpful in promoting homework compliance and in reducing conflict during exposure tasks (Silverman & Kurtines, 1996).

Therapeutic relationship. Throughout treatment, the therapist adopts a problem-focused, present-oriented, structured, and directive stance in providing skills to the child and guiding him or her through challenging exposure activities (Chorpita, 2007; Silverman & Kurtines, 1996). Although CBT treatments do not identify the therapeutic relationship as the primary mechanism of change as is the case in other therapies, the development of a warm and trusting therapeutic relationship is regarded as necessary, although not sufficient, for successful treatment (Kase & Ledley, 2007). By developing a trusting relationship, the child is more likely to participate in difficult tasks and anxiety-provoking situations (Chorpita, 2007; Kendall & Hedtke, 2006). Indeed, the development of a strong therapeutic relationship early in treatment has been found to predict a greater reduction of symptoms mid-treatment while improvement in the alliance as treatment progresses is associated with greater symptom reduction after treatment (Chiu, Mcleod, Har, & Wood, 2009). Therefore, manualized treatments note that it is essential to take the time during early sessions to develop a good rapport (Kase & Ledley, 2007).

Common Components of CBT Treatment

Although there is some variability across manualized programs in terms of which components are included or emphasized, in general there is a high degree of consistency with respect to the core strategies employed in these treatments. Moreover, exposure-based interventions are invariably included as the cornerstone of treatment. In a study analyzing 322 randomized clinical trials for child mental health disorders, Chorpita and Daleiden (2009) identified the most common practices for anxiety treatment to be exposure, relaxation, cognitive techniques, modeling, and psychoeducation. These findings are largely consistent with an earlier analysis conducted by Albano and Kendall (2002), though the latter analysis also identified relapse prevention as an additional component. Other, more specific, techniques that are commonly included in treatment are problem solving, contingency reinforcement, and affective education (Ginsburg & Kingery, 2007; Kendall and Suveg, 2006).

Psychoeducation. The goal of psychoeducation is to teach children and their family members about the nature of anxiety and how it can best be managed, thus establishing the cognitive groundwork for the exposures that will occur later in the treatment (Chorpita, 2007). Psychoeducation often includes identifying typical anxious symptoms; normalizing anxiety (in part, by highlighting its universality and the important protective function it serves); sharing information on the causes, prevalence, and course of anxiety disorders; and providing an overview of treatment, including the goals of CBT (Ginsburg & Kingery, 2007). Information regarding the CBT model is typically presented, with a particular emphasis on the relationship between anxious thoughts, feelings, and behaviors. Children and parents are informed that changes in one of these

components will typically lead to changes in the others and the ways in which different treatment strategies target various components are discussed. While psychoeducation is often emphasized at the beginning of therapy, it also continues throughout sessions. By consistently providing and reinforcing information, children become less anxious about treatment and are thus able to better acquire the knowledge and skills needed to overcome their anxiety (Ginsburg & Kingery, 2007; Kase & Ledley, 2007).

Exposure. Exposure involves the child confronting the very situations that cause him or her anxiety and distress. The goals of exposure are to reduce anxiety and avoidance through both habituation and the provision of “corrective” information (e.g., regarding the level of threat associated with a given situation, the child’s ability to cope and anticipated consequences of exposure; Kase & Ledley, 2007). The rationale for exposure is explained to both the parent(s) and the child in developmentally appropriate, accessible terms, thus increasing the likelihood that both will understand the purpose of exposures and be willing to engage in these anxiety-producing tasks outside of therapy (Ginsburg & Kingery, 2007).

There are many variants of exposure therapy but a primary distinction is whether the confrontation with the feared stimuli occurs directly (known as “in-vivo” exposure) or by having the child visualize him or herself in the feared situation (known as “imaginal” exposure; Ginsburg & Kingery, 2007). An additional variant pertains to the intensity of the exposure. Typically, exposure therapy with children involves gradual exposure to increasingly intense stimuli, as guided by a “fear hierarchy” that progresses from low-level exposures to more anxiety-provoking ones (Chorpita, 2007; Kendall et al., 2010). However, in some cases, more intensive or sudden exposure to the feared stimuli can also

be used (Ginsburg & Kingery, 2007). When such exposure is direct, it is referred to as “flooding” whereas it is termed “implosion” when the intensive exposure is imaginal. Regardless of the approach adopted, it is important that exposures be repeated and prolonged in order to ensure that habituation and the desired learning does, in fact, occur. Consistent rating of the child’s fear of the given situation is important in order to track such habituation (Chorpita, 2007).

Exposure is usually first introduced to both the child and parent, as both are typically involved in exposure tasks outside of therapy. Psychoeducation is typically provided about the efficacy of exposure and how it serves to reduce anxiety through habituation and the “corrective” information it provides. This information plus active encouragement for both the parent and child are intended, in part, to increase the likelihood that both will be willing to partake in confronting feared stimuli. Prior to initiating exposure work per se, the therapist works with the child and parent to construct the aforementioned “fear hierarchy,” ranking the child’s fears from least to most anxiety provoking. The resulting hierarchy provides a guideline for which exposures should occur first and the order in which feared stimuli will be confronted (Ginsburg & Kingery, 2007). Unless flooding or implosion are being used, exposures are typically done gradually, starting at the low end of the hierarchy and working up. In doing so, children gradually face their fears and are able to build confidence in their ability to face anxiety-provoking situations (Silverman & Kurtines, 1996). Also, as described above, a reward list for contingency management can be developed at this time in order to motivate the child to participate in exposure therapy (Ginsburg & Kingery, 2007).

Skills building.

Emotion skills training. Emotion skills training, also referred to as affective education, involves teaching children to identify emotions in themselves and others through facial expressions, postures, and tone of voice (Ginsburg & Kingery, 2007; Pahl & Barrett, 2010) as well as familiarizing them with what emotions may arise in specific situations (Hannesdottir & Ollendick, 2007). Descriptions of the somatic sensations (e.g., racing heart, shortness of breath) often accompanying specific emotions (e.g., anxiety) begins within emotion skills training but is developed further in somatic skills training (Ginsburg & Kingery, 2007). Emotion skills are often taught using artwork (e.g., drawing faces to match an emotion) or role-play activities (Kendall & Hedtke, 2006). By providing affective education to children, it is possible to increase their ability to recognize the onset of negative emotion, which can thus serve as a cue to initiate the use of learned coping skills (Hannesdottir & Ollendick, 2007).

Somatic skills training. In somatic management training, children learn to manage their physiological responses and reduce their own anxiety (Albano & Kendall, 2002). These skills are often taught as independent coping skills but their use may also be encouraged in anxiety-provoking situations such as those that children face during exposure tasks (Ginsburg & Kingery, 2007). Relaxation training can be helpful in controlling the physiological symptoms that tend to develop in anxiety-provoking situations (Ginsburg & Kingery, 2007). Techniques such as breathing retraining, where children learn to breathe more deeply, slowly, and evenly, can be taught in order to aid the child in coping with stressful situations and the associated physiological symptoms of anxiety (Kendall & Hedtke, 2006). Breathing techniques are often coupled with

visualization where children are encouraged to imagine themselves in a peaceful place (Ginsburg & Kingery, 2007). Progressive Muscle Relaxation, an additional relaxation technique, has children repeatedly practice alternating between tensing and relaxing their muscles in order to improve their ability to detect muscle tension and to respond by inducing a state of relaxation (Ginsburg & Kingery, 2007).

Relaxation techniques are initially taught by the therapist through modeling and guided practice during therapy sessions. This in-session instruction is supplemented by extensive practice both at home (as guided by relaxation scripts and audio recordings of instructions provided by the therapist) and in various stressful real-world situations (Ginsburg & Kingery, 2007).

Cognitive skill building.

Cognitive restructuring. Cognitive restructuring helps children to understand how thoughts, emotions and behaviors can influence each other to either exacerbate or decrease their experience of anxiety (Ginsburg & Kingery, 2007). Through the process of restructuring cognitions, children learn to attend to their thoughts, identify those that contribute to their anxiety, question these thoughts, consider different ways of looking at the situation that provoked them, and come up with more adaptive alternatives. Cognitive restructuring as applied to anxiety often helps children to recognize that they may be prone to “cognitive errors” such as overestimating the probability of a bad thing happening and exaggerating (“catastrophizing”) the consequences of adverse events. Children learn to identify the common thoughts they have in anxiety-provoking situations, to identify these thoughts as “thinking traps,” and to apply “self-talk”

strategies for responding adaptively to such anxious thoughts (Kase & Ledley, 2007; Kendall & Hedtke, 2006).

Cognitive restructuring is often taught by first demonstrating how thoughts influence emotions and behaviors. Children then learn that it is possible to have different thoughts in the same situation and how to “gather evidence” in order to determine how realistic a thought might be (Ginsburg & Kingery, 2007). Ultimately, the child learns to identify his or her maladaptive thoughts in feared or anxiety-provoking situations, collects evidence for and against the thought, and then develops an alternative, more adaptive thought (Ginsburg & Kingery, 2007). While this process is ideal, it is not always possible and, thus, children are also taught coping skills such as positive “self-talk” strategies they can use to manage their anxiety during the situation (Kase & Ledley, 2007). For example, when a child who has separation anxiety begins to feel anxious about being away from her mother while at school, she may not have the time or the privacy to go through the process of collecting evidence for her anxious thoughts and developing adaptive alternatives. In this case, positive “self-talk” such as “you can do this” or “I am safe here” may help the child to manage her anxiety in the moment.

Problem solving. Problem solving training involves teaching a systematic, multi-step approach to addressing problems so that children can learn to make a plan to cope with their anxiety regardless of the situation (Ginsburg & Kingery, 2007). Such training is thought to be useful in that it helps children to realize that their problems are not catastrophic but manageable, promotes focus on clarifying and solving problems rather than on one’s anxious response to them, and provides opportunities for children to

experience success in managing problems rather than feeling overwhelmed by them (Chorpita & Southam-Gerow, 2006).

The steps of problem solving typically involve the following: describing the problem and identifying goals for the solution, generating alternative solutions, evaluating the alternatives and determining their likely effectiveness in meeting the identified goals, selecting and enacting the best strategy, and evaluating the success of the outcome (Chorpita & Southam-Gerow, 2006). It is often helpful for the child to work through these steps in relation to various hypothetical and actual problems in session with the support and encouragement of the therapist prior to trying problem solving outside of sessions. Some programs for treating child anxiety offer useful mnemonic strategies for helping children to remember and utilize their problem solving skills. For example, Ginsburg and Kingery (2007) present the SOLVE acronym where children learn to **S**ettle down, **O**wn their problem, **L**ist solutions, **V**ote for one solution after deciding on the pros and cons of each option and **E**ngage in one of the solutions that seems the most appropriate.

Modeling. In order to help the child to develop many of the skills necessary to effectively manage anxiety, modeling is often used. Modeling refers to the process of a child observing another person successfully confronting an anxiety-provoking situation (Chorpita & Southam-Gerow, 2006). Through modeling, the therapist (or other model) demonstrates to the child how desired coping behaviors can be used in such situations (Kendall & Hedtke, 2006). For example, in the case of a child who is afraid of spiders, the therapist may model looking at a book of spiders while enacting coping skills such as deep breathing or positive self-talk. Modeling can be used during various components of

treatment and its actual application may vary depending on the topic. For example, during cognitive restructuring, therapists can “think aloud” in order to model adaptive responses to their own anxious thoughts in an effort to show the child how he or she can do the same (Ginsburg & Kingery, 2007). Models can include, but are not limited to, the therapist, parents, siblings, peers, or even fictional characters depicted in cartoons, films, or books (Chorpita & Southam-Gerow, 2006).

There are four types of modeling that can be utilized in treating children with anxiety: live, symbolic, covert, and participant (Chorpita & Southam-Gerow, 2006). In live modeling, as in the examples given above, the therapist or another person directly models the desired behavior to the child. In symbolic modeling, the desired behavior is shown via drawings, photographs, videos, or other representational medium (e.g., a puppet show). In covert modeling, the child is asked to imagine the therapist or other model confronting the feared stimuli and enacting the desired behavior. Finally, in participant modeling, the child first observes the desired behavior as demonstrated by the model and then is asked to confront the feared situation and enact the same adaptive behaviors.

Relapse prevention. Relapse prevention is often stressed in the final stages of therapy and is a vital part of treatment (Linares-Scott & Feeny, 2006). During this phase, skills learned throughout treatment are reviewed and the therapist talks with the child and parents about preventing relapse (Ginsburg & Kingery, 2007). Specifically, the child is reminded of the progress he or she has made during treatment and the techniques that have been learned are summarized (Chorpita, 2007). The child also identifies which skills were the most useful and thus most applicable to future anticipated and unanticipated

anxiety-provoking situations. These skills become the child's "tool kit" that can be used when anxiety arises in the future (Kase & Ledley, 2007).

Children are helped to understand that the goal of therapy was not to remove all anxiety but to help them to cope with it in the future (Kendall & Hedtke, 2006). The need for reasonable expectations regarding the inevitability of future anxiety is stressed while reinforcing the fact that they now have the tools needed to cope with such anxiety effectively (Ginsburg & Kingery, 2007; Kase & Ledley, 2007). Children also can be encouraged to set goals to continue to work on after termination and to anticipate situations that may be anxiety-provoking in the future so that they can plan for how to handle such situations using their newly acquired skills (Kase & Ledley, 2007).

Typical Sequencing of Treatment

Although manualized CBT programs for child anxiety are similar in terms of the treatment components they include, some differ with respect to how they sequence those components. For example, whereas Kendall's Coping Cat program teaches cognitive and behavior skills prior to beginning exposures, Silverman and Kurtine's Transfer of Control approach teaches these techniques in conjunction with exposures (Kendall & Hedtke, 2006; Silverman & Kurtines, 1996).

Despite these alternative approaches, recommendations for sequencing have been made by leading researchers in the field of child anxiety (Ginsburg & Kingery, 2007). According to these recommendations, treatment typically begins with psychoeducation about anxiety disorders and the CBT model. Next, a fear hierarchy is developed and the child begins to participate in low-level exposures coupled with contingency management. Then, depending on the needs of the child, relaxation training for somatic symptoms or

cognitive restructuring for negative cognitions can be taught. As treatment continues, children are taught to problem solve and a coping plan is developed. Finally, relapse prevention is addressed. While this provides a general sequence for treatment, researchers also encourage the therapist to continually monitor the progress of the child and make adjustments to the treatment plan as needed (Ginsburg & Kingery, 2007).

Parent Involvement

An additional common theme across CBT treatments for child anxiety is parent involvement (Ginsburg & Kingery, 2007). The inclusion of parents in treatment has been recommended by many experts in the field of child anxiety (e.g., Chorpita, 2007; Kendall et al., 2010; Kendall & Hedtke, 2006; Silva, Gallagher, & Minami, 2006) and has some empirical support. Including parents in treatment is thought to have numerous benefits. It provides the opportunity for parents to ask questions, gain additional information about their child's treatment, and to provide useful information about the child to the therapist. It also can provide the opportunity for therapists to educate parents on parenting issues that may be influencing their child's anxiety (Albano & Kendall, 2002; Ginsberg & Kingery, 2007). Additionally, by enlisting parents as "co-therapists" who can extend the work of therapy outside of sessions, parent involvement can both facilitate generalization of treatment gains while also addressing time and resource limitations of therapists (Mahoney et al., 1999).

Empirical studies have found that parental satisfaction with treatment is significantly higher when parents are directly involved, thus suggesting that parental involvement may increase parental support, motivation, and compliance with treatment as well as child attendance (Nauta, Scholling, Emmelkamp, & Minderaa, 2003). Studies also

have identified a significant relationship between increased parental knowledge and parent empowerment, which in turn has been found to be related to increased help-giving practices such as actively supporting the development of child competencies, creating opportunities for joint decision making, providing empathy, and active listening (Dempsey & Dunst, 2004; Mahoney et al., 1999). Such help-giving behaviors may well be vital to parents' role in helping their children to master techniques learned in treatment as well as to provide them with the emotional support needed to face anxiety-provoking situations. Collectively these empirical findings along with the purported benefits noted above and the virtually unanimous recommendation among experts who have developed CBT programs for anxious youth provide a strong argument for involving parents in treatment for their child's anxiety.

In many ways, parents are ideally positioned to participate in and contribute to treatment. They can serve as consultants, collaborators, and co-clients (Kendall & Choudury, 2003). Parents are helpful consultants in that they are typically broadly present in their children's lives and primarily responsible for their care (Rapee, Abbott, & Lyneham, 2006). As a result, they can be valuable sources of information regarding the child's past development and current functioning as well as possible maladaptive patterns they may have in relating to their children (Kendall & Choudury, 2003; Suveg et al., 2006). As collaborators, parents actively participate in the treatment and its related activities (Kendall & Choudury, 2003), control reinforcers that can be used to motivate the child to practice targeted skills and face feared stimuli, and can be valuable sources of support for implementing exposure tasks (Pahl & Barrett, 2010; Suveg et al., 2006). As co-clients, parents may actually participate in aspects of the treatment such as family

therapy or parent training (Kendall & Choudury, 2003). Often, parents play a combination of these roles at different points in treatment with the level of involvement often depending on the individual needs of the child (Ginsburg & Kingery, 2007).

In practice, the nature of parent involvement in CBT treatment ranges along a wide continuum. Minimal parent involvement may include occasional parent meetings (e.g. twice during the entire treatment) in order to get additional information, inform parents about their child's progress, and answer any questions they may have (Kendall & Hedtke, 2006). Slightly greater parent involvement may include regular brief parent meetings (e.g., following each child session; Chorpita, 2007). In such meetings, parents may learn parenting strategies to assist their children in managing anxious behaviors and reaching treatment goals (Mahoney et al., 1999). In some cases, parents may be involved directly in treatment through family or group therapy (e.g., Cobham, Dadds, & Spence, 1998; Howard & Kendall, 1996; Shortt, Barrett, & Fox, 2001). In such cases, parents receive the same psychoeducation as in other levels of involvement but also play an active role in treatment as they participate in learning and applying target along with the child. Finally, maximal involvement of parents in treatment may entail parent-implemented treatment, where the parent delivers the treatment while the therapist provides occasional support via phone or email sessions (Lyneham & Rapee, 2006; Rapee, Spence, Cobham, & Wignall, 2000). In addition to direct parent involvement in the child's treatment, parents may also receive parent training or treatment for the management of their own anxiety in order to reduce the negative impact of their parenting style, behaviors, cognitions, and/or emotional states on their anxious child (Nauta et al., 2003).

In contrast to the aforementioned studies that identified benefits related to variables such as parent satisfaction and empowerment, results of studies examining whether parental involvement actually translates into improved outcomes for the child have been mixed. While some studies have found that parent involvement is more helpful in reducing child anxiety to clinically non-significant levels than individual treatment alone (Barrett et al., 1996; Howard & Kendall, 1996; Silverman et al., 1999), others have found no difference between individual and family-involved treatment (Barrett et al., 2001; Nauta et al., 2003; Silverman et al., 2008). Moreover, other studies suggest that certain child variables may mediate the impact of involving parents in treatment. In one such study, younger children (7-10 years) as well as females were found to benefit from parent involvement while older children and males did not (Barrett et al., 1996). In considering these findings, the authors of this study speculated that the enhancement of parenting skills may be more helpful when younger children are involved and that parents may interact with anxious male and female children differently. Finally, parent involvement has been found to be particularly helpful when the child's parent also suffers from anxiety symptoms (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008).

As noted, several studies have examined the relationship between parent involvement and the efficacy of CBT for treating child anxiety (Barrett et al., 2001; Barrett et al., 1996; Howard & Kendall, 1996; Nauta et al., 2003; Silverman et al., 1999; Silverman et al., 2008). However, due to the mixed nature of the results of such investigations, the question of whether parent involvement is helpful in CBT treatment for children with anxiety disorders remains unanswered (Silverman, Kurtines, Jaccard, & Pina, 2009; Silverman et al., 2008), meaning additional research is needed to provide

more definitive conclusions (Mcleod et al., 2007; Silverman et al., 2009; Silverman et al., 2008).

There are several possible explanations for the inconclusiveness of these studies. First, the nature and degree of parent involvement varied considerably across these studies. For example, Silverman's study involved parent sessions concurrent with child-focused treatment (Silverman et al., 1999) whereas Kendall et al. (2008) studied parents who were directly involved in treatment via family-based CBT.

Another under-explored factor that may have affected the outcome of parent involvement studies is parent psychopathology (Bogels & Brechman-Toussaint, 2006). Only some of the studies investigating parent involvement have considered parental psychopathology, a source of variability that may have contributed to mixed findings. Attesting to the possible impact of parental psychopathology are the results of a study conducted by Cobham and colleagues (1998), where it was found that children with one or two anxious parents respond less favorably to child-focused treatment. Although speculative, anxious parents may be less likely or able to help their children confront anxiety-provoking situations since parents themselves may be inclined towards avoidance of such situations. Thus, they may collude with the child's avoidance or otherwise adversely affect the child's ability to fully participate in treatment, thereby reducing its efficacy. This variable is particularly important to consider given that children with anxious parents tend to benefit more from treatment (as compared with those without anxious parents) when their parents are taught skills to manage their own symptoms (Cobham et al., 1998).

Possible Relevance of Parental Knowledge Deficits

In addition to the considerations noted above, it is possible that the evidence for parental involvement enhancing the efficacy of CBT for child anxiety is not more overwhelming because parents have not been consistently provided with adequate knowledge about both child anxiety and CBT treatment. Unfortunately, because studies on parent involvement have not accounted for parents' pre-existing knowledge of child anxiety and CBT (Nauta et al., 2003), it has not even been possible to accurately assess the impact of intervention related to these potentially critical variables. Nonetheless, to the extent that interventions have not adequately increased parents' knowledge in these areas, parents' efficacy in implementing various components of the treatment may have been limited in multiple ways. For example, lacking adequate knowledge about their child's anxiety disorder may limit parents' ability to respond appropriately to anxious behavior (e.g., which behaviors to ignore and which to reinforce). Inadequate understanding of CBT treatment may render parents unprepared to perform some of the tasks required of them (e.g., helping their children with exposure tasks). Furthermore, the potential benefits of parental involvement in treatment may be unrealized if parents are unclear about their specific roles in treatment (e.g., co-client, collaborator, co-therapist). Finally, parents may also be lacking adequate knowledge of the resources available that would enable them to gain further information about the child's disorder or CBT treatment.

In light of the potentially critical role of parental knowledge about childhood anxiety and CBT in mediating the impact of involving parents in treatment for their anxious children, it appears that there is much to be gained by ensuring that parents are

provided with such information. This objective might be accomplished effectively by developing a manual that educates parents about their child's anxious disorder and its treatment, informs them about the roles they may play in treatment, and provides them with a list of resources for support and additional information.

Rationale for the Project

Given that CBT is currently the preferred treatment for child anxiety; that parents can play a role in the development, maintenance, and exacerbation of child anxiety; and that, despite mixed findings from efficacy studies, parent involvement in treatment is widely recommended, the development of a manual designed to educate parents about child anxiety disorders in general and to facilitate their involvement in their child's CBT would appear to have numerous potential benefits. Although intended to be useful to any parent with a child receiving CBT for Generalized Anxiety Disorder, Separation Anxiety Disorder, Specific Phobia, or Social Phobia, expert opinion suggests that a parent manual may be particularly helpful for parents who suffer from anxiety themselves (Cobham et al., 1998; Hughes et al., 2008), for parents experiencing other personal problems such as marital discord (Albano & Kendall, 2002), for parents of younger children (Kendall & Choudhury, 2003), and for parents of children with higher levels of distress (Albano & Kendall, 2002).

Objectives and Goals

The research objectives of this project were as follows:

1. Conducted a review of the literature on child anxiety, CBT treatments for child anxiety, and the roles parents may play in developing, maintaining, and treating child anxiety

2. Identified relevant information about child anxiety, common themes in and components of CBT treatments, and the potential roles parents may take in CBT treatment for child anxiety
3. Developed a resource manual for parents with children receiving CBT treatment for child anxiety

The goals for this project are to increase the efficacy of CBT treatment for children with anxiety disorders by creating a manual designed to increase parents' understanding of information relevant to treatment and to optimize their active participation in treatment.

Specific goals for the manual are as follows:

1. To increase parents' knowledge of the goals, format, and content of CBT treatment for child anxiety. It is anticipated that this will increase parental knowledge regarding the rationale for various components of the treatment as well as the likelihood that parents will be able to participate in and contribute effectively to the treatment.
2. To inform parents about the opportunities for parental involvement in treatment and how they can help to generalize therapeutic gains to home and other settings.
3. To educate parents about the warning signs of relapse so that they are prepared to recognize early signs of relapse in their children and to take appropriate action.
4. To provide parents with additional resources such as websites and books pertaining to child anxiety disorders and their treatment.

5. To provide a resource that therapists can provide to parents to facilitate and optimize their involvement in treatment.

Research Methodology

Overview

This clinical dissertation project involved the development of a manual for parents with children receiving Cognitive Behavioral Therapy (CBT) treatment for anxiety disorders. The manual content focuses on information about CBT as well as the potential role parents may play in their child's treatment. The project goal is to increase parents' knowledge about CBT and enhance their ability to help their children to benefit from treatment and to successfully manage their anxiety in the future. The target audience for this manual is parents and guardians² who have children between the ages of 8 and 13 receiving CBT for anxiety disorders in a range of settings including private practice, community mental health centers, and hospitals. The manual is most appropriate for children with Generalized Anxiety Disorder (GAD), Social Phobia (SoP), Separation Anxiety Disorder (SAD), and Specific Phobia as these disorders are the most commonly targeted by current manualized CBT treatments. The manual is not appropriate for parents of children with Obsessive Compulsive Disorder (OCD), Post Traumatic Stress Disorder (PTSD), and Panic Disorder since these disorders often require more specialized adaptations of CBT.

Rationale For This Project

Enhancing parent knowledge of CBT for child anxiety disorders as well as their involvement in such treatments are areas that need attention. Focusing this psychoeducational resource on CBT is warranted given that it represents the current treatment of choice for child anxiety disorders. Multiple factors support the decision to

² For the sake of expediency, the term "parents" will be used throughout this document to refer to parents, legal guardians, and any other adult caretakers who assume responsibility for the child with respect to his or her CBT treatment.

target the resource towards parents. First, parents can and often do play a significant role in the development, maintenance, and/or exacerbation of child anxiety. Additionally, parents are ideally positioned to enhance treatment efficacy and to help generalize the benefits of treatment to the child's everyday life. This is due not only to the simple fact that children tend to be under the care of their parents most of the time but also because parents are well situated to motivate their children to engage in various treatment components through both their relationship with the child and their control of meaningful reinforcers. Although the results of research investigating the effects of actively involving parents in their anxious children's treatment with CBT is mixed, it suggests that parent participation may be helpful. In fact, the leading CBT treatment programs for child anxiety disorders are unanimous in recommending that parents be involved in treatment. Specific recommendations include involving parents as consultants, collaborators, and co-clients.

Goals of the Project

The goal of this resource manual is to increase parents' knowledge of the goals, format, and content of CBT for child anxiety disorders. It is anticipated that this manual will increase parental knowledge of treatment as well as the likelihood that parents will be able to contribute effectively to treatment. The manual also informs parents about the opportunities for involvement in treatment and provides techniques they can use to prompt and reinforce target skills in the home and elsewhere. In addition, the manual includes information about the warning signs of relapse so that parents are prepared to respond appropriately. Finally, the manual provides parents with additional resources such as websites and books pertaining to child anxiety disorders and their treatment.

Resource Development

Literature review. A thorough literature review was conducted in order to provide the background information and rationale for the manual. The review was divided into four sections. The first section focused on core common features of childhood anxiety disorders and their epidemiology in order to establish a general fund of knowledge about these disorders. The second section explored a leading theoretical model (viz., the “triple vulnerability model”) of how various biopsychosocial factors interact to contribute to the development of childhood anxiety disorders. Particular attention was paid to family factors in order to become familiar with current theory and empirical data pertaining to the role of parents in the development, maintenance, and exacerbation of child anxiety. The third section pertained to treatments for child anxiety disorders and focused on identifying effective pharmacologic and psychosocial treatments for these disorders, highlighting the status of CBT as the psychosocial treatment of choice, reviewing the theoretical model underlying the use of CBT for anxiety, summarizing relevant outcome literature, noting the proliferation of manualized treatment, and describing the typical structure, format, and common components of CBT. The final section explored the rationale for parent involvement in treatment, the various ways in which parents may be incorporated into treatment, and the empirical literature regarding parent involvement.

The primary literature reviewed was identified through searches in online databases including Psychinfo, Psycharticles, Google Scholar, and Scopus. Specific search terms included various terms related to child anxiety (e.g., *normal fears, risk factors, etiology, epidemiology, heritability, development, physiology, anxiety disorders,*

common features, comorbidity); family factors; parenting style; various terms related to CBT treatment (e.g., *evidence-based treatment, manuals, efficacy, outcome, theory, manualized treatments, parent involvement, psychoeducation, contingency management, exposure, relaxation, cognitive skills, emotion skills, problem solving, relapse prevention*); therapeutic rapport with children; and manual dissemination.

CBT treatment manuals for child anxiety disorders were reviewed in order to provide the foundation for determining what information should be provided to parents regarding CBT treatments. The primary CBT manuals reviewed were those that appeared most often in the outcome literature. These manuals included *Cognitive-Behavioral Therapy for Anxious Children: Therapist Manual* (Kendall & Hedtke, 2006), *Transfer of Control: A Psychosocial Intervention Model for Internalizing Disorders in Youth* (Silverman & Kurtines, 1996), and *Modular Cognitive-Behavioral Therapy for Childhood Anxiety Disorders* (Chorpita, 2007). In addition, a selection of representative self-help books for parents of children suffering from anxiety were reviewed in order to become familiar with materials currently available for parents and to identify potential deficits that this manual can fill. The books reviewed were chosen based on a basic search of an online database (viz., amazon.com) that parents may use to locate information pertaining children's anxiety disorders and their treatment. The self-help books reviewed include *Anxiety Cure for Kids: A Guide for Parents* (Spencer, Dupont & Dupont, 2003), *Helping Your Anxious Child: A Step-by-Step Guide for Parents* (Rapee, Spence, Cobham, & Wignall, 2000), *Help for Worried Kids: How Your Child can Conquer Anxiety* (Last, 2006), and *Freeing Your Child From Anxiety: Powerful,*

Practical Solutions to Overcome Your Child's Fear, Worries, and Phobias (Chansky, 2004).

Finally, the researcher updated the literature review as the resource manual was being developed. Specifically, periodic literature searches were conducted using the aforementioned databases and search terms. Moreover, periodic reviews of Websites and LISTSERVS devoted to child anxiety (e.g., www.childanxiety.net, www.childfirst.ucla.edu, <http://anxiety.psych.ucla.edu>, www.childanxiety.org) were conducted.

Format and Structure for the Manual

The manual is organized into chapters. Where possible, a uniform format for presenting information was used across and within chapters (e.g., common subheadings within treatment component descriptions). Efforts were made to keep content within each chapter brief in order to make reading the manual reasonable for busy parents. The manual is accessible, containing a simple table of contents, clear headings and subheadings, and informal language free from psychological jargon. Finally, the manual includes content boxes throughout the chapters, containing helpful hints for parents on particular topics, referrals to appendices for material samples and resources, and vignettes or other types of examples intended to vivify key content.

Content of the Manual

The manual is written as a guide for parents to utilize while their children are participating in CBT treatment. The opening chapter of the manual provides an introduction addressing the purpose, objectives, and goals of the manual. This chapter identifies the intended audience of the manual as well as particular content that is not

addressed (e.g., a description of anxiety and its disorders, assessment/evaluation issues, identifying a therapist). The introduction also provides a rationale for selecting CBT as the focus of the manual, including a brief description of the treatment and the basis for it representing the current treatment of choice for anxious children. Moreover, the chapter discusses the potential roles parents may play (both in and out of the formal treatment setting) in reducing their child's anxiety (e.g., modeling, empathy, not colluding with avoidance, supporting, encouraging children to face feared situations).

The remaining chapters of the manual address the key components that are generally included in treatment and how parents can contribute to treatment during each phase. Each chapter focuses on a common component typically included in CBT treatment for child anxiety disorders, including (a) psychoeducation, (b) emotional skills building, (c) exposure, (d) relaxation skills training, (e) cognitive skills, and (f) planning for the future and preventing relapse. Within each chapter, common subheadings related to each treatment component include a brief description of the treatment component, a description of what is likely to occur in sessions, possible homework assignments, a description of the roles parents may play, and a discussion of likely challenges and potential obstacles. Finally, appendices of additional resources (including Websites and books) and samples of homework materials from commonly used manuals was included at the end of the manual.

Evaluation of the Resource

Although a formal evaluation of the completed manual is beyond the scope of this project, a plan for such an evaluation has been articulated as part of the Discussion chapter.

Results

Cognitive Behavioral Therapy for Your Anxious Child: A Guide for Parents is a manual for parents with children receiving CBT treatment for the most commonly diagnosed anxiety disorders. It was created to enhance parents' ability to understand and support their child's treatment. The manual can be found in its entirety in Appendix C.

Discussion

Summary of this Project

The purpose of the manual, *Cognitive Behavioral Therapy for Your Anxious Child: A Guide for Parents*, is to provide a resource for parents with children (ages 8-13 years) receiving Cognitive Behavioral Therapy (CBT) for anxiety disorders (specifically, Generalized Anxiety Disorder, Separation Anxiety Disorder, Specific Phobia, and Social Phobia, as these are the disorders most commonly diagnosed in childhood). Existing literature indicates that anxiety disorders are among the most common psychiatric disorders affecting children and adolescents, with prevalence estimates ranging from 10% to 20% (Kendall et al., 2010). The impact of anxiety disorders on the lives of children is substantial. In addition to causing significant distress, such disorders also cause impairment across several domains including academic, social, and recreational functioning. Attesting to the severity of this impact, a great amount of research has been conducted regarding the treatment of child anxiety disorders. While other treatment approaches such as pharmacotherapy have been found to be effective, CBT has emerged as the current treatment of choice for child anxiety disorders given the substantial evidence for its efficacy. This evidence is based on a large number of empirical studies conducted on manualized CBT programs that have been developed for the treatment of anxious youth. These studies indicate favorable results, with the percentage of participants who no longer meet criteria for an anxiety disorder following CBT generally falling between 60% and 80% (Ginsburg & Kingery, 2007) and with durability of treatment gains lasting up to six years (Barrett et al., 2001). Specific areas of

improvement resulting from CBT include decreased anxious symptoms and increased academic and social functioning (Wood, 2006).

Leading researchers and clinicians in the field of CBT for child anxiety disorders have examined the potential benefits of involving parents in CB treatment. While the results of empirical studies regarding parent involvement are mixed, authors of the leading treatment manuals unanimously recommend parent involvement in CBT for child anxiety. Experts suggest that parent involvement in treatment is warranted given that parents are typically broadly present in their child's life and therefore, have substantial opportunity to contribute to the treatment of their child's anxiety. Benefits for including parents in treatment are numerous. Involving parents in treatment gives therapists the opportunity to gather detailed information regarding the child's past development and current functioning from the person who likely knows him the best. Also, having parents involved in treatment provides the opportunity for therapists to educate parents on parenting issues that may be influencing their child's anxiety (Albano & Kendall, 2002; Ginsburg & Kingery, 2007). Regular involvement also allows parents to learn about the skills taught in session so that they can help generalize the benefits of treatment. For example, parents can help monitor homework (used frequently in CBT treatment) and assist in its completion. They can also encourage and reward practice of learned skills outside of the therapy room.

While resources have been developed that educate parents on anxiety disorders and provide them with general information about treatment, existing resources do not provide a detailed guide to the most commonly used treatment for anxiety disorders, CBT. Given this limitation, this manual is intended to provide more in-depth

psychoeducation and guidance to parents not just about anxiety, but also about CBT-oriented anxiety treatment. This can help parents to understand the nature of CBT as well as the potential roles they may play throughout treatment. As a result, parents may be empowered to participate in ways that are likely to maximize the effectiveness of CBT.

Development of the Manual

The development of this manual was based on an extensive literature review of biopsychosocial factors contributing to anxiety disorders as well as CB treatment for anxiety disorders. Primary treatment manuals in the area of CBT for child anxiety were also reviewed and provided the foundation of information for this manual. The purpose of using these manuals was to base the content of the parent manual on a review of what are widely recognized to be the “leading” CBT manuals that represent the current “state-of-the-art” treatment for child anxiety disorders. The manuals reviewed include: *Modular cognitive-behavioral therapy for childhood anxiety disorders* by Bruce Chorpita (2007), *Cognitive-behavioral therapy for anxious children: Therapist manual* by Philip Kendall and Kristina Hedtke (2006), and *Anxiety and phobic disorders: A pragmatic approach* by Wendy Silverman and William Kurtines (1996). Existing self-help books for parents were also reviewed to determine what is currently available to parents. This review helped to identify potential gaps in the existing literature that could be filled by this manual.

Goals

The primary goal of developing this manual was to create a resource that will increase parents’ knowledge of CBT treatment for child anxiety in order to increase the likelihood that parents will be able to participate in and contribute effectively to the

treatment. This goal was pursued by addressing a wide range of issues in the manual including, a) educating parents on the rationale, goals, format, and content of CBT treatment, b) informing parents about the opportunities for parental involvement in treatment and how they can help to generalize therapeutic gains to home and other settings, c) educating parents about the warning signs of lapse and relapse so that they are prepared to take appropriate action if needed, and d) providing parents with additional resources such as websites and books pertaining to child anxiety disorders and their treatment. While therapists are expected to be the primary source of the aforementioned information, this manual was also designed to be an adjunctive resource to facilitate and optimize parental knowledge about and involvement in treatment.

Strengths of the Current Manual

This manual provides a comprehensive resource for parents to use while their child is receiving CBT as well as a reference for use after treatment is over. While most other available resources for parents (e.g., self-help books) do not address CBT in enough detail for parents to know what their child is doing in treatment, this manual covers all the core components of CBT in detail and is sequenced to parallel the typical progression of therapy based on popular CBT treatment manuals. In learning this information, parents can gain a sense of what their child is doing in treatment and learn a common language to communicate with their child about anxiety and its treatment. By providing details about and samples of homework assignments from major manuals, parents are placed in a better position to understand the purpose and nature of these assignments and are thus better able to facilitate their completion. In addition, the manual provides parents with detailed descriptions on the roles they can play in treatment and tips on how to approach and

maximize their effectiveness in these roles. The provision of this knowledge is expected to increase the likelihood of effective assistance and decrease the likelihood of inadvertent interference with treatment (e.g., protecting their child from exposures).

There are also strengths related to the style and structure of this manual. Efforts were made to utilize parent-friendly, jargon-free language presented with an empathic tone. Clear examples were incorporated throughout in order to enhance parents' ability to comprehend content. As mentioned previously, the manual's structure parallels the typical sequence of CBT treatment. This structure increases the likelihood that parents will be able to easily follow along with the flow of their child's treatment. Additionally, each chapter is self-contained which allows the parent to read content out of sequence as needed to coincide with current components of their child's therapy or to review select content. Finally, across each chapter, a parallel format is followed (e.g., uniform headings) and footnotes are used instead of scientific citations in order to make the manual more user-friendly.

Limitations of the Current Manual

There are several limitations associated with the current manual. While attempts were made to make the manual limited in length, it is likely that the length may be too long for parents with busy lives and many responsibilities. Also, while efforts were made to remain current with developing knowledge in the field, the information included in the manual is limited to the information available at the time of the manual's development and does not include new developments and updated information. One way this is addressed is by providing referrals to additional resources including websites that can be more easily updated with new information.

This manual is designed to focus on anxiety disorders most commonly diagnosed in children. However, the manual may not be of great use to parents of children with other anxiety disorders (e.g., Obsessive Compulsive Disorder, Post Traumatic Stress Disorder). Furthermore, the manual does not account for all treatment modifications that may be made in order to meet the unique needs of each child. As a result, the manual may not translate to some unique cases or modifications that may be made by therapists.

Important Considerations not Addressed

Anxiety disorders are often associated with co-morbid disorders such as depression, externalizing disorders, and other anxiety disorders (Albano, et al., 1996; Verduin & Kendall, 2003). As a result of these co-morbid disorders, adjustments to treatment are often needed. Unfortunately, common co-morbidities and potential adjustments to treatment are not addressed in this manual. The manual also does not address the potential ways that parents can help children with treatment approaches that may be used to address these co-morbid disorders.

While this manual touches on roles that parents reading the manual can play in treatment, it does not address the role other important family members may play. Siblings can be important contributors to treatment in that they can serve as role models to the child involved in treatment. Specifically, siblings can model appropriate coping behaviors and other adaptive behaviors in anxiety-provoking situations. Siblings can also help with treatment by getting involved in homework assignments. For example, an anxious child could interview their older sister about a time when she was anxious and find out what she did to cope. Furthermore, siblings can be encouraged to provide support or encouragement to their sibling as he works on managing his anxiety. In addition to

siblings, the manual could address how the primary spouse reading the manual can help to educate and enlist the support and assistance of the other parent (where applicable). For example, the primary parent could educate her spouse on providing rewards, prompting the use of new skills, encouraging approach as opposed to avoidance, and learning when it is appropriate to provide praise and when it is not. In doing so, the entire family could further decrease inadvertent interference and further enhance their child's ability to benefit from treatment.

While attempts were made to address diversity, it is largely not addressed throughout the manual. This is in part due to the fact that diversity is a neglected area in the literature and source manuals used to inform the content of this parent manual. Fortunately, the core CBT principles and techniques covered in this manual are likely to apply across all clients, including those from diverse backgrounds (Chorpita, 2007). However, the nuances involved in how clinicians need to be sensitive to cultural context with respect to how principles and techniques are applied to and implemented with diverse clients are not addressed in this manual nor in the source manuals from which its content was derived.

There are aspects of the presentation of the manual that may not have been adequately addressed. Specifically, there are possible inconsistencies in the use of content boxes throughout the manual. Also, the visual presentation of the manual was largely not addressed. Specifically, the manual would likely benefit from the inclusion of illustrations, pictorials, or the use of color. Such inclusion of graphics would enhance the appearance of the manual and would make it more parent-friendly.

Potential Improvements to the Manual

There are a number of modifications that would likely improve the current manual. The length of the manual could be shortened by reorganizing content in order to reduce repetition (e.g., listing the common roles parents will play across treatment components in one location rather than in each chapter) or by using more succinct writing. Although adding information may contribute to the length of the manual, the inclusion of information not initially addressed may improve the quality of the manual. For example, the manual would benefit from addressing common co-morbidities associated with child anxiety disorders as well as the typical treatment approaches utilized to treat these disorders. Additionally, the manual could be improved by addressing diversity issues and cultural considerations. For instance, the manual could present a brief review of the existing knowledge about utilizing CBT with diverse groups followed by a discussion of possible adaptations that could be made to CBT for anxious children in order to meet the needs of various cultural groups. Finally, the formatting and presentation of the manual could be improved by increasing the consistency of the use of content boxes and by incorporating more graphics and a greater use of color.

Plans for Evaluation of the Current Manual

While a formal evaluation of this manual was beyond the scope of this project, future directions should include such an evaluation. The first step in the evaluation will begin by asking the authors of the treatment manuals used to develop this project to serve on an expert panel that will evaluate and provide feedback on the existing manual. A structured questionnaire will be developed and used to gather feedback in specific areas (e.g., content, format/presentation, accessibility, usefulness, strengths, limitations). This

feedback will then be incorporated into a revised manual. If these authors are not available to participate, this step will be omitted and the evaluation will begin with the next step. The second step will be to recruit a larger panel including experts in the field of CBT for child anxiety (including but not limited to clinical researchers who run academically-based child anxiety treatment clinics and those that publish in the field of CBT for child anxiety) as well as clinicians in community counseling centers and other treatment facilities that provide CBT for children with anxiety disorders. This panel will be asked to review the manual and provide feedback in the aforementioned specific areas. This feedback will then be incorporated into a revised manual.

Using the revised manual resulting from the review of expert panels, an empirical study will be conducted to determine if this manual enhances the treatment efficacy of CBT for child anxiety disorders. This study will utilize a between-group experimental design. The subject pool will be families with children (ages 8-13 years) who are receiving CBT treatment for Separation Anxiety Disorder, Generalized Anxiety Disorder, Specific Phobia, or Social Phobia. Clinics specializing in the treatment of childhood anxiety with CBT would be good recruitment sources or possible research partners for this endeavor. Once participants are recruited, parents in these families will be randomly assigned to either receive (experimental group) or not receive (control group) the revised manual to supplement their child's CBT treatment. Parents in the experimental group who receive the manual will be instructed to review it while their child is in treatment and to raise questions or comments with their child's therapist. After therapy is completed, treatment outcomes for participants will be compared. First, diagnostic recovery rates and the level of anxious symptoms will be evaluated. Common measures including the

Anxiety Disorders Interview Schedule for DSM-IV: Child and Parent Versions (ADIS for DSM-IV C/P; Albano & Silverman, 1996), the Revised Children's Manifest Anxiety Scale, Second Edition (RCMAS-2; Reynolds, & Richmond, 2008), and the Multidimensional Anxiety Scale of Children (MASC; March, 1997) will be utilized to collect these data. The data for each group will be compared to determine if a significantly greater decrease occurred in the group whose parents received the manual. In addition, specific questionnaires will be developed to evaluate parent's post-treatment understanding of anxiety disorders and of CBT, level of parent involvement in treatment, child homework compliance, and parent satisfaction with treatment in order to see if the manual had the intended effects. Next, the durability of any treatment gains will be evaluated. Specifically, follow-up data using the aforementioned measures will be collected to determine the durability of treatment gains at six months and, subsequently, at one year. Questionnaires measuring parents' continued understanding of anxiety disorders and CBT treatment will also be utilized at six months and one year. These outcomes will then be compared between groups. Based on the results of this study, revisions of the manual may be warranted.

Plans for Dissemination

Dissemination of this manual is premature at this time as it has not yet been evaluated. After the aforementioned evaluations and initial experimental study are completed with encouraging results and/or results leading to a revision of the manual, dissemination will then be considered. First, the results of the empirical study may be submitted to a journal that publishes studies related to the treatment of childhood anxiety. Publication of the manual in a form that can be disseminated to providers in the

community may also be considered. Finally, additional, more easily disseminated formats such as websites and mobile applications (“phone apps”) may be considered.

Conclusion

Parent involvement in the treatment of child anxiety disorders is an area that continues to need further attention. There is a need for more studies on how parent involvement in treatment can be utilized and enhanced to increase the likelihood that treatment outcomes are positive and maintained. Additional resources providing parents with information about specific effective approaches of treating child anxiety disorders are also needed. Providing parents with a resource that gives them specific information about the treatment of choice for child anxiety disorders may be a helpful way to enhance parents’ knowledge and increase their ability to contribute positively to treatment. This manual, although in the early stages of its development, shows potential for helping parents to facilitate the treatment of their child’s anxiety disorder.

References

- Albano, A.M., Chorpita, B.F., & Barlow, D.H. (1996). Child anxiety disorders. In Mash, E.J. & Barkley, R.A. *Child psychopathology* (pp. 196-241). New York, NY: Guilford Press.
- Albano, A.M., Chorpita, B.F., & Barlow, D.H. (2003). Child anxiety disorders. In Mash, E.J. & Barkley, R.A. (Eds.), *Child Psychopathology 2nd Edition* (pp.196-241). New York, NY: Guilford Press.
- Albano, A.M., Detweiler, M.F., & Logsdon-Conradsen, S. (1999). Cognitive-behavioral interventions with socially phobic children. In Russ, S.W. & Ollendick, T.H. (Eds.) *Handbook of psychotherapies with children and families* (pp. 255-280). New York, NY: Kluwer Academic/Plenum Publishers.
- Albano, A.M. & Kendall, P.C. (2002). Cognitive behavioral therapy for children and adolescents with anxiety disorders: Clinical research advances. *International Review of Psychiatry, 14*, 129-134. doi: 10.1080/09540260220132644.
- Albano, A.M. & Silverman, W.K. (1996). *Anxiety disorders interview schedule for DSM-IV child version: Clinical manual*. Oxford: Oxford University Press.
- American Academy of Child and Adolescent Psychiatry. (2007). Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(2), 267-283. doi: 10.1097/01.chi.0000246070.23695.06
- American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders 4th Edition*. Washington, DC: American Psychiatric Association.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders 4th Edition (text revision)*. Washington, DC: American Psychiatric Association.
- Barlow, D.H. (2000). Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory. *American Psychologist, 55*(11), 1247-1263. doi: 10.1037/0003-066X.55.11.1247
- Barlow, D.H. (2002.) *Anxiety and its disorders: The nature and treatment of anxiety and panic, 2nd edition*. New York, NY: Guilford Press.
- Barrett, P.M. (2004). *FRIENDS for life: Group leader's manual*. Brisbane, Australia: Australian Academic Press.

- Barrett, P.M., Dadds M.R., & Rapee, R.M. (1996). Family treatment of childhood anxiety: A controlled trial. *Journal of Consulting and Clinical Psychology, 64*(2), 333-342. doi: 10.1037/0022-006X.64.2.333
- Barrett, P.M., Duffy, A.L., Rapee, R.M., & Dadds, M.R. (2001). Cognitive-behavioral treatment of anxiety disorders in children: Long-term (6 year) follow-up. *Journal of Consulting and Clinical Psychology, 69*(1), 135-141. doi: 10.1037/0022-006X.69.1.135
- Barrett, P.M. & Ollendick, T.H. (2004). *Handbook of interventions that work with children and adolescents: Prevention and treatment*. New York, NY: John Wiley & Sons.
- Barrett, P.M., Rapee, R.M., Dadds, M.R., & Ryan, S.M. (1996). Family enhancement of cognitive style in anxious and aggressive children. *International Society of Research in Child and Adolescent Psychopathology, 24*(2), 187-203. doi: 10.1007/BF01441484
- Barrett, P.M. & Shortt, A.L. (2003). Parental involvement in the treatment of anxious children. In Kazdin, A.E. & Weisz, J.R. (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 101-119). New York, NY: Guilford Press.
- Bogels, S.M. & Brechman-Toussaint, M.L. (2006). Family issues in child anxiety: Attachment, family functioning, parental rearing and beliefs. *Clinical Psychology Review, 26*(7), 834-856. doi: 10.1016/j.cpr.2005.08.001
- Brady, E.U. & Kendall, P.C. (1992). Comorbidity of anxiety and depression in children and adolescents. *Psychological Bulletin, 111*(2), 244-255. doi: 10.1037/0033-2909.111.2.244
- Brown, A.M., Deacon, B.J., Abramowitz, J.S., Dammann, J., & Whiteside, S.P. (2007). Parents' perceptions of pharmacological and cognitive-behavioral treatments for childhood anxiety disorders. *Behavior Research and Therapy, 45*, 819-828. doi: 10.1016/j.brat.2006.04.010
- Cartwright-Hatton, S., McNicol, K., & Doubleday, E. (2006). Anxiety in a neglected population: Prevalence of anxiety disorders in pre-adolescent children. *Clinical Psychology Review, 26*(7), 817-833. doi: 10.1016/j.cpr.2005.12.002
- Cartwright-Hatton, S., Roberts, C., Chitsabesan, P., Fothergill, C. & Harrington, R. (2004). Systematic review of the efficacy of cognitive behavior therapies for childhood and adolescent anxiety disorders. *Journal of Clinical Psychology, 43*(4), 421-436. doi: 10.1348/0144665042388928

- Chansky, T.E. (2004) *Freeing your child from anxiety: Powerful, practical solutions to overcome your child's fears, worries and phobias*. New York, NY: Broadway Books.
- Chansky, T.E. & Kendall, P.C. (1997). Social expectancies and self-perceptions in anxiety-disordered children. *Journal of Anxiety Disorders, 11*(4), 347-363. doi: 10.1016/S0887-6185(97)00015-7
- Chiu, A.W., McLeod, B.D., Har K., & Wood, J.J. (2009). Child-therapist alliance and clinical outcomes in cognitive behavioral therapy for child anxiety disorders. *Journal of Child Psychology and Psychiatry, 50*(6), 751-758. doi: 10.1111/j.1469-7610.2008.01996.x
- Chorpita, B.F. (2007). *Modular cognitive-behavioral therapy for childhood anxiety disorders*. New York, NY: Guilford Press.
- Chorpita, B.F., Albano, A.M., & Barlow, D.H. (1996). Cognitive processing in children: Relation to anxiety and family influences. *Journal of Clinical Child Psychology, 25*(2), 170-176. doi: 10.1207/s15374424jccp2502_5
- Chorpita, B.F., Brown, T.A., & Barlow, D.H. (1998). Perceived control as a mediator of family environment in etiological models of childhood anxiety. *Behavior Therapy, 29*, 457-476. doi: 10.1016/S0005-7894(98)80043-9
- Chorpita, B.F. & Daleiden, E.L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials. *Journal of Consulting and Clinical Psychology, 77*(3), 566-579. doi: 10.1037/a0014565
- Chorpita, B.F. & Southam-Gerow, M.A. (2006). Fears and anxieties. In E.J. Mash and R.A. Barkley (Eds.), *Treatment of childhood disorders (3rd ed.)* (pp. 271-335). New York, NY: Guilford Press.
- Cobham, V.E., Dadds, M.R., & Spence, S.H. (1998). The role of parental anxiety in the treatment of childhood anxiety. *Journal of Consulting and Clinical Psychology, 66*(6), 893-905. doi: 10.1037/0022-006X.66.6.893
- Compton, S.N., Kratochvil, C.J., & March, J.S. (2007). Pharmacotherapy for anxiety disorders in children and adolescents: An evidence-based medicine review. *Pediatric Annals, 37*(7), 504-517.
- Cooper, P.J., Fearn, V., Willets, L., Seabrook, H., & Parkinson, M. (2006). Affective disorder in the parents of a clinic sample of children with anxiety disorder. *Journal of Affective Disorders, 93*, 205-212. doi: 10.1016/j.jad.2006.03.017

- Costello, E.J. & Angold, A. (1995). Epidemiology. In March, J.S. (Eds.), *Anxiety disorders in children and adolescents* (pp. 109-124). New York, NY: Guilford Press.
- Craske, M.G. (1999) *Anxiety disorders: Psychological approaches to theory and treatment*. Los Angeles, CA: Westview Press.
- Dempsey, I. & Dunst, C.J. (2004). Helpgiving styles and parent empowerment in families with a young child with a disability. *Journal of Intellectual & Developmental Disability, 29*(1), 40-51. doi: 10.1080/13668250410001662874
- Drake, K.L. & Kearney, C. (2008). Child anxiety sensitivity and family environment as mediators of the relationship between parent psychopathology, parent anxiety sensitivity, and child anxiety. *Journal of Psychopathology and Behavioral Assessment, 30*(2), 79-86. doi: 10.1007/s10862-007-9055-z
- Dumas, J.E. & LaFreniere, P.J. (1993). Mother-child relationships as sources of support or stress: A Comparison of competent, average, aggressive, and anxious dyads. *Child Development, 64*, 1732-1754. doi: 10.2307/1131466
- Eley, T.C., Bolton, D., O'Connor, T.G., Perrin, S., Smith, P. & Plomin, R. (2003). A twin study of anxiety-related behaviours in pre-school children. *Journal of Child Psychology and Psychiatry, 44*(7), 945-960. doi: 10.1111/1469-7610.00179
- Falk, D.E., Yi, H., & Hilton, M.E. (2008). Age of onset and temporal sequencing of lifetime DSM-IV alcohol use disorders relative to Comorbid mood and anxiety disorders. *Drug and Alcohol Dependence, 94* (1-3), 234-245. doi: 10.1016/j.drugalcdep.2007.11.022
- Flannery-Schroeder, E.C. & Kendall, P.C. (2000). Group and individual cognitive-behavioral treatments for youth with anxiety disorders: A randomized clinical trial. *Cognitive Therapy and Research, 24*(3), 251-278. doi: 10.1023/A:1005500219286
- Gar, N.S. & Hudson, J.L. (2008). An examination of the interactions between mothers and children and anxiety disorders. *Behaviour Research and Therapy, 46*(12), 126-1274. doi: 10.1016/j.brat.2008.08.006
- Gerlsma, C., Emmelkamp, P.M., & Arrindell, W.A. (1990). Anxiety, depression, and perception of early parenting: A meta-analysis. *Clinical Psychology Review, 10*(3), 251-277. doi: 10.1016/0272-7358(90)90062-F
- Ginsburg, G.S. & Kingery, J.N. (2007). Evidence-based practice for child anxiety disorders. *Journal of Contemporary Psychotherapy, 37*(3), 123-132. doi: 10.1007/s10879-007-9047-z

- Greaves-Lord, K., Ferdinand, R.F., Sondejker, F.E., Dietrich, A., Oldehinkel, A.J., Rosmalen, J.G., Ormel, J., & Verhulst, F.C. (2007). Testing the tripartite model in young adolescents: Is hyperarousal specific for anxiety and not depression? *Journal of Affective Disorders, 102* (1-3), 55-63. doi: 10.1016/j.jad.2006.12.009
- Grisel, J.E., Rasmussen, P.R. & Sperry, L. (2006). Anxiety and depression: Physiological and pharmacological considerations. *Journal of Individual Psychology, 62*(4), 397-416.
- Gullone, E. (2000). The development of normal fear: a century of research. *Clinical Psychology Review, 20*(4), 429-451. doi: 10.1016/S0272-7358(99)00034-3
- Hannesdottir, D.K. & Ollendick, T.H. (2007). The role of emotion regulation in the treatment of child anxiety disorders. *Clinical Child and Family Psychology Review, 10*(3), 275-293. doi: 10.1007/s10567-007-0024-6
- Hammerness, P., Harpold, T., Petty, C., Mendard, C., Zar-Kessler, C., & Biederman, J. (2008). Characterizing non-OCD anxiety disorders in psychiatrically referred children and adolescents. *Journal of Affective disorders, 105*(1-3), 213-219. doi: 10.1016/j.jad.2007.05.012
- Howard, B.L. & Kendall, P.C. (1996). Cognitive-behavioral family therapy for anxiety-disordered children: A multiple-baseline evaluation. *Cognitive Therapy and Research, 20*(5), 423-443. doi: 10.1007/BF02227906
- Hughes, A.A., Hedtke, K. A., & Kendall, P.C. (2008). Family functioning in family of children with anxiety disorders. *Journal of Family Psychology, 22*(2), 325-328. doi: 10.1037/0893-3200.22.2.325
- In-Albon, T. & Schneider, S. (2006). Psychotherapy of childhood anxiety disorders: A meta-analysis. *Psychotherapy and Psychosomatics, 76*, 15-24. doi: 10.1159/000096361
- Kase, L. & Ledley, D.R. (2007). *Anxiety disorders*. Hoboken, N.J.: John Wiley & Sons.
- Kashani, M.D., Vaidya, A.F., Soltys, S.M., Dandoy, M.A., Katz, L.M., & Reid, J.C. (1990). Correlates of anxiety in psychiatrically hospitalized children and their parents. *The American Journal of Psychiatry, 147*(3), 319-323.
- Kazdin, A.E. & Weisz, J.R. (2003). *Evidence-based psychotherapies for children and adolescents*. New York, NY: Guilford Press.
- Keeton, C. & Ginsburg, G.S. (2008). Combining and sequencing medication and cognitive-behavior therapy for childhood disorders. *International Review of Psychiatry, 20*(2), 159-164. doi: 10.1080/09540260801889047

- Kendall, P.C. (1994). Treating anxiety disorders in children: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 62(1), 100-110. doi: 10.1037/0022-006X.62.1.100
- Kendall, P.C., Aschenbrand, S.G., & Hudson, J.L. (2003). Child focused treatment for anxiety. In Kazdin, A.E. & Weisz, J.R. (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 81-100). New York, NY: Guilford Press.
- Kendall, P.C. & Beidas, R.S. (2007). Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity. *Professional Psychology: Research and Practice*, 38(1), 13-20. doi: 10.1037/0735-7028.38.1.13
- Kendall, P.C. & Choudhury, M.S. (2003). Children and adolescents in cognitive-behavioral therapy: Some past efforts and current advances, and the challenges in our future. *Cognitive Therapy and Research*, 27(1), 89-104. doi: 10.1023/A:1022542814822
- Kendall, P.C., Flannery-Schroeder, E., Panichelli-Mindel, S.M., Southam-Gerow, M., Henin, A., & Warman, M. (1997). Therapy for youths with anxiety disorders: A second randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 65(3), 366-380. doi: 10.1037/0022-006X.65.3.366
- Kendall, P.C., Furr, J.M., & Podell, J.L. (2010). Child-focused treatment of anxiety. In Kazdin, A.E., & Weisz, J.R. (Eds.), *Evidence-based psychotherapies for children and adolescents, 2nd edition* (pp. 45-60). New York, NY: Guilford Press.
- Kendall, P.C. & Hedtke, K.A. (2006). *Cognitive-behavioral therapy for anxious children: Therapist manual*. Ardmore, PA: Workbook Publishing.
- Kendall, P.C., Hudson, J.L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disorder youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology*, 76(2), 282-297. doi: 10.1037/0022-006X.76.2.282
- Kendall, P.C., Panichelli-Mindel, S.M., Sugarman, A., & Callahan, S.A. (1997). Exposure to child anxiety: Theory, research and practice. *Clinical Psychology: Science and Practice*, 4(1), 29-39. doi: 10.1111/j.1468-2850.1997.tb00096.x
- Kendall, P.C., Safford, S., Flannery-Schroeder, E., & Webb, A. (2004). Child anxiety treatment: Outcomes in adolescence and impact on substance use and depression at 7.4 year follow-up. *Journal of Consulting and Clinical Psychology*, 72(2), 276-287. doi: 10.1037/0022-006X.72.2.276

- Kendall, P.C. & Suveg, C. (2006). Treating anxiety disorders in youth. In Kendall, P.C. (Ed.), *Child and adolescent therapy* (pp. 243-294). New York, NY: The Guilford Press.
- Kendall, P.C. & Treadwell, K.R. (2007). The role of self-statements as a mediator in treatment for youth with anxiety disorders. *Journal of Consulting and Clinical Psychology, 75*(3), 380-389. doi: 10.1037/0022-006X.75.3.380
- King, N.J. & Ollendick, T.H. (1989). Children's anxiety and phobic disorders in school settings: Classification, assessment, and intervention issues. *Review of Educational Research, 59*(4), 431-470. doi: 10.2307/1170206
- Krain, A.L. & Kendall, P.C. (2000). The role of parental emotional distress in parent report of child anxiety. *Journal of Clinical Child Psychology, 29*(3), 328-335. doi: 10.1207/S15374424JCCP2903_4
- Last, C.G. (2006). *Help for worried kids: How your child can conquer anxiety and fear*. New York, NY: Guilford Press.
- Linares-Scott, T.J. & Feeny, N.C. (2006). Relapse prevention techniques in the treatment of childhood anxiety disorders: A case example. *Journal of Contemporary Psychotherapy, 36*, 151-157. doi: 10.1007/s10879-006-9019-8
- Lyneham, H.J. & Rapee, R.M. (2006). Evaluation of therapist-supported parent-implemented CBT for anxiety disorders in rural children. *Behaviour Research and Therapy, 44*, 1287-1300. doi: 10.1016/j.brat.2005.09.009
- Mahoney, G., Kaiser, A., Girolametto, L., MacDonald, J., Robinson, C., Safford, P., & Spiker, D. (1999). Parent education in early intervention: A call for a renewed focus. *Topics in Early Childhood Special Education, 19*(3), 131-140. doi: 10.1177/027112149901900301
- March, J.S. (1997). *Multidimensional anxiety scale for children*. San Antonio : Pearson Education, Inc.
- McClure, E.B., Brennan, P.A., Hammen, C., & Le Brocque, R.M. (2001). Parental anxiety disorders, child anxiety disorders, and the perceived parent-child relationship in an Australian high-risk sample. *Journal of Abnormal Child Psychology, 29*(1), 1-10. doi: 10.1023/A:1005260311313
- McLeod, B.D., Wood, J.J., & Weisz, J.R. (2007). Examining the association between parenting and childhood anxiety: A meta-analysis. *Clinical Psychology, 27*(8), 986-1003. doi: 10.1016/j.cpr.2006.09.002
- Monk, C.S., Nelson, E.E., McClure, E.B., Mogg, K., Bradley, B.P., Leibenluft, E., ...Pine, D.S. (2006). Ventrolateral prefrontal cortex activation and attentional

- bias in response to angry faces in adolescents with general anxiety disorder. *American Journal of Psychiatry*, 163, 1091-1097. doi: 10.1176/appi.ajp.163.6.1091
- Moore, P.S., Whaley, S.E., & Sigman, M. (2004). Interactions between mothers and children: Impacts of maternal and child anxiety. *Journal of Abnormal Psychology*, 113(3), 471-476. doi: 10.1037/0021-843X.113.3.471
- Morris, T.L. & March, J.S. (2004). *Anxiety disorders in children and adolescents*. New York, NY: Guilford Press.
- Nauta, M.H., Scholing, A., Emmelkamp, P.M.G., & Minderaa, R.B. (2003). Cognitive-behavioral therapy for children with anxiety disorders in a clinical setting: No additional effect of a cognitive parent training. *Journal of American Academy of Child and Adolescent Psychiatry*, 42(11), 1270-1278. doi: 10.1097/01.chi.0000085752.71002.93
- Pahl, K. M. & Barrett, P.M. (2010). Interventions for anxiety disorders in children using group cognitive-behavioral therapy with family involvement. In Kazdin, A.E. & Weisz, J.R. (Eds.), *Evidence-based psychotherapies for children and adolescents, 2nd edition* (pp. 61-79). New York, NY: Guilford Press.
- Pine, D.S., Cohen, P., Gurley, D., Brooke, J., & Ma, Y. (1998). The risk for early-adulthood anxiety and depressive disorders in adolescents with anxiety and depressive disorders. *Archives of General Psychiatry*, 55(1), 56-64. doi: 10.1001/archpsyc.55.1.56
- Puliafico, A.C. & Kendall, P.C. (2006). Threat-related attentional bias in anxiety-disordered youth: A review. *Clinical Child and Family Psychology Review*, 9(3-4), 162-180. doi: 10.1007/s10567-006-0009-x
- Rapee, R.M. (1997). Potential role of childrearing practices in the development of anxiety and depression. *Clinical Psychology Review*, 17(1), 47-67. doi: 10.1016/S0272-7358(96)00040-2
- Rapee, R.M., Abbott, M.J., & Lyneham, H.J. (2006). Bibliotherapy for children with anxiety disorders using written materials for parents: A Randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 74(3), 436-444. doi: 10.1037/0022-006X.74.3.436
- Rapee, R.M., Spence, S.H., Cobham, V., & Wignall, A. (2000). *Helping your anxious child: A step-by-step guide for parents*. Oakland, CA: New Harbinger Publications.

- Reinblatt, S.P. & Riddle, M.A. (2007). The pharmacological management of childhood anxiety disorders: A review. *Psychopharmacology*, *191*(1), 67-86. doi: 10.1007/s00213-006-0644-4
- Reynolds, C.R. & Richmond, B.O. (2007). *Revised children's manifest anxiety scale: Second edition*. Los Angeles: Western Psychological Services.
- Rosenberg, D.R., Banerjee, P., Ivey, J.L., & Lorch, E.R. (2003). Psychopharmacology of child and adolescent anxiety disorders. *Psychiatric Annals*, *33*(4), 273-278.
- Schieffelbein, V.L. & Susman, E.J. (2006). Cortisol levels and longitudinal cortisol change as predictors of anxiety in adolescents. *The Journal of Early Adolescents*, *26*(4), 397-413. doi: 10.1177/0272431606291943
- Shortt, A.L., Barrett, P.M., & Fox, T.L. (2001). Evaluating the FRIENDS program: A cognitive-behavioral group treatment for anxious children and their parents. *Journal of Clinical Child Psychology*, *30*(4), 525-535. doi:10.1207/S15374424JCCP3004_09
- Silva, R.R., Gallagher, R., & Minami, H. (2006). Cognitive-behavioral treatments for anxiety disorders in children and adolescents. *Primary Psychiatry*, *13*(5), 68-76.
- Silverman, W.K. & Kurtines, W.M. (1996). *Anxiety and phobic disorders: A pragmatic approach*. New York, NY: Plenum Press.
- Silverman, W.K., Kurtines, W.M., Ginsburg, G.S., Weems, C.F., Lumpkin, P.W., & Carmichael, D.H. (1999). Treating anxiety disorders in children with group-cognitive-behavioral therapy: A randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *67*(6), 995-1003. doi: 10.1037/0022-006X.67.6.995
- Silverman, W.K., Kurtines, W.M., Jaccard, J., & Pina, A.A. (2009). Directionality of change in youth anxiety treatment involving parents: An initial evaluation. *Journal of Consulting and Clinical Psychology*, *77*(3), 474-485. doi: 10.1037/a0015761
- Silverman, W.K., Pina, A.A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, *37*(1), 105-130. doi: 10.1080/15374410701817907
- Southam-Gerow, M.A. & Chorpita, B.F. (2007). Anxiety in children and adolescents. In Mash, E.J. & Barkley, R.A. *Assessment of childhood disorders (4th ed.)* (pp. 347-397). New York, NY: Guilford Press.

- Southam-Gerow, M.A. & Kendall, P.C. (2000). A preliminary study of the emotion understanding of youths referred for treatment of anxiety disorders. *Journal of Clinical Child Psychology, 29*(3), 319-327. doi: 10.1207/S15374424JCCP2903_3
- Spencer, S.H., Dupont, R.L., & Dupont, C.M. (2003). *Anxiety cure for kids: A guide for parents*. Hoboken, NJ: John Wiley & Sons, Inc.
- Suveg, C., Roblek, T.L., Robin, J., Krain, J., Aschenbrand, S., & Ginsburg, G.S. (2006). Parent involvement when conducting cognitive-behavioral therapy for children with anxiety disorders. *Journal of Cognitive Psychotherapy: An International Quarterly, 20*(3), 287-299. doi: 10.1891/jcop.20.3.287
- Suveg, C., Zeman, J., Flannery-Schroeder, E., & Cassano, M. (2005). Emotional socialization in families of children with an anxiety disorder. *Journal of Abnormal Child Psychology, 33*(2), 145-155. doi: 10.1007/s10802-005-1823-1
- Van Ingen, D.J. Freiheit, S.R., & Vye, C.S. (2009). From the lab to the clinic: Effectiveness of cognitive-behavioral treatments for anxiety disorders. *Professional Psychology: Research and Practice, 40*(1), 69-74. doi: 10.1037/a0013318
- Verduin, T.L. & Kendall, P.C. (2003). Differential occurrence of comorbidity within childhood anxiety disorders. *Journal of Clinical Child and Adolescent Psychology, 32*(2), 290-295. doi: 10.1207/S15374424JCCP3202_15
- Vos, T., Haby, M.M., Magnus, A., Mihalopoulos, C., Andrews, G., & Carter, R. (2005). Assessing cost-effectiveness in mental health: Helping policy makers prioritize and plan health services. *Australian and New Zealand Journal and Psychiatry, 39*(8), 701-712. doi: 10.1111/j.1440-1614.2005.01654.x
- Walkup, J., Albano, A.M., Piacentini, J., Birmaher, B., Compton, S.N., Sherrill, J.T.,...Kendall, P.C. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *The New England Journal of Medicine, 359*(26), 2753-2766. doi: 10.1056/NEJMoa0804633
- Weems, C.F., Zakem, A.H., Costa, N.M., Cannon, M.F., & Watts, S.E. (2005). Physiological response and childhood anxiety: Association with symptoms of anxiety disorders and cognitive bias. *Journal of Clinical Child and Adolescent Psychology, 34*(4), 712-723. doi: 10.1207/s15374424jccp3404_13
- Whaley, S.E., Pinto, A., & Sigman, M. (1999). Characterizing interactions between anxious mothers and their children. *Journal of Consulting and Clinical Psychology, 67*(6), 826-836. doi: 10.1037/0022-006X.67.6.826

- Wood, J.J. (2006). Effect of anxiety reduction on children's school performance and social adjustment. *Developmental Psychology, 42*(2), 345-349. doi: 10.1037/0012-1649.42.2.345
- Wood, J.J., Chiu, A.W., Hwang, W. Jacobs, J., & Ifekwunigwe, M. (2008). Adapting cognitive-behavioral therapy for Mexican American students with anxiety disorders: Recommendations for school psychologists. *School Psychology Quarterly, 23*(4), 515-532. doi: 10.1037/1045-3830.23.4.515
- Wood, J.J., McLeod, B.D., Sigman, M., Hwang, W., & Chu, B.C. (2003). Parenting and childhood anxiety: Theory, empirical findings, and future directions. *Journal of Child Psychology and Psychiatry, 44*(1), 134-151. doi: 10.1111/1469-7610.00106

APPENDIX A
Literature Review

Section A1. Empirical Literature

Author	Title/Year	Sample	Measures	Key Findings
Barrett, P.M., Dadds, M.R., & Rapee, R.M.	Family treatment of childhood anxiety: A controlled trial (1996)	N=79, age 7 to 14, 45 male and 34 female, no significant demographic differences, anxiety disorders-separation anxiety (SAD), overanxious disorder (OAD), social phobia (SoP)	Revised Children's Manifest Anxiety Scales (RCMAS), Fear Survey Schedule for Children-Revised (FSSC-R), The Children's Depression Inventory (CDI), The Child Behavior Checklist (CBCL), The Family Enhancement of Avoidant Responses (FEAR)	Found that CBT and CBT plus family involvement were more effective than wait list. Also found additional benefits of family involvement in CBT.
Barrett, P.M., Duffy, A.L., Dadds, M.R., & Rapee, R.M.	Cognitive-behavioral treatment of anxiety disorders in children: Long term (6 year) follow-up (2001)	N=52, children who completed treatment for a study 6 years ago (Barrett, Dadds & Rapee, 1996), ages 13 to 21, 28 male and 24 female, anxiety disorders (OAD, SAD, SoP)	Anxiety Interview Disorder Schedule for Children (ADIS-C), Revised Children's Manifest Anxiety Scale (RCMAS), Fear Survey Schedule for Children-Revised (FSSC-R), Children's Depression Inventory (CDI), Child Behavior	Found that 85.7%of participants no longer fit criteria for anxiety disorder. Gains made at 12 months were maintained. CBT and CBT plus family involvement were equally effective in long-term follow up.

Author	Title/Year	Sample	Measures	Key Findings
			Checklist (CBCL)	
Barrett, P.M., Rapee, R.M., Dadds, M.M., & Ryan, S.M.	Family enhancement of cognitive style in anxious and aggressive children (1996)	N= 199, ages 7 to 14, 107 boys and 92 girls, children with anxiety, oppositional behavior and a nonclinical sample, demographics not discussed	ADIS-C and ADIS-P (Anxiety Disorders Interview Schedule for Children and Parent-version), The Child Behavior Checklist (CBCL)	Found that anxious children tend to interpret ambiguous situations as more threatening than nonclinical and oppositional children; they used more avoidant behavior, and their avoidance level was higher following family discussions.
Brown, A.M., Deacon, B.J., Abramowitz, J.S., Dammann, J., & Whiteside, S.P.	Parents' perceptions of pharmacological and cognitive-behavioral treatments for childhood anxiety disorders (2007)	N=71, age 5 to 18, 39.4% female, parents of children with anxiety disorders- Obsessive Compulsive Disorder (OCD), Generalized Anxiety Disorder (GAD), SAD, SoP, Specific	Anxiety Disorders Interview Schedule for DSM-IV-Child Version (ADIS-C), Treatment Perceptions Questionnaire-Parent Version (TPQ-P), Spence Children's Anxiety Scale	Found that both medication and CBT were perceived as acceptable and effective but CBT was more so (regardless of severity, medication was more favorable for older children; more interference in lives meant

Author	Title/Year	Sample	Measures	Key Findings
		Phobia, Panic, Anxiety NOS, 94.1% Caucasian	for Parents (SCAS-P), Modified Sheehan Disability Scale (mSDS)	more likely to endorse meds).
Chansky, T.E. & Kendall, P.C.	Social expectancies and self-perceptions in anxiety-disordered children (1997)	N=78, age 9 to 15, 45 boys, anxiety disorders (OAD, avoidant, SAD), anxious group- White (37), control group- White (19)	Anxiety Disorder Interview Schedule (ADIS), Child Behavior Checklist (CBCL), Social Anxiety Scale-Revised (SASC-R), Self-Perception Profile, Social Expectancies Questionnaire (SEQ), Negative Affectivity Self-Statements Questionnaire (NASSQ), State-Trait Anxiety Inventory for Children (STAIC), Thought-Listing, Child Sociability Scales (CSS)-Parent and Teacher	Found that anxious children report more negative social expectations, lower social self-competence, and higher levels of social anxiety than those without anxiety. Both parents and teachers rated anxious children as more socially maladjusted. Found social anxiety to be the best predictor of social expectancies.

Author	Title/Year	Sample	Measures	Key Findings
Chiu, A.W., McLeod, B.D., Har, K., & Wood, J.J.	Child-therapist alliance and clinical outcomes in cognitive behavioral therapy for child anxiety disorders (2009)	N=34, ages 6- 13 years, 24 male and 10 female, anxiety disorders (SAD, SoP, GAD), 62% Caucasian, 5.9% Latino, 2.9% Asian/Pacific Islander, 2.9% African American, 26.5% mixed	The Therapy Process Observational Coding System for Child Psychotherapy- Alliance Scale (TPOCS-A)	Found a strong child-therapist alliance early in treatment predicts increased symptom reduction. Also, the improvement of the therapeutic alliance throughout treatment predicts better outcomes post- treatment.
Chorpita, B.F., Albano, A.M., & Barlow, D.H.	Cognitive processing in children: Relation to anxiety and family influences (1996)	N=12, ages 9 to 13, 7 girls, anxiety disorders (OCD, SAD, SoP, Panic Disorder with Agoraphobia), demographics not discussed	Anxiety Disorders Interview Schedule for DSM-IV, Child and Parent Versions (ADIS-IV- C/P), State- Trait Anxiety Inventory for Children (STAIC), Ambiguous Situations Questionnaire (ASQ)	Found that there is a high correlation between trait anxiety and anxious responses. Also found that parents tend to influence the responses (related to parent anxiety). In addition, anxious children tend to respond to threatening experiences in avoidant ways.

Author	Title/Year	Sample	Measures	Key Findings
Chorpita, B.F., Brown, T.A., & Barlow, D.H.	Perceived control as a mediator of family environment in etiological models of childhood anxiety (1998)	N=93, age 6 to 15, 46 boys and 47 girls, anxiety disorder- Agoraphobia, GAD, OCD, Post Traumatic Stress Disorder (PTSD), SAD, SoP, Specific Phobia, Anxiety NOS, 94.6% Caucasian, 2.2% African American, 1.1% Hispanic, 2.2% Chinese American	Anxiety Disorders Interview Schedule for DSM-IV, Child and Parent Versions (ADIS-IV-C/P), Nowicki-Strickland Locus of Control Scale (NSLOC), Revised Children's Manifest Anxiety Scale (RCMAS), Children's Depression Inventory (CDI), Child Behavior Checklist (CBCL), Children's Attribution Style Questionnaire (CASQ), Family Environment Scale (FES), Clinical Severity Ratings	Presented a mediational model for the interactions of various factors. Found that family environment characterized by limited opportunity for personal control is associated with anxiety and negative affect.

Author	Title/Year	Sample	Measures	Key Findings
Chu, B.C. & Kendall, P.C.	Positive association of child involvement and treatment outcome with a manual-based cognitive-behavioral treatment for children with anxiety (2004)	N=63, ages 8 to 14, 37 boys and 26 girls, anxiety disorders (GAD, SAD, SoP), 79.4% Caucasian, 4.8% Latino, 3.2% Asian, 4.8% other	The Anxiety Disorders Interview Schedule for Children-Parent/Child Versions (ADIS-C/P), The Child Involvement Rating Scale (CIRS)	Found that children who are treated with a manualized CBT treatment have more positive treatment outcomes if they are more involved in treatment. The indicator tends to be high involvement at mid-treatment but not early in treatment.
Chu, B.C. & Kendall, P.C.	Therapist responsiveness to child engagement: Flexibility within manual-based CBT for anxious youth (2009)	N=63, age 8 to 14, 58.7% boys, anxiety disorders (GAD, SoP, SAD Specific Phobia), 79.4% Caucasian, 7.9% African American, 4.8% Latino, 3.2% Asian, 4.3% other	The Anxiety Disorders Interview Schedule for Children-Parent/Child Versions (ADIS-P/C), The Child Involvement Rating Scale (CIRS), Coping Cat Adherence Checklist-Flexibility Scale (CCPAC-F), Therapist Flexibility Questionnaire-Revised: Frequency and Overall Rating Scale (TFQ-R)	Found that therapist flexibility is associated with increased child involvement later in treatment, which also predicted improvement post-treatment.

Author	Title/Year	Sample	Measures	Key Findings
Cobham, V.E., Dadds, M.R., & Spence, S.H.	The role of parental anxiety in the treatment of childhood anxiety (1998)	N=67, age 7 to 14, 34 boys and 33 girls, children with anxiety disorders (SAD, OAD, GAD, SoP, simple phobia, agoraphobia) parents with and without anxiety disorders, all Australian	Anxiety Disorders Interview Schedule for Children and Parent-version (ADIS-C/P), Revised Children's Manifest Anxiety Scale (RCMAS), State-Trait Anxiety Inventory for Children (STAIC), adult version of the STAI, Child Behavior Checklist-Revised (CBCL)	In the child anxiety-only condition, 82% of children no longer met criteria for anxiety while 80% of CBT plus family involvement no longer met criteria. However, in the child and parent anxiety condition- 39% in CBT condition no longer met criteria while 77% in CBT plus family involvement no longer met criteria.
Compton, S.N., McKnight, C.D., & March, J.S.	Combining medication and psychosocial treatments: An evidence based medicine approach (2007)	Review, randomized control trials between 1997-2207 related to anxiety disorders and medication.	N/A	This review found that SSRIs are effective treatments for anxiety disorders in youth and supports the use of a combination of CBT and medication.

Author	Title/Year	Sample	Measures	Key Findings
Cooper, P.J., Fearn, V., Willetts, L., Seabrook, H., & Parkinson, M.	Affective disorder in the parents of a clinic sample of children with anxiety disorder (2006)	N=130, age 6 to 16, no specification of gender, 80% Caucasian in control, 96% Caucasian in anxiety group	Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV) and SCID	Found higher rates of anxiety in parents of children with anxiety disorders. For mothers, this was true for current and lifetime rates. For fathers, lifetime social phobia was the only one with a higher rate. Overall, parents with children with anxiety disorders had higher rates of both parents with anxiety disorders than the control.
Costello, E.J., Mustillo, S., Erkanili, A., Keeler, G., & Angold, A.	Prevalence and development of psychiatric disorders in childhood and adolescence (2003)	N=1420 randomly selected from 20,000 children, ages 9 to 13, no specification of gender, from 11 counties in western North Carolina, 8% African American, <1% Latino, 3% American Indians, the rest Caucasian	The Child and Adolescent Psychiatric Assessment (CAPA)	At least 1 in 6 children will have a psychiatric disorder at any time and 1 in 3 will have one by the age of 16. Anxiety disorders have a high comorbidity rate with depression in either direction. Anxiety disorders in girls are linked with later substance use

Author	Title/Year	Sample	Measures	Key Findings
				disorders.
Dempsey, I. & Dunst, C.J.	Helpgiving styles and parent empowerment in families with a young child with a disability (2004)	Survey, N=141, preschool-aged children with disabilities in USA (67) and Australia (55), no specification of gender	Enabling Practices Scale (EPS), Family Empowerment Scale (FES)	Found that help-giving styles are crucially associated with empowerment in both groups.
Drake, K.L. & Kearney, C.A.	Child anxiety sensitivity and family environment as mediators of the relationship between parent psychopathology, parent anxiety sensitivity, and child anxiety (2008)	N=157, anxious youth and their parents, ages 7-18, 59.1% female, 76.7% European American, 8/7% Hispanic American, 5.3% African American, 1.3% Native American	Child Anxiety Sensitivity Index (CSI), Multidimensional Anxiety Scale for Children (MASC), Anxiety Sensitivity Index (ASI), Symptom Checklist-90-Revised (SCL-90-R), Family Environment Scale (FES)	Found that child anxiety sensitivity mediated the relationship between parent psychopathology and child anxiety. Also, family conflict and control mediate the relationship between parent psychopathology and child anxiety as well as between parent anxiety sensitivity and child anxiety.

Author	Title/Year	Sample	Measures	Key Findings
Dumas, J.E. & La Freniere, P.J.	Mother-child relationships as sources of support or stress: A comparison of competent, average, aggressive and anxious dyads (1993)	N=12 (30 of each group-competent, average and aggressive anxious dyads), girls mean age is 49.9 months and boys mean age is 48.8 months, 48 boys and 72 girls, mainly French-Canadian background	Child Behavior Checklist-Teacher Report Form (TRF), observations	Found that competent dyads had the best functioning and anxious and aggressive dyads had the most aversive functioning. With their own mothers, children performed like competent and average children but with unfamiliar moms, anxious and aggressive children were ignored or were ambivalent; mothers of anxious children had the most aversive behavior and affect, and had a consistent pattern of negative reciprocity. Those moms behaved differently with unfamiliar children. The pattern of anxious mother-child dyads is marked by intrusive

Author	Title/Year	Sample	Measures	Key Findings
				control, conflict, and aversive affect, which interfere with task completion.
Eley, T.C., Bolton, D., O'Connor, T.G., Perrin, S., Smith, P., & Plomin, R.	A twin study of anxiety-related behaviours in pre-school children (2003)	N= 4,564 twin pairs (723 monozygotic male, 769 dizygotic male, 818 monozygotic female, 760 dizygotic female, 1494 opposite sex dizygotic), age 18 months to 4 years, anxiety disorders (SAD, OCD, OAD, GAD)	16-item questionnaire on anxiety related behaviors in young children	Found phenotypic and genetic overlap and differentiation of patterns in anxiety-related behaviors in pre-school children.

Author	Title/Year	Sample	Measures	Key Findings
Falk, D.E. Yi, H. & Hilton, M.E.	Age of onset and temporal sequencing of lifetime DSM-IV alcohol use disorders relative to comorbid mood and anxiety disorders (2008)	N=19205, age 18 years and older, gender not specified, anxiety disorders (panic without agoraphobia and with agoraphobia, specific phobia, SoP, GAD) also mood disorders (major depression, dysthymia, mania, and hypomania), oversampled blacks, hispanics and young adults (18-24 to balance these groups in the population)	NIAA Alcohol Use Disorders and Associated Disabilities Interview Schedule (DSM-IV Version (AUDADIS-IV), Self-reports	Phobias have earliest onset, anxiety and mood disorders have latest, and alcohol use and dependence (AUD) is in between; phobia is more likely to occur before alcohol abuse but GAD tends to occur after AUDS. AUD tends to come before five of the nine MADS (mood and anxiety disorders) indicating AUD may cause or lead to MAD. Two MADS come before AUD (specific and social) Regardless of direction, the lag time tends to be long (7-16 years). Few gender differences were found.

Author	Title/Year	Sample	Measures	Key Findings
Flannery-Schroeder, E.C. & Kendall, P.C.	Group and individual cognitive-behavioral treatments for youth with anxiety disorders: A randomized clinical trial (2000)	N=37, age 8 to 14, 46% boys, anxiety disorders (GAD, SAD, SoP), 8% minorities,	Revised Children's Manifest Anxiety Scale (RCMAS), The State-Trait Anxiety Inventory for Children (STAIC), The Coping Questionnaire-Child (CQ-C), The Social Anxiety Scale for Children-Revised (SASC-R), The Children's Depression Inventory (CDI), Harter's Self Perception Profile for Children (SPPC), Loneliness Scale (LS), The Friendship Measure-Child (FM-C), The Recall of Content Questionnaire (RCQ), Child's Perception of Therapeutic Relationship (CPTTR), Group Satisfaction Questionnaire (GSQ), The Child Behavior Checklist (CBCL), The	Found that significantly more individuals in the treatment conditions were without a diagnosis than the wait-list condition on many of the measures (73% individual, 50% group). A measure of child distress showed improvement only for those in individual treatment. There was no difference on measures of social functioning. Treatment gains were maintained three months following treatment.

Author	Title/Year	Sample	Measures	Key Findings
			State-Trait Anxiety Inventory for Children-Parent version (STAIC-P), The Coping Questionnaire Parent (CQ-P), The Parent's Rating Scale of Child's Competence (PRSC), The Social Activities Scale-Parent (SAS-P), The Friendship Measure-Parent (FM-P), Teacher Report Form (TRF), Anxiety Disorder Interview Schedule (ADIS-IV-C/P)	
Gar, N.S. & Hudson, J.L.	An examination of the interactions between mothers and children with anxiety disorders (2008)	N=135 dyads, age 4 to 16 years, no specification of gender, anxious children and their mothers (GAD, SoP, SAD, Specific Phobia, Anxiety NOS, OCD, PTSD, panic with and without agoraphobia)	Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV), Spence Children's Anxiety Scale-Child and Parent Report (SCAS-P, SCAS), Depression Anxiety Stress Scales (DASS)	Found that mothers of anxious children are more over-involved with their children regardless of parents' own anxiety when compared to mothers of non-anxious children. They were also found to be more

Author	Title/Year	Sample	Measures	Key Findings
				overprotective, self-sacrificing, nonobjective and critical.
Gerlsma, C., Emmelkamp, P.M.G., & Arrindell, W.A.	Anxiety, depression, and perception of early parenting: A meta-analysis (1990)	meta-analysis, parents of depressed and anxious children, discusses adaptation to different cultures	The Childrens' Reports of Parental Behavior Inventory (CRPBI), Egna Minnen Beträffand Uppfostran (EMBU), The Parental Bonding Instrument (PBI)	Found that phobic disorders are related to less affection and more control while associations with depressed kids are less clear.
Greaves-Lord, K., Ferdinand, R.F., Sondejker, F.E., Dietrich, A., Oldehinkel, A.J., Rosmalen, J.G., Ormel, J., & Verhulst, F.C.	Testing the tripartite model in young adolescents: Is hyperarousal specific for anxiety and not depression? (2007)	N=1027, 10-13 years old, young adolescents with anxiety and depression, 53% female, no specification of diversity	The Child Behavior Checklist (CBCL), Revised Child Anxiety and Depression Scale (RCADS)	Hyperarousal was found to be a component of anxiety as well as depression.

Author	Title/Year	Sample	Measures	Key Findings
Hammerness, P., Harpold, T., Petty, C., Mendard, C., Zar-Kessler, C., & Biederman, J.	Characterizing non-OCD anxiety disorders in psychiatrically referred children and adolescents (2008)	N=1375, 794 anxious 581 disruptive, mean age 10.7, 547 anxious boys and 454 nonanxious boys, anxiety disorders (non-OCD) compared to non-anxious disruptive, addresses SES only	Interviews of parents and children, Schedule for Affective Disorders and Schizophrenia for School-Age Children-Epidemiologic Version (K-SADS-E)	50% had at least one anxiety disorder and were highly comorbid with mood disorders and pervasive developmental disorders; also tends to be comorbid with other anxiety disorders. Found that anxiety is associated with social and academic impairment. Anxious children had more impaired GAFs than disruptive children.
Howard, B.L. & Kendall, P.C.	Cognitive-behavioral family therapy for anxiety-disordered children: A multiple-baseline evaluation (1996)	N=6, ages 9-13 years, 5 male and one female, anxiety disorders (OAD,SAD), diversity not discussed	Anxiety Disorders Interview Schedule for Children (ADIS-C), Fear Survey Schedule for Children-Revised (FSSC-R), Revised Children's Manifest Anxiety Scale (RCMAS), Coping Questionnaire-Child (CQ-C),	Found that CBT family treatment is effective in reducing symptoms of anxiety and is maintained at 4 months.

Author	Title/Year	Sample	Measures	Key Findings
			The State-Trait Anxiety Inventory for Children (STAIC), Children's Depression Inventory (CDI), Child Behavior Checklist-Parent Form (CBCL), Coping Questionnaire-Parent (CQ-P), State-Trait Anxiety Inventory for Children-Modification for Parents (A-Trait-P), Self-Report Family Inventory (SFI), O'Leary-Porter Scale (OPS), Child Behavior Checklist-Teacher Report Form (TRF)	

Author	Title/Year	Sample	Measures	Key Findings
Hughes, A. A., Hedtke K.A., & Kendall, P.C.	Family functioning in family of children with anxiety disorders (2008)	N=230, mean age 10.3, 53% boys and 47% girls, anxiety disorders (SAD, SoP, GAD, Specific phobia, OCD), 86% Caucasian, 14% other	Family Assessment Device (FAD), Revised Children's Manifest Anxiety Scale (RCMAS), State-Trait Anxiety Inventory-Trait (STAI-T), The Children's Depression Inventory (CDI), Beck Depression Inventory-II (BDI-II), The Children's Global Assessment Scale (CGAS)	Found that maternal and paternal anxiety and depression predicted worse family functioning, which is associated with worse child outcomes on the basis of child, parent, and clinical measures. Child anxiety and depression was associated with family functioning but not when parental anxiety and depression was taken into account.
Kashani, M.D., Vaidya, A.F., Soltys, S.M., Dandoy, M.A., Katz, L.M., & Reid, J.C.	Correlates of anxiety in psychiatrically hospitalized children and their parents (1990)	N=100, age 7 to12, 73 boys and 27 girls, children admitted to an inpatient child psychiatry service (SAD, Phobia, OAD), 91 Caucasian, 9 African American	Diagnostic Interview for Children and Adolescents, Diagnostic Interview for Children and Adolescents-Parents Version, Revised Children's Manifest Anxiety Scale, Life Events Checklist, Piers-Harris Children's Self-	Found a significant relationship between child anxiety and parent's anxiety. Also, parents of anxious children report difficulties with family relations.

Author	Title/Year	Sample	Measures	Key Findings
			Concept Scale	
Kendall, P.C.	Treating anxiety disorders in children: Results of a randomized clinical trial (1994)	N=47, age 9 to 13, 52% boys and 48% girls, anxiety disorders (OAD, SAD, Avoidant), 78% White, 22% African American	Revised Children's Manifest Anxiety Scale (RCMAS), The State-Trait Anxiety Inventory for Children (STAIC), Fear Survey Schedule for Children-Revised (FSSC-R), Children's Depression Inventory (CDI), Coping Questionnaire-Child (CO-C), The Children's Negative Affectivity Self-Statement Questionnaire (NASSQ), Child Behavior Checklist (CBCL), State-Trait Anxiety Inventory for Children-Modification of Trait Version for Parents (STAIC-A-Trait-P), Child	Found that, following CBT treatment 60% of participants no longer met criteria for an anxiety disorder. This was maintained at the one-year follow-up.

Author	Title/Year	Sample	Measures	Key Findings
			Behavior-Teacher Report Form, The Child's Perception of Therapeutic Relationship (CPTR)	
Kendall, P.C., Flannery-Schroeder, E., Panichelli-Mindel, S.M., Southam-Gerow, M., Henin, A., & Warman, M.	Therapy for youths with anxiety disorders: A second randomized clinical trial (1997)	N=94, age 9 to 13, 58% boys, anxiety disorders (OAD, SAD, AD), 87% Caucasian	The Anxiety Disorder Interview Schedule, Child and Parent versions (ADIS-C/P), Revised Children's Manifest Anxiety Scales (RCMAS), The State-Trait Anxiety Inventory for Children (STAIC), Fear Survey Schedule for Children-Revised (FSSC-R), Children's Depression Inventory (CDI), Coping Questionnaire-Child version (CQ-C), Children's	Found that those who received CBT treatment for anxiety improved significantly more than those on the waitlist. 53% no longer met criteria for their primary diagnosis. These gains were maintained at the one-year follow up. Age and comorbidity did not affect outcome.

Author	Title/Year	Sample	Measures	Key Findings
			Negative Affectivity Self-Statement Questionnaire (NASSQ), Child Behavior Checklist (CBCL), STAIC-Modification of Trait version for parents (STAIC-A-Trait-P), Coping Questionnaire-Parent version (CQ-P), The State-Trait Anxiety Inventory, Beck Depression Inventory (BDI), The CBCL-Teacher Report Form (TRF), Behavioral Observations, Child's Perception of Therapeutic Relationship (CPTR), Parental Involvement Ratings (PIRs)	

Author	Title/Year	Sample	Measures	Key Findings
Kendall, P.C., Hudson, J.L., Gosch, E., Flannery-Schroeder, E., & Suveg, C.	Cognitive-behavioral therapy for anxiety disorders youth: A randomized clinical trial evaluating child and family modalities (2008)	N=161, age 7 to 14, 44% female, anxiety disorders (SAD, SoP, GAD) 85% Caucasian, 9% African American, 3% Hispanic, 3% other/mixed	Anxiety Disorders Interview Schedule for Children (ADIS-C/P), Multidimensional Anxiety Scale for Children (MASC), Coping Questionnaire-Child (CQ-C), Child Behavior Checklist (CBCL), Teacher Report Form (TRF), Coping Questionnaire-Parent (CQ-P), Anxiety Disorder Interview Schedule for DSM-IV Lifetime Version (ADIS-IV-L), Child's Perception of Therapeutic Relationship (CPTR)	Family CBT and Individual CBT were better than family-based educational/support/attention (FESA) in reducing the presence and principalty of the principle anxiety disorder, Individual CBT outperformed Family CBT and FESA and teacher reports. Family CBT outperformed Individual CBT when both parents had an anxiety disorder.

Author	Title/Year	Sample	Measures	Key Findings
Kendall, P.C., Safford, S., Flannery-Schroeder, E., & Webb, A.	Child anxiety treatment: Outcomes in adolescence and impact on substance use and depressions at 7.4 year follow up (2004)	N=86 (91% of original sample), age 15 to 22, 385 female in original sample, anxiety (GAD, SoP, SAD), 86% Caucasian, 6% African American, 25% Latino, 2% Asian, 4% Biracial	Anxiety Disorder Interview Schedule for DSM-IV, Child Version and Parent Version (ADIS-C/P), Anxiety Disorders Interview Schedule for DSM-IV, Lifetime (ADIS-IV-L), Comprehensive Adolescent Severity Inventory (CASI), Revised Children's Manifest Anxiety Scale (RCMAS), Children's Depression Inventory (CDI), Coping Questionnaire-Child (CQ-C), Adolescent Perceived Events Scale (APES), Child Behavior Checklist (CBCL), Coping Questionnaire-Parent (CQ-P), State-Trait Anxiety Inventory for Child (STAIC)	Most of those treated 7.4 years ago maintained their gains and also shows beneficial effects on sequelae (reduced involvement in and difficulty with things related to substance use) but did not seem to have an effect on later development of mood disorders (although those who didn't recover were more likely to have an episode of depression after leaving the treatment center).

Author	Title/Year	Sample	Measures	Key Findings
Krain, A.L. & Kendall, P.C.	The role of parental emotional distress in parent report of child anxiety (2000)	N=239, age 7.5 to 15, 57.9% males, anxiety disorders (OAD/GAD, SAD, avoidant/SoP, OCD, simple, Panic, agoraphobia, PTSD), 86.25% Caucasian	Parents-State-Trait Anxiety Inventory for Children-Modification of Trait Version for Parents (STAIC-A-TRAIT-P) , Beck's Depression Inventory (BDI), State-Trait Anxiety Inventory for Children-Parent Version, Measures-Children-State-Trait Anxiety Inventory	Found that mothers and fathers report more anxiety in their children than the children do themselves. Also found that there was no relationship between parent anxiety and report of child anxiety but there was a relationship of parent emotional distress and child anxiety for girls only. Parent report of child anxiety was more correlated with self-report of younger kids.
Linares-Scott, T.J. & Feeny, N.C.	Relapse prevention techniques in the treatment of childhood anxiety disorders: A case example (2006)	case study, N=1, age 9, female, anxiety disorder, SAD and AD/OS, ethnicity not specified	N/A	Found that the Coping Cat model is effective in treating a child with anxiety disorder NOS and SAD. Found relapse prevention techniques to be helpful at termination and one year follow up.

Author	Title/Year	Sample	Measures	Key Findings
Lyneham, H.J. & Rapee, R.M.	Evaluation of therapist-support parent-implemented CBT for anxiety disorders in rural children (2006)	N=100, age 6 to 12, 51% male, children with all forms of anxiety disorders, 90% Caucasian, rural and remote communities	Anxiety Disorders Interview Schedule for Children for DSM-IV (ADIS-C-IV), Spence Children's Anxiety Scale (SCAS), Revised Children's Manifest Anxiety Scale (RCMAS), Children's Depression Inventory (CDI), Children's Automatic Thoughts Scale (CATS), Child Behavior Checklist (CBCL), Parenting Stress-Index-Short-Form (PSI), Depression Anxiety Stress Scale-Short Version (DASS)	Found that bibliotherapy of any form produces superior outcomes to no treatment and that supplementing bibliotherapy with therapist-client contact is an effective way of treating anxiety disorders in primary school children. Using scheduled telephone sessions produces the best outcomes.

Author	Title/Year	Sample	Measures	Key Findings
McClure, E.B., Brennan, P.A., Hammen, C., & Le Brocque, R.M.	Parental anxiety disorders, child anxiety disorders, and the perceived parent-child relationship in an Australian high-risk sample (2001)	N=816, age 15, 50.7% male, anxious children and their parents (anxiety disorders, depression, combination), Australian	Structured Clinical Interview for DSM-IV (SCID), Children's Report of Parental Behavior Inventory (CRPBI), Beck Depression Inventory (BDI), Schedule for Affective Disorders and Schizophrenia in School-Aged Children (K-SADS-E)	Found that maternal anxiety disorders predicted anxiety disorders in children but this was not true for fathers. No evidence was found for perceived parenting in the association between mother and child anxiety disorders.
Monk, C.S., Nelson, E.E., McClure, E.B., Mogg, K., Bradley, B.P., Leibenluft, E., ...Pine, D.S.	Ventrolateral prefrontal cortex activation and attentional bias in response to angry faces in adolescents with general anxiety disorder (2006)	N= 33, age 9 to 17, 17 boys, anxiety disorder- GAD, ethnicity not specified	N/A	Found that anxious adolescents with GAD show greater right ventrolateral prefrontal cortex activation and attentional bias away from any faces (compared to healthy adolescents).

Author	Title/Year	Sample	Measures	Key Findings
Moore, P.S., Whaley, S.E., & Sigman, M.	Interactions between mothers and children: Impacts of maternal and child anxiety (2004)	N=68 (in 4 sets of dyads), age 7 to 15, 35 boys and 33 girls, children and parents with and without anxiety disorders, majority Caucasian (79%)	The Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS), Anxiety Disorders Interview Schedule for Children and Parents (ADIS-IV C/P)	Found that anxious and nonanxious mothers with anxious children are less warm toward child and grant them less autonomy. Anxious mothers and nonanxious mothers of anxious children were likely to catastrophize; anxious moms are more likely to expect negative outcomes and express it to their child and nonanxious mothers also were likely to predict disasters.
Nauta, M.H., Scholing, A., Emmelkamp, P.M.G., & Minderaa, R.B.	Cognitive-behavioral therapy for children with anxiety disorders in a clinical setting: No additional effect of cognitive parent training (2003)	N=79, age 7 to 18, 39 boys and 40 girls, anxiety disorders (SAD, SoP, GAD, Panic with and without agoraphobia), all white	The Anxiety Disorder Interview Schedule Child and Parent versions (ADIS-C/P), The Child Behavior Checklist (CBCL), The Spence Child Anxiety Scale-parent version (SCAS-p), The	Found that CBT treatment was better than waitlist and that there were no additional benefits of adding parent training; possible reasons are given including the fact that a lot of info was packed into 7

Author	Title/Year	Sample	Measures	Key Findings
			Spence Child Anxiety Scale (SCAS-c), The Fear Survey Schedule for Children-Revised (FSSC-R), The Children's Depression Inventory (CDI)	sessions and it may have been too much.
Pine, D.S., Cohen, P., Gurley, D., Brooke, J. & Ma, Y.	The risk for early-adulthood anxiety and depressive disorders in adolescents with anxiety and depressive disorders (1998)	N=776, age 9 to 18, 50% male anxiety disorders (simple phobia, SAD, OAD, SoP, panic, GAD) also considers depression, 90% Caucasian	Diagnostic Interview Schedule for Children (DISC)	Found support for chronicity of disorders by tracing them from adolescents to adulthood. Some were specific to the same disorder (SoP and simple) while others tended to lead to other disorders (OAD, GAD, panic, major depression) Most adult disorders are preceded by adolescent internalizing disorders.
Rapee, R.M., Abbott, M.J., & Lyneham, H.J.	Bibliotherapy for children with anxiety disorders using written materials for parents: A randomized controlled trial	N=267, Standard Group Treatment (90), Waitlist (87), age 6 to 12, Waitlist- 29.9% female, Bibliotherapy-	Anxiety Disorders Interview Schedule for DSM-IV-Child and Parent version (ADIS-C/P), Spence	Found that using bibliotherapy with no therapy contact was better than waitlist but not better than group CBT

Author	Title/Year	Sample	Measures	Key Findings
	(2006)	35.7% female, Group- 53.3% female, anxiety disorders (SAD, GAD, SoP, OCD, specific, panic), does not discuss ethnicity	Children's Anxiety Scale (SCAS), Children's Automatic Thoughts Scale (CATS), Child Behavior Checklist (CBCL)	(group CBT included parent training).
Schiefelbein, V.L. & Susman, E.J.	Cortisol levels and longitudinal cortisol change as predictors of anxiety in adolescents (2006)	N=106, age 9 to 14, anxiety disorders (SoP, GAD) 56 boys and 52 girls, 104 Caucasian, 2 African American	Diagnostic Interview Schedule for Children (DISC)	Found that greater increase in cortisol levels predicts higher general and social anxiety in girls but not boys.
Shortt, A.L., Barrett, P.M., & Fox, T.L.	Evaluating the FRIENDS program: A cognitive-behavioral group treatment for anxious children and their parents (2001)	N=71, age 6 to 10, 29 boys, anxiety disorders (SAD, GAD, SoP), 925 Australian	The Revised Children's Manifest Anxiety Scale (RCMAS), Child Behavior Checklist (CBCL), a satisfaction questionnaire	Found that 69% of participants in the family-based group CBT treatment did not have a diagnosis following treatment compared to 6% of the waitlist group. 68% of the treatment group was diagnosis free after 12 months.

Author	Title/Year	Sample	Measures	Key Findings
Silverman, W.K., Kurtines, W.M., Ginsburg, G.S., Weems, C.F., Lumpkin, P.W., & Carnichael, D.H.	Treating anxiety disorders in children with group cognitive-behavioral therapy: A randomized clinical trial (1999)	N=56, age 6 to 16, 34 boys and 22 girls, anxiety (GAD, OAD, SoP), 26 White, 26 Hispanic, 4 other	The Anxiety Disorder Interview Schedule for Children and Parents versions (ADIS-C/P), The Revised Children's Manifest Anxiety Schales's (RCMAS), The Children's Depression Inventory (CDI), CBCL, RCMAS-P	Found that 64% of children were better after GCBT compared to 13% waitlist, maintained at 3,6, and 12 month follow up leveling off between 6 and 12 months. Concluded that a time limited group format with concurrent parent sessions is a useful treatment for children with anxiety disorders.
Silverman, W. K., Kurtines, W.M., Ginsburg, G.S., Weems, C.F., Rabian, B., & Serafini, L.T.	Contingency management, self-control, and education support in the treatment of childhood phobic disorders: A randomized clinical trial (1999)	N=104, age 6 to 16, 54 boys, anxiety disorders (simple phobia, SoP, agoraphobia) 63% Euro-American, 37% Hispanic American, 2% other	The Anxiety Disorders Interview Schedule for Children-Parent/Child Versions (ADIS-C/P), Revised Children's Manifest Anxiety Schedule (RCMAS), Fear Survey Schedule for Children-Revised (FSSC-R), Fear Thermometer (FT), Children's	Found that children in all treatment conditions improved from manualized treatment. Both contingency management and self-control were found to be helpful forms of CBT treatment. Surprisingly, just providing educational support was enough to improve tx outcome as well.

Author	Title/Year	Sample	Measures	Key Findings
			Depression Inventory (CDI), Children's Negative Cognitive Error Questionnaire (CNCEQ), Parent-completed RCMAS (RCMAS/P), Parent-completed FSSCI-R (FSSC-R/P), Child Behavior Checklist (CBCL), Parent Global Rating of Severity (PGRS)	
Silverman, W.K., Kurtines, W.M., Jaccard, J., & Pina, A. A.	Directionality of change in youth anxiety treatment involving parents: An initial evaluation (2009)	N=119, age 7 to 16), 68 boys, 51 girls, children with (SAD, SoP, GAD, specific phobia, panic with agoraphobia, OCD) 33.6% European American, 61.3% Hispanic, 5.1% other	Anxiety Disorder Interview Schedule for DSM-IV: Child and Parent Version (ADIS for DSM-IV C/P), Anxiety Disorders Interview Schedule for DSM-IV (ADIS-IV), The Revised Children's Manifest Anxiety Scale (RCMAS); The Revised Children's Manifest Anxiety Scale	Youth anxiety was reduced significantly with both minimal and active parent involvement. Also found that the dynamics of change may flow from parent to child as well as child to parent.

Author	Title/Year	Sample	Measures	Key Findings
			Parent Version (RCMAS/P), The Child Behavior Checklist (CBCL), Conflict Behavior Questionnaire (CBQ), Symptom Checklist-90-Revised (SCL-90-R)	
Southam-Gerow, M.A. & Kendall, P.C.	A preliminary study of the emotion understanding of youths referred for treatment of anxiety disorders (2000)	N=38, age 7.5 to 14, 53% boys and 47% girls, children with anxiety (SAD, GAD, SoP), 82% Caucasian	Revised Children's Manifest Anxiety Scale (RCMAS)-Kusche Affective Interview Revised (KAI-R), Wechsler Intelligence Scale for Children Third Edition (WISC-III) Anxiety Disorder Interview Schedule for Children (ADIS-IV-C/P), Child Behavior Checklist (CBCL), State-Trait Anxiety Inventory for Children-Modification of Trait Version for Parents	Referred youth have a less developed understanding of hiding and changing their emotions compared to non-referred youth but no difference in understanding of emotion cues and multiple emotions. General intelligence did not have a significant relation with these indexes. Also found that hiding and changing emotions are related to emotional regulation.

Author	Title/Year	Sample	Measures	Key Findings
			(STAIC-P)	
Suveg, C., Zeman, J., Flannery-Schroeder, E., & Cassano, M.	Emotional socialization in families of children with an anxiety disorder (2005)	N=52, age 8 to 12, 24 boys, children with anxiety disorders (GAD, SAD, SoP, Specific Phobia) and their mothers, all Caucasian and primarily middle SES	The Hollingshead Four Factor Index of Social Status, Vocabulary subtest of the Wechsler Intelligence Scale for Children-Third Edition or Wechsler Adult Intelligence Scale Third Edition, The Revised Children's Manifest Anxiety Scale (RCMAS), The Children's Depression Inventory (CDI), Anxiety Disorders Interview	Found that mothers of anxious children were less verbal, used less positive words related to emotions, and discouraged their children from having emotional discussions more than the control group while the control group mothers and children used more emotional expressiveness.

Author	Title/Year	Sample	Measures	Key Findings
			Schedule for DSM-IV, Child and Parent versions (ADIS-IV C/P), Symptom Checklist-90-Revised (SCL-90-R), Mother-Child Emotion Interaction Task, Family Environment Scale (FES)	
Verduin, T.L. & Kendall, P.C.	Differential occurrence of comorbidity within childhood anxiety disorders (2003)	N=199, age 8 to 13, 114 boys and 85 girls, anxiety disorders (GAD, SAD, SoP), 85% White	Anxiety Disorders Interview Schedule-Children and Parent versions (ADIS-C/P)	Found that SAD had the highest comorbid diagnoses. Specific phobia is more common in primary SAD than in primary SoP but both groups are similar to those with primary GAD. Mood disorders are more commonly comorbid with GAD and SoP than with SAD, Externalizing disorders were not found to be comorbid across all groups. Functional enuresis was most common in SAD.

Author	Title/Year	Sample	Measures	Key Findings
Walkup, J.T., Albano, A.M., Piacentini, J., Birmaher, B., Compton, S.N., Sherrill, J.T., ...Kendall, P.C.	Cognitive behavioral therapy, Sertraline, or a combination in childhood anxiety	N=488, age 7 to 17, 242 female, anxiety disorders (SAD, GAD, SoP), 78.9% White	Anxiety Disorders Interview Schedule for DSM-IV-TR, Child Version; Clinical Global Impression-Improvement scale, Pediatric Anxiety Rating Scale, The Children's Global Assessment Scale.	Found that 80.7% of children receiving a combination treatment improved while 59.7% of children improved with CBT and 54.9% improved with Sertraline. 23.7% improved with placebo.
Weems, C.F., Zakem, A.H., Costa, N.M., Cannon, M.F., & Watts, S.E.	Physiological response and childhood anxiety: Association with symptoms of anxiety disorders and cognitive bias (2005)	N=49, 6-17 years, 55% girls, anxious children (excluding PTSD and specific phobia) and their parents (86% mothers), 55% African American, 27% Euro-American, 8% Hispanic, 10% mixed,	Revised Child Anxiety and Depression Scale (RCADS), RCADS parent version, (RCADS-P), Children's Depression Inventory (CDI), CNCEQ, The Childhood Anxiety Sensitivity Index (CASI), Revised Fear Survey Schedule for Children (FSSC-R)	Found that heart rate and skin conductance response are associated with youth report of anxiety but not their parent's report. Physiological responses are associated with anxious but not depressed youth. Also found that there is an interaction between physiological responses and cognitive bias in predicting anxiety disorders.

Author	Title/Year	Sample	Measures	Key Findings
Whaley, S.E., Pinto, A., & Sigman, M.	Characterizing interactions between anxious mothers and their children (1999)	N=36 dyads, age 7 to 14, 20 boys and 16 girls, children with a wide range of anxiety disorders, largely Caucasian and middle class	Anxiety Disorder Interview Schedule for DSM-IV (ADIS-IV), Schedule for Affective Disorders and Schizophrenia for School-Aged Children (K-SADS)	Found that anxious mothers tend to be less warm and positive, less granting of autonomy, more critical and catastrophizing, Maternal anxiety predicts the less warmth and positivity while child anxiety predicts less autonomy. Mother-child interaction behavior is most predictive of child anxiety.
Wood, J.J.	Effect of anxiety reduction on children's school performance and social adjustment (2006)	N=40, age 6 to 13, 60% boys, diagnoses (SAD, GAD, SoP), 60% Caucasian, 22.5% multiracial, 10% Latino, 2.5% African American	Anxiety Disorders Interview Schedule for DSM-IV-Child and Parent Version (ADIS-C/P), Multidimensional Anxiety Scale for Children (MASC), Perceived Competence Scale for Children (PCSC), Child Anxiety Impact Scale (CAIS),	Found that decreased anxiety following CBT interventions predicts increased school performance and social function.

Author	Title/Year	Sample	Measures	Key Findings
			Child Behavior Checklist (CBCL) specifically the CBCL School Performance scale, CBCL Social Competence Scale, and CBCL internalizing scale	

References

- Barrett, P.M., Dadds M.R., & Rapee, R.M. (1996). Family treatment of childhood anxiety: A controlled trial. *Journal of Consulting and Clinical Psychology, 64*(2), 333-342. doi: 10.1037/0022-006X.64.2.333
- Barrett, P.M., Duffy, A.L., Rapee, R.M., & Dadds, M.R. (2001). Cognitive-behavioral treatment of anxiety disorders in children: Long-term (6 year) follow-up. *Journal of Consulting and Clinical Psychology, 69*(1), 135-141. doi: 10.1037/0022-006X.69.1.135
- Barrett, P.M., Rapee, R.M., Dadds, M.R., & Ryan, S.M. (1996). Family enhancement of cognitive style in anxious and aggressive children. *International Society of Research in Child and Adolescent Psychopathology, 24*(2), 187-203. doi: 10.1007/BF01441484
- Brown, A.M., Deacon, B.J., Abramowitz, J.S., Dammann, J., & Whiteside, S.P. (2007). Parents' perceptions of pharmacological and cognitive-behavioral treatments for childhood anxiety disorders. *Behavior Research and Therapy, 45*, 819-828. doi: 10.1016/j.brat.2006.04.010
- Chansky, T.E. & Kendall, P.C. (1997). Social expectancies and self-perceptions in anxiety-disordered children. *Journal of Anxiety Disorders, 11*(4), 347-363. doi: 10.1016/S0887-6185(97)00015-7
- Chiu, A.W., McLeod, B.D., Har K., & Wood, J.J. (2009). Child-therapist alliance and clinical outcomes in cognitive behavioral therapy for child anxiety disorders. *Journal of Child Psychology and Psychiatry, 50*(6), 751-758. doi: 10.1111/j.1469-7610.2008.01996.x
- Chorpita, B.F., Albano, A.M., & Barlow, D.H. (1996). Cognitive processing in children: Relation to anxiety and family influences. *Journal of Clinical Child Psychology, 25*(2), 170-176. doi: 10.1207/s15374424jccp2502_5
- Chorpita, B.F., Brown, T.A., & Barlow, D.H. (1998). Perceived control as a mediator of family environment in etiological models of childhood anxiety. *Behavior Therapy, 29*, 457-476. doi: 10.1016/S0005-7894(98)80043-9
- Chu, B.C. & Kendall, P.C. (2004). Positive association of child involvement and treatment outcome with a manual-based cognitive-behavioral treatment for children with anxiety. *Journal of Counseling and Clinical Psychology, 72*(5), 821-829. doi: 10.1037/0022-006X.72.5.821

- Chu, B.C. & Kendall, P.C. (2009). Therapist responsiveness to child engagement: Flexibility within manual-based CBT for anxious youth. *Journal of Clinical Psychology, 65*(7), 736-754. doi: 10.1002/jclp.20582
- Cobham, V.E., Dadds, M.R., & Spence, S.H. (1998). The role of parental anxiety in the treatment of childhood anxiety. *Journal of Consulting and Clinical Psychology, 66*(6), 893-905. doi: 10.1037/0022-006X.66.6.893
- Compton, S.N., Kratochvil, C.J., & March, J.S. (2007). Pharmacotherapy for anxiety disorders in children and adolescents: An evidence-based medicine review. *Pediatric Annals, 37*(7), 504-517.
- Cooper, P.J., Fearn, V., Willets, L., Seabrook, H., & Parkinson, M. (2006). Affective disorder in the parents of a clinic sample of children with anxiety disorder. *Journal of Affective Disorders, 93*, 205-212. doi: 10.1016/j.jad.2006.03.017
- Costello, E.J. & Angold, A. (1995). Epidemiology. In March, J.S. (Eds.), *Anxiety disorders in children and adolescents* (pp. 109-124). New York, NY: Guilford Press.
- Dempsey, I. & Dunst, C.J. (2004). Helppgiving styles and parent empowerment in families with a young child with a disability. *Journal of Intellectual & Developmental Disability, 29*(1), 40-51. doi: 10.1080/13668250410001662874
- Drake, K.L. & Kearney, C. (2008). Child anxiety sensitivity and family environment as mediators of the relationship between parent psychopathology, parent anxiety sensitivity, and child anxiety. *Journal of Psychopathology and Behavioral Assessment, 30*(2), 79-86. doi: 10.1007/s10862-007-9055-z
- Dumas, J.E. & LaFreniere, P.J. (1993). Mother-child relationships as sources of support or stress: A Comparison of competent, average, aggressive, and anxious dyads. *Child Development, 64*, 1732-1754. doi: 10.2307/1131466
- Eley, T.C., Bolton, D., O'Connor, T.G., Perrin, S., Smith, P. & Plomin, R. (2003). A twin study of anxiety-related behaviours in pre-school children. *Journal of Child Psychology and Psychiatry, 44*(7), 945-960. doi: 10.1111/1469-7610.00179
- Falk, D.E., Yi, H., & Hilton, M.E. (2008). Age of onset and temporal sequencing of lifetime DSM-IV alcohol use disorders relative to Comorbid mood and anxiety disorders. *Drug and Alcohol Dependence, 94* (1-3), 234-245. doi: 10.1016/j.drugalcdep.2007.11.022
- Flannery-Schroeder, E.C. & Kendall, P.C. (2000). Group and individual cognitive-behavioral treatments for youth with anxiety disorders: A randomized clinical trial. *Cognitive Therapy and Research, 24*(3), 251-278. doi: 10.1023/A:1005500219286

- Gar, N.S. & Hudson, J.L. (2008). An examination of the interactions between mothers and children and anxiety disorders. *Behaviour Research and Therapy*, *46*(12), 126-1274. doi: 10.1016/j.brat.2008.08.006
- Gerlsma, C., Emmelkamp, P.M., & Arrindell, W.A. (1990). Anxiety, depression, and perception of early parenting: A meta-analysis. *Clinical Psychology Review*, *10*(3), 251-277. doi: 10.1016/0272-7358(90)90062-F
- Hammerness, P., Harpold, T., Petty, C., Mendard, C., Zar-Kessler, C., & Biederman, J. (2008). Characterizing non-OCD anxiety disorders in psychiatrically referred children and adolescents. *Journal of Affective disorders*, *105*(1-3), 213-219. doi: 10.1016/j.jad.2007.05.012
- Howard, B.L. & Kendall, P.C. (1996). Cognitive-behavioral family therapy for anxiety-disordered children: A multiple-baseline evaluation. *Cognitive Therapy and Research*, *20*(5), 423-443. doi: 10.1007/BF02227906
- Hughes, A.A., Hedtke, K. A., & Kendall, P.C. (2008). Family functioning in family of children with anxiety disorders. *Journal of Family Psychology*, *22*(2), 325-328. doi: 10.1037/0893-3200.22.2.325
- Kashani, M.D., Vaidya, A.F., Soltys, S.M., Dandoy, M.A., Katz, L.M., & Reid, J.C. (1990). Correlates of anxiety in psychiatrically hospitalized children and their parents. *The American Journal of Psychiatry*, *147*(3), 319-323.
- Kendall, P.C. (1994). Treating anxiety disorders in children: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *62*(1), 100-110. doi: 10.1037/0022-006X.62.1.100
- Kendall, P.C., Flannery-Schroeder, E., Panichelli-Mindel, S.M., Southam-Gerow, M., Henin, A., & Warman, M. (1997). Therapy for youths with anxiety disorders: A second randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *65*(3), 366-380. doi: 10.1037/0022-006X.65.3.366
- Kendall, P.C., Hudson, J.L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disorder youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology*, *76*(2), 282-297. doi: 10.1037/0022-006X.76.2.282
- Kendall, P.C., Safford, S., Flannery-Schroeder, E., & Webb, A. (2004). Child anxiety treatment: Outcomes in adolescence and impact on substance use and depression at 7.4 year follow-up. *Journal of Consulting and Clinical Psychology*, *72*(2), 276-287. doi: 10.1037/0022-006X.72.2.276

- Krain, A.L. & Kendall, P.C. (2000). The role of parental emotional distress in parent report of child anxiety. *Journal of Clinical Child Psychology, 29*(3), 328-335. doi: 10.1207/S15374424JCCP2903_4
- Linares-Scott, T.J. & Feeny, N.C. (2006). Relapse prevention techniques in the treatment of childhood anxiety disorders: A case example. *Journal of Contemporary Psychotherapy, 36*, 151-157. doi: 10.1007/s10879-006-9019-8
- Lyneham, H.J. & Rapee, R.M. (2006). Evaluation of therapist-supported parent-implemented CBT for anxiety disorders in rural children. *Behaviour Research and Therapy, 44*, 1287-1300. doi: 10.1016/j.brat.2005.09.009
- McClure, E.B., Brennan, P.A., Hammen, C., & Le Brocque, R.M. (2001). Parental anxiety disorders, child anxiety disorders, and the perceived parent-child relationship in an Australian high-risk sample. *Journal of Abnormal Child Psychology, 29*(1), 1-10. doi: 10.1023/A:1005260311313
- Monk, C.S., Nelson, E.E., McClure, E.B., Mogg, K., Bradley, B.P., Leibenluft, E., ...Pine, D.S. (2006). Ventrolateral prefrontal cortex activation and attentional bias in response to angry faces in adolescents with general anxiety disorder. *American Journal of Psychiatry, 163*, 1091-1097. doi: 10.1176/appi.ajp.163.6.1091
- Moore, P.S., Whaley, S.E., & Sigman, M. (2004). Interactions between mothers and children: Impacts of maternal and child anxiety. *Journal of Abnormal Psychology, 113*(3), 471-476. doi: 10.1037/0021-843X.113.3.471
- Nauta, M.H., Scholing, A., Emmelkamp, P.M.G., & Minderaa, R.B. (2003). Cognitive-behavioral therapy for children with anxiety disorders in a clinical setting: No additional effect of a cognitive parent training. *Journal of American Academy of Child and Adolescent Psychiatry, 42*(11), 1270-1278. doi: 10.1097/01.chi.0000085752.71002.93
- Pine, D.S., Cohen, P., Gurley, D., Brooke, J., & Ma, Y. (1998). The risk for early-adulthood anxiety and depressive disorders in adolescents with anxiety and depressive disorders. *Archives of General Psychiatry, 55*(1), 56-64. doi: 10.1001/archpsyc.55.1.56
- Rapee, R.M., Abbott, M.J., & Lyneham, H.J. (2006). Bibliotherapy for children with anxiety disorders using written materials for parents: A Randomized controlled trial. *Journal of Consulting and Clinical Psychology, 74*(3), 436-444. doi: 10.1037/0022-006X.74.3.436
- Schiefelbein, V.L. & Susman, E.J. (2006). Cortisol levels and longitudinal cortisol change as predictors of anxiety in adolescents. *The Journal of Early Adolescents, 26*(4), 397-413. doi: 10.1177/0272431606291943

- Shortt, A.L., Barrett, P.M., & Fox, T.L. (2001). Evaluating the FRIENDS program: A cognitive-behavioral group treatment for anxious children and their parents. *Journal of Clinical Child Psychology, 30*(4), 525-535. doi:10.1207/S15374424JCCP3004_09
- Silverman, W.K., Kurtines, W.M., Ginsburg, G.S., Weems, C.F., Lumpkin, P.W., & Carmichael, D.H. (1999). Treating anxiety disorders in children with group-cognitive-behavioral therapy: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 67*(6), 995-1003. doi: 10.1037/0022-006X.67.6.995
- Silverman, W.K., Kurtines, W.M., Ginsburg, G.S., Weems, C.F., Rabian, B., & Serafini, L.T. (1999). Contingency management, self-control, and education support in the treatment of childhood phobic disorders: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 77*(3), 504-16.
- Silverman, W.K., Kurtines, W.M., Jaccard, J., & Pina, A.A. (2009). Directionality of change in youth anxiety treatment involving parents: An initial evaluation. *Journal of Consulting and Clinical Psychology, 77*(3), 474-485. doi: 10.1037/a0015761
- Southam-Gerow, M.A. & Kendall, P.C. (2000). A preliminary study of the emotion understanding of youths referred for treatment of anxiety disorders. *Journal of Clinical Child Psychology, 29*(3), 319-327. doi: 10.1207/S15374424JCCP2903_3
- Suveg, C., Zeman, J., Flannery-Schroeder, E., & Cassano, M. (2005). Emotional socialization in families of children with an anxiety disorder. *Journal of Abnormal Child Psychology, 33*(2), 145-155. doi: 10.1007/s10802-005-1823-1
- Verduin, T.L. & Kendall, P.C. (2003). Differential occurrence of comorbidity within childhood anxiety disorders. *Journal of Clinical Child and Adolescent Psychology, 32*(2), 290-295. doi: 10.1207/S15374424JCCP3202_15
- Walkup, J., Albano, A.M., Piacentini, J., Birmaher, B., Compton, S.N., Sherrill, J.T.,...Kendall, P.C. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *The New England Journal of Medicine, 359*(26), 2753-2766. doi: 10.1056/NEJMoa0804633
- Weems, C.F., Zakem, A.H., Costa, N.M., Cannon, M.F., & Watts, S.E. (2005). Physiological response and childhood anxiety: Association with symptoms of anxiety disorders and cognitive bias. *Journal of Clinical Child and Adolescent Psychology, 34*(4), 712-723. doi: 10.1207/s15374424jccp3404_13
- Whaley, S.E., Pinto, A., & Sigman, M. (1999). Characterizing interactions between anxious mothers and their children. *Journal of Consulting and Clinical Psychology, 67*(6), 826-836. doi: 10.1037/0022-006X.67.6.826

Wood, J.J. (2006). Effect of anxiety reduction on children's school performance and social adjustment. *Developmental Psychology*, 42(2), 345-349. doi: 10.1037/0012-1649.42.2.345

Section A2. Non-Empirical Literature

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
Abramowitz, J.S., Deacon, B.J., & Whiteside, S.P.	Exposure therapy for anxiety: Principles and practice	Book	To provide a comprehensive resource for treating anxiety disorders	Provided detailed descriptions and guidance for conducting exposure with a wide range of anxiety disorders.	
Albano, A.M., Chorpita, B.F., & Barlow, D.H.	Child anxiety disorders. In Mash, E.J. & Barkley, E.J. (1996). Child Psychopathology.	Book chapter	To provide an overview of child anxiety disorders	Provided a description of anxiety disorders and addressed issues such as development, prognosis, epidemiology, sociodemographic variables and comorbidity. Also reviewed issues of etiology including genetics, temperament, psychosocial factors and parenting.	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
Albano, A.M., Detweiler, M.F., & Logsdon-Conradsen, S.	Cognitive-behavioral interventions with socially phobic children. In Russ, S.W. & Ollendick, T.H. (1999). Handbook of psychotherapies with children and families.	Book chapter	To review the phenomenology and cognitive-behavioral interventions for treating children with social phobia	In addition to describing social phobia, this chapter discussed the typical procedures used for the assessment and treatment of social phobia. The chapter also provided evidence for the efficacy of cognitive-behavioral therapy for the treatment of social phobia.	
Albano, A.M. & Kendall, P.C.	Cognitive-behavioral therapy for children and adolescents with anxiety disorders: Clinical research advances (2002)	Literature review	To review the empirical evidence for cognitive-behavioral treatment for child anxiety	Provided an overview for the CBT model and an example of a manualized protocol for anxiety in youth. Also showed that CBT has been found to yield results that maintain for at least one year. Finally, critiqued CBT, finding that it has	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				rigorous and standardized assessment procedures, clinically meaningful outcome criteria, and long-term effects.	
American Academy of Child and Adolescent Psychiatry	Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders (2007)	Practice parameters	To review the evidence from research and practice and to make recommendations for best practice	While various approaches to treatment of anxiety disorders are reviewed, this article concluded that CBT is the treatment of choice for child and adolescent anxiety disorders. Recommendations for treatment included assessing and treating anxiety early, considering co-morbid disorders, and evaluating the severity of the disorder. The use of pharmacotherapy was also	This article is helpful for demonstrating what is being recommended for actual practice in child anxiety disorders right now.

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				suggested.	
Barlow, D.H.	Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory (2000)	Review	To review emotions theory and present the triple vulnerability model as a means of explaining the development of anxiety	Explained triple vulnerability theory as: A generalized biological vulnerability, a generalized psychological vulnerability based on early experiences, and a specific psychological vulnerability. This model was then used to explain the evolution of various anxiety disorders.	
Barlow, D.H.	Anxiety and its disorders (2002)	Book	To provide a comprehensive review of anxiety disorders	Provided information related to the development of anxiety as well as its biological factors. Also	Good source for general information on anxiety disorders.

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				discussed classifications of the various anxiety disorders and provided specific information regarding each anxiety disorder.	
Barrett, P.M.	FRIENDS for life: Group leader's manual (2004)	Treatment manual	To provide a treatment approach for treating child anxiety disorders in a family or group format	Presented a treatment for child anxiety using a 10 session and 2 booster session model. In addition to the treatment of the child's anxiety, the manual also involves parent training for reinforcement, contingency management, planned ignoring, cognitive techniques, communication, problem solving and maintenance.	This manual is an excellent resource for information to include in the parent manual.

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
Barrett, P.M. & Ollendick, T.H.	Handbook of interventions that work with children and adolescents: Prevention and treatment	Book	To provide information about evidence-based and information on a wide range of psychological disorders in children and adolescents	Reviewed the theoretical foundations and evidence for evidence-based treatments. Also discussed prevention programs	
Barrett, P.M. & Shortt, A.L.	Parental involvement in the treatment of anxious children. In Kazdin, A.E. & Weisz, J.R. (2003). Evidence-based psychotherapies for children and adolescents.	Book chapter	To review the evidence for family-based treatment and to present one such treatment, the FRIENDS program	Found that parents play an important role in their child's treatment for anxiety and addresses the importance of considering each case to determine how parents should be involved. Explained the FRIENDS program, which targets parents as well as anxious children and provided evidence for the efficacy of this program.	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
Bogels, S.M. & Brechman-Toussaint, M.L.	Family issues in child anxiety: Attachment, family functioning, parental rearing and beliefs (2006)	Review	To review issues in family functioning that may affect child anxiety	Stated that there is evidence that family functioning is associated with child anxiety (e.g., high or low cohesion, high or low adaptability). Also found that over-controlling parenting styles and rejecting family environments are associated with child anxiety but that the direction of this relationship is unclear. Implications for treatment were reviewed and included the assertion that, if parental anxiety is left untreated, the efficacy of CBT for child anxiety may be compromised	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
Brady, E.U. & Kendall, P.C.	Comorbidity of anxiety and depression in children and adolescents (1992)	Review	To review the development, assessment, diagnosis and clinical considerations of anxiety and depression	Found similarities and differences between individuals with anxiety disorders and depression. Stated that research on family connections is limited in both disorders. Offered the possibility of a temporal relation between anxiety and depression with older children being more likely to have both and younger children tending to have one or	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				the other. The order of onset remains unclear.	
Cartwright-Hatton, S., McNicol, K., & Doubleday, E.	Anxiety in a neglected population: Prevalence of anxiety disorders in pre-adolescent children (2006)	Literature review	To review anxiety disorders in international pre-adolescents (under the age of 12)	Concluded that the occurrence of anxiety disorders ranges from 2.6% (American, 11 year olds) to 41.2% (Japanese, 7 to 9 years old). The most common disorder in this group was separation anxiety disorder. Anxiety disorders seemed to be more common than depressive disorders.	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
Cartwright-Hatton, S., Roberts, C., Chitsabesan, P., Fothergill, C., & Harrington, R.	Systematic review of the efficacy of cognitive behaviour therapies for childhood and adolescent anxiety disorders (2004)	Literature Review	To review the efficacy of CBT for child anxiety disorder (excluding social phobia, PTSD, OCD)	After reviewing 10 studies of individuals under the age of 19, the study concluded that the remission rate of individuals receiving CBT treatment was 56.5% (vs. 34.8% control group), which suggests the CBT is more effective than no-treatment.	
Chansky, T.E.	Freeing your child from anxiety: Powerful, practical solutions to overcome your child's fears, worries and phobias (2004)	Book	To provide information to parents about their child's anxiety disorders	Reviewed normative versus abnormal fear and worries in children and provided information about the major anxiety disorders. Discussed the treatment of child anxiety disorders and provided	While the suggestions for managing anxiety in this book are geared more towards parent-implemented treatments, some of the suggestions may be helpful to incorporat

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				suggestions for how to manage major issues associated with anxiety.	e in the parent manual!
Chorpita, B.F.	Modular cognitive-behavioral therapy for childhood anxiety disorders (2007)	Book and treatment manual	To provide a comprehensive CBT treatment model for child anxiety disorders	Reviewed instructions for exposure treatments and presented an argument for the use of a modular treatment. Presented treatment modules for developing a fear ladder, psychoeducation about anxiety (both for parents and children), exposure, cognitive restructuring, and social skills training. Also presented information for involving parents in treatment.	The parent sections of this treatment may be helpful in considering the parent information that may be useful for this parent manual.

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
Chorpita, B.F. & Daleiden, E.L.	Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials (2009)	Literature review	To evaluate randomized clinical trials of treatments for children and adolescents and to identify the major practice elements of treatments for major psychological disorders	Reviewed 322 randomized clinical trials (including 615 treatment protocols) of child mental health treatments. Findings specific to anxiety disorders indicated that the most common practice elements in anxiety disorder treatments include exposure, relaxation, cognitive components, modeling, and psychoeducation.	
Chorpita, B.F. & Southam-Gerow, M.A.	Fears and Anxieties. In Mash, E.J. & Barkley, R.A. (2006). Treatment of childhood disorders (3rd ed)	Book chapter	To review theoretical and diagnostic issues regarding fear and anxiety and to discuss treatment considerations for anxiety	Reviewed various theories regarding the development of fears and anxiety and discussed when normative fears and anxieties	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
			disorders in children	become disorders. Also discussed treatment strategies including exposures, modeling, cognitive techniques, relaxation, psychoeducation, emotion skills training, contingency management, and problem solving.	
Costello, E.J. & Angold, A.	Epidemiology. March, J.S. (1995). In Anxiety disorders in children and adolescents	Book chapter	To review the epidemiology of anxiety disorders in children and adolescents	Reviewed epidemiological studies regarding anxiety and discussed the findings. The issues discussed include prevalence, comorbidity, continuity and risk factors of anxiety disorders.	
Craske, M.G.	Anxiety disorders: Psychological approaches to theory and treatment (1999)	Book	To review anxiety disorders across the lifespan	Discussed features, etiology, and specific features of anxiety disorders.	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				Also discussed treatments for these disorders.	
Donovan, C.L. & Spence, S.H.	Prevention of child anxiety disorders (2000)	Review	To address the issues surrounding prevention of child anxiety disorders	Discussed the risk factors associated with child anxiety, including parental behavior, parental anxiety and parent-child attachment. Also discussed issues of prevention that focus on both child and parent approaches. Notable parental suggestions included modeling appropriate behavior, the use of reinforcement, reduction of parental anxiety behaviors, reducing over-protection and criticism, encouraging	This article is useful in providing tips for parents that can aid in the assistance of their child's treatment.

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				exposures, ignoring undesirable behaviors, and avoiding talking about potential threats of situations.	
Ginsburg, G.S. & Kingery, J.N.	Evidence-based practice for child anxiety disorders (2007)	Literature review	To review evidence-based treatments for child anxiety disorders and to describe specific strategies used in CBT treatment	Found that CBT is most efficacious compared to other treatments with improvements occurring in 60 to 80 percent of participants. Also reviewed various treatment techniques including psychoeducation, exposure, contingency management, cognitive restructuring, affective education and relapse prevention. Discussed the various	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				ways parents can be involved depending on the child's needs.	
Ginsburg, G.S., Silverman, W.K., & Kurtines, W.M.	Family involvement in treating children with phobic and anxiety disorders: A look ahead (1995)	Review	To review the common characteristics of parents and families of children with anxiety	Found that parents who have children with anxiety may also have symptoms of anxiety. Also found that there are maladaptive family patterns (e.g., high conflict, control, lack of familial support and cohesion, limited participation in recreational/social/intellectual activities, poor communication and problem solving). Suggested a transfer of control model to enhance therapy	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				through parent involvement and addressed poor family patterns that may serve as blocks to the transfer.	
Grisel, J.E., Rasmussen, P.R., & Sperry, L.	Anxiety and depression: Physiological and pharmacological considerations (2006)	Review	To provide a conceptual integration of the physiological and psychological processes related to anxiety and depression	Found common factors across anxiety disorders including feelings of unease with a chronic and unremitting course as well as a gradual worsening over time. Stated that SSRIs are the pharmacological treatment of choice for anxiety. Described the role of the hypothalamic-pituitary-adrenal axis in anxiety. Found that physiological	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				responses to anxiety included increased heart rate, blood pressure changes and increased respiration.	
Gullone, E.	Psychotherapy of child anxiety disorders	Review	To review normal fears in children	Found that with age, fear decreases in prevalence and intensity. Specific fear in children tends to be transitory and there are predictable changes with development.	
Hannesdottir, D.K. & Ollendick, T.H.	The role of emotion regulation in the treatment of child anxiety disorders (2007)	Review	To review the role of emotion regulation in the treatment of child anxiety disorders	Described emotion regulation as the ability to control emotion. Discussed the common difficulty of such control in children with anxiety disorders. Suggested that emotion regulation may not be adequately addressed in CBT	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				<p>treatments and described possible techniques for enhancing emotion regulation including psychoeducation, refocusing and reframing. Also described how emotion regulation may be addressed at the family level.</p>	
<p>In-Albon, T. & Schneider, S.</p>	<p>Psychotherapy of childhood anxiety disorders: A meta-analysis (2006)</p>	<p>Meta-analysis</p>	<p>To compare the efficacy of psychotherapy treatments for child anxiety</p>	<p>Found CBT to be the treatment of choice for child anxiety. Also found no difference in efficacy between individual and group treatments or child and family treatments.</p>	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
Kase, L. & Ledley, D.R.	Anxiety disorders (2007)	Book	To provide a comprehensive review of anxiety disorders	Provided details about specific steps of CBT treatment and addressed specific considerations related to treating children and adolescents. Found that CBT is an effective treatment for anxiety disorders in children and adolescents when compared to no-treatment.	
Kazdin, A.E. & Weisz, J.R.	Evidence-based therapies for children and adolescents (2003)	Book	To describe evidence-based practices for treating children and adolescents with a wide range of presenting problems	Provided information on both child-focused treatment of anxiety as well as the role of parent involvement in the treatment of child anxiety.	
Keeton, C.P. & Ginsburg, G.S.	Combining and sequencing medication and cognitive-behavior therapy for	Review	To review the use of pharmacotherapy and cognitive-behavioral therapy for childhood	Summarized the evidence for each treatment and discussed issues surrounding	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
	childhood anxiety disorders (2008)		anxiety disorders	sequencing, combining and integrating treatments. Found both treatments to be effective but supported integrative treatment. Also concluded that sequencing of treatments should be considered on a case-by-case basis.	
Kendall, P.C., Aschenbrand, S.G., & Hudson, J.L.	Child focused treatment for anxiety. In Kazdin, A.E. & Weiss, J.R. (2003). Evidence-based psychotherapies for children and adolescents	Book chapter	To review information regarding parent involvement in the treatment of child anxiety disorders	Discussed the role parents play in child anxiety as well as in its treatment (e.g., bringing children to therapy, facilitating avoidance). Also discussed reasons for including parents in treatment and how to assess for the level of parent	Good source for discussing dissemination of evidence-based manuals.

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				involvement that is needed. Finally, reviewed the treatment program FRIENDS that involves parents in treatment.	
Kendall, P.C. & Beidas, R.S.	Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity (2007)	Review	To discuss ways of smoothing the path for the dissemination of empirically supported treatments from research labs to community practice	Found that there are difficulties with disseminating empirically supported treatments and made suggestions for how to make this process easier. The authors suggested the use of meditational analysis, treatment process studies and flexibility in the use of manuals in order to facilitate the dissemination process. "Flexibility with fidelity" is suggested when	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				adapting manualized treatments.	
Kendall, P.C. & Choudhury, M.S.	Children and adolescents in cognitive-behavioral therapy: Some past efforts and current advances, and the challenges in our future (2003)	Literature review	To review CBT for child and to adolescent anxiety and discuss the role of parents in anxiety and treatment	Found that "anxiety is a central focus of CBT treatment evaluations." Stressed the importance of considering what is developmentally normal before thinking about what is abnormal. Discussed the role of parents and points out major gaps in the literature regarding the benefit of parent involvement. Pointed out possible roles for parents and state that involvement varies with age and	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				<p>nature of presenting problem. Parent over-involvement may be linked to certain anxiety disorders so not involving parents might be suggested. Mediators of outcome included age, ethnicity, gender, problem type, severity, therapist training and mode of delivery. Found that medication has mixed findings and needs more research.</p>	
<p>Kendall, P.C., Furr, J.M., & Podell, J.L.</p>	<p>Child-focused treatment of anxiety. In Weisz, J.R. & Kazdin, A.E. (2010). Evidence-based psychotherapies for children and</p>	<p>Book Chapter</p>	<p>To review a specific CBT treatment (<i>Coping Cat</i>) for child anxiety disorders.</p>	<p>Presented a review of the <i>Coping Cat</i> CBT treatment for children. Also reviewed the evidence for the efficacy of this treatment.</p>	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
	adolescents				
Kendall, P.C. & Hedtke, K.	Cognitive-behavioral therapy for anxious children: Therapist manual (2006)	Treatment manual	To provide a therapist guide to administering the Coping Cat treatment for child anxiety	Presented a 16-session program using both behavioral and cognitive components to treat child anxiety. Included psychoeducation, exposure, problem solving, development of a FEAR hierarchy, and cognitive restructuring.	
Kendall, P.C., Panichelli-Mindel, S.M., Sugarman, A., & Callahan, S.A.	Exposure to child anxiety: Theory, research, and practice (1997)	Review	To provide an overview of cognitive behavioral theory for child anxiety disorders	Reviewed the CB theory of child anxiety disorders. Described the Coping Cat treatment approach and concluded that both individual and family-based approaches have been shown to be effective.	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				<p>Also addressed affect and social competence in children with anxiety as well as familial factors related to anxiety (e.g., granting less autonomy, being less accepting, having lower expectations, holding rigid cognitive ideas about the child's coping abilities). Also discussed the dissemination of treatment from research to practice and called for more information in this area.</p>	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
Kendall, P.C. & Suveg, C.	Treating anxiety disorders in youth. In Kendall, P.C. (2006). Child and adolescent therapy: Cognitive behavioral procedures	Book chapter	To provide an overview of child anxiety disorders, its origins, and its treatment using cognitive behavioral strategies	Reviewed normative development of anxiety and its features. Also discussed the family issues that tend to be associated with anxiety (e.g., maladaptive parenting styles) and discussed working with families while treating children. Also reviewed the common components of CBT treatment including, psychoeducation, cognitive skills, problem solving, contingency management, modeling and exposures. Finally, provided examples from the	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				Coping Cat program.	
King, N.J. & Ollendick, T.H.	Children's anxiety and phobic disorders in school settings: Classification, assessment, and intervention issues (1989)	Review	To discuss normative fears, assessment and classifications of childhood anxiety disorders as well as the treatment of these disorders	Stated that fears are normal but can become maladaptive. Found that fear reduction procedures can work and that many of these techniques can be used in school settings. Called for flexibility in the implementation of these procedures depending on developmental issues. Finally, called for multimodal assessment of anxiety disorders.	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
Last, C.G.	Help for worried kids: How your child can conquer anxiety and fear (2006)	Book	To provide a resource for parents of children with anxiety	Provided descriptions of anxiety disorders and offered resources for additional help in managing child's anxiety.	
Mahoney, G., Kaiser, A., Girolametto, L, MacDonald, J., Robinson, C., Safford, P., & Spiker, D.	Parent education in early intervention: A call for a renewed focus (1999)	Literature review	To explore the benefits of having parent involvement in early intervention for children	Concluded that parent education is vital to early intervention and should include information about child's current needs, parenting strategies, parent-child interactions strategies, management of problem behavior, and instructions on teaching skills.	
Manassis, K.	Keys to parenting your anxious child (2008)	Book	To provide a resource for parents of children with anxiety	Discussed reasons for anxiety as well as ways that the parents can help their children to cope with anxiety.	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
McLeod, B.D., Wood, J.J., & Weisz, J.R.	Examining the association between parenting and childhood anxiety: A meta-analysis (2007)	Meta-analysis	To review studies investigating the relationship between parenting and child anxiety	Found that there is a small relationship between parenting and child anxiety, accounting for 4% of the variance in child anxiety. Also suggested that methodological differences between studies may account for some of the variance in studies on parenting.	
Morris, T.L. & March, J.S.	Anxiety disorders in children and adolescents (2004)	Book	To review child anxiety disorders and its treatment	Found that CBT is an effective treatment for anxiety. Discussed various techniques that are helpful in CBT treatment including exposures, contingency management, modeling, and cognitive strategies.	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				Also, discussed Coping Cat as an evidence-based treatment and reviewed its techniques and applicability to a range of groups.	
Pahl, K.M. & Barrett, P.M.	Interventions for anxiety disorders in children using group cognitive-behavioral therapy with family involvement. In Weisz, J.R. & Kazdin, A.E. (2010). Evidence-based psychotherapies for children and adolescents	Book Chapter	To review a CBT treatment program (FRIENDS) for children and adolescents for groups or families.	Provided detailed information on the treatment program FRIENDS including details on treatment components and a review of treatment efficacy.	
Puliafico, A.C. & Kendall, P.C.	Threat-related attentional bias in anxiety-disordered youth: A review (2006)	Review	To evaluate factors that influence threat-related attentional bias in youth with anxiety disorders	Provided a rationale for why anxious youth have a bias towards threat-related cues. Also identified temperament , trait	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				anxiety, and state anxiety as influences to threat-related attentional biases.	
Rapee, R.M.	Potential role of childrearing practices in the development of anxiety and depression (1997)	Review	To review the role of parents in the development of child anxiety	Found that rejection and control from parents may be positively related to later anxiety and depression in children.	
Rapee, R.M., Spence, S.H., Cobham, V., & Wignall, A.	Helping your anxious child: A step-by-step guide for parents (2000)	Book	To provide parents with a guide to understand and help their child's anxiety	Provided information on anxiety, tips on parenting an anxious child, instructions for facing feared situations, and ideas for managing problems.	
Reinblatt, S.P. & Riddle, M.A.	The pharmacological management of childhood anxiety disorders: A review (2007)	Review	To review pharmacological treatments for child anxiety disorders	Presented a review of psychopharmacological treatment based on empirical evidence. Found good evidence for the use of several pharmacolog	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				ical agents, particularly serotonin reuptake inhibitors (SSRIs).	
Rosenberg, D.R., Banerjee, P., Ivey, J.L., & Lorch, E.R.	Psychopharmacology of child and adolescent anxiety disorders (2003)	Review	To review pharmacological treatments for child and adolescent anxiety disorders	Found that psychopharmacological treatments can be effective for treating various forms of child anxiety disorders.	
Silva, R.R., Gallagher, R., & Minami, H.	Cognitive-behavioral treatments for anxiety disorders in children and adolescents (2006)	Review	To review the evidence for CBT treatments as well as parent involvement in such treatments	Found that CBT is efficacious and reviewed the recent advances in CBT treatments including combining various behavioral and cognitive approaches. The article also discussed the importance of including parents in treatment when appropriate and addressed the importance to not blame	This article provides websites to parent whom are interested in getting further information on their child's anxiety.

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				parents for their role in their child's anxiety. Websites for further information for parents were provided.	
Silverman, W.K. & Kurtines, W.M.	Transfer of control: A psychosocial intervention model for internalizing disorders in youth. In Hobbs, E.D. & Jensen, P.S. (1996). Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice	Book	To provide a treatment approach for treating child anxiety disorders	Described efforts to develop evidence-based psychosocial interventions . Explained the transfer of control approach to be used in exposure-based interventions .	
Silverman, W.K., Pina, A.A., & Viswesvaran, C.	Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents (2008)	Literature review	To review psychosocial treatment for anxiety disorders	Found that individual CBT, group CBT, group CBT with Parents, group CBT for Social Phobia, and Social Effectiveness Training for children with	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				Social phobia are "probably efficacious" while others are possibly efficacious or experimental .	
Southam-Gerow, M.A. & Chorpita, B.F.	Anxiety in children and adolescents. Mash, E.J. & Barkley, R.A. (2007). In Assessment of childhood disorders (4th ed.)	Book chapter	To review information regarding child anxiety disorders including diagnostic issues, comorbidities and assessment	Discussed normative fears in children and provided the diagnostic criteria for various anxiety disorders found in children and adolescents. Also reviewed the assessment measures used with this population including diagnostic interviews and observational assessment.	
Spencer, S.H., Dupont, R.L. & Dupont, C.M.	Anxiety cure for kids: A guide for parents (2003)	Book	To provide a resource for parents of children with anxiety	Provided a description of anxiety disorders and addressed issues such as treatment, medication,	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				relaxation, cognitive restructuring, school anxiety, family's role in anxiety, and advice for other adults in the child's life.	
Suveg, C., Roblek, T.L., Robin, J., Krain, A., Aschenbrand, S., & Ginsburg, G.S.	Parent involvement when conducting cognitive-behavioral therapy for children with anxiety disorders (2006)	Literature review	To review parent involvement in CBT treatment	Concluded that parent involvement in CBT can be both helpful and harmful. Involvement tended to be more helpful for younger children, girls, children with parents with anxiety disorders, and if parents are "part of the problem."	
van Ingen, D.J., Freiheit, S.R., & Vye, C.S.	From the lab to the clinic: Effectiveness of cognitive-behavioral treatments for anxiety disorders (2009)	Meta-analysis	To review studies regarding CBT treatments in an effort to determine the efficacy of dissemination of CBT treatments from	Found that CBT treatments were associated with significant improvements in anxiety symptoms at the end of treatment and at follow	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
			research to community clinics	up. Concluded that CBT does generalize to the real world.	
Vos, T., Haby, M.M., Magnus, A., Mihalopoulos, C., Andrews, G., & Carter, R.	Assessing cost-effectiveness in mental health: Helping policy makers prioritize and plan health services (2005)	Review	To discuss options for improving the efficacy of mental health services by directing available resources towards "best practice" cost-effective services	Found that cost-effective treatment options (e.g., CBT for anxiety disorders) are being underutilized while more expensive treatments (e.g., medications) continue to be overutilized. Called for these findings to be considered by practitioners.	
Wood, J.J., McLeod, B.D., Sigman, M., Hwang, W., & Chu, B.C.	Parenting and childhood anxiety: Theory, empirical findings, and future directions (2003)	Review of the literature	To review the relationship between parenting and child anxiety	Found that parent-child interactions (parenting control) are linked to shyness and child anxiety. Some studies found that the role of parent	

Author	Title/Year	Type of Resource	Purpose	Content Summary	Comments
				<p>acceptance and modeling of anxious behaviors were important. Additional evidence found that self-reported parenting style was related to child's trait anxiety. State that while no definitive conclusions are possible at this time regarding parent-child interactions, patterns are evident.</p>	

References

- Abramowitz, J.S., Deacon, B.J., Whiteside, S.P. (2011). *Exposure therapy for anxiety: Principles and practice*. New York: Guilford Press.
- Albano, A.M., Chorpita, B.F., & Barlow, D.H. (1996). Child anxiety disorders. In Mash, E.J. & Barkley, R.A. *Child psychopathology* (pp. 196-241). New York, NY: Guilford Press.
- Albano, A.M., Detweiler, M.F., & Logsdon-Conradson, S. (1999). Cognitive-behavioral interventions with socially phobic children. In Russ, S.W. & Ollendick, T.H. (Eds.) *Handbook of psychotherapies with children and families* (pp. 255-280). New York, NY: Kluwer Academic/Plenum Publishers.
- Albano, A.M. & Kendall, P.C. (2002). Cognitive behavioral therapy for children and adolescents with anxiety disorders: Clinical research advances. *International Review of Psychiatry, 14*, 129-134. doi: 10.1080/09540260220132644.
- American Academy of Child and Adolescent Psychiatry. (2007). Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(2), 267-283. doi: 10.1097/01.chi.0000246070.23695.06
- Barlow, D.H. (2000). Unraveling the mysteries of anxiety and its disorders from the perspective of emotion theory. *American Psychologist, 55*(11), 1247-1263. doi: 10.1037/0003-066X.55.11.1247
- Barlow, D.H. (2002.) *Anxiety and its disorders: The nature and treatment of anxiety and panic, 2nd edition*. New York, NY: Guilford Press.
- Barrett, P.M. (2004). *FRIENDS for life: Group leader's manual*. Brisbane, Australia: Australian Academic Press.
- Barrett, P.M. & Ollendick, T.H. (2004). *Handbook of interventions that work with children and adolescents: Prevention and treatment*. New York, NY: John Wiley & Sons.
- Barrett, P.M. & Shortt, A.L. (2003). Parental involvement in the treatment of anxious children. In Kazdin, A.E. & Weisz, J.R. (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 101-119). New York, NY: Guilford Press.
- Bogels, S.M. & Brechman-Toussaint, M.L. (2006). Family issues in child anxiety: Attachment, family functioning, parental rearing and beliefs. *Clinical Psychology Review, 26*(7), 834-856. doi: 10.1016/j.cpr.2005.08.001

- Brady, E.U. & Kendall, P.C. (1992). Comorbidity of anxiety and depression in children and adolescents. *Psychological Bulletin*, *111*(2), 244-255. doi: 10.1037/0033-2909.111.2.244
- Cartwright-Hatton, S., McNicol, K., & Doubleday, E. (2006). Anxiety in a neglected population: Prevalence of anxiety disorders in pre-adolescent children. *Clinical Psychology Review*, *26*(7), 817-833. doi: 10.1016/j.cpr.2005.12.002
- Cartwright-Hatton, S., Roberts, C., Chitsabesan, P., Fothergill, C. & Harrington, R. (2004). Systematic review of the efficacy of cognitive behavior therapies for childhood and adolescent anxiety disorders. *Journal of Clinical Psychology*, *43*(4), 421-436. doi: 10.1348/0144665042388928
- Chansky, T.E. (2004) *Freeing your child from anxiety: Powerful, practical solutions to overcome your child's fears, worries and phobias*. New York, NY: Broadway Books.
- Chorpita, B.F. (2007). *Modular cognitive-behavioral therapy for childhood anxiety disorders*. New York, NY: Guilford Press.
- Chorpita, B.F. & Daleiden, E.L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials. *Journal of Consulting and Clinical Psychology*, *77*(3), 566-579. doi: 10.1037/a0014565
- Chorpita, B.F. & Southam-Gerow, M.A. (2006). Fears and anxieties. In E.J. Mash and R.A. Barkley (Eds.), *Treatment of childhood disorders (3rd ed.)* (pp. 271-335). New York, NY: Guilford Press.
- Costello, E.J. & Angold, A. (1995). Epidemiology. In March, J.S. (Eds.), *Anxiety disorders in children and adolescents* (pp. 109-124). New York, NY: Guilford Press.
- Craske, M.G. (1999) *Anxiety disorders: Psychological approaches to theory and treatment*. Los Angeles, CA: Westview Press.
- Donovan, C.L. & Spence, S.H. (2000). Prevention of child anxiety disorders.
- Dumas, J.E. & LaFreniere, P.J. (1993). Mother-child relationships as sources of support or stress: A Comparison of competent, average, aggressive, and anxious dyads. *Child Development*, *64*, 1732-1754. doi: 10.2307/1131466

- Ginsburg, G.S. & Kingery, J.N. (2007). Evidence-based practice for child anxiety disorders. *Journal of Contemporary Psychotherapy*, 37(3), 123-132. doi: 10.1007/s10879-007-9047-z
- Ginsburg, G.S., Silverman, W.K., & Kurtines, W.M. (1995). Family involvement in treating children with phobic and anxiety disorders: A look ahead. *Clinical Psychology Review*, 15(5), 457-473. doi: 10.1016/0272-7358(95)00026-L
- Grisel, J.E., Rasmussen, P.R. & Sperry, L. (2006). Anxiety and depression: Physiological and pharmacological considerations. *Journal of Individual Psychology*, 62(4), 397-416.
- Gullone, E. (2000). The development of normal fear: a century of research. *Clinical Psychology Review*, 20(4), 429-451. doi: 10.1016/S0272-7358(99)00034-3
- Hannesdottir, D.K. & Ollendick, T.H. (2007). The role of emotion regulation in the treatment of child anxiety disorders. *Clinical Child and Family Psychology Review*, 10(3), 275-293. doi: 10.1007/s10567-007-0024-6
- In-Albon, T. & Schneider, S. (2006). Psychotherapy of childhood anxiety disorders: A meta-analysis. *Psychotherapy and Psychosomatics*, 76, 15-24. doi: 10.1159/000096361
- Kase, L. & Ledley, D.R. (2007). *Anxiety disorders*. Hoboken, N.J.: John Wiley & Sons.
- Kazdin, A.E. & Weisz, J.R. (2003). *Evidence-based psychotherapies for children and adolescents*. New York, NY: Guilford Press.
- Keeton, C. & Ginsburg, G.S. (2008). Combining and sequencing medication and cognitive-behavior therapy for childhood disorders. *International Review of Psychiatry*, 20(2), 159-164. doi: 10.1080/09540260801889047
- Kendall, P.C., Aschenbrand, S.G., & Hudson, J.L. (2003). Child focused treatment for anxiety. In Kazdin, A.E. & Weisz, J.R. (Eds.), *Evidence-based psychotherapies for children and adolescents* (pp. 81-100). New York, NY: Guilford Press.
- Kendall, P.C. & Beidas, R.S. (2007). Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity. *Professional Psychology: Research and Practice*, 38(1), 13-20. doi: 10.1037/0735-7028.38.1.13
- Kendall, P.C. & Choudhury, M.S. (2003). Children and adolescents in cognitive-behavioral therapy: Some past efforts and current advances, and the challenges in our future. *Cognitive Therapy and Research*, 27(1), 89-104. doi: 10.1023/A:1022542814822

- Kendall, P.C., Furr, J.M., & Podell, J.L. (2010). Child-focused treatment of anxiety. In Kazdin, A.E., & Weisz, J.R. (Eds.), *Evidence-based psychotherapies for children and adolescents, 2nd edition* (pp. 45-60). New York, NY: Guilford Press.
- Kendall, P.C. & Hedtke, K.A. (2006). *Cognitive-behavioral therapy for anxious children: Therapist manual*. Ardmore, PA: Workbook Publishing.
- Kendall, P.C., Panichelli-Mindel, S.M., Sugarman, A., & Callahan, S.A. (1997). Exposure to child anxiety: Theory, research and practice. *Clinical Psychology: Science and Practice, 4*(1), 29-39. doi: 10.1111/j.1468-2850.1997.tb00096.x
- Kendall, P.C. & Suveg, C. (2006). Treating anxiety disorders in youth. In Kendall, P.C. (Ed.), *Child and adolescent therapy* (pp. 243-294). New York, NY: The Guilford Press.
- King, N.J. & Ollendick, T.H. (1989). Children's anxiety and phobic disorders in school settings: Classification, assessment, and intervention issues. *Review of Educational Research, 59*(4), 431-470. doi: 10.2307/1170206
- Last, C.G. (2006). *Help for worried kids: How your child can conquer anxiety and fear*. New York, NY: Guilford Press.
- Linares-Scott, T.J. & Feeny, N.C. (2006). Relapse prevention techniques in the treatment of childhood anxiety disorders: A case example. *Journal of Contemporary Psychotherapy, 36*, 151-157. doi: 10.1007/s10879-006-9019-8
- Mahoney, G., Kaiser, A., Girolametto, L., MacDonald, J., Robinson, C., Safford, P., & Spiker, D. (1999). Parent education in early intervention: A call for a renewed focus. *Topics in Early Childhood Special Education, 19*(3), 131-140. doi: 10.1177/027112149901900301
- Manassis, K. (2008). *Keys to parenting your anxious child*. New York, NY: Barron's Educational Series, Inc.
- McLeod, B.D., Wood, J.J., & Weisz, J.R. (2007). Examining the association between parenting and childhood anxiety: A meta-analysis. *Clinical Psychology, 27*(8), 986-1003. doi: 10.1016/j.cpr.2006.09.002
- Morris, T.L. & March, J.S. (2004). *Anxiety disorders in children and adolescents*. New York, NY: Guilford Press.
- Pahl, K. M. & Barrett, P.M. (2010). Interventions for anxiety disorders in children using group cognitive-behavioral therapy with family involvement. In Kazdin, A.E. & Weisz, J.R. (Eds.), *Evidence-based psychotherapies for children and adolescents, 2nd edition* (pp. 61-79). New York, NY: Guilford Press.

- Puliafico, A.C. & Kendall, P.C. (2006). Threat-related attentional bias in anxiety-disordered youth: A review. *Clinical Child and Family Psychology Review*, 9(3-4), 162-180. doi: 10.1007/s10567-006-0009-x
- Rapee, R.M. (1997). Potential role of childrearing practices in the development of anxiety and depression. *Clinical Psychology Review*, 17(1), 47-67. doi: 10.1016/S0272-7358(96)00040-2
- Rapee, R.M., Spence, S.H., Cobham, V., & Wignall, A. (2000). *Helping your anxious child: A step-by-step guide for parents*. Oakland, CA: New Harbinger Publications.
- Reinblatt, S.P. & Riddle, M.A. (2007). The pharmacological management of childhood anxiety disorders: A review. *Psychopharmacology*, 191(1), 67-86. doi: 10.1007/s00213-006-0644-4
- Rosenberg, D.R., Banerjee, P., Ivey, J.L., & Lorch, E.R. (2003). Psychopharmacology of child and adolescent anxiety disorders. *Psychiatric Annals*, 33(4), 273-278.
- Silva, R.R., Gallagher, R., & Minami, H. (2006). Cognitive-behavioral treatments for anxiety disorders in children and adolescents. *Primary Psychiatry*, 13(5), 68-76.
- Silverman, W.K. & Kurtines, W.M. (1996). *Anxiety and phobic disorders: A pragmatic approach*. New York, NY: Plenum Press.
- Silverman, W.K., Pina, A.A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, 37(1), 105-130. doi: 10.1080/15374410701817907
- Southam-Gerow, M.A. & Chorpita, B.F. (2007). Anxiety in children and adolescents. In Mash, E.J. & Barkley, R.A. *Assessment of childhood disorders (4th ed.)* (pp. 347-397). New York, NY: Guilford Press.
- Spencer, S.H., Dupont, R.L., & Dupont, C.M. (2003). *Anxiety cure for kids: A guide for parents*. Hoboken, NJ: John Wiley & Sons, Inc.
- Suveg, C., Roblek, T.L., Robin, J., Krain, J., Aschenbrand, S., & Ginsburg, G.S. (2006). Parent involvement when conducting cognitive-behavioral therapy for children with anxiety disorders. *Journal of Cognitive Psychotherapy: An International Quarterly*, 20(3), 287-299. doi: 10.1891/jcop.20.3.287
- Van Ingen, D.J. Freiheit, S.R., & Vye, C.S. (2009). From the lab to the clinic: Effectiveness of cognitive-behavioral treatments for anxiety disorders. *Professional Psychology: Research and Practice*, 40(1), 69-74. doi: 10.1037/a0013318

Vos, T., Haby, M.M., Magnus, A., Mihalopoulos, C., Andrews, G., & Carter, R. (2005). Assessing cost-effectiveness in mental health: Helping policy makers prioritize and plan health services. *Australian and New Zealand Journal and Psychiatry*, 39(8), 701-712. doi: 10.1111/j.1440-1614.2005.01654.x

Wood, J.J., McLeod, B.D., Sigman, M., Hwang, W., & Chu, B.C. (2003). Parenting and childhood anxiety: Theory, empirical findings, and future directions. *Journal of Child Psychology and Psychiatry*, 44(1), 134-151. doi: 10.1111/1469-7610.00106

Appendix B

Permissions

Section B1. Workbook Publishing Permissions

To Whom It May Concern:

I am completing a doctoral dissertation at Pepperdine University entitled “Enhancing Cognitive Behavioral Treatment for Childhood Anxiety Disorders: A Parent Manual.” The manual is intended to improve outcomes for children undergoing CBT for anxiety disorders by providing parents with descriptive information about such treatment and guiding them as to how they might best be involved. The *Coping Cat* program is among the manualized treatments that I am using both (a) to guide my decisions regarding relevant content to include and (b) to highlight to parents as a “model,” state-of-the-art program. With respect to the latter, there is certain content from the program that I would like to include as part of the parent manual that I am producing. Thus, I am requesting permission to reprint in my dissertation excerpts from the following:

Kendall, P. & Hedtke, K.A. (2006). *The Coping Cat Workbook: Second Edition*. Ardmore, PA: Workbook Publishing.

The specific excerpts that I would like permission to reproduce are:

- 1) (pp. 7): Assignment beginning with “If I were in this situation I would feel...” including text and boxes for drawing a face.
- 2) (pp. 10): Assignment requiring child to write about two situations that happened to him during the week.
- 3) (pp. 10): Assignment requiring child to write about someone else’s emotional reaction to a situation during the week.
- 4) (pp. 11): Activities menu: “How do my family members show that they’re scared?”
- 5) (pp.12): Assignment: “How do our bodies tell us we’re anxious?” and image of body.
- 6) (pp. 13): Assignment: “Let’s answer some questions about how our body reacts.” Including all descriptions and images of bodily reactions on this page.
- 7) (pp. 18): Assignment: “Tense or relaxed?” including text, pictures, and rating boxes.
- 8) (pp.21): “Situation 1” text box including text and rating box.
- 9) (pp. 22): Assignment: “What’s in the thought bubble?” Including text and images.
- 10) (p. 40): Assignment: “Make our own FEAR plan card.” Also, accompanying Coping Card on (pp. 79).
- 11) (pp. 41): Assignment beginning with “Time 1” including description of FEAR acronym.
- 12) (pp. 73): Text box of reward menu including image.

These excerpts are to be used to provide examples of typical assignments that may be assigned to children receiving CBT for anxiety. Samples from other well-regarded

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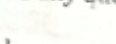
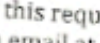
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- 1) (pp. 222)- Fear Ladder including text, chart, and thermometer image
- 2) (pp. 223)- "Feelings" including image of girl
- 3) (pp. 243)- Discrete practice record including text and images of thermometers
- 4) (pp. 253)- "What I Took Back From Anxiety" including text lines and images
- 5) (pp. 262)- Two Column Thought Record
- 6) (pp. 263)- Five Column Thought Record
- 7) (pp. 266)- "How do we know what someone is feeling" including all images.
- 8) (pp. 267)- "Here are things you can feel when you're scared..." including both columns (words and images)
- 9) (pp. 274)-STOP record

These excerpts are to be used to provide examples of typical assignments that may be assigned to children receiving CBT for anxiety. Samples from other well-regarded

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Section B3. Springer Permissions

Hello.

My name is. I am a doctoral student at Pepperdine University and am working on my dissertation. I am interested in using images from the book *Anxiety and Phobic Disorders: A Pragmatic Approach* (Silverman & Kurtines, 1996) in my dissertation and was hoping to gain information about how to submit my request for permissions. If you could provide me with this information or the appropriate contact information to gain permissions, it would be greatly appreciated.

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Appendix C

**Cognitive Behavioral Therapy for Your Anxious Child:
A Guide for Parents**

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Chapter 1: Introduction to the Manual

Who is This Manual For?

Anxiety Disorders are one of the most commonly diagnosed mental health problems in children. If you are reading this manual, your child may be among the 9-15% of children in the general population who suffer from an anxiety disorder³. At this point, you may be feeling scared and perhaps even overwhelmed by what your child is going through. You may be wondering when or even if he⁴ is going get better. Fortunately, there is a wealth of information that can ease your mind, help to answer your questions, and guide you through your child's recovery. This manual is one such resource. Before reading further, let's be sure that this manual is right for you.

- Ⓢ This manual is for parents and other caretakers⁵ who have children between the ages of 8 and 13 receiving Cognitive Behavioral Therapy (CBT) for anxiety disorders.
- Ⓢ This manual assumes that children have already been appropriately assessed and diagnosed with an anxiety disorder. It also assumes that children have either been referred for or have already begun CBT treatment.
- Ⓢ While there are many different types of anxiety disorders, this manual will be most helpful for parents of children with Generalized Anxiety Disorder (GAD), Social Phobia (SoP), Separation Anxiety Disorder (SAD), and Specific Phobia.
- Ⓢ This manual may not be as useful for parents of children with the following disorders: Obsessive Compulsive Disorder (OCD), Post-Traumatic Stress Disorder (PTSD), and Panic Disorder. Although CBT is used to treat these disorders, such treatment often involves specific techniques and unique considerations that won't be covered in this manual.

Content Box...

Do you have a child with OCD, PTSD, or Panic Disorder? The "Association for Behavioral & Cognitive Therapies Website provides useful information about these disorders as well as their treatments. Just follow these steps:

- Go to this Website: www.abct.org
- Click on "The Public and the Media"
- Click on "Evidence Based Practices for Youth"
- Click on "The Public"
- Click on "Fear, Worry, and Anxiety"
- Click on your child's disorder

³ Southam-Gerow & Chorpita, 2007

⁴ For convenience sake, the male pronoun will be used when referring to children even though the manual is intended for parents of both male and female children.

⁵ The term "parents" will be used to refer to all relevant caretakers. The female pronoun will be used when referring to caregivers even though female caretakers, male caregivers, or both may use the manual.

What is the Purpose of This Manual?

Now that you have decided that this manual is right for you, you may be wondering what exactly it will do for you. The purpose of this manual is to provide you with a resource that will help you to better understand the treatment your child is receiving and enhance your ability to help him benefit from it. Sounds good, right? So now you may be wondering, “How will this be done?” Well, if your child is going to be learning the principles and skills that make up CBT, what better way to help you understand his treatment than to guide you through CBT, too! This manual will do just that by providing you with a wealth of information about the goals, format, and content of CBT so that you can understand what he is learning and how you can best help him through the process of treatment.

Here is a list of some of the main topics you will learn about by reading this manual:

- ② Common components of CBT for child anxiety disorders.
- ② Opportunities to get involved in treatment.
- ② Techniques to encourage your child to use his learned skills in his day-to-day life and ways to reinforce him for making the effort to do so.
- ② Information that will prepare you to appropriately manage your child’s anxiety.
- ② Warning signs to be mindful of after treatment has ended that your child’s anxiety may be returning and tips on how to best respond.
- ② Resources providing additional information you may want or need.

Ultimately, all of this information is designed to empower you to help your child successfully manage his own anxiety thus improving his functioning at school, at home, and in social and recreational settings.

Why do Parents Play Such an Important Role in Treatment?

You might be wondering, “How is my involvement going to make a difference?” There are many reasons why parents can often be “difference makers” in the success of their child’s treatment. First, parents generally spend more time with their children than does anyone else. This means that parents have more opportunities than anyone to respond to their child’s anxiety and anxiety-related behaviors in ways that can improve their child’s symptoms. Of course, no one is perfect. Sometimes, despite the best intentions, parents also can respond in ways that can inadvertently worsen their child’s symptoms. Therefore, an additional goal of this manual (as well as that of treatment providers) is to help parents learn to respond to their child’s anxious symptoms in a way that will increase the likelihood of reducing them over time.

Parents can also make a big difference by helping with treatment. Because they spend so much time with their children and are often able to provide

meaningful praise and rewards, parents are in a great position to motivate their child to engage in treatment. Parents can also play an important role in helping their child learn to use his newly acquired skills outside of therapy sessions in real-world situations that make him anxious. In order to make the most of your child's treatment, it is important that you take a proactive role so that he can benefit from all that you can contribute.

What isn't Included in This Manual?

There is an endless supply of information out there that can help you understand various aspects of your child's anxiety disorder and its treatment. While this manual will provide you with a lot of information about your child's CBT treatment, it won't cover many other topics that may be useful to you in your efforts to learn about and help your child with his anxiety disorder. Below, you will find a summary of topics not covered by this manual. This section will also provide you with helpful hints about where to go for more information, if you are interested.

Descriptive information about anxiety and its disorders. If you are reading this manual, you already know that your child has an anxiety disorder and you probably also know which specific disorder(s) he has. Knowing more about your child's specific anxiety disorder can further enhance your ability to help him through treatment and beyond. While this manual does not provide descriptive information about each anxiety disorder, you are encouraged to seek out more information about your child's disorder so that you can better understand what he is going through.

Content Box...

Want to find out more about your child's anxiety disorder?
Go to Appendix A of this manual to learn more about where to find
information about anxiety and its disorders.

Assessment and evaluation issues. This manual assumes that your child has already been assessed and diagnosed with an anxiety disorder. Therefore, information about evaluation and diagnostic process will not be covered.

Content Box...

While there will inevitably be differences across clinicians in the specific way that anxiety is assessed, there are some generally recognized standards that exist regarding both the process and the content of such evaluations. If you are interested in learning more about how your child was assessed, talk to your child's therapist. You may also check out the American Academy of Child and Adolescent Psychiatry Website. Just follow these directions:

- Go to the Website www.aacap.org
- Click on "For Families"
- Under "Learn about Mental Illnesses/Disorders", click "Anxiety Disorders Resource Center"
- Under "Clinical Resources", click "Practice Parameters for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders"
- Scroll down to "Screening" and "Evaluation" sections

Identifying therapists. If you are using this manual, then you and your child have been referred to or have already initiated CBT with a licensed Mental Health professional. Therefore, ways of identifying therapists will not be addressed in this manual.

Content Box...

Please refer to the following website for assistance in locating a therapist if needed. Just follow these steps:

- Go to this website: www.abct.org
- click on "The Public and the Media"
- click on "Find a Therapist"

You can also contact your insurance company for referrals.

Dealing with coexisting mental health disorders. Many children with anxiety disorders also suffer from other mental health problems. These are called comorbidities. The most common comorbidities for children with anxiety disorders are depression and disruptive behavior disorders (such as ADHD).⁶ Although the manual will not be addressing these comorbidities specifically, it is assumed that the evaluation your child received assessed for these potentially co-occurring problems and that any comorbid disorders are being addressed as part of your child's overall treatment.

Content Box...

If you believe that your child may have a comorbid disorder that is not being treated, please speak to your child's therapist to address these concerns.

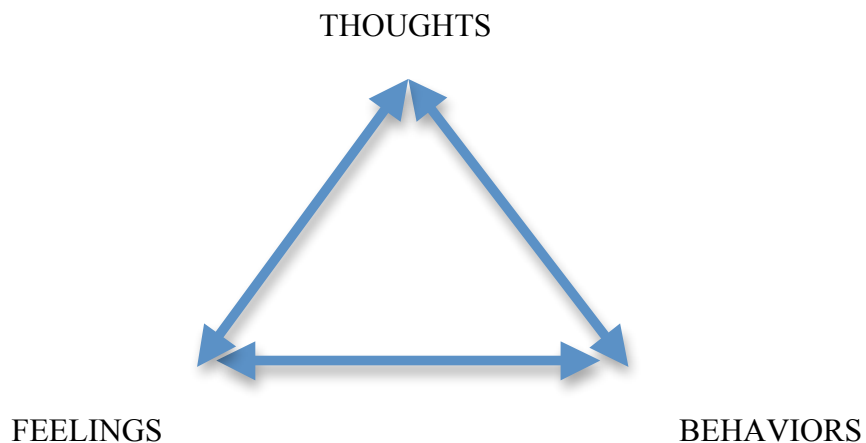
⁶ Albano, Chorpita, & Barlow, 1996; Verduin & Kendall, 2003

Why Does This Manual Focus on CBT?

There are many different types of therapies out there. As mentioned earlier in this chapter, this manual will focus specifically on Cognitive Behavioral Therapy (CBT). If you have never heard of CBT, you may be wondering, “What exactly is it?” or “Why focus on this treatment instead of the others?” Let’s answer some of those questions before moving on.

What is CBT? CBT for anxiety disorders is a type of therapy that includes many different components, or parts. The treatment almost always includes educating children about anxiety and its treatment (called *psychoeducation*), teaching children to modify their negative, anxiety-provoking self-talk and thoughts (called *cognitive coping skills* or *cognitive restructuring*), helping children to manage their physical symptoms of anxiety (called *somatic skills training*), helping children to face feared situations (called *exposure*), and teaching children about signs that their anxiety may be returning and helping them to know what to do (called *relapse prevention*)⁷. In learning these strategies, children become able to recognize signs of anxiety and to use specific skills to cope with it on their own. The strategies of CBT may be foreign to you right now, but don’t worry; you will learn all about them in this manual.

A primary focus of CBT is teaching children about the relationship between thoughts, feelings, and behaviors. Specifically, children learn that anxiety shows itself in each of these three areas, as well as in their bodies. Here is an example to help illustrate how anxiety can be expressed in each of these areas: If a child is fearful about sleeping at a friend’s house, he might think, “What if something happens to my mother while I am away?”(thought). This may make him so anxious (feeling) and physically distressed (e.g., stomach distress) that he decides not to go to the sleep over (behavior). After children understand how anxiety shows up in thoughts, feelings, physical sensations, and behaviors, they then learn that each of these components can influence the others and that by changing one component, it is possible to change the others.



⁷ Albano & Kendall, 2002

Here's a figure that may help you to better understand the relationship between thoughts, feelings, and behaviors. The double arrows indicate the bi-directional relationship between two components.

CBT is usually a short-term treatment that can range in length anywhere from six to twenty or more sessions. The length of therapy often depends on the therapist's approach to treatment as well as the individual needs of the child. CBT is sometimes guided by a treatment manual. Developed by experts in the field of child anxiety disorders, such manuals typically provide an overarching structure and step-by-step instructions that guide the therapist in providing the treatment. The manual may also include a "workbook" to help you and your child practice and apply the skills he is learning. You should feel free to ask your child's therapist if she is formally using a manualized treatment or if a particular manual informs her treatment.

Content Box...

Refer to Appendix A for a list of well-regarded manualized treatments and referrals for more information about them.

Why is CBT the best available treatment for anxious children? CBT for child anxiety disorders is an *evidence-based treatment*. This means that it has been tested through good quality research and has been found to benefit children with anxiety disorders. In fact, behavioral and cognitive-behavioral therapies are the *only* psychological treatments supported by substantial evidence⁸. Consequently, current guidelines for mental health professionals recommend that CBT be included as part of any treatment plan for child anxiety⁹.

What about medication? While research on the use of medications for child anxiety disorders is limited, some studies have found that they can help to reduce anxiety symptoms and improve general functioning in children. These studies identify a group of drugs known as Selective Serotonin Reuptake Inhibitors (SSRIs) as the preferred medication treatments for child anxiety disorders¹⁰. Names of SSRIs commonly used to treat child anxiety disorders include Zoloft, Paxil, and Luvox.¹¹ In sound clinical trials involving children suffering from Generalized Anxiety Disorder, Separation Anxiety Disorder, Social Phobia, and Obsessive Compulsive Disorder, the majority of children receiving SSRI medication have experienced significant reductions in their anxiety symptoms that exceed those experienced by children taking placebos¹².

⁸ Barrett & Ollendick, 2004; Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Ginsburg & Kingery, 2007; Silverman, Pina, & Viswesvaran, 2008.

⁹ AACAP, 2007

¹⁰ Rosenberg, Banerjee, Ivey, & Lorch, 2003

¹¹ Compton, Kratochvil, & March, 2007

¹² Compton, Kratochvil, & March, 2007

At this point, you might be asking which treatment is more helpful, CBT or medication? Although this is a good question, a definitive answer is not yet available. A few studies have compared three groups of anxious children; one receiving CBT, one receiving an SSRI medication, and a third receiving both CBT and medication. These studies generally find that both CBT and SSRI medications are effective treatments. However, they also indicate that the combination of CBT and medication tends to be more effective than either treatment used alone¹³. Although these studies may suggest that combination treatment is the best choice, it is important to consider that the results of these studies reflect group averages only and do not capture the individual characteristics and needs of each child. This means that for some individual children, CBT will be the most effective treatment, for others medication will be the most beneficial, and for still others the combination of the two will be best. Unfortunately there is no way to predict which treatment or combination of treatments is going to be most effective for your child. It is up to you, as the parent, to inform yourself about the available treatments, weigh the options, and make the best decision for you and your child.

Given that you are reading this manual, you have already decided to initiate CBT as one treatment approach for your child. With respect to medication treatment, you may have already decided to pursue it, already decided against it, or may be considering it but struggling with mixed feelings about this type of intervention. If you are having such a struggle, speak to your child's therapist and/or physician about the pros and cons of medication for your child. You may also want to consult a child psychiatrist to get a more thorough medication evaluation from an expert in this area. Such consultations can be useful in helping you to make this personal decision. Regardless of your decision about medication, this manual will still be helpful if your child continues to participate in CBT.

Content Box...

It is important that all of your child's treatment providers coordinate their care to provide the best possible treatment for your child. You are your child's best advocate so talk to his treatment providers and let them know what other treatments he is receiving.

What Roles can Parents Play in CBT for Child Anxiety?

During the time that your child is in treatment, you may be asked to take on a number of roles. Here is a list of some of the roles you may play in treatment¹⁴:

¹³ Walkup, Albano, Piacentini, Birmaher, Compton, Sherrill, Ginsburg...Kendall, 2008; Compton, Kratochvil, & March, 2007

¹⁴ Kendall & Choudhury, 2003; Mahoney, G., Kaiser, A., Girolametto, L., MacDonald, J., Robinson, C., Safford, P., & Spiker, D, 1999

- ☉ *“The Informant”*: You are a valuable source of information regarding your child’s past development and current functioning. For this reason, you will likely be called upon to inform your child’s therapist about relevant background information.
- ☉ *“The Assistant Coach”*: As a parent, you are in the perfect position to encourage your child’s participation in treatment. Perhaps the best way to do this is by reinforcing your child (e.g., by providing praise and rewards) when he practices the skills he is learning in therapy and faces feared situations (also known as “exposure”). You can also serve as a valuable source of encouragement and support as your child participates in exposures (see Chapter 4), as this is often the most important but also the most difficult part of treatment.
- ☉ *“The Co-Therapist”*: Since you spend more time with your child than the therapist, you are better able to help your child practice his newly learned skills outside of treatment. In playing this role, you increase the likelihood that your child will use these skills to successfully manage anxiety in his daily life.
- ☉ *“The Co-Client¹⁵”*: In some instances, you or your entire family may be asked to become clients in treatment as well. For example, as a co-client, you may learn the best parenting strategies to manage your child’s anxiety. You may also learn CBT skills that you can use for yourself (for example, to better manage your own anxiety). Learning these skills will help you to model appropriate behavior to your child.

There are other roles you may take that can help to improve your child’s anxiety. While some general roles for parents are discussed here, more specific roles and ways in which parents may contribute to treatment will be addressed in further detail throughout the remaining chapters of the manual. But first, let’s review some more general ways you may be able to help your child throughout treatment.

Empathy and support. Empathy refers to truly understanding and sharing in another person’s emotional state. For parents, empathy is conveying to their child an understanding of his emotions and point of view¹⁶. In providing empathy and support to your child, you can help him to feel understood and supported as he faces his anxiety throughout treatment.

Modeling. In CBT, modeling refers to a parent or therapist demonstrating the use of a particular skill in an anxiety-provoking situation¹⁷. While the therapist will model desired behaviors in therapy, your child will benefit from having you model desired behaviors and skills outside of therapy, making it more likely that he will use them appropriately. In subsequent chapters, this manual will point out specific skills and behaviors that you may be able to model for your child. While this

¹⁵ Kendall & Choudhury, 2003, pg. 93

¹⁶ Psychogiou, L., Daley, D., Thompson, M.J., & Sonuga-Barke, J.S., 2008

¹⁷ Chorpita & Southam-Gerow, 2006

manual will provide periodic suggestions for how to model specific skills, you should speak to your child's therapist on an ongoing basis about how you might be most helpful in modeling various aspects of treatment.

Supportively pushing your child past his comfort zone. One of the most important ways you can help your child is by encouraging him to face his fears so that he can overcome them. It is normal as a parent to feel strongly the need to protect your child from experiencing anxiety and distress. Despite this urge, confronting fear-provoking situations is a necessary and vital step in overcoming anxiety and, therefore, encouraging non-avoidance is essential. Some ways to do this include facing the feared situation with your child or even facing your own fears with your child present in order to model appropriate "facing the fear" behavior. To find out more about how you can do this, see Chapter 4, "Exposure."

Some Additional Factors for You to Consider

Experiencing your own mental health difficulties? It is not uncommon for parents of anxious children to struggle with anxious symptoms themselves. In addition to anxiety, research has also suggested that depression is more common among parents of anxious children. Having a child in the family who is struggling with an anxiety disorder can, in and of itself, be a significant stressor that can leave parents feeling overwhelmed. Struggling with these or other mental health issues can make it more difficult for parents to help their child benefit from treatment. Therefore, if you find that you are experiencing psychological distress, it is important that you too seek mental health services. In doing so, you can not only enhance your own well-being but also better position yourself to help your anxious child.

What if aspects of treatment clash with your cultural background or personal beliefs? At times, the style of the therapist or some aspects of treatment may clash with some of your cultural traditions, practices, and beliefs. Although this can occur in a wide variety of ways, examining a particular example may help to prepare you to recognize and respond to these situations. Below you will find an example of a Mexican American child whose mother identifies an inconsistency between the family's culture and traditional CBT treatment¹⁸.

¹⁸ Example adapted from Wood, Chiu, Hwang, Jacobs, & Ifekwunigwe, 2008; Maldonado-Duran, Lubin, Manguia-Wellman, & Lartigue, 2002

Example of a Cultural Clash...

Juan is an eight-year-old Mexican American child receiving CBT for Separation Anxiety Disorder. In gathering information on Juan's current behavior, the therapist learned that Juan is still sleeping in bed with his parents and decided that one goal of therapy should be getting Juan to sleep in his own bed so that he can become more independent. When Juan's mother learned of this goal, she became upset since it is common in her culture for children of Juan's age to sleep in bed with their parents, particularly since several generations of their family live together in a small two-bedroom home leaving little room for Juan to have his own bed.

Strategy for what to do when elements of treatment are culturally inconsistent. If you identify a conflict between CBT and your culture as Juan's mother did, follow this general strategy in order to address the issue:

- ⊗ First, don't be shy! Raise the issue with your child's therapist as soon as you notice it.
- ⊗ Then, have an open conversation with your child's therapist about your discomfort with this particular aspect of treatment. Try to be specific in explaining which aspects of your culture or belief system conflict with the treatment.
- ⊗ Finally, work collaboratively with your child's therapist to develop a strategy for modifying the treatment so that your child can gain the benefits of the intervention in a way that feels culturally consistent.

Example of a Cultural Clash Continued...

Juan's mother decided to speak to her child's therapist right away so she called and scheduled a meeting. During the meeting, Juan's mother explained to the therapist why she felt that the goal of getting Juan to sleep alone was inconsistent with the family's culture and circumstances. She was sure to provide clear details about her cultural beliefs so that the therapist was able to understand the reasons for concern. Juan's therapist agreed that the goal was inconsistent with the family's culture and agreed to modify treatment. Juan's mother and the therapist worked together to decide that while encouraging Juan to sleep alone at this time was not culturally consistent, it would be consistent for Juan to work on being more independent at school. The treatment focused on increasing Juan's independence from his mother during the school day.

How to Use This Manual

As discussed earlier in this chapter, this manual provides you with detailed information about the common components of CBT treatment for child anxiety disorders. Although the sequencing of these components can vary across therapists and children, the general content tends to remain similar whenever CBT is being used to treat anxious

children. Therefore, these common components will be presented with the expectation that you will consider the suggestions below in determining how best to use this manual.

This manual can be used in a number of ways. In order to find out which is best for you, you need to know some details about the approach your child's therapist will be taking with treatment. Consider asking about the following:

- ☉ *Is your child's therapist using a treatment manual?*
 - If yes, what treatment components are involved in the manual?
 - If no, what treatment components does the therapist plan on using?
 - If a manual is being used, does the therapist typically adhere very closely to the manual or does she use it more as a general guide for treatment that is tailored for each individual? If the latter, how does she go about determining the best ways to tailor the manual and what does she anticipate with respect to modifying the manual for your child?

Content Box...

Regardless of the treatment approach, it will be helpful to get a general idea of what components will be included and in what order they will be taught.

Once you know what components are being used and in what order, you can decide how you would like to proceed with this manual.

- ☉ Your first option is to read the manual from beginning to end prior to your child beginning treatment or as soon as possible after treatment has begun. This will help you to get the full picture of your child's treatment. You can always go back and familiarize yourself with a particular component when needed.
- ☉ The second option is to match your reading with your child's ongoing treatment, reading the appropriate chapter just before your child begins to learn that component. You can always refer to the manual as needed for reminders about ways to help with a particular component or how to face trouble spots.

If the therapist is already aware that you are using this manual, be sure to have a conversation with her about the best ways for you to coordinate its use with your child's treatment. It will be important to decide how the manual's content will be discussed and how your questions emerging from your review of the manual will be addressed. If the therapist is not aware that you are using this manual, be sure to draw her attention to it and then address the above points about its use.

Conclusions

Now that you are oriented to this manual, it's time to turn your attention to CBT and learn ways that you can get involved in order to help your child. Each of the following chapters addresses one of the common components of CBT that will likely be part of your child's treatment. Within each chapter you will find common sections, providing a description of the component, noting what is likely to happen in each session, listing possible homework your child will receive, reviewing roles you can play, and identifying possible trouble spots that may arise. Be sure to attend to the "Content Boxes" as they provide useful references, examples, and referrals to relevant appendices. The appendices in the back of this manual will be particularly helpful in pointing you in the right direction to gain further information if you need

Chapter 2: Psychoeducation

A Brief Description

Psychoeducation refers to the component of treatment during which you and your child will learn about anxiety and will be given a general overview of CBT treatment¹⁹. The education about anxiety will likely include information about the ways in which anxiety can help us to function in every day life, the signs that anxiety may be becoming a problem, and the typical symptoms of anxiety disorders. Detailed information about your child's specific diagnosis (or diagnoses) should also be provided. The education about CBT will likely include a broad description of treatment and its components as well as a discussion of how your child's therapeutic goals will be met. Information that is typically provided on both of these topics will be presented in greater detail in the sections below.

Psychoeducation is often the first component of CBT. However, your child's therapist should provide and reinforce information intended to educate you and your child about his disorder and treatment consistently throughout therapy.

Benefits. Listed below are some of the many important benefits of psychoeducation for both you and your child.

Benefits for your child include:

- Ⓢ Helping your child see anxiety as a “normal” emotion and giving your child a way to understand and discuss the symptoms he has been experiencing.
- Ⓢ Understanding the various ways that anxiety commonly presents itself (fearful thoughts, bodily symptoms, nervous feelings, avoidant behavior)²⁰.
- Ⓢ Understanding the rationale for CBT, what he'll be doing in treatment, and how it will help him to face his fears and manage his symptoms.
- Ⓢ Becoming less anxious about treatment, which can allow him to better learn the information and skills needed to overcome anxiety.

Benefits for parents include:

- Ⓢ Learning about your child's disorder, including possible contributing factors and symptoms of his anxiety.
- Ⓢ Finding out about what the therapist plans to do in treatment in order to help your child.
- Ⓢ Possibly alleviating some of your concerns about your child's symptoms by helping you to see them as “typical” manifestations of anxiety rather than “bizarre” or highly unusual.
- Ⓢ Developing a common language with which to speak to your child about his anxiety and treatment²¹.

¹⁹ Ginsburg & Kingery, 2007

²⁰ Ginsburg & Kingery, 2007

- Teaching you how to assist in “managing” your child’s anxious behaviors²².

Content Box...

Most therapists include one-on-one sessions with parents as part of treatment. This is often where vital psychoeducational information is provided. If you have not been offered a parent session or at least some time at the end of your child’s sessions in order to receive this information, contact your child’s therapist to set up a meeting.

What is Likely to Happen in Sessions?

General information. What you and your child learn and when it is covered will depend on several factors. These include the nature of the specific cognitive-behavioral treatment approach being used (e.g., does the treatment follow a specific manual that specifies the type and timing of content to be covered?), the unique approach and preferences of your child’s therapist, and the unique needs of your child. With respect to the latter, factors such as your child’s age, his presenting problems, and his previous experience in therapy can all influence the type of information your child will learn during psychoeducation. Despite these differences, most CBT programs for childhood anxiety disorders tend to include similar information.

In general, psychoeducational information tends to be delivered to both parents and children in discussions during sessions. However, children will likely acquire additional information through workbook exercises while parents may receive additional information through readings suggested by the therapist.

Orientation to anxiety. The following section will provide an overview of some of the key content likely to be covered as part of the psychoeducational components devoted to teaching you and your child about anxiety.

Often the first thing that both children and parents learn about anxiety is that it is actually a “normal” emotion. In fact, everyone experiences anxiety from time to time. It is important to recognize that anxiety serves some very important functions for us. Most notably, it helps alert us to danger and prepares us to deal with potentially threatening situations²³. Thus, as part of psychoeducation, children learn that anxiety can actually protect them from harm and help them to safely adapt to new situations. It is important that children learn to identify the signs of anxiety so they can protect themselves in situations of real threat and so they can use the anxiety management skills they will be learning in therapy in situations where anxiety is not adaptive or helpful. Therefore, one of the major goals of psychoeducation is to teach children how to identify typical

²¹ Ginsburg & Kingery, 2007

²² Silverman & Kurtines, 1996

²³ Chorpita, 2007; Kendall & Hedtke, 2006

symptoms of anxiety. While each child experiences anxiety somewhat differently, it will likely be helpful to be aware of the typical information your child will learn about the main domains where anxious symptoms tend to show themselves.

The main domains of anxiety symptoms include:

- ☉ Mood/affect²⁴
 - Common symptoms include nervousness, anxiousness, and irritability.
 - For example, a child suffering from separation anxiety disorder may feel fearful or nervous when leaving his parents for the day.
- ☉ Bodily reactions²⁵
 - Common symptoms include racing heart, sweating, and rapid breathing.
 - For example, a child suffering from social phobia may begin to sweat or feel his heart racing before he goes to a crowded playground.
- ☉ Negative “self talk” and anxious thoughts²⁶
 - For example, a child with generalized anxiety may tell himself, “something bad is going to happen” or “I can’t do this.”
- ☉ Anxious behaviors²⁷
 - Common symptoms include avoidance, “freezing,” pacing, and biting nails.
 - For example, a child with a specific phobia of spiders may stay away from anything that reminds him of spiders. He may avoid books/movies like *Charlotte’s Web* or may avoid going to the park where he might see spiders.

Content Box...

Refer to Chapters on “Emotion Skills Training,” “Exposures,” and “Cognitive Skills Training,” to find out more about these symptoms and how your child will learn to manage them.

When does anxiety become a problem? While anxiety is a normal, expected, and often-helpful reaction to threatening situations, it also can become problematic under certain circumstances²⁸. Anxiety may be a problem if it lasts longer and is more intense than expected in a given situation, if it causes significant distress, and if it interferes with important areas of life including but not limited to school and social activities. For example, it is typical for someone who is about to give a speech in front of a group of

²⁴ Southam-Gerow & Kendall, 2000

²⁵ Greaves-Lord, Ferdinand, Sondejker, Dietrich, Oldehinkel, Rosmalen, Ormel, & Verhulst, 2007; Schiefelbein & Susman, 2006; Weems, Zakes, Costa, Cannon, & Watts, 2005

²⁶ Kendall & Treadwell, 2007

²⁷ Kendall & Suveg, 2006

²⁸ Ginsburg & Kingery, 2007

people to experience an increase in his heart rate, some sweating, and a feeling of nervousness. However, if that person were to get so nervous that he is unable to start or complete his speech, anxiety has likely become “problematic.” These criteria pertaining to the intensity of the anxious features, how distressing they are, and whether they interfere with functioning were likely among the considerations that your child’s clinician used to determine that your child is suffering from an anxiety disorder that warrants treatment.

General information on anxiety disorders. There are a total of nine anxiety disorders identified in the current diagnostic manual used by mental health professionals (referred to as the Diagnostic and Statistical Manual of Mental Disorders or DSM-IV-TR)²⁹. These include Panic Disorder, Agoraphobia, Generalized Anxiety Disorder (GAD), Separation-Anxiety Disorder (SAD)³⁰, Obsessive-Compulsive Disorder (OCD), Specific Phobia, Social Phobia (SoP), Posttraumatic Stress Disorder, and Acute Stress Disorder. Although any of these disorders may be diagnosed in childhood, the ones most commonly diagnosed in youth include Separation Anxiety Disorder (SAD) and Generalized Anxiety Disorder (GAD)³¹. While each of the nine anxiety disorders noted above is distinct, they often have symptoms that overlap. As a result, it is common for children suffering from anxiety to exhibit symptoms from many different disorders. For example, someone who has social phobia and, therefore experiences intense anxiety and fear of embarrassing himself in social situations, may also experience panic attacks (e.g., sweating, rapid heart rate, dizziness, chest pain, fear of losing control) prior to or during social situations. A child who has lots of generalized anxiety and worry might also have a highly specific fear of thunderstorms. Regardless of the symptoms or the specific diagnosis, most anxiety disorders tend to persist if left untreated.

Nature, prevalence, and course of anxiety disorders. As listed above, there are a variety of anxiety disorders that can afflict youth. If you are reading this manual, your child has already been assessed and diagnosed with one of the following disorders: SAD, GAD, SoP, or Specific Phobia. As part of treatment, your child’s therapist will be providing you and your child with information that is specific to your child’s anxiety disorder(s). While space does not permit this manual to provide specific information about each anxiety disorder, the following is a brief discussion of the nature, prevalence, and course of anxiety disorders in general.

Definitive causes of anxiety disorders have not yet been identified. However, current expert opinion states that anxiety disorders typically develop through a combination of biological and environmental factors³². Biological factors include a genetic vulnerability towards anxious states and a temperament (or early-emerging

²⁹ American Psychiatric Association, 2000

³⁰ Although the DSM-IV-TR places SAD in a section of the manual entitled “Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence” rather than in the “Anxiety Disorders” section, it is clearly an anxiety disorder and warrants inclusion here.

³¹ Cartwright-Hatton, McNicol, & Doubleday, 2006; Hammerness, Harpold, Petty, Menard, Zar-Kessler, & Biederman, 2008

³² Ginsburg & Kingery, 2007

personality trait) that is prone towards what is called “negative affectivity.”³³ Children with negative affectivity are prone to experience distressing emotions (including fear, worry, and sadness) more readily or with less provocation than their peers. Studies have suggested that this proneness towards negative affectivity is a common risk factor across various anxiety disorders. However, experts believe that certain environmental risk factors might need to be present to trigger the onset of a diagnosable anxiety disorder in a child who is vulnerable by virtue of his genetic makeup or negative affectivity³⁴. The relevant environmental risks might be experiences that generally undermine a child’s sense that he can control things in his life (e.g., not being put in a position where he can face and cope with new challenges) and/or experiences that contribute to a child focusing his anxiety on a specific object or situation (e.g., being teased by peers; being in a car accident).

An example may be helpful to demonstrate how genetics, temperament, and environment may interact and lead to the development of an anxiety disorder.

Example....

Bobby, age 8, comes from a family where many of his relatives have struggled with anxiety. His mother has been treated for Generalized Anxiety Disorder and both his grandfather and his cousin have been diagnosed with Social Phobia (genetic vulnerability). Since Bobby was a baby, he has always reacted to situations with more distress and fear than his brothers and sisters. Temperamentally, he is easily upset and cries with little provocation (negative affectivity). Because Bobby’s mother worries about how helpless he seems and wants to protect him from becoming upset, she frequently steps in to solve problems for him, including conflicts with his siblings and friends. She gives Bobby a lot of reassurance and takes him with her whenever she can so he feels safe (environmental factors that may undermine his sense of control). As Bobby grew up, he became reliant on his mother to solve his problems and is increasingly anxious about leaving her. One night, Bobby’s mother was late coming home from work. Bobby’s father told Bobby that his mother was in an accident and got hurt but provided no additional details. Although his mother suffered only minor injuries, Bobby became extremely upset and was inconsolable until she returned home and he was convinced that she was ok (environmental risk related to an experience that focused his anxiety on separation). Since that time, Bobby gets so upset when his mother leaves that he gets physically sick. When Bobby’s mother took him to see a therapist, he was diagnosed with Separation Anxiety Disorder.

The diagnostic evaluation conducted on your child might have identified biological and/or environmental risk factors that may have contributed to his difficulties with anxiety. However, it is typically the case that it is not possible to definitively identify the cause or causes of an anxiety disorder in any given child. Fortunately, it is usually not necessary to identify a specific cause for treatment to be successful³⁵.

³³ Barlow, 2002; Chorpita, 2007

³⁴ Barlow, 2002

³⁵ Chorpita, 2007; It is important to note that the one exception to this is when a child’s anxious symptoms are due to a specific medical problem (e.g., thyroid) that requires a specific medical intervention (e.g., synthetic hormone replacement).

Content Box...

Check out the following Website for more information regarding your child's specific anxiety disorder(s):

- Go to the Website: www.abct.org
- Click on "The Public and the Media"
- Click on "Evidence Based Practices for Youth"
- Click on "The Public"
- Click on "Fear, Worry, and Anxiety"
- Click on your child's disorder

Orientation to treatment. The following section will provide an overview of some of the key content likely to be covered as part of the psychoeducational component devoted to educating parents and children about treatment. While the psychoeducation you receive throughout your child's treatment should provide you with a good base of knowledge regarding CBT, this manual will complement that knowledge by helping you to further understand each component of treatment as well as how you will be able to help along the way.

One of the first and most important things your child will learn is that, given that anxiety is a necessary and often helpful emotion, the goal of CBT is to help the child become skilled at identifying and managing anxious symptoms, not to eliminate anxiety completely³⁶. The information and skills that follow in this as well as in subsequent chapters will help your child to successfully meet this important goal.

The CBT model. The CBT model is the foundation of CBT treatment. It provides a straightforward way of understanding both the nature of anxiety disorders as well as how they are treated. Specifically, it explains how thoughts, feelings, and behaviors interact to either increase or decrease anxiety.

Content Box...

Refer to page 5 of the "Introduction" Chapter to see a diagram of the CBT model and to learn more about the relationship between thoughts, feelings, and behaviors.

The CBT model is presented to children in order to help them understand how anxiety can be expressed in various thoughts, feelings, and behaviors as well as how each of these components can interact with each other³⁷. Below you will find an example that will help to demonstrate this important point.

³⁶ Chorpita, 2007; Kendall & Hedtke, 2006; Silverman & Kurtines, 1996

³⁷ Barlow, 2002

Example... The Relationship Between Thoughts, Feelings and Behaviors

Tom is a 10-year-old boy who is terrified of speaking in public. Today he is particularly anxious because he has to present a book report in front of his entire class. As he sits in class waiting his turn to speak, he begins to think, “I’m going to make a fool out of myself” (thought). As he thinks this anxious thought, he begins to feel nervous (feeling). By the time he gets up to speak, Tom is so nervous that he makes several mistakes throughout his speech (behavior). Although he was able to make it through the speech, he felt so embarrassed that he is now inclined to avoid all opportunities to speak in front of others (behavior).

As you can see in the previous example, a child’s anxious thoughts can quickly lead to anxious feelings and maladaptive behaviors. Such a “domino effect” can occur regardless of which component (thought, feeling, or behavior) initiates the cycle. For example, a child who is afraid of the dark may wake up in the middle of the night in a dark room and immediately feel anxious (including physical manifestations of anxiety such as racing heart rate or sweating). This feeling may lead him to think “something must be wrong” or “I’m not safe here” which could result in behaviors (that ultimately increase his anxiety) such as going to sleep in his parents’ room or sleeping with the lights on.

Just as the CBT model explains how the relationship between thoughts, feelings, and behaviors can lead to the development, maintenance, or worsening of anxiety, it also explains how changing one of these aspects can change the others, either increasing or decreasing anxiety. For this reason, the model is critical in guiding treatment, since your child will learn skills to target each component of the model in order to decrease his anxiety. Let’s continue with the example above in order to demonstrate how each aspect of the model may be targeted to decrease anxiety. To learn more about the skills discussed in the following paragraphs as well as other skills your child may learn in treatment that will target his anxiety, refer to the upcoming chapters of this manual.

Example of Targeting Negative “Self-Talk”...

While Tom used to have the anxious thought, “I’m going to make a fool out of myself,” treatment is now helping him to develop more positive, accurate, and adaptive self-statements. For example, he is practicing telling himself, “Lots of people get nervous when talking in front of others,” and “I can be nervous and still do a good job.”

Example of Targeting Bodily/Somatic Symptoms (for the purpose of reducing anxious feelings)...

Tom tends to feel anxious prior to speaking in public. In order to help him to reduce these feelings, he is learning to use skills such as deep breathing and progressive muscle relaxation so that he can calm himself down in situations where he wants or needs to speak in front of others.

Example of Targeting Maladaptive Behaviors...

Skill Building... Tom's anxiety has contributed to many unhelpful behaviors (e.g., avoiding eye contact, speaking very softly) that make public speaking even harder for him. This has left him lacking in confidence when it comes to speaking in front of others. To work on this issue, treatment is focusing on teaching and reinforcing skills related to public speaking in order to help increase his skills and confidence. For example, he is learning to speak clearly and to make good eye contact with an audience by watching video clips of effective public speakers and repeating the adaptive behaviors that they model.

Exposure... Tom's anxiety has led him to be fearful of speaking in front of others. In treatment, exposure activities are focusing on helping Tom to face his fears. Specifically, after developing a coping plan for dealing with his anxiety (including positive self-talk, relaxation, and using his improved public speaking skills), he is asked to practice speaking in front of others in a broad range of contexts, starting with situations that produce only a low level anxiety and gradually working up to the most anxiety-provoking situations. Tom's experiences, including his level of anxiety before, during, and after the speech as well as the effectiveness of his coping strategies, are being evaluated and tracked over time to identify any changes that make occur.

As your child begins to learn these and other skills to manage and decrease his anxiety, he will also learn that the more he practices, the easier facing his fears will become³⁸. Again, this chapter is providing just an introduction to treatment, and many of the typical skills your child may learn will be covered in more detail in the chapters ahead. Tips that can assist you in helping your child practice his newly learned skills will be provided below as well as within each topic-specific chapter. But first, let's review a few more important aspects of the psychoeducational phase of treatment.

Other important aspects of psychoeducation. There are many additional pieces of information that you and your child will gather during the psychoeducational phase of treatment. First, you and your child will learn that CBT has a structure and focus that is unique from many other treatments. CBT for anxiety is generally short-term (approximately 16-20 sessions), although the length of treatment tends to vary based on the needs of the child. Treatment is largely "present-focused." In other words, while other forms of therapy may focus on past factors that might have contributed to the development of anxiety, CBT focuses more on addressing factors in the here-and-now that maintain or worsen the child's anxiety. CBT is also an active treatment, involving learning, mastering, and implementing various skills. As with any skill, mastery doesn't happen passively but requires a great deal of engagement, coaching, and practice. Such skill building, therefore, involves active participation of the therapist, child, and the parent. Active practice of learned skills occurs both in and out of treatment. Of course, since your child spends most of his time outside of the therapy room, homework

³⁸ Chorpita, 2007

becomes a critical component of treatment as it provides practice that will enable him to master skills necessary for effectively managing real-life anxiety-provoking situations.

An additional hallmark of CBT treatment is that it is collaborative³⁹. Early in treatment, your child will learn that he is not alone as he works towards managing his anxiety. Instead, he will learn that therapy involves him, his therapist, and you working together “as a team” to learn how to manage or control his anxious symptoms. Your child will likely begin by relying heavily on his therapist as well as on you for guidance and support. At this stage it is especially important that you gain as much information as possible from the therapist as well as from other resources such as this manual so that you can help your child to develop the knowledge he needs to take charge of his own anxiety. Over the course of treatment, the direct guidance provided by the therapist and you will be gradually faded so that your child is taking more and more responsibility for implementing the skills he has learned and managing his anxiety on his own⁴⁰. By gradually taking on more and more responsibility, your child will begin to realize that he now possesses the ability to manage his own anxiety. The following example may help to demonstrate the importance of collaboration and the gradual development of your child’s independence in managing his anxiety.

Example Developing Independence Through Collaboration...

David is an 8-year-old boy suffering from social phobia. He has a difficult time making friends since he is so anxious being around others. In order to work on this problem, David, his therapist, and his mother all agree that exposure activities, where he faces situations that make him anxious, will be helpful. Early in treatment, David practices playing near other children at the park while his mother and therapist stay close by. This behavior helps him to feel supported in performing this anxiety-provoking task. As therapy continues and David’s anxiety begins to decrease in social situations, he is then asked to play near other children at the park with his mother and therapist across the playground instead of right next to him. Finally, as he learns more skills and becomes less anxious in other social situations, David is asked to conduct such an exposure on his own. Specifically, he is asked to approach children and ask them to play with him during recess at school. Through this gradual exposure, David begins feeling confident in his ability to manage his anxiety on his own.

An additional aspect of treatment that is often discussed during psychoeducation is the fact that CBT typically involves ongoing monitoring of the treatment and its effects. Monitoring will occur in several ways. First, the therapist will check in with your child frequently to be sure that he understands and is benefiting from treatment. Also, you and your child might be asked to complete various measures (questionnaires, rating scales) to monitor your child’s progress. In addition to completing the measures, you can also share your impressions of how well your child is understanding and implementing

³⁹ Chorpita, 2007; Silverman & Kurtines, 1996

⁴⁰ Silverman & Kurtines, 1996

what he is learning in treatment as well as what sort of impact the treatment is having on his anxious symptoms and overall functioning.

In addition to the general information on CBT covered during psychoeducation, you and your child will most likely receive an overview of the components of treatment that your child will be learning and participating in. The common components of CBT generally include psychoeducation (discussed here), emotion skills training, exposure, relaxation, cognitive skills training, and relapse prevention. These components will be reviewed in detail in the remaining chapters of this manual.

Typical Homework

As mentioned earlier, homework is a core component of effective CBT treatment. For this reason, it is likely that your child’s therapist will provide a number of homework assignments to your child as well as to you during the psychoeducational phase of treatment. This will help to ensure that both of you learn the basic information about anxiety and CBT treatment. The following is a description of typical homework assignments that may be assigned during the psychoeducational phase of treatment.

Identifying feeling assignments. Identifying feelings assignments are designed to help children develop their knowledge of feelings. Such assignments often focus on identifying and labeling feeling states in various people and situations. Because children may lack the knowledge and skill required to distinguish between a broad range of emotions and may therefore confuse one emotion for another, these assignments are often helpful in building children’s ability to accurately identify and differentiate emotions. Such assignments also help children to develop their emotional vocabulary. Activities might include labeling the emotions depicted in a series of drawings or video clips or writing about times when he felt a certain emotion (e.g., happy, anxious) including describing what happened and how he knew he felt that way⁴¹. Your child may also be asked to play “*Emotional Charades*” with you, or other willing family members or friends. Emotional Charades is a game where one person acts out an emotion and the other has to provide the label for the feeling. This activity is not only fun but also helps prepare your child for recognizing and identifying various feelings states.

Content Box...

Refer to Appendix B page 121 of this manual to see a sample of a homework assignment focusing on identifying feelings from a popular CBT manual.

If your child seems to be struggling with the assignment, it may be helpful for you to work with him to identify what the obstacles are and then help him to overcome them. Here is an example to demonstrate how you may help:

⁴¹ Kendall & Hedtke, 2006

Example... Helping Your Child Identify Feelings

Let's say your child is having a difficult time remembering times when he felt happy. First, let him know that it is okay if he is having a tough time with his homework and that you are there to help him. Then, brainstorm or even suggest instances from your shared past when you know he was "happy" in order to help him jump-start the process.

Self-monitoring anxiety. Throughout treatment, your child is going to be experiencing his anxiety at different levels of intensity (low, moderate, high). It is often helpful for your child to be able to monitor and track the changes in his levels of anxiety. This cannot only help him to notice when he is becoming more anxious, thus cueing him to use his coping skills, it can also help him to realized when his anxiety is decreasing, indicating improvement in his ability to manage anxiety.

In preparing for this type of assignment, children typically learn how to rate anxiety. Some may use a verbal rating scale (e.g., 0-8, lowest to highest)⁴², while others may use something more visual like a fear thermometer⁴³. The following figure provides an example of such a rating scale. Ratings near the bottom of the thermometer should correspond with manageable levels of anxiety, but as his anxiety ratings creep up towards the top, he may find it "too hot to handle!"

Example of a feeling thermometer...

See Appendix B page 122 for a sample of the feelings thermometer.

Personal journals, daily diaries, or other regularly-completed forms can be great tools for helping children to monitor their anxiety⁴⁴. They can not only provide a safe place for your child to write about and explore his anxious thoughts and feelings, they can also serve as a powerful tool for evaluating the relationship between his thoughts, feelings, and behaviors in day to day situations. Such writing assignments may be presented in many different structured and unstructured forms. For example, in a structured journaling assignment, your child may be asked to describe various aspects of anxiety-provoking situations including the antecedents (what came before?), his responses (anxiety? negative thoughts? physical sensations?), and consequences (what were the results?). Your child may then be asked to rate his anxiety on an agreed upon scale (see examples above). Unstructured assignments may include having your child write freely about any naturally arising anxiety, with encouragement to include content related to the situation in which it arose, his thoughts, feelings, and bodily sensations. At this point the goal of both the structured and unstructured assignments is to build the skill of identifying anxious reactions while also identifying the anxiety-provoking situations in

⁴² Kendall & Hedtke, 2006

⁴³ Chorpita, 2007

⁴⁴ Silverman & Kurtines, 1996

which they arise. Applying new skills to change the anxious response will come later on in treatment.

What Roles Can Parents Play?

Some of the important roles that you can play during the psychoeducational phase of treatment have already been discussed above. However, let's take a look at a few more roles that you can play during this and other phases of treatment.

Informant. The psychoeducational phase is an excellent opportunity for you to serve as a provider of vital information in treatment. While your child's therapist will likely ask him to provide much of the information about his anxiety, you are also a vital source of information regarding his current and past behavior, difficulties, and strengths. Sharing this information with your child's therapist is particularly important for younger children who may have more difficulty verbalizing their experiences. Another way you can collaborate with the therapist is to inform her of any tensions or problems in your relationship with your child or within the family so that they can be evaluated and addressed, since such problems may impact your child's ability to fully benefit from therapy.

Supporter. In addition to being a source of information in treatment, you can also be your child's "biggest fan." In session, therapists often provide praise and reinforcement to children when they do something well or make efforts to learn and practice new skills. This encourages children to continue doing desired behaviors. Given that you are with your child for much of the time outside of treatment, you also are ideally positioned to provide praise and reinforcement as he practices and implements his new skills. This is a role that you can begin now and maintain throughout treatment. There are several ways to do this:

- ☉ Providing verbal praise (For example, "I'm proud of you for facing your fears!" or "I'm glad you are using your skills!")
- ☉ Providing non-verbal praise (For example, smiling, thumbs up, pat on the back, hugs)
- ☉ Contingency Management (see below)

Contingency management. Contingency management refers to the process of providing rewards or "reinforcement" for a previously agreed upon task⁴⁵. It is often used to motivate children to practice targeted skills being taught in sessions (e.g., deep breathing), to face feared situations, and to help children see that these skills can be applied in the real world. The expectation is that, by reinforcing a given behavior immediately after it is completed, the behavior is more likely to be done again. The following is an example of how contingency management might be used.

⁴⁵ Ginsburg & Kingery, 2007

Example of Contingency Management...

Farid is an 11-year-old boy with a fear of the dark. In treatment, he is working on developing the ability to sit in the dark for an extended period of time. He agreed with his therapist and his mother that each time he is able to successfully lie in his bed in the dark for at least 15 minutes, he will receive a new baseball card. If he lays in his bed in the dark for 30 minutes, he will receive two baseball cards. If he is able to lie in his bed in the dark for at least 15 minutes a day for at least 4 of the 7 days in a given week, he will receive a full pack of baseball cards.

As the parent, you will play a central role in contingency management, particularly because you will likely be the one providing the majority of the rewards. The therapist will probably work with you and your child early in treatment to develop a list of tangible rewards that can be earned throughout treatment by practicing target skills and facing feared situations. Treatment manuals often recommend that rewards (or tokens such as stickers or points that can be accrued and exchanged for items on the reward list) should be given based on the child's effort rather than his actual success with a given task.

Content Box...

Refer to Appendix B page 123 for a sample of a reward menu a popular treatment manual.

Contingency contracts specify the exposure that your child will participate in or skill to be practiced, when it will occur, and how the task will be rewarded⁴⁶. This can be helpful in increasing the likelihood that your child will complete his homework assignments and may also help to reduce conflict during exposure tasks or other homework assignments. The following is a sample of a contingency list similar to what your child may create.

Example of a Contingency Contract...

Activity	Expected Completion Time	Reward
Journal about anxiety	Monday by 5pm	30 minutes of TV
Complete thought record	Before next session	30 minutes of TV
Complete Item #1 from Fear Hierarchy	Tuesday at 3pm	Stay up 15 min. late

⁴⁶ Silverman & Kurtines, 1996

Being your child's biggest fan and source of rewards isn't without its problems. Some parents find it difficult to provide verbal praise and/or to consistently implement contingency management programs. Other parents may find it difficult for other reasons such as a busy work schedule that keeps them away from their child for much of the day. If you find that this is true for you, raise the issue in a private phone call or session with your child's therapist so that she can help you brainstorm ways to overcome such difficulties.

Co-therapist. As your child begins to learn important information about anxiety and its treatment, it is important that you, as his parent, learn this information as well. While this manual will provide you with a broad account of the content usually covered in the psychoeducational phase of treatment, it will be important to gain further information from your child's therapist, as she will provide more detailed descriptions of this material.

Through parent sessions and this manual, you will be learning a wealth of information about your child's treatment. This is a powerful tool for you as it allows you to reinforce his developing knowledge. You can do this by talking to him about what you have both learned, noting examples where it applies to his day-to-day life, and helping him to further understand this important information. Furthermore, by arming yourself with knowledge about your child's anxiety and its treatment, you are positioning yourself to answer questions your child may have. This knowledge is particularly important given that children may be reluctant to ask questions of the therapist but may be more comfortable raising them with a parent.

Helping your child monitor his anxiety. Learning to identify antecedents, responses, and consequences of anxiety and deciding "how anxious" one is feeling requires a level of insight that may be difficult for young children. For this reason, your role in helping your child to monitor his anxiety can be extremely important. You may initially prompt or remind your child when appropriate occasions arise to complete the self-monitoring assignments (e.g., when your child, who is afraid of being around dogs, walks by a dog on the street, you may remind him to make note of his thoughts, feelings, and bodily sensations as well as rate his anxiety level.). It may also be helpful if you and your child initially fill out such forms together, taking the time to review the standard components of the monitoring process. Later, as your child begins to understand the assignment better, you can gradually reduce your involvement to the point where you are simply checking in with him to ensure the homework was completed, rewarding him when it's done, or helping him to troubleshoot any problems that may have prevented him from completing it. If he is having difficulty, it may be helpful for you to model identifying situations that make you anxious and rate your reactions. Below is an example of how you might do this:

Example of Modeling the Identification of Anxious Reactions...

Assignment: Identify a time when you felt anxious. For the purposes of this exercise, pick something that won't be upsetting for your child to talk about. Let's say you were anxious the last time you were going to meet a new neighbor.

Antecedents: Preparing a basket of muffins to take to the neighbor, walking across the street to meet the neighbor.

Reactions: Sweating; racing heart worrying that the neighbor won't like you.

Rate your level of anxiety: Moderate level of anxiety (6 out of 10).

Consequences: You were so nervous that you stumbled over your words when introducing yourself to the neighbor; you realized how silly you were being when she thanked you for coming by and invited you in for tea.

Possible Trouble Spots

It is natural for both you and your child to come across “trouble spots” throughout treatment. For this reason, this manual will attempt to identify some of the common trouble spots that can occur in various stages of treatment and offer some suggestions for how to respond. Below you will find a few of the common trouble spots that can occur during the psychoeducational phase of treatment.

Difficulty understanding the treatment rationale. CBT is a multifaceted treatment with a strong theoretical background and rationale. It is vital that both parents and children understand the basic CBT model (e.g., how thoughts, feelings, and behaviors can interact with one another to increase or decrease anxiety) prior to beginning some of the more difficult tasks of the therapy. When first beginning a CBT treatment, it is common for either the child or parent to not understand one or more aspects of the model underlying treatment. For example, your child may have difficulty understanding how thoughts, feelings, and behaviors influence each other. He may also have difficulty understanding how changing one component (a thought, for example) can change the others. Examples, like those provided in this manual, (see pp. 5 and 6 of the Introduction chapter) and the materials provided as part of treatment may help your child to better understand this relationship and overcome this trouble spot.

What can you do? In your child's day-to-day life, you can continually look for opportunities to illustrate key aspects of the model. For example, you may point out that when he thought his younger brother stole his toy (thought), he got angry (feeling) and yelled at his brother (behavior), but then relaxed (feeling) and apologized (behavior) when he found out the toy was really hidden under the bed.

Parental difficulty understanding the treatment rationale. Parents may also have difficulties with regards to the treatment rationale. A typical difficulty for parents in

this area is not fully appreciating the importance of letting their child experience some anxiety so that he can learn to overcome it. This could interfere with the child's ability to be successful in treatment so it is important for parents, perhaps with the assistance of the therapist, to overcome this trouble spot early in treatment.

What can you do? At times, it can be hard for parents to admit that they are having difficulty understanding the rationale for treatment. This is not an issue to feel embarrassed or shy about as it is not uncommon for parents to need some time and extra assistance from the therapist to understand the rationale underlying treatment. If you notice that you or your child is unclear about an aspect of the psychoeducational phase, contact your child's therapist and ask for additional help in clarifying the material.

Motivation/Homework Non-Compliance. As previously discussed, homework is a vital part of CBT treatment. However, homework is typically something that children don't enjoy doing. For a wide range of reasons, children may not be motivated to participate in out-of-session activities or to complete their homework, particularly when it may create anxiety. For this reason, it is important that parents remind their children of the rationale for the homework, provide encouragement, and use contingency management to ensure that children complete these important assignments.

So why might your child be non-compliant with homework? Let's review some of the major reasons for this trouble spot and discuss what you can do to help.

Your child doesn't understand the assignment itself. It is possible that your child may not understand the assignment he was given. This is a common problem and one that you can easily assist with.

What can you do? First, ask to see the assignment. If the assignment is clear to you (whether based on this manual, information provided by the therapist, or common sense), then help your child to understand it. If you don't understand the assignment, contact your child's therapist and ask for help. Again, there is no reason to be embarrassed if you need to ask for help; not only will doing so make it more likely that treatment will be successful but your therapist recognizes that it is part of her job to ensure that her child clients and their parents understand what it is they are being asked to do and why. Let's look at an example⁴⁷:

Example of Helping Your Child Understand Homework...

Let's say your child is working on an assignment that requires him to describe a situation in which he felt nervous, scared, or worried. He comes to you and tells you he is having difficulty understanding what it means to experience being "worried." In order to help him, you can define what it means to be worried. For example, you can tell him that being worried means that a person is concerned about something or is having thoughts about something bad happening. You may also provide an example of the last time you felt worried. You may share that you were worried the last time your child fell off the swing and you weren't sure if he broke his leg until the doctor was able to look at it.

⁴⁷ The example provided is based upon the *Coping Cat* Manual by Philip Kendall, PhD and Kristina Hedtke, PhD

Your child doesn't appreciate the rationale for the assignment. Homework is an important component of treatment as it allows your child to learn and practice important skills. While most of the assignments are quite different than school homework (e.g., involving active practice or exposures), children may still resist doing them. While he may lack the motivation to do his therapy homework, it is important that your child complete his assignments in order for treatment to work.

What can you do? One of the best ways to be sure that he completes the homework, is to ensure he understands why it is so important for him to do so⁴⁸. While your child's therapist should make the rationale for homework clear, you can also help your child to understand this important point by using your newly acquired knowledge. For example, you might tell your child that doing his therapy homework is a lot like lifting weights to build muscles. The more he "works out" his skills, the stronger he will get and the better he will be at using the skills to manage his anxiety. Feel free to get creative in picking a metaphor or example that will work well with your child's knowledge and interests (e.g., riding a bike, mastering a video game, learning a sports-related skill).

Content Box...

As always, if you are unsure of the rationale for a particular assignment or task, check in with your child's therapist and ask for help.

Your child is frightened about the negative consequences of doing homework. Some CBT homework requires your child to face his fears and anxieties. This is not an easy task for anyone. For this reason, it is important to confront his resistance to doing such homework with care and compassion.

What can you do? As his parent, it may be helpful for you to normalize his anxiety. You may say to him, "talking about your feelings can be scary" or "it's natural to be afraid to face your fears." It may also be helpful to ask him specifically what he is afraid of so that you can brainstorm together ways that may make homework less scary for him. Below is an example that may help you approach this trouble spot:

⁴⁸ Kendall & Hedtke, 2006

Example of Helping Your Child Face His Fears...

Let's say your child has been assigned the task of facing his fear of the dark. He may approach you and tell you that he is afraid to do the exposure. If this is the case, ask him what he is afraid of. This will give him the opportunity to voice his specific fear. For example, he may say, "I'm afraid the fear will keep getting worse and worse." He might also say, "I won't be able to stand it," or "something bad is going to happen." First, thank him for sharing his fears with you and let him know that it is normal to be scared to face your fears. Next, you can respond to his fears by saying "Like your therapist said, you will likely feel anxious at first but if you hang in there and stay in the situation, the fear will go down." You might also say, "being in the situation is the only way to find out that the things you are afraid of won't actually happen or that they aren't actually that scary after all." Finally, you can also remind him to use his coping skills (e.g., relaxation, breathing skills" to calm himself down. Always remember to praise your child for facing his fears and completing the assignment.

Using the above suggestions and examples, you should be able to make a big difference in your child's willingness to complete his homework. Nonetheless, despite your best efforts, you may find that your child is still unwilling. Be sure to inform your child's therapist when this occurs, despite any embarrassment that you may feel. Such assignments are among the most important ways that your child will learn new skills and the therapist will not be able to generate strategies to help overcome your child's resistance to doing homework if she is unaware of the problem.

Chapter 3: Emotion Skills Training

A Brief Description

Emotion skills training, also called affective education, refers to the component of treatment during which your child will learn about various emotions and their manifestations. This component of treatment is generally separated into two parts: (1) general emotion skills training and (2) emotion skills training for anxiety.

General emotion skills training. General emotion skills training focuses on educating your child on a broad range of emotions, both positive and negative⁴⁹. The goal of this training is to build your child’s “emotional vocabulary” by increasing his ability to use words to describe emotions. This work involves teaching your child to identify emotions by learning which facial expressions, postures, tones of voice, and/or physical sensations tend to accompany certain emotions⁵⁰. He may also learn common thoughts and behaviors that can accompany these emotions as well as typical situations in which specific emotions arise⁵¹.

Benefits for your child include:

- ⊗ Increasing his ability to accurately label emotions.
- ⊗ Improving his emotional vocabulary in order to help him communicate his emotional experiences more precisely.
- ⊗ Teaching him to identify a range of emotions so that he can more accurately differentiate between emotions, (e.g., how to tell the difference between nervous and relaxed).

Benefits for parents include:

- ⊗ Developing a common language with your child to describe emotions.
- ⊗ Improving communication with your child.

Emotion skills training for anxiety. Emotion skills training for anxiety focuses on teaching your child how anxiety is expressed through facial expressions, postures, tones of voice, and/or physical sensations as well as through anxious thoughts and behaviors. This education focuses on both the common manifestations of anxiety as well as those specific to your child. Focusing on how anxiety is uniquely expressed in your child will help him and his therapist to identify his “emotional profile” of anxiety. This profile is a description of the physical reactions and sensations, thoughts, feelings, and behaviors that are the most prominent for your child when he experiences anxiety⁵². Developing this profile will help your child to better understand how these domains affect one another to increase or decrease anxiety (as discussed in the “Psychoeducation

⁴⁹Kendall & Hedtke, 2006

⁵⁰Ginsburg & Kingery, 2007

⁵¹Hannesdottir & Ollendick, 2007

⁵²Chorpita, 2007

Chapter”). During this component of treatment, it is also likely that your child will begin to identify the specific situations that tend to arouse his anxious profile. He may also learn how to rate his level of anxiety at this time. Specific techniques for learning emotion skills for anxiety will be elaborated upon below.

Benefits. The benefits of emotion skills training for anxiety include those described above for general emotion skills (e.g., for children: increasing emotional vocabulary; for parents: developing a common language). However, there are also some unique associated with emotion skills training for anxiety.

Benefits for your child include:

- ⊙ Enhancing his understanding of the components of anxiety (thoughts, feelings, behaviors, and physical sensations), which will prepare him to better understand how these components influence one another to increase or reduce anxiety.
- ⊙ Increasing his ability to recognize the onset of anxiety so that he knows when to use his coping skills.
- ⊙ Identifying specific situations that tend to arouse his anxiety so that he can prepare himself to use appropriate coping skills.

Content Box...

Your child will learn many coping skills throughout CBT treatment that will help him to manage his anxiety. The remaining chapters of this manual will address many of these skills.

- ⊙ Learning how to rate anxiety and practicing this skill can:
 - Help your child to more precisely specify how anxious he is at various times and in various situations.
 - Help your child to appreciate that anxiety need not be eliminated to be improved.
 - Help him to identify improvements in his anxious symptoms.

Benefits for parents include:

- ⊙ Learning the common manifestations of anxiety can help you:
 - Identify your child’s symptoms as signs of anxiety and not as signs of a potentially serious medical condition. This realization can, in turn, help ease anxiety or distress about your child’s experience.
 - Learn to recognize when your child is becoming anxious so that you are able to encourage him to use appropriate coping skills.

What is Likely to Happen in Sessions?

General information. Emotion skills training can occur as part of the psychoeducational component of treatment or as its own separate component. Regardless, it is expected that emotion skills training will occur early in treatment since it provides the basis for building many other skills that will be learned later in therapy. Emotion skills training usually begins with general emotion skills education and is then followed by education specific to anxiety. Given that your child is in treatment to learn how to manage his anxiety, greater attention will naturally be given to developing emotion skills specific to anxiety.

General emotion skills training. An overview of general emotion skills training was presented at the beginning of this chapter. The following section will provide a more in-depth exploration of the key content covered in this phase of treatment as well as the common methods used to teach these general emotion skills.

General emotion skills training involves teaching your child how to identify and differentiate various emotions⁵³. In order to determine the amount of training needed to teach these skills, the therapist will likely first assess your child's emotional knowledge. Common emotion words may be reviewed to determine how familiar your child is with typically-used terms. Depending on his existing knowledge, your child may learn new words to help him describe a broader range of emotions. For example, many children know what it feels like to be frustrated. However, they may not know the term used to describe that feeling. Emotion skills training provides the opportunity for children to learn a new word to describe this emotion and, as a result, increase their "emotional vocabularies."



In addition to learning words for emotions, your child will learn the internal and external manifestations of each emotion. These manifestations include facial expressions, postures, tones of voice, and/or physical sensations⁵⁴ as well as possible thoughts and behaviors. Learning the manifestations of common emotions will enhance your child's ability to notice when he is feeling one emotion versus another. There are several techniques that may be used to teach this important skill. For example, your child may develop a "feelings dictionary"⁵⁵ using words and pictures to help him learn and remember important emotions. Following is an example of what a section of such a dictionary might look like:

⁵³ Kendall & Hedtke, 2006

⁵⁴ Ginsburg & Kingery, 2007

⁵⁵ Kendall & Hedtke, 2006, pp. 9

Sample of a “feelings dictionary” ...

<u>Word</u>	<u>Description</u>	<u>Picture</u>
Sad	unhappy, down, “bummed”	
Angry	mad, “pissed off”	

The dictionary can be a great way for your child to keep track of all the emotions he knows or has learned. It can also be a great resource for him to refer to throughout treatment as he works on accurately identifying his emotions.

Another commonly used technique for learning the manifestations of emotions is playing “*Emotional Charades*.” This game, introduced in the Psychoeducation chapter, involves your child and his therapist taking turns acting out certain emotions while the other guesses what emotions are being portrayed⁵⁶. Facial expressions, body movements, “spoken” thoughts, and verbal descriptions can all be used to convey the desired emotion. This game is a fun way for your child to practice identifying and labeling emotions.

Once your child has learned to accurately identify both positive and negative emotions, he may then practice identifying what emotions typically occur in specific situations. Helping your child to identify how he, as well as others, may feel in certain situations can help him to further understand why he feels the way he feels and what “triggers”, or causes may arouse specific emotions. One popular technique for teaching this skill is using short stories or pictures to present various situations and asking your child to identify the emotion that the person in the story/picture may be experiencing. The following is an example of this technique:

Example...

John is presented with a picture strip of a man walking down a dark alley at night. He is asked to decide, based on the series of pictures, what the man may be experiencing. John looks at the dark, scary-looking alley and decides that the man may be feeling *fear* since this is likely a common emotion experienced in such a situation.

⁵⁶ Kendall & Hedtke, 2006

Content Box...

Refer to Appendix B page 124 for a sample of a similar homework assignment involving this technique.

The techniques described above, as well as others that may be introduced to your child by his therapist, will all be helpful as your child works to increase his general emotion skills. Once your child's therapist gets the sense that your child has established a good foundation of these skills, the focus of this component of treatment will shift to emotion skills training specific to anxiety.

Emotion skills training for anxiety. An overview of emotion skills training for anxiety was presented at the beginning of this chapter. This section provides a more in-depth exploration of the key content covered in this phase of treatment as well as the common methods used to teach these skills.

One of the first things your child will likely learn during emotion skills training for anxiety is the various domains of anxiety (e.g., thoughts, feelings, behaviors, and physical manifestations). This knowledge, addressed in greater detail below, will help your child to identify when he is experiencing anxiety. Learning the “common manifestations” of anxiety will likely provide some relief to your child as this information gives him the opportunity to see that others have experiences similar to his own when they feel anxious⁵⁷.

Thoughts. Anxious thoughts or “cognitive symptoms” are the things we think of when we experience anxiety⁵⁸. Such thoughts generally tend to involve danger, risk, and the possibility of bad things happening but the specifics vary from child to child. Part of your child's work during emotion skills training as well as during other components of training (such as Exposure and Cognitive Restructuring) will be to identify the anxious thoughts that arise for him in his feared situations. Common anxious thoughts may include fears that something terrible is going to happen and/or doubts about one's ability to cope.

Feelings. Anxious feelings primarily involve being nervous, fearful, or anxious. Other feelings that may also be experienced include irritability and sadness. Your child is likely well aware that he is experiencing unpleasant, distressing feelings even if he does not yet have the appropriate labels to identify them. Treatment will not only help him to label his feelings but to understand how his feelings affect and are affected by his thoughts and behaviors. He will also learn to view certain specific bodily sensations (e.g., sweating, trembling) and thoughts (e.g., “Something bad is going to happen”) as signs that he is feeling anxious.

⁵⁷ Kendall & Hedtke, 2006

⁵⁸ Chorpita, 2007

Behaviors. Behavioral symptoms can be identified by noticing the things we do when we are anxious⁵⁹. Examples include pacing, “freezing,” seeking reassurance, and, most importantly, avoiding or leaving situations that make us anxious. Your child will likely be encouraged to examine his own behavior in feared situations in order to identify which behaviors may be associated with his anxiety. Changing these behaviors will likely be a target of exposure sessions later in treatment.

Physical manifestations. The common somatic sensations that accompany anxiety include (but are not limited to): stomachache, racing heart, rapid breathing, flushed face, sweating, and trembling⁶⁰.

Content Box...

Refer to the following Website for a complete list of physical sensations of anxiety:

- Go to the Website: www.livingwithanxiety.com
- Click on “Physical Symptoms” in the left-hand column
- Click on each symptom to learn more

When learning the common signs of anxiety, your child will likely begin by examining them through the experiences of others prior to looking at his own anxiety. This technique, sometimes referred to as “distancing,” is typically used by therapists since looking at others’ experiences is usually less distressing than looking at one’s own⁶¹. In fact, this approach allows your child to understand key concepts and practice important skills (such as labeling emotions) “from a safe distance” and with less resistance by first considering them in and applying them to others. Once your child has time to become familiar with these concepts and skills, he will likely feel safer in applying them to himself. There are several techniques that your child’s therapist may use to help him to practice skills through the experience of others. For example, in an effort to normalize your child’s anxious reactions, the therapist may demonstrate the skill of identifying manifestations of anxiety by providing examples from her own life. For example, she may share a story about the last time she needed to give a speech in public and then identify the anxious thoughts, feelings, and behaviors she experienced. In order to develop skills in identifying manifestations of anxiety, your child may also be encouraged to think about and examine the reactions of others including movie/book/cartoon characters, family members, or friends who have also been in anxiety-provoking situations.

⁵⁹ Chorpita, 2007

⁶⁰ Chorpita, 2007; Kendall & Hedtke, 2006

⁶¹ Kendall & Hedtke, 2006

Example of Examining Anxiety in Others...

Phil is learning to identify the signs of anxiety and is feeling pretty anxious about it. His therapist suggests Phil consider how others may show signs of anxiety. She shows him a video clip of a little league baseball player getting ready to play in a big game. Phil is asked to identify the signs of anxiety that the baseball player is showing. Phil correctly identifies the sweat on the baseball player's face, his shaking hands, and his flushed face.

Content Box...

Just as your child's therapist will begin by exploring anxiety through others' experiences, you too can help your child by practicing this technique at home.

What can you do? Prior to talking to your child about his own anxiety, try talking about it not as it relates to him but as it relates to you or someone else.

Example: You could say something like, "I know when I started my first day of work and needed to meet new people, I felt pretty anxious. I can usually tell I'm anxious because my stomach aches and I my hands begin to shake a little bit. I also notice anxious thoughts like 'these people aren't going to like me or 'I can't handle this.'"

When can you do it? There will be many opportunities for you to use this skill including but not limited to: when you are trying to gather information about your child's anxiety, when you are trying to reinforce or explain an important piece of information about anxiety, or when you are trying to promote the use of a particular anxiety management technique.

As your child becomes more comfortable identifying manifestations of anxiety through others' experiences, he will likely then be asked to recall situations from his own life in which he felt anxious. By looking at times when he felt anxious, your child will more likely be able to accurately identify the anxious symptoms that are specific to him. One way to help your child to accurately identify these symptoms is to have him imagine himself back in the very situations in which the anxiety occurred in order to allow him to come in contact with and better describe the anxiety he felt. This activity is called an "Imaginal Exercise." At this point in treatment, your child is not yet being asked to confront the situations in which he becomes anxious. Therefore, the goal here is not to "expose" your child to the anxiety (which comes later on) but to develop a clear enough memory of anxiety-provoking experiences so that he can identify in some detail how he felt at the time. The anxiety-provoking situations your child recalls will likely be written down and used later when developing the list of feared situations he will face during the "exposure" component of treatment⁶². Identifying signs of anxiety is just the first step in managing anxiety.

⁶² Kendall & Hedtke, 2006

Content Box...

Refer to the “Exposure” chapter to learn more about how your child will face his fears. Refer to the “Relaxation Training,” chapter and the “Cognitive Skills” chapter to learn more about how your child will learn to manage these symptoms.

Rating anxiety. The process of rating anxiety was first introduced in the “Psychoeducation” chapter of this manual. Please refer to page 28 of that chapter to refresh your memory about anxiety ratings and typically-used rating scales.

As discussed above, your child will begin to think about anxiety-provoking situations during emotion skills training for anxiety. Rating the intensity of his anxiety during these times as well as during other tasks (e.g., homework) can be a helpful way for your child to keep track of his anxiety. Practicing rating anxiety during emotion skills training while he is still at a relatively “safe distance” from his feared situations will help prepare your child to use these ratings during more anxiety-provoking exposure tasks later in treatment. Refer to the “Exposure” to learn more about these exposure tasks and how rating scales may be used during them.

Techniques for learning emotion skills for anxiety. Below is a sample of some of the many techniques that can be used to help your child learn emotion skills for anxiety.

Role-plays. Role-play activities are popular in teaching children new skills in CBT. These techniques involve acting out different scenarios related to your child’s anxiety. Role-plays will likely be used throughout therapy to gather information about your child and to practice skills learned during various stages of treatment⁶³. During the emotion-skills training segment of treatment, one purpose of role-plays is to provide an opportunity for your child to explore his feelings in a feared situation with the support of the therapist⁶⁴. Role-playing a feared situation helps to make the memory of the experience more vivid. This, in turn, can help your child to better identify the physical sensations, thoughts, feelings, and behaviors that accompany his anxiety. Role-plays in session may entail your child and his therapist coming up with various scenarios and taking turns acting them out using facial expressions, other physical reactions (e.g., shaking, biting nails, moving away), or voicing anxious thoughts (e.g., “This is too much for me.”) to demonstrate anxiety. The following is an example of a possible role-play:

⁶³ Kendall & Hedtke, 2006

⁶⁴ Kendall & Hedtke, 2006

Example of a Role-Play...

Let's say your child has social phobia and is afraid to start school this year as a result. Your child and his therapist may come up with a scenario where they are both students starting the first day of school. They might act out leaving their parents' cars and walking towards the school. The therapist may pretend to sweat and bite her nails while saying out loud "I'm afraid no one will like me." Your child may practice making an anxious face and telling his mother he doesn't feel well so he can go home and avoid facing social situations at school.

Content Box...

See the "What Roles Can Parents Play" section below to learn more about how you can help with role-plays outside of session.

Artwork. In addition to role-plays, art activities such as drawing and labeling pictures can be helpful ways to assist your child in understanding the physical sensations, feelings, and behaviors associated with anxiety. He may also add "thought bubbles" to pictures to identify anxious thoughts⁶⁵. Such activities may be helpful ways for your child to describe scenarios when he or others experienced anxiety. The following is a list of possible art activities your child may try⁶⁶:

- ⊗ Drawing faces to match an emotion
- ⊗ Labeling bodily reactions to anxiety on a cartoon or picture
- ⊗ Filling in thought bubbles/clouds on pictures
- ⊗ Making a collage of emotions using words, drawings, and magazine clippings
- ⊗ Creating a "feeling dictionary" (described above)

Content Box...

Refer to Appendix B, pp. 125-131 for a sample of common emotion skills tasks for anxiety from a popular children's manual.

Developing a strong foundation of knowledge about emotions in general, and most importantly, about anxiety in particular is a "prerequisite" skill for teaching children the coping skills covered later in treatment. The amount of time spent teaching your child emotion skills depends upon his pre-existing knowledge of anxiety and other emotions as well as his age and verbal abilities.

⁶⁵ Chorpita, 2007

⁶⁶ Chorpita, 2007; Ginsburg & Kingery, 2007

Typical Homework

Many of the techniques used in session can also be assigned as homework (e.g., conducting role plays, creating art work). Below are examples of homework assignments that may be given during the emotion skills training phase of treatment as well as tips for how you may help with such assignments.

Learning how the body reacts to anxiety. As discussed above, learning the body's common reactions to anxiety is an important component of this phase of treatment. Homework assignments targeting the development of this knowledge may require your child to evaluate both his own reactions and the reactions of others. Your child may be asked to examine and identify the bodily reactions of both real and imaginary people/characters in books, drawings, pictures, and videos. For example, he may be assigned worksheets asking him to circle body parts affected by anxiety. He also may be given a worksheet asking him to match physical sensations with the appropriate emotion. In such a worksheet, one column may list the physical manifestations (e.g., smiling, sweating) of various emotions and the other column may have drawings of people experiencing certain emotions (e.g., happy, anxious). Your child can practice matching physical manifestations to the appropriate emotion by connecting a line from one column to the other, (e.g., connecting smiling with happy). Another option for learning how the body reacts to anxiety may involve asking your child to write a short description of his own experiences with emotions. For example, your child might be asked to write about a time during his week when he felt a particular emotion. While the target of this assignment may be identifying physical manifestations of the emotion, he may also be encouraged to describe the thoughts, feelings, and behaviors that accompanied his experience.

Content Box...

Refer to Appendix B pp. 125-131 for various samples of homework assignments designed to help your child learn how his body reacts to anxiety.

What Roles Can Parents Play?

While some of the roles that you can play during the emotion skills component of treatment have been discussed above, others are addressed below.

Supporter. As with every other component of treatment, one of your primary roles in your child's therapy is that of supporter. There are many ways you can provide support including encouraging your child to practice skills and complete homework as well as providing praise for his efforts. Particularly when your child is having a difficult time, it is helpful if you acknowledge that what he is being asked to do may be difficult. At the same time, you should remind him of the rationale for and importance of making efforts to complete various tasks.

Contingency management. It is important that your child be rewarded for his efforts throughout treatment in order to keep him motivated. Therefore, homework completion and the practicing of emotion skills during this phase of treatment may be added to your child’s contingency list so that he may be rewarded for his efforts. The following is a sample contingency list for practice activities related to emotion skills. Remember, the points earned for activities will later be exchanged for tangible or activity rewards (e.g., desired toy, treat, or extra TV time). For more detail about contingency management, see the Psychoeducation chapter. Also, see “Possible Trouble Spots” below for tips on when you may use contingency management during Emotion Skills Training.

<i>Sample Contingency List for Emotion Skills...</i>		
<u>Activity</u>	<u>Expected Completion Time</u>	<u>Reward</u>
Identifying signs of emotions worksheet	Wednesday at 7pm	5 points
Complete role-play with mom	Tuesday at 5pm	5 points
Writing about a time he felt anxious	Before next session	10 points

Co-therapist. Your child spends only a small amount of time during the week with his therapist. During that time, he will learn a great deal of information and a broad range of skills. Although this time is invaluable, your child will likely need some additional assistance in learning this information and practicing these skills outside of the therapy room. Providing this support is a perfect role for you as his parent. For example, if your child is struggling with homework or practicing new skills, you can offer to help. This kind of help is okay in the beginning of treatment since your child is just learning these skills. However, be aware that your involvement should be gradually faded out as your child becomes more knowledgeable and confident in his skills. See the “Typical Homework” section above for other tips on how you can be a “co-therapist” through role-plays and modeling.

Preparing to help with emotion skills. As your child practices identifying emotions, it may be a good idea for you to take some time to consider the best way for you to describe certain emotions. The following is an idea for how to familiarize yourself with the process of identifying signs of emotions.

Preparing to Help Your Child with Emotion Skills...

Try asking yourself, “If you had to describe the feeling of happiness, what would you say? What about nervousness? Fear?” Go through the process of describing your own experience of each emotion. This can prepare you to assist your child as he learns to describe his own emotions. In doing so, you will also likely be reminded of situations in which you felt a particular emotion. Keep these situations in mind in case your child asks you to describe a time when you felt a certain emotion.

Modeling. As your child is learning how he experiences different aspects of emotions, particularly anxiety, you may help by modeling how to identify your own manifestations of anxiety (including bodily reactions, thoughts, feelings, and behaviors). The following is an example of how you may model this important skill for your child:

Example of Modeling...

Steven is having a difficult time describing how his body reacts to anxiety. He approaches his mother with this problem. In order to help him see how identifying reactions to anxiety is done, she decides to share with him a time when she felt anxious. She tells him about the last time she was at the grocery store. She describes waiting in line at the checkout counter. As the cashier began to bag her items, she reached into her purse and pulled out her wallet. Much to her surprise, her credit card wasn't there. As she describes to her son how she began anxiously digging through her over-sized purse to find her card, she also describes the way her body was feeling. She tells Steven, “I noticed that my chest muscles began to tighten and I began to sweat.” She may also identify anxious thoughts she had such as “This is a disaster” or “I can't handle this.” Steven's mom ends the story by telling him how she finally found the card tucked into her jeans pocket and how she subsequently noticed the tension in her chest relaxing and her body beginning to calm down.

Role-playing. In addition to modeling, you may also use role-plays where you and your child act out being in a situation and describe together your manifestations of anxiety including physical sensations, thoughts, feelings, and behaviors. The following is an example of how you may model this important skill for your child:

Example of Role-Playing...

Continuing with the example above, Steven's mother may ask him to act out her anxious situation. In this role-play, Steven may act like the checkout person while his mom plays herself. Then, mom and Steven may switch roles allowing him to act out how he would respond to the situation.

Possible Trouble Spots

Below you will find a few of the common trouble spots that can occur during the emotion skills phase of treatment.

Homework non-compliance. At this point in treatment, your child is going to begin imagining himself in feared situations. Although your child will not formally confront feared situations with the intent of reducing his anxiety until the Exposure component of treatment (see Chapter 4), imagining situations for the purpose of learning the various manifestations of anxiety will also likely create a certain amount of anxiety. As a result, he may avoid completing homework tasks in order to protect himself from his anxiety.

What can you do? It is important that you check in with your child about homework completion to be sure that he is getting the full benefit of treatment. If you find that he is avoiding homework assignments, check in with him to see if he is able to provide a reason. If he describes feeling fearful or reluctant, empathize with him that homework can be difficult. Also, provide encouragement to increase the likelihood that he will complete the homework assignment. You can do so by reminding him that homework is practice, and practice will help him to get better at managing his anxiety. You can also provide incentives to encourage him to complete his homework assignments. In addition to your verbal praise, check your child's contingency list to see if there is a reward your child can receive for making an effort or for completing his homework during this phase of treatment. Reminding your child of these incentives will likely increase his motivation.

Your desire to protect your child. As your child begins to identify and discuss feared situations and the various manifestations of anxiety, you may notice a temporary increase in his anxiety. It is natural to feel the need to protect your child from these feelings. However, protecting him may inadvertently hinder his progress in facing his anxiety. The reality is that people must deliberately trigger and experience anxiety in order to learn how to manage it. Although challenging, it is important to keep this fact in mind to make it easier for you to allow and even encourage your child to experience his anxiety.

What can you do? If you have concerns that your child's level of anxiety is too high, discuss this issue with his therapist. She will be able to assess his anxiety, determine if his level of anxiety is appropriate for this stage of treatment, and make any needed modifications to how treatment is being implemented.

Chapter 4: Exposure

A Brief Description

Exposure is the single most important component of treatment when it comes to reducing your child's anxiety⁶⁷. In fact, it is the most effective tool available for the treatment of anxiety. Exposure is defined as the practice of confronting the very objects and/or situations that cause anxiety or distress. There are two ways that exposure can occur⁶⁸. The first type of exposure is referred to as "in vivo" exposure. This involves directly confronting feared objects/situations "in real life." The second type of exposure is referred to as "imaginal" exposure (also known as "in vitro" exposure). This involves visualizing oneself facing feared objects/situations. The exposure component of treatment tends to take place using repeated "practice" or exposure "sessions" both in and outside of the therapy sessions (e.g., at home, in the community).

Rationale for exposure. It might seem strange that the most essential component of treatment is one that requires your child to deliberately induce distress by having him confront the very things that he fears the most. Let's consider why this is such a vital part of treatment and how facing fears will actually help decrease anxiety and the avoidance that so often accompanies it.

Habituation. When a child faces his fears over and over again, the repeated exposure causes his anxiety and avoidance to decrease naturally. This process is referred to as *habituation*⁶⁹. Habituation stems from a basic biological property. Specifically, our nervous systems are wired so that, with repeated exposure to the same feared object or situation, our bodies stop responding with anxiety/fear. If you think about it, it is likely that you can recall an example of how this habituation process has occurred in your own life. Let's take a look at an example:

Example of Habituation...

Let's say that you were anxious about flying at one time in your life. While your anxiety may have been extremely high when you first began flying, you likely noticed that your anxiety decreased over time the more that you exposed yourself to flying.

Corrective information. In addition to habituation, exposures can help to reduce fear and avoidance by "proving ourselves wrong." In other words, when we repeatedly face a feared object or situation and don't experience the bad outcomes that we expect, our fear of that object or situation will be reduced. This process is called learning through "corrective information"⁷⁰. Corrective information promotes certain kinds of learning that reduces fear and avoidance such as:

⁶⁷ Silverman & Kurtines, 1996

⁶⁸ Ginsburg & Kingery, 2007

⁶⁹ Ginsburg & Kingery, 2007

⁷⁰ Kase & Ledley, 2007

- Ⓢ Learning that expected feared outcomes don't actually occur.
- Ⓢ Realizing that anxiety doesn't increase endlessly but tends to decrease over time.
- Ⓢ Recognizing that it is possible to cope with even the most feared situations.

Example of Corrective Information...

Let's say that your fear of flying relates mostly to the concern that you will be overwhelmed by anxiety while "stuck" on an airplane, ("I won't be able to tolerate my anxiety if I fly"). However, if you repeatedly fly (in spite of your anxiety) without being overwhelmed by your anxiety, you would learn "corrective information" about the actual (versus imagined) threat of flying in a plane ("I can tolerate my anxiety while flying in a plane"), and your fear would decrease.

Current thinking in the field of child anxiety treatment is that these "corrective" learning experiences are only effective if they occur when the child is actively experiencing fear/anxiety. This is why simply telling your child things like "your anxiety will decrease in time", "the things you're afraid of are unlikely to happen," or "you can handle this", in and of themselves, are unlikely to help. Your child needs to learn these truths experientially, while confronting the things or situations that make him anxious through exposure.

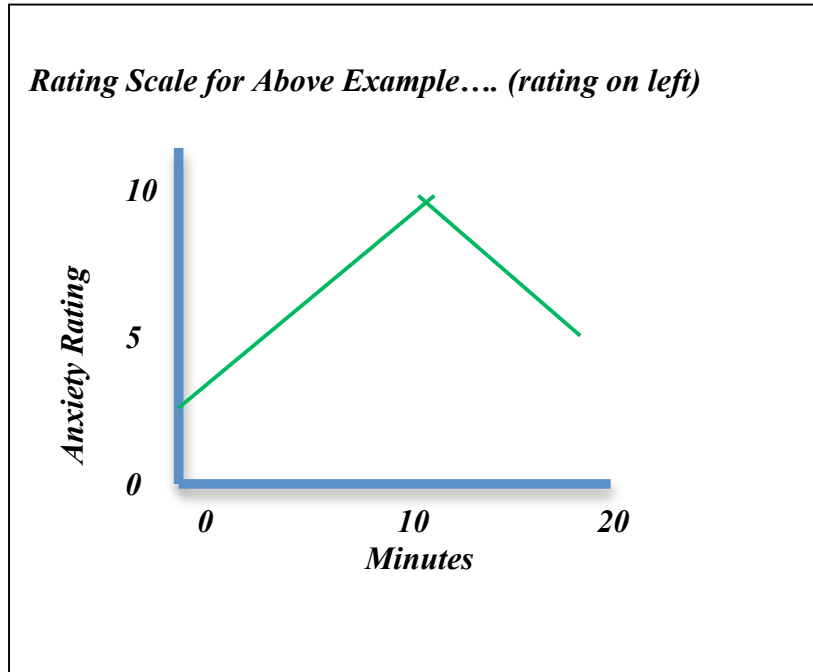
Goals of exposure sessions. The overarching goal of exposure is to reduce anxiety and avoidance. This often requires repeated exposure over several trials or practices. When doing exposure work, therapists look for evidence of two types of habituation in order to demonstrate that the intervention is working as intended⁷¹. First, anxiety reduction needs to occur within each practice session, which is referred to as "within-trial habituation." In order to achieve this type of habituation, the exposure must go on long enough within each session so that the anxiety can peak (reach its highest level) and then diminish. Here is an example of this type of habituation. The example uses rating scales that have been discussed in previous chapters.

⁷¹ Chorpita, 2007

Example of Within-Trial Habituation...

Let's say that your child has a fear of dogs (a Specific Phobia). For an exposure session, he is asked to go inside a pet store with his therapist and walk around until his anxiety level reduces by at least 50% from its peak level. Prior to beginning the trial, your child's therapist asks him for his anxiety rating at "baseline." Your child reports that his baseline anxiety is a 2 (on a 0-10 scale). Your child and the therapist agree to check in about his anxiety rating every couple of minutes throughout the exposure session. Within the first 5 minutes of the exposure, your child reports that his anxiety rating is a 5. At 10 minutes, it "peaks" for a brief period of time at 8. After 15 minutes, he reports that his anxiety rating has decreased to a 5 and, after 20 minutes, he reports it has reduced to a 4. This demonstrates the decrease of anxiety within an exposure session that occurs in "within-trial habituation."

Rating Scale for Above Example.... (rating on left)

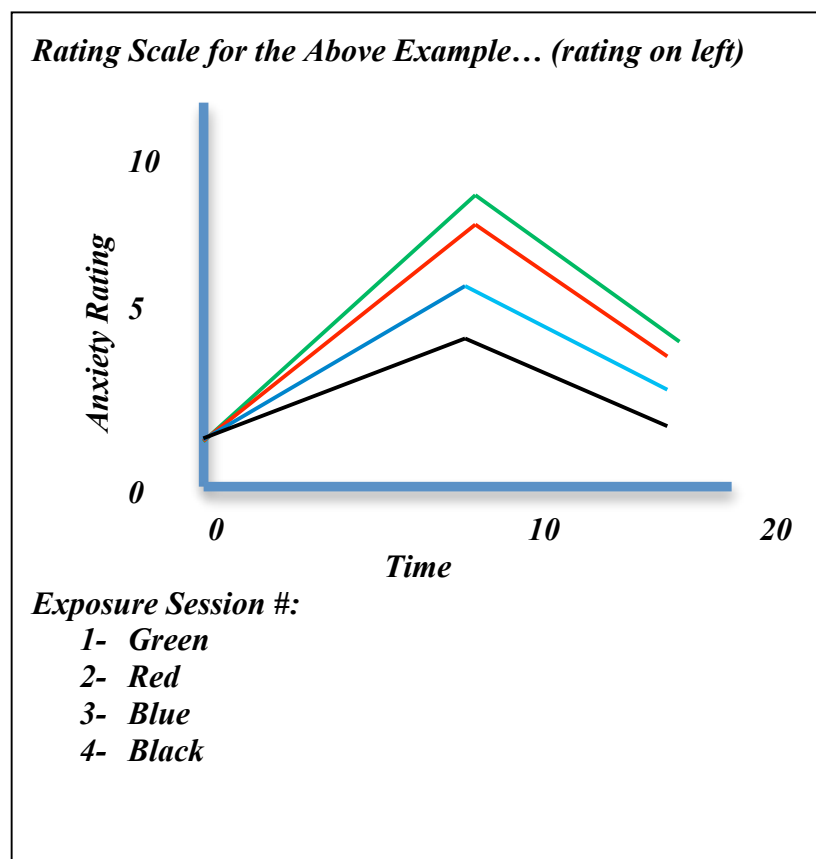


The second type of habituation, referred to as "between-trial habituation"⁷², occurs across different exposure sessions. In order to achieve this type of habituation, exposure sessions must be repeated enough times so that anxiety decreases significantly from session to session. In other words, when your child faces a feared situation over and over again, he "habituates" or gets used to it and anxiety reduction occurs. The way to tell that between-trial habituation is occurring is by examining changes in your child's anxiety level across different exposure sessions. It is expected that, across sessions, the initial level of fear your child experiences when he begins exposure will reduce. It also is expected that the highest level of fear your child experiences should decline and the rate at which his fear decreases should increase over repeated exposure sessions. Let's continue the example above to see how between-trial habituation occurs:

⁷² Chorpita, 2007

Example of Between-Trial Habituation...

During your child's first exposure session, his anxiety went from a baseline (pre-exposure) level of 2 and a peak of 8 all the way down to a 4. With each successive exposure session involving your child going to the pet store, his anxiety peaks at a lower level, declines more quickly, and ends at a lower point. By the fourth exposure session, his anxiety rating level still begins at 2 (baseline) but it now peaks at a 4 instead of an 8. Furthermore, instead of ending the practice session at a 4, your child's anxiety is reduced all the way back down to a 2. These changes in his anxiety ratings show that, over the course of four exposure sessions, his anxiety related to being in the pet store has reduced significantly.



Other important information about exposure. In addition to the information about exposure shared above, following is some other information that is important to know.

Exposure is usually gradual. Exposure to feared stimuli (situations/objects) usually occurs gradually, starting with a low-level (least feared) stimulus and working up to the highest-level (most feared) stimulus⁷³. The stimuli involved in exposure are usually

⁷³ Chorpita, 2007

based on a Fear Hierarchy or Fear Ladder, a list of feared situations related to your child's most prominent and impairing fears. These hierarchies, introduced in the previous chapter, will be covered in more detail below.

There are several reasons why the gradual approach is most commonly used. First, facing low-level fears is often easier to accomplish and thus allows your child to recognize his ability to face his fears. This initial success in facing lower-level fears can enable him to develop confidence in his ability to face more challenging (high-level) feared situations later on in treatment. Gradual exposure also tends to be used because it is less distressing for your child than having him face his most intense fears all at once.

Alternative approaches. In addition to gradual exposure, there are other approaches that may be used in exposure sessions⁷⁴. The first alternative approach is referred to as “flooding.” This approach involves a sudden and intense exposure to a highly feared situation “in vivo.” The second alternative approach is referred to as “implosion.” This approach involves sudden and intense exposure to a highly feared situation that is imagined. Flooding and implosion are used less often than gradual exposure, particularly with children, since the sudden and intense experience of anxiety is more distressing for children than gradual exposure. Despite this fact, your child's therapist may decide to use these techniques if they will benefit your child. These techniques are no less effective and may even work more quickly than gradual approaches provided that your child can tolerate the higher level of distress and can engage in the exposure long enough to benefit from this approach.

One reason your child's therapist may choose to use these techniques is if avoidance of a particular situation needs to be overcome quickly. Here is an example to demonstrate such a situation:

Example...

Let's say that your child suffers from Separation Anxiety and is missing a significant amount of school as a result. His school absences may create a more immediate need to help him face more intense fears (e.g., being away from you for a longer period of time or at a greater distance) in exposure sessions so that his anxiety regarding separation from you can be reduced more rapidly, enabling him to increase his school attendance.

Given that gradual exposure is the most commonly used approach with children, the remainder of this manual will presume that the therapy your child will receive will involve gradual exposure⁷⁵.

Benefits. The benefits of exposure for children have been addressed above (see the “Rationale” section of this chapter). These benefits include providing corrective

⁷⁴ Ginsburg & Kingery, 2007

⁷⁵ In cases where your child's therapist is opting to use more intensive or sudden exposure, consult with her to ensure that you understand the rationale for this choice and reinforce it with your child. You might also ask the therapist how the exposure will work and how your role in it might differ when using sudden/intensive exposure.

information and increasing confidence in one's ability to handle feared situations, which, along with habituation, help children to reduce anxiety and avoidance.

Benefits for parents include:

- ⊗ Providing you with “corrective information.”
 - Teaching you some of the same things your child learns from exposure sessions.
 - Helping you to see that:
 - The feared outcomes that your child expects don't actually occur.
 - Your child's anxiety doesn't increase endlessly but tends to decrease over time.
 - Your child is able to cope with feared situations.
- ⊗ Helping you feel more comfortable in encouraging your child to approach his fears instead of avoid them in the future.
- ⊗ Easing your anxieties about the exposure process.

What is Likely to Happen in Sessions?

General information. Prior to beginning exposure activities, the rationale and procedures for exposure therapy should be explained to both you and your child. The specific content of exposure sessions will vary depending on your child's anxious symptoms and unique needs. However, the rationale and general steps involved will remain largely the same. The general steps for exposure practice will be described later on in this chapter.

The “Fear Hierarchy” or “Fear Ladder”⁷⁶. Exposure sessions are based on lists commonly termed Fear Hierarchies or Fear Ladders. These lists specify things that make your child anxious and may include a broad range of items including but not limited to feared activities, objects, places, and sensations. When the initial hierarchy or ladder is developed, each item will likely be examined to see if it can be broken down into smaller, more manageable parts so that your child can begin facing his fears in a tolerable way. Much like a ladder, the items on the hierarchy represent incremental steps, each one moving your child closer and closer to his goal of overcoming fear and managing anxiety. This list will become your child's “battle plan” for tackling his fear and anxiety.

Your child's hierarchy will be specific to his fears (the nature of which may be reflected in his diagnosis). However, your child may have additional anxieties that are unrelated to the fears that brought him to therapy. For example, a child diagnosed with Separation Anxiety Disorder may also be uncomfortable around dogs. While his hierarchy list will likely focus only on specific situations involving separation from his parents, it is possible separate hierarchies can be developed so that he may address other fears (e.g., of dogs) as well.

⁷⁶ Chorpita, 2007; Kendall & Hedtke, 2006

Developing the hierarchy. Your child’s therapist will work with you and your child to develop a Fear Hierarchy based on the fears related to his diagnosis. Although the hierarchies developed for different children will vary in length (number of items), it is generally suggested that they contain at least 10 items⁷⁷.

Items, or feared situations and/or objects that go on the list will likely be gathered throughout the beginning of therapy. As these items are collected, the therapist may identify and incorporate features or details of the feared situations that may make your child more or less anxious. For example, for a child with Separation Anxiety Disorder, factors that may alter the level of anxiety experienced may involve the distance that the child is from his parent (e.g., if his parent is in another room of the house vs. just outside of the house vs. far away) as well as how long the separation will last (several minutes vs. several hours vs. a full day or more). Using the feared situations and/or objects as well as these specific details that impact the level of anxiety experienced, fears will be broken down into highly specific items and ranked (lowest to highest) based on the level of anxiety created by the situation. See the “Rating Anxiety” section below for more information on rating anxiety. Once the hierarchy is completed, the finished list will determine the order in which your child’s feared situations are confronted⁷⁸.

Your role in developing the Fear Hierarchy. As the parent, you may play an important role in developing your child’s Fear Hierarchy. His therapist will likely ask you what you believe are your child’s feared situations as well as what aspects of those situations make them more or less challenging for him. You may also be asked to provide input on the ranking (or ordering) of items once the first draft is developed. In addition to reviewing the list as a whole and considering potential items that may have been omitted, you also can provide useful feedback regarding the initial items on the hierarchy (low-level exposures). These initial exposure items are important and need to be chosen carefully since they are the first items your child will encounter and can “set the stage” for the subsequent exposure work. Since you know your child best, it may be helpful for you to collaborate with the therapist when these items are being chosen to be sure that they are “doable.” This will minimize the “intimidation” and maximize the possibility of an early success that your child can build upon. Good places to start are with things your child currently does but that are accompanied by some anxiety. Referring back to the earlier example of a child with a fear of dogs, if your child is able to stand outside of a pet store but experiences some anxiety, perhaps a good place to start would be repeated exposure to standing in front of the pet store.

Content Box...

Refer to Appendix B page 132 for a sample of a Fear Hierarchy from a popular treatment manual.

⁷⁷ Chorpita, 2007

⁷⁸ Ginsburg & Kingery, 2007

Rating anxiety. The process of rating anxiety was first introduced in the “Psychoeducation” chapter in this manual. Please refer back to that section for a reminder about anxiety ratings, if needed. Your child may have been introduced to anxiety ratings during the Psychoeducation phase of treatment. If he was not, he will most likely learn how to rate his anxiety now, prior to beginning exposure sessions.

Anxiety ratings (level of anxiety) are a vital part of exposure work as they help to ensure that exposure items are, in fact, producing anxiety and to what degree. Ratings are also important in that they help to identify and keep track of changes in anxiety during and across exposure sessions (e.g., “within-“ and “between-session habituation”). Thus, these ratings are critical in determining and documenting that your child is benefitting from exposure. Your child will likely be asked to provide anxiety ratings during exposure sessions, which will be recorded on an anxiety rating record form. Ratings may, at times, be recorded by your child himself but will typically be done by either you or the therapist. The intervals at which his anxiety ratings will be taken will vary depending on the treatment manual or therapist as well as on the nature of the exposure task. Anxiety ratings may be taken throughout each exposure session, including ratings before and after each session⁷⁹. For example, continuous ratings across an exposure session may be recorded every 3 minutes, starting with the “baseline” at 0 minutes and concluding with a rating when the exposure session ends (e.g., while standing in front of the pet store). Alternatively, anxiety ratings may also be taken only before and after each discrete exposure session (e.g., before and after eating in front of others). Below is a sample of continuous and before/after (sometimes referred to as “pre-post”) record forms:

Example of Continuous Rating Record Form... (child standing in front of the dog store (recording interval: every 3 minutes))

<u><i>Time Interval</i></u>	<u><i>Anxiety Rating (0-10)</i></u>
<i>0 minutes (before exposure)</i>	<i>2</i>
<i>3 minutes</i>	<i>5</i>
<i>6 minutes</i>	<i>8</i>
<i>9 minutes</i>	<i>8</i>
<i>12 minutes</i>	<i>5</i>
<i>15 minutes</i>	<i>3</i>

⁷⁹ Chorpita, 2007

Example of Before/After Rating Record Form... (child eating in front of others at a small, uncrowded restaurant (exposure practice 1-3))

<u>Session #</u>		<u>Anxiety Rating (0-10)</u>
1.)	<i>Before</i>	2
	<i>After</i>	5
2.)	<i>Before</i>	2
	<i>After</i>	3
3.)	<i>Before</i>	2
	<i>After</i>	2

It is important to note that your child’s anxiety ratings and how quickly they decline will differ depending on the level of exposure (low vs. high) as well as the particular situation. Prolonged exposure sessions and repeated practice of various lengths will likely be needed to reduce your child’s anxiety to a manageable level. This requires patience and determination from both you and your child.

Coping strategies. Coping strategies are defined as tools or behaviors used to help manage anxiety or fear but not to avoid it⁸⁰. These strategies are often taught prior to or while your child is beginning to participate in exposure practice. Generally, your child should have a mastery of a given coping skill prior to utilizing it in an exposure task.

The foremost researchers and practitioners in the field agree that coping skills are excellent tools to be used *before* and *after* exposure sessions as well as at any other time your child may feel anxious. However, there are some differences of opinion and practice as to whether or not such skills should be used *during* exposure sessions per se. The leading treatment manuals used for child anxiety disorders (which are also the manuals primarily used to guide the development of this manual) support the idea of using specific coping strategies during exposure tasks⁸¹. Let’s take a look at the specific skills used during exposure as part of these manualized treatments:

⁸⁰ Hedtke, Kendall, & Tiwari, 2009

⁸¹ Chorpita, 2007; Kendall & Hedtke, 2006; Silverman & Kurtines, 1996

- ⊙ Self-control behaviors
 - Cognitive restructuring/thought challenging/cognitive coping (or “coping thoughts”)
 - Relaxation skills

- ⊙ Developing action plans
 - Problem-solving
 - Carrying a coping card with reminders of appropriate coping skills to use and steps to follow in an exposure session

While these manuals support the use of the aforementioned coping skills during exposure sessions, others in the field assert that the use of such skills can dilute the anxiety experienced during exposure, rendering it less effective⁸². According to these researchers and/or practitioners, such skills may be allowed early in treatment to help ease your child into exposure activities. Subsequently however, they recommend that the use of these skills should be faded out in order for him to reap the full benefits of the exposure practice. Given that this parent-guide is based primarily on the approaches adopted by the major treatment manuals for child anxiety, the remaining content herein will be guided by their treatment approach, which recommends using coping skills during exposure sessions. However, you should be aware that your child’s therapist may choose to exclude the use of coping skills during exposure per se and only focus on having your child use them outside of formal exposure sessions.

Although the major treatment manuals support coping skill use during exposure sessions, not all behaviors your child may engage in to sooth himself are deemed acceptable. In fact, there are many such behaviors that are explicitly discouraged. So, what behaviors are ok and which are not? One relevant distinction to keep in mind is between coping behaviors and safety-seeking behaviors⁸³. Let’s examine what these terms refer to and gain a better understanding of why coping behaviors but not safety-seeking behaviors may be permissible during exposure sessions.

Coping behaviors. Coping behaviors are a group of coping skills that are encouraged for use during exposure practice. These behaviors include those (listed above) suggested for use by the leading treatment manuals (e.g., problem solving strategies, thought challenging, positive self-talk, relaxation).

So, why are these behaviors deemed appropriate for use during exposure? First of all, the use of these specific skills facilitate cognitive change and the reduction of fear by helping your child come up with alternative and realistic thoughts about the situation he is confronting and his ability to cope with it⁸⁴. These skills also facilitate the completion of exposure sessions so that your child can realize their benefits. These include identifying vital corrective information without avoidance (e.g., “I *can* do this!”, “What I

⁸² Abramowitz, Deacon, & Whiteside, 2011

⁸³ Hedtke, Kendall, & Tiwari, 2009

⁸⁴ Hedtke, Kendal, & Tiwari, 2009

expected to happen didn't actually happen.”). Finally, the use of coping behaviors teaches your child that he can face his fears on his own rather than relying on someone else to help him.

Safety-seeking behaviors. Safety-seeking behaviors are a group of behaviors that are not suggested for use during exposure. These behaviors include those which help a child to feel safe in the presence of perceived threat but that keep him from fully engaging in the exposure activity⁸⁵. Examples of such behaviors including checking behaviors (e.g., a youngster who fears wetting his pants in public checking to make sure he knows where all the bathrooms are immediately upon entering a given setting), seeking verbal reassurance (e.g., constantly asking his parents or therapist if he is going to be ok), and mentally “checking out” (e.g., thinking about something else unrelated to the exposure in order to distance himself from the anxiety). These behaviors are forms of avoidance that will ultimately prevent your child from fully engaging in the exposure task and prevent him from getting the “corrective information” he needs to decrease his anxiety. For example, he may misattribute his ability to tolerate the anxiety or the avoidance of a negative outcome to a safety-seeking behavior. (“The reason I was able to stand my anxiety is because my mom told me I would be ok.”). Also, he may misattribute the decrease of his anxiety to the safety-seeking behavior.

Now that you have information on both the recommended and the discouraged behaviors for coping during exposures, you may be wondering how you are going to tell the difference between a coping behavior and a safety-seeking behavior. Perhaps an example may be helpful in illustrating this important distinction.

Example of Coping Behavior vs. Safety-Seeking Behaviors...

Bobby, a 10-year-old boy afraid of dogs, is participating in an exposure session that requires him to walk up to the gate of a local dog park and stand there for until his anxiety decreases at least 50% from its peak level. An appropriate coping behavior for Bobby is positive self-talk (e.g., “You can do this”, “You will be ok”). A safety-seeking behavior that would not be appropriate would be if Bobby asked his mother to assure him that he will be ok.

In the example above, it is preferable that Bobby does not seek reassurance from his mother (as he may come to believe that he needs such reassurance to tolerate the exposure or fail to realize that his anxiety would have subsided without his mother's reassurance). This is an important point with regards to exposure work and will be addressed further in the “Possible Trouble Spots” section below. Also, refer to the subsequent chapters of this manual for more information on the coping strategies that are encouraged for use both within and outside of exposure sessions.

Preparing your child for exposure. There are several techniques that your child's therapist may use to prepare your child for exposure work. Perhaps the most commonly used technique is modeling⁸⁶. Modeling (introduced on p. X in the

⁸⁵ Hedtke, Kendall, & Tiwari, 2009

⁸⁶ Chorpita, 2007; Kendall & Hedtke, 2006; Silverman & Kurtines, 1996

“Psychoeducation” chapter) is generally used first before your child conducts an exposure session on his own⁸⁷. As mentioned in the “Emotion Skills Training” chapter, modeling is a useful technique given that hearing about or watching others facing their fears allows a “safe distance” for your child to learn about facing his fears before actually doing it himself. Your child’s therapist may use several approaches to modeling. First, she may model confronting her own feared situations in order to show your child how exposure works. For example, she may say that she has a fear of spiders. In order to model facing her fear, she may bring in a picture book of spiders (e.g., opening the book, flipping through the pages, taking several minutes to look at the spiders). She may also describe the signs of anxiety that she notices as they arise (e.g., racing heart, shaking hands) as well as the anxious thoughts she may be having (e.g., “I can’t handle this anymore!”). While the therapist describes her anxiety, she may also rate her anxiety level at specific intervals so that she can keep track of it as it decreases over time (e.g., after the first 5 minutes, anxiety is a 5, after 10 minutes, anxiety is a 3).

Another approach your child’s therapist may use in modeling is facing one or several of the items on your child’s fear ladder. This would be appropriate early in treatment as it can help your child “get over the hump” as he begins exposure work. However, it is important that your child does not begin to rely on this modeling as a form of reassurance. In fact, your child’s therapist should gradually fade out this type of modeling once your child begins to conduct his own exposure sessions in order to maximize the effectiveness of the exposure. As the parent, you may also be asked to get involved in modeling exposures (both to your own fears and to items on your child’s Fear Hierarchy). See the “What Role Parents Can Play” section below for more detail on how you may use modeling to help your child.

General steps to exposure. Exposure practice for a given item typically first occurs in session where the therapist is present and can monitor your child as he begins this difficult component of treatment. Exposure work generally begins imaginally as imagining facing a feared situation often creates less anxiety and thus makes the initial exposure work more manageable for your child. Typically, after your child experiences success (i.e., habituation) through imaginal work, “in vivo” exposure will then be introduced. While some exposure work can be conducted “in-vivo” during session (e.g., phoning a classmate to invite him over for a “play date”), “imaginal” exposure will be needed for certain hierarchy items that can’t be reproduced during therapy sessions (e.g., eating lunch at the school cafeteria). In such cases, in-vivo exposure of that item will eventually need to happen outside of session. Exposure work outside of session will either occur with the therapist accompanying your child outside of the office-setting or through homework (where, depending on the circumstances, you may or may not be present with your child). Of course, if your child’s therapist will be taking him out of the office to conduct an exposure-session, this should be done only if your consent has been obtained.

Additional “imaginal” and/or “in-vivo” exposure practice of each hierarchy item will likely be assigned for homework so that repeated practice can occur. Once your child

⁸⁷ Kendall & Hedtke, 2006

learns in-session exposures, he should be prepared to handle out-of-session exposure, as the steps are generally the same. While parental involvement will likely be expected at the beginning of exposure homework for all children, it is possible that your involvement may be encouraged throughout this phase of treatment, particularly if your child is younger and not at a level where it would be reasonable for him to engage in certain hierarchy items alone.

As your child begins to learn the procedures for exposure practice, you will likely be asked to join one or several sessions so that you are able to observe the exposure procedures. This will prepare you to better help with exposure tasks when they are assigned for homework. During this time, you should also be provided with instructions on the roles that you should and should not assume during exposure sessions. See “What Role Parents Can Play” section below to learn more about appropriate roles for you to play during exposure practice.

The steps. Following are the steps that tend to occur during a single exposure session. The specific target of each exposure will vary depending on specific needs of your child. Refer to the “Examples of Exposure Practice” section below for examples of what these steps look like in action.

1. Selecting the item to practice from his Fear Hierarchy

- ☉ Starting from the beginning of the Fear Hierarchy (lowest level fears), he will work his way up the ladder until he reaches the top (highest level fears).

2. Creating a plan for confronting the feared situation

- ☉ Your child will be helped to identify **coping skills** to use before, during, and/or after the exposure (e.g., positive self-talk, relaxation, etc)⁸⁸.
- ☉ He will be helped to predict possible **obstacles** (e.g., negative thoughts) that may come up during the exposure and review adaptive ways to respond⁸⁹.
- ☉ Along with the therapist or you he will develop a “**contract**”⁹⁰ identifying the specific object or situation to be faced, when the exposure session will occur, how many times the exposure task will be repeated, and what the reward will be. Refer to Appendix B page 133 for a sample contract.

3. Reviewing the rationale and purpose of exposure practice (conducted by therapist in-session and by you outside of session)

- ☉ **Rationale:** The rationale for exposure practice is to “test out” fears your child may have about something bad happening in a feared situation, his ability to cope with his anxiety, or that his anxiety will get worse and worse until it overwhelms him.

⁸⁸ Kendall & Hedtke, 2006

⁸⁹ Chorpita, 2007

⁹⁰ Kendall & Hedtke, 2006; Silverman & Kurtines, 1996

- Ⓢ **Purpose:** To help your child to (1) habituate to feared situations, (2) obtain “corrective information,” (3) identify potential “false alarms” (i.e., when he may be experiencing intense anxiety in situations that do not warrant such a reaction), and (4) realize that he can reduce his fears but that anxiety is not meant to be eliminated completely.

4. Performing the exposure

- Ⓢ Your child will engage in an exposure that will be either **imaginal** or “**in vivo**.” Refer to the “Psychoeducation” chapter for definitions.
 - The approach used will be specified in the contract. For many items, regardless of where they are on the hierarchy, exposure trials will first be conducted imaginally in the therapy session prior to exposure occurring in vivo. Imaginal practice can help your child be better prepared to confront his feared situations “face-to-face” later on.
- Ⓢ The exposure may involve **props** such as books, toys, videos, or even people.
- Ⓢ The length of an exposure trial for a given item on your child’s hierarchy may vary from session to session (and from item to item). Here are some criteria your child’s therapist will use to help determine **when a session should end**. You should expect to receive guidance from the therapist on this, particularly for items that you will be overseeing as homework assignments when the therapist will not be present:
 - **Time:** your child may be instructed to end his exposure after a set period of time (e.g., 5 minutes).
 - **Anxiety rating:** your child may be instructed to remain in the exposure trial long enough for his anxiety to decrease (for his rating to get to a sufficiently low level).
 - *Suggested Ratings:* Items starting at a 5 or above (on a 0-10 scale) should reduce to a 3 or less; items starting at a 4 or below should be reduced to a 1 or less (or until 30 minutes passes)⁹¹.

While a timed approach may be taken by some therapists, the general consensus from the widely-used manuals for treating child anxiety disorders is that the child’s anxiety should be reduced at least 50-60% from its peak prior to ending the exposure trial⁹². If a timed approach is used, it is possible that a child’s anxiety may not decrease or may even increase during the time designated for the exposure trial. In most cases, the child will be encouraged to remain in the exposure if at all possible, even though this means extending the time initially designated⁹³. In other cases, the exposure intensity may be reduced in some way. For example, if a child is conducting an exposure trial requiring him to stand next to a dog but he is not experiencing a reduction in anxiety after the agreed upon time, the therapist may decide to move the dog back several feet in an

⁹¹ Chorpita, 2007

⁹² Chorpita, 2007; Kendall & Hedtke, 2006

⁹³ Abramowitz, Deacon, & Whiteside, 2011

effort to make the reduction of your child's anxiety more likely⁹⁴. See the "Possible Trouble Spots" section below for more information on this topic.

Remember, the same exposure will likely be repeated over and over again (either imaginably, in-vivo, or both) within a concentrated period of time before your child's anxiety decreases sufficiently to move on to the next item. The goal is that through repeated exposure trials your child's anxiety when facing a given situation will reduce to a tolerable (or even non-existent) level. In other words, your child will become "bored" with the situation instead of anxious⁹⁵.

What will the therapist be doing during exposure sessions? Your child's therapist will take on both active and passive roles during your child's exposure work. One active role your child's therapist will take is that of rater. In other words, at the agreed upon intervals, she will prompt your child to rate his anxiety on a scale he is familiar with using. Another active role your child's therapist may take is to provide prompts to your child when needed in order to encourage him to approach or stick with the exposure task.

Although these are some active roles your child's therapist may take, her primary role will be rather passive. During the majority of the exposure session, your child's therapist will likely be sitting in silence while your child faces the target situation. Prompts are generally only provided as needed to keep your child on task. Silence on the part of the therapist is extremely important for several reasons. First, the inactive role is consistent with the purpose of exposure in that the child is supposed to learn to face his fears on his own. Second, distraction or reassurance of any kind might dilute the experience of anxiety needed to reap the benefits of exposure.

Examples of exposure practice. The following are examples of in-therapy and out-of-therapy exposures practices. While some exposure activities may be more easily conducted either within or outside of session, it is important to note that exposure sessions do not need to occur exclusively in one setting or the other. In fact, it is possible that, with many hierarchy items, a combination of both in and out-of-therapy exposure can be used. Therefore, an example of a combination exposure practice will also be provided.

⁹⁴ Chorpita, 2007

⁹⁵ Kendall & Hedtke, 2006

Example of In-Therapy Exposure...

Jonathon has a specific phobia of spiders. In session, he and his therapist begin with the first item on his hierarchy, looking at pictures of spiders. They develop a contract to conduct the exposure as part of today's session and agree to rate anxiety continuously at 2-minute intervals throughout the exposure practice. They also agree that the exposure will continue until Jonathon's anxiety reduces to at least a rating of 3 (on a 0-10 scale). As a reward, they agree that Jonathon will get 10 minutes of game time if he completes the exposure practice. The therapist reminds Jonathon of the rationale and purpose of exposure and the exposure begins. Given that this is Jonathon's first practice session, it is expected that repeated trials will be needed before his anxiety level is reduced to a manageable level.

Example of Out-of-Session Exposure...

As Jonathon continues to face his fear of spiders, he is given the homework assignment of practicing the fifth item on his hierarchy, going to a spider exhibit at the local museum. This item was first practiced imaginally in session until the therapist determined that he is now ready to confront it "in vivo." The contract Jonathan develops with his therapist specifies that he must go to the museum and look at live spiders that are behind glass enclosures at the exhibit until his anxiety rating reduces to a 3. The contract also specifies that Jonathon will be rewarded with 30 minutes of TV when he completes the exposure task. Jonathon's mother was brought into session to review the contract. She was told to be as passive as possible during the exposure session but that she can play the important roles of rater and monitor during the exposure. Specifically, she can be sure that Jonathon stands no farther than arms length away from the exhibits and that he is not engaging in any avoidance or safety-seeking behaviors. She also agreed to follow through with the reward after the exposure is complete.

Example of Combination (In and Out-of-Session) Exposure...

As described above, Jonathon began his exposure to spiders by looking at a book with pictures of spiders. During his first exposure practice, Jonathon's anxiety rating was a 9 and reduced to a 3 but it took a complete hour. Since Jonathon's anxiety took a significant amount of time to decrease to a manageable level, his therapist decided that Jonathon needed to continue to practice this exposure before moving on to other items on his hierarchy (e.g., going to the spider museum). This type of repeated practice is expected for most items on the hierarchy. Jonathon, his therapist, and his mother all agree that Jonathon will continue to look at the spider picture book in five out-of-session homework exposure practices during the next week. A contract for each exposure is developed.

What happens after exposure trials? After an individual exposure trial is completed, your child's experience with the exposure will be reviewed. Here is a list of common questions that your child's therapist may ask him⁹⁶. These questions will give your child the opportunity to process his experience in the exposure trial and help him to recognize his successes as well as what coping behaviors worked or didn't work for him.

⁹⁶ Chorpita, 2007

In addition, responding to these questions will help him to recognize potential misconceptions he has had about a given feared situation (“corrective information”). You too can help your child to process his exposure work after each trial. See the “What Role Parents Can Play” section below for more information. Remember, several exposure trials may occur within one therapy session so he may be asked these questions several times.

- Ⓞ What did he think would happen? What actually happened?
- Ⓞ How does he feel? What did he notice happening to his anxiety over the course of the practice session?
- Ⓞ What did he say to himself (self-talk)?
- Ⓞ How did he handle it? Was he able to handle it better than he thought?
- Ⓞ Was it easier than he thought?
- Ⓞ What was the hardest part?
- Ⓞ What does he imagine would happen if he kept practicing?

In addition to reviewing your child’s experience, the therapist should also provide praise for his efforts and/or successes. This helps him to recognize and develop a sense of pride in his accomplishments. As a parent, you can replicate these efforts after a therapy session, if the therapist tells you of his efforts or accomplishments. You can also provide such praise after “homework” exposure sessions are completed.

Typical Homework

While homework is a vital aspect of each component of your child’s treatment, it is particularly important during the exposure phase. Remember, repeated practice and sufficient exposure are necessary for success, so the more practice, the better. Below are examples of homework assignments that may be given during the exposure phase of treatment as well as tips for how you may help with such assignments.

Developing a Fear Hierarchy. Early in the exposure phase of treatment, your child will develop a Fear Hierarchy or Fear Ladder. While much of this work will likely occur in session, some of it may also be assigned for homework (e.g., generating possible items for the hierarchy). As the parent, you may also be asked to get involved both during and outside of sessions in developing the Fear Hierarchy, as discussed earlier in this chapter.

Exposure activities. Exposure activities as homework will likely be a constant once the exposure phase of treatment begins and will generally continue until your child’s fears have reduced substantially. The target (i.e., what feared object, activity, or situation will be faced) of homework exposure sessions will likely be identified from the Fear Hierarchy and planned with the therapist during therapy sessions. As the parent, you should be informed of the plan for the homework exposure task. If you are not involved in the development of the exposure contract, your child’s therapist will likely fill you in on the plan prior to or at the end of your child’s therapy session. If you have not been

informed about the plans for exposure practice in a given week, be sure to ask the therapist so that you can have an accurate understanding of what should occur and what your role should be. This puts you in the best position to help your child.

Your child should receive sufficient psychoeducation and, in many instances, practice with exposure in session prior to being assigned exposure practice outside of session. Therefore, he should feel relatively prepared to conduct “homework exposure trials.” You can follow the steps described in the “General Steps of Exposure” section above to be sure that he is conducting exposure practice correctly. For details on how you can help him with out-of-therapy exposure practice, see the “What Role Can Parents Play?” section below.

What Roles Can Parents Play?

As in other components of CBT treatment for child anxiety, there are several important roles that you may play through the exposure component of treatment. Below is a list of some of the typical roles you may play.

Supporter. The role of providing support is one you will play throughout treatment. During exposure sessions, there are several specific ways in which you can provide support. First, you can provide your child with encouragement as he prepares to conduct exposure trials. This can help him to feel more confident as he moves towards facing his fears. While it is important that you remain relatively passive during the exposure trial, you can encourage your child to approach the feared stimuli or to stay in the situation when he is clearly avoiding or struggling with the exposure task. In addition, you can also encourage your child to apply the coping skills he has learned. Be sure to encourage him to only use the skills approved by his therapist.

Co-therapist. During the exposure phase of treatment, your child will be learning a lot of information and will be practicing a number of skills. While this learning will first occur in the therapy session, much of the practice will occur outside of session. Therefore, your role as a co-therapist is extremely important during this phase of treatment. Like the therapist, you too can use modeling of coping skills or exposure work in order to help your child get “over the hump” early in this phase of treatment. However, remember that such modeling should be gradually phased out so that your child does not become dependent upon an adult first demonstrating the exposure task in order for him to be able to do it on his own, as this will dilute the benefit of the exposure.

Preparing to help with exposure. Exposure practice is a challenging and emotional process in which the therapist (and you) are asking your child to face some of the things that he fears the most. It may be helpful for you to practice facing some of the fears from your child’s hierarchy so that you can better understand what he is being asked to do.

Planning or preparing for exposure trials. As discussed above, an important component of exposure work is the development of a contract. It is possible that your

child will develop weekly contracts in the therapy session with his therapist. If so, you can review the contract with him prior to beginning the exposure session so that he remembers exactly what he needs to do and the incentive for trying to do so. If a contract has not been developed, you can develop a contract with him. Here is what to do:

- ⊗ List exactly what item from the Fear Hierarchy your child will face.
- ⊗ Be specific! What specific behaviors are to be done? When and where will they be done? When will the session end? Which coping skills are ok to use?
- ⊗ Decide on a reward for both completion of the task and for a “good faith” effort at completion.

Once the contract is set, create adequate “protected time” for the exposure session (when neither you or your child will be disturbed by others, phone calls, texts, etc.). Then, make sure that your child has everything he needs to successfully conduct the exposure trial. There are several additional things you may need to do. For example, you may need to drive to a specific location or gather necessary objects or props. Before your child is ready to begin the exposure session, you may want to normalize any fears your child may have about facing feared situations. You may also remind your child of the rationale for exposure work and the importance of completing assigned tasks.

Finally, you can also emphasize (when true) the gradual, step-by-step nature of the exposure. This is particularly important so that your child knows that he will be moving continuously forward in facing his fears but that this will occur at a tolerable pace and that he will not be asked to do anything that he can’t handle. At the same time, it is important that, as he begins to build self-confidence and self-efficacy through exposure to low-level fears, your child understand that he must also challenge himself to face more difficult situations.

During exposure sessions. During exposure trials, the primary task will be to obtain and track his anxiety ratings by asking him at the agreed upon intervals and documenting the ratings on a form. While prompts may sometimes be needed to get your child to approach or to continue engaging in feared situations, it is important that you and others do not provide too much distraction during exposure sessions. Distraction can keep your child from fully experiencing the anxiety and therefore benefiting from the exposure task. Do your best to remain quiet and not interfere so that your child can get the most out of the experience. Also, refrain from excessive reassurance or praise *during* exposure. Again, this can keep your child from fully exposing himself to the feared situation and can dilute the effectiveness of the exposure. Remember that full exposure is important to allow your child to build self-confidence, to learn how to manage anxiety on his own, and to allow the intended “corrective” learning to occur. Encouraging your child to confront his fears while refraining from giving reassurance during such exposure work can be difficult for parents given that it is a natural instinct for you to protect and comfort your child. See the “Possible Trouble Spots” for more details and for tips on how to manage your desire to protect and reassure your child.

After exposure sessions. Once the exposure is over, you no longer have to maintain a passive stance and can freely interact with your child. Just as your child's therapist will ask questions about your child's experience in session, you too can ask these questions following exposure trials outside of session (e.g., "What did he think would happen?", "What actually happened?", "How does he feel?", "What did he notice happening to his anxiety over the course of the exposure session?"). Asking such questions can help to consolidate learning of "corrective information" and help your child to recognize his successes. Be sure to review the appropriate questions to ask with your child's therapist before using this technique with your child.

The time after exposure practice is also a time for praise and reward. Be sure to praise your child for his effort and, if applicable, his completion of the exposure task. When you provide praise, be specific about what you are praising. For example, don't just say "Great job" but "You did a great job facing your fears when you played with your friends in the yard while I was inside." When providing rewards, be sure to follow through with the reward agreed upon in the contract. The reward should be provided as soon as possible after the behavior so that there is a clear connection between the exposure activity and the reward. Above all, following through with the reward is extremely important, as it will increase the likelihood that your child will comply with future exposure tasks.

Although your child may begin to develop confidence in his ability to face his fears after a few successful exposure trials, multiple exposure trials are typically needed to achieve substantial reductions in anxiety and to keep high levels of anxiety from returning (addressed further in the final chapter of this manual). Therefore, you must encourage your child to repeatedly engage in exposure work. This is true both while your child is involved in therapy and after therapy is over.

Finally, you will likely be asked by your child's therapist to provide feedback regarding the exposure sessions you supervise and their outcomes. You may provide such feedback by speaking with the therapist or by completing forms. This feedback is vital for your child's therapist as it will help her to know how your child is doing and how to best proceed with exposure work.

Possible Trouble Spots

Given that exposure work is such a vital component of treatment, it is extremely important that your child stick to the agreed upon procedures for his exposure sessions. When you notice that he is not, it is important to address possible trouble spots immediately. Below you will find a few of the common trouble spots that can occur during the exposure phase of treatment.

Your child doesn't understand the rationale for exposure. The rationale for exposure practice can be difficult to understand, particularly for younger children and those that are just beginning treatment.

What can you do? If you believe that your child is having difficulty comprehending what he needs to do in an exposure session and why he needs to do it, you can take steps to help him better understand. First, clarify the rationale for exposure for yourself. You can use the information you gathered through parent-sessions, the therapist, as well as from this manual. Next, ask your child to tell you more about his difficulty understanding. What does he know? What might he be misunderstanding or missing? Then, use your knowledge to help your child better understand what he needs to do and why.

Example...

Brian is a 10-year-old boy afraid of animals. He was assigned a low-level exposure task requiring him to watch a documentary about farm animals until his anxiety rating drops by 60%. When the agreed upon date and time for the exposure approaches, Brian complains to his mother that he does not understand why he needs to do the exposure session. After reviewing the information she wrote down from her parent-session as well as from this manual, Brian's mother explains to him that facing his fears can help him to overcome them and can also help him to control his anxiety instead of being controlled by it.

In addition to explaining the rationale for exposure, you may also provide examples from your child's own experience that can help him to see the power of exposure work in reducing fears.

Example...

In an effort to help Brian understand why exposure to animals may be helpful, his mother reminds him of a time when he successfully faced his fears in the past. She reminds him that he used to be afraid of being in the water but after learning how to swim and repeatedly going in the pool, he wasn't afraid anymore.

If, despite your best efforts, your child continues to struggle to understand the rationale for exposure, contact your child's therapist immediately for guidance and do not wait until the next session.

Your child does not understand what he is supposed to do. Even if your child understands the rationale for exposure work, he may not be clear on what he is supposed to do to successfully complete a given exposure task.

What can you do? If this is the case, review the handout or contract for the assignment to ensure that you know what your child is being asked to do. If there is no handout, call your child's therapist to clarify the assignment. Next, remind yourself of the typical steps of exposure trials using information provided by the therapist and in this manual. Refer to the "General Steps to Exposure" section above for more information. Using this knowledge, correct any misconceptions your child may have and explain to him what he needs to do by applying the general steps of exposure to his specific exposure task. You can talk your child through what he will need to do prior to the

exposure session or model the exposure briefly to remind him of what the exposure is supposed to “look like”. However, remember to gradually phase out this modeling as your child gets more experienced. Also, remember not to do the exposure trial with your child. If he continues to have trouble conducting the exposure trial on his own, contact his therapist immediately.

Example of Exposure Steps...

- 1) What is the item from the Fear Hierarchy?... lay in bed at night with the lights off until his anxiety rating reduces to at least a 3.
- 2) What is the plan? On the agreed upon day and time, your child will lay in bed with the lights off. He will say his anxiety rating out loud so that his mother, standing outside the door, is able to record it. They agreed that his anxiety rating will be taken before the exposure trial and at 5-minute intervals until his anxiety reaches a 3.
- 3) Remind your child of the rationale...facing his fear can help him to overcome it and can also help him to control his fear instead of being controlled by it
- 4) Child conducts the exposure
- 5) Evaluate the exposure... *What did he think would happen? What actually happened? How does he feel? What did he notice happening to his anxiety over the course of the exposure session?*

You are unsure of the rationale or procedures. Both the rationale and procedures for exposure can be difficult to understand, particularly early in treatment. If you are unsure of the rationale for exposure work, refer to this manual or call your child’s therapist for clarification. With regards to procedures, it is common for parents to be unsure of their specific role (e.g., when is it ok to get involved). It is also common for parents to wonder if their child is “doing it right.”

What can you do? Much of the information needed to clear up this confusion is contained in this chapter. For example, refer to the “Exposure Steps” or the “What Role Parents Can Play” sections above for information that can help you to better understand both you and your child’s roles before, during, and after exposure sessions. If you are still unclear about these roles, don’t hesitate to contact your child’s therapist.

Your child avoids exposure sessions. There are several reasons as to why your child may avoid conducting exposure trials. First, he may not understand what he is supposed to do (refer to the appropriate “trouble spot” above to learn how to handle this). Another common reason your child might avoid exposure trials may be that he is fearful of facing his fears.

What can you do? If you notice that your child is avoiding exposure work, be sure to confront him about it right away. Ask him what he is experiencing and provide

validation that facing his fears is difficult. Also, make sure he understands the rationale and procedures as addressed above so that he is clear on why it is important for him to face his fears as well as on what exactly he needs to do. In addition, you can remind him that he needs to face and experience his fears in order to overcome them or even remind him of past experiences when he overcame his fears by facing the things he was afraid of. You can also remind him about the agreed upon reward for the exposure task in order to increase his motivation. If one was not yet agreed upon, make a contingency contract with your child listing the specific reward he will get after completing the exposure session. Sometimes the chosen reward may not be motivating enough for your child, which can also decrease his willingness to participate in exposure. If this is the case, check in with your child's therapist about modifying the rewards. Finally, as always, provide encouragement and support to your child prior to and after exposure sessions.

Sometimes avoidance of exposure practice may be related to the items on the Fear Hierarchy. For instance, if the items early in the Fear Hierarchy are too anxiety-provoking, your child may be more likely to avoid completing the agreed upon exposure. It is important to take a proactive stance with the Fear Hierarchy to avoid this as a problem. Ensure, in collaboration with the therapist, that the items are carefully selected and sequenced so as to maximize the possibility of success that your child can continually build upon. It may be possible that the Fear Hierarchy needs to be re-worked so that the "steps on the ladder" (how much more anxiety provoking one item is than the last) are closer together. If the above suggestions do not help to decrease your child's avoidance of exposure work, be sure to consult with your child's therapist.

Child uses avoidance behaviors during exposure practice. If your child is completing exposure session but does not seem to be benefiting from them, it is possible that he may be using avoidance behaviors during the exposure. While this can help him to decrease his anxiety in the moment, it is problematic (as discussed earlier in this chapter) since it keeps your child from fully engaging in and benefiting from the exposure task. Examples of avoidance behaviors may include the following:

- ⊗ Closing his eyes while watching a movie containing a feared object
- ⊗ Safety-seeking behaviors such as seeking verbal assurance or keeping something with him that makes him feel safe⁹⁷
- ⊗ Mentally "checking out" (e.g., intentionally thinking of something else instead of what he is supposed to be engaging in)

What can you do? If you notice that your child is using avoidance behaviors during exposure work, you should address this with your child's therapist right away. In addition, there are other steps that you can take to help your child. For instance, you can reinforce the idea of not using avoidance behaviors before the exposure session begins. You can also watch your child during exposure, keeping an eye out for avoidance behaviors and providing prompts to approach the feared stimuli rather than avoid it.

⁹⁷ Hedtke, Kendall, Tiwari, 2009

Example...

George's mom knows that George tends to carry his favorite stuffed animal, a teddy bear, with him when he is feeling anxious. She notices that he has been holding his teddy bear while talking about the plan for the exposure session, which requires him to look at a picture book of spiders. She reminds him that he needs to put his teddy bear down prior to beginning the activity and George agrees. During the exposure trial, George starts looking towards his teddy bear, which he can see on the floor in the other room. When his mom notices this behavior, she reminds George not to pick up his teddy bear and to continue to approach his feared-situation. She also moves the bear out of sight so that he is not tempted by it.

Parents' desire to protect their child. It is natural for parents to want to protect their children, particularly when they are putting themselves in anxiety-provoking and fearful situations. However, this protection can inadvertently keep your child from benefiting fully from the exposure task as it may slow down or stop his progress, the development of confidence, and his sense of agency (or personal control)⁹⁸.

What can you do? In order to make sure that your behaviors do not inadvertently interfere with your child's progress, review this manual and consult with the therapist in order to clarify the roles that are appropriate for you to play during exposure sessions. Also, use reassuring self-talk and coping statements (e.g., "I can tolerate my anxiety while I watch my child do something that upsets him because it will help him in the long run") as a helpful way to remind yourself of why it is important for your child to experience his anxiety fully and how your efforts to reduce the anxiety will only make the treatment less effective and prolong the time needed for your child to overcome his anxiety. Finally, you should also avoid reassurance, praise, or "rescuing" during exposure sessions. Remember, you can give lots of praise and encouragement after exposure trials are complete!

Child only completes part of the task. Sometimes, despite his best efforts, your child may not complete the entire exposure task. For example, if the task is to go to the play ground and talk to a new child, he may be able to go to the playground and play near children but he may not yet be able to tolerate the anxiety related to approaching another child.

What can you do? If your child is unable to complete his assigned exposure task, it is still important to reward him for his efforts (as well as partial successes). However, he should not earn the full reward agreed upon in the contract but can instead be given an alternative reward to reinforce his efforts. This alternative reward may be agreed upon in the contract or may need to be chosen after the exposure session is complete. The reward should be similar to the originally agreed-upon reward but a smaller amount. For example, instead of getting to watch 30 minutes of extra TV, he gets to watch 15 minutes of extra TV. Be sure to talk to your child's therapist about the possibility of breaking

⁹⁸ Silverman & Kurtines, 1996

down the hierarchy item into smaller parts or increments as this may make it easier for your child to confront and succeed in facing the fearful task.

Your child's anxiety does not decrease within a practice session. Although the goal of each exposure session is to reduce your child's anxiety, this does not always occur.⁹⁹ There are several reasons why anxiety levels may not decrease during sessions. First, the exposure episode may have been too short, thus not allowing for enough time for your child's anxiety to decrease (e.g., your child's anxiety is still at a 7 when he stops the exposure trial). If you believe that your child is ending the exposure session early, you should encourage him to remain engaged in the exposure trial until his anxiety decreases sufficiently. If the exposure trial continues and his anxiety still does not decrease, adjustments to the item or the hierarchy may need to be made. For example, the therapist might decide to make an adjustment to the exposure item so that your child's anxiety is able to decrease naturally (e.g., increasing the distance your child can stand from a feared object). If this works, it may be an indication that the exposure item as originally defined was too hard. Another option may be that your child has progressed along his fear hierarchy too quickly, before he was ready. In this case, your child may need to return to an earlier item on the fear hierarchy for additional exposure work prior to returning to this item. Finally, it is possible that the steps on the ladder are too "far apart" (too big of a difference from the level of anxiety produced in one feared situation to the next). This may lead to a strong anxious reaction that prompts your child to "escape" the exposure prematurely, before his anxiety has decreased. Readjustments to the hierarchy can be made so that your child may confront his fear in more manageable steps.

What if his anxiety does not decrease across sessions? Even if your child's anxiety decreases within an exposure session, it is possible that his anxiety will not decrease across sessions. Your child's therapist may identify this problem based on forms you fill out about your child's exposure work. Possible questions you may be asked are: *How are the exposures going? Do you perceive a decrease in his anxiety?*

What can you do? If you are noticing that your child's anxiety is not reducing within or across practice sessions and the therapist has not, be sure to draw her attention to it. In situations such as this, your child's therapist may suggest decreasing time between practice sessions or scheduling them more frequently (e.g., doing the same exposure every day or multiple times per day rather than having a few days in between)¹⁰⁰.

⁹⁹ Silverman & Kurtines, 1996

¹⁰⁰ Chorpita, 2007

Chapter 5: Relaxation Skills

A Brief Description

Relaxation skills training, also referred to as somatic management training, teaches children to manage their physiological, or bodily, responses to stressful situations so that they can reduce their anxiety¹⁰¹. Typical physiological signs of anxiety include a racing heart, sweating, rapid breathing, and trembling. Refer to the “Emotion Skills” chapter for more information about the common physiological signs of anxiety.

Uses of relaxation skills. There are many important uses for relaxation skills, both inside and outside of the context of therapy¹⁰². Within therapy, relaxation can be used to manage anxiety as it arises while practicing other skills (e.g., if your child becomes anxious while practicing modifying anxious thoughts, he could utilize a relaxation skill to decrease his anxiety prior to returning to the exercise). Relaxation can also be used during exposure tasks to help your child gain control over his physiological symptoms. Reducing such symptoms will make it more likely that your child will remain in the exposure task long enough to experience its full benefit (e.g., habituation, corrective information). Outside therapy, relaxation can be used as an independent coping skill that is part of your child’s “tool kit,” or his set of skills used to manage anxiety. In fact, once your child has mastered relaxation, he can use it to manage anxiety throughout his life.

Types of skills learned. There are many different types of relaxation skills and it is common for multiple skills to be taught during the course of treatment. In manualized treatments, the same skills are generally taught to each child¹⁰³, although more focus is usually put on the skills that target the child’s unique anxious profile. Also, while skills are often taught independently, they can also be used in combination (e.g., visualization exercises that promote deep, even breathing). The following is a list of the common relaxation skills taught to children receiving CBT for anxiety. Descriptions of these skills as well as information on how they are taught in treatment will be discussed in detail later in this chapter.

- ⊗ Breathing Retraining
- ⊗ Progressive Muscle Relaxation (PMR)
- ⊗ Visualization (Imagery)

Benefits. Listed below are some of the benefits of relaxation skills for both you and your child.

Benefits for your child include:

- ⊗ Teaching him to manage his own physical reactions to anxiety.

¹⁰¹ Albano & Kendall, 2002; Ginsburg & Kingery, 2007; Silverman & Kurtines, 1996

¹⁰² Ginsburg & Kingery, 2007

¹⁰³ Kendall & Hedtke, 2006; Silverman & Kurtines, 1996

- Teaching him that he has control over his bodily responses when they have felt out of control in the past.
- Building his sense of self-control in order to help increase his positive expectations for therapy.
- Increasing his belief in his ability to gain mastery over anxiety and, thus, increasing his self-confidence .
- ⊗ Providing him with a powerful tool he can use to relax in a broad range of situations throughout his life.
- ⊗ Learning to relax the physiological symptoms of anxiety in order to produce positive effects on other anxious symptoms (due to the mutual influences between somatic, emotional, cognitive, and behavioral components of anxiety).

Benefits for parents include:

- ⊗ Providing the opportunity for you to learn relaxation skills along with your child (addressed further below).
 - Teaching you how to help your child practice and use relaxation skills.
 - Learning helpful ways to manage your own anxiety through exposure to the relaxation skills your child is learning.
 - Helping you to see your child's anxiety as more controllable or manageable by watching him acquire and apply these skills.
- ⊗ Providing a common language for you and your child to speak about relaxation skills.

What is Likely to Happen in Sessions?

General information. Relaxation skills are usually taught to both child and parent¹⁰⁴. While it may seem strange that you will be taught skills during your child's treatment, increasing your knowledge about relaxation is actually a vital part of your child's success during this phase of therapy. Because relaxation skills require specific techniques and frequent practice both in and outside of the therapy session, you can be a great resource to your child outside of therapy as he works to learn these new skills. In order to do so, it is important that you know precisely how these skills are done.

In an effort to prepare you to help your child, the therapist will likely review with you important information including the rationale for teaching relaxation, the specific skills your child will learn, how the techniques will be taught, and the role you may play in helping your child acquire these skills. Most likely, you will be given the opportunity to learn relaxation techniques by joining your child in session as he learns the skills. You may either learn along with him or watch him as he demonstrates what he has just learned. This will help you to become familiar with what he will likely be practicing for homework so that you are in the best position to help¹⁰⁵. While it is helpful for you to

¹⁰⁴ Silverman & Kurtines, 1996

¹⁰⁵ Kendall & Hedtke, 2006

know these skills, you will not be expected to “master” them right away. The therapist will likely provide you with materials such as scripts, readings, audio recordings, or “apps” (an application on a mobile device) so that you can assist your child in his practice. This manual can also be a resource for helping you learn the rationale and techniques for many relaxation skills, so remember to refer back to this chapter as needed.

Early in relaxation training, your child will likely need more support and guidance from both you and his therapist as he learns these new skills. This is particularly true for younger children who may have a more difficult time understanding the concepts involved in relaxation. As treatment progresses, it is important that the assistance you and your child’s therapist provide be gradually faded out so that your child can develop confidence in his ability to use these skills on his own. If you find that your child is relying too heavily on you or seeking a lot of reassurance, it is vital that you encourage him to try the skills on his own. Providing encouragement such as reminding your child that he has the tools he needs to do these skills may help motivate him as he works towards independent skills use¹⁰⁶.

General guidelines of how skills are taught. As previously discussed, your child may be taught some or all of the relaxation techniques described in the following sections of this chapter. Regardless of the skills that are taught, the teaching of each skill will likely begin with psychoeducation. This introduction may include a description of and rationale for the given technique. Following this educational piece, modeling will often be used to teach the skill to your child so that he is able to see what each skill looks like “in action.” As with learning other skills for managing anxiety, it is likely that practice of a given relaxation skill will progress from modeling by the therapist, to the child and the therapist practicing together, and then finally to the child practicing with your help or on his own¹⁰⁷.

As your child learns new skills, he will likely practice repeatedly in session to ensure that he knows how to use them. This gives the therapist the opportunity to observe his technique and provide feedback if needed. He will also be expected to extend his practice through homework assignments. Typical homework assigned during this phase of treatment and how you can assist with them will be addressed below.

The skills. Following are descriptions of the relaxation techniques commonly taught during this phase of treatment. Remember that, in teaching these skills, your child’s therapist will likely follow the general guidelines described above.

Breathing retraining. Breathing retraining teaches your child how to breathe correctly by using deep, slow, and even breaths¹⁰⁸. It may seem strange to teach this skill since we all know how to breathe. However, many of us do not know how to breathe efficiently, particularly when anxious. Furthermore, the shallow, quick breathing that is

¹⁰⁶ Silverman & Kurtines, 1996

¹⁰⁷ Kendall & Hedtke, 2006

¹⁰⁸ Kendall & Hedtke, 2006

associated with anxiety can actually make anxious reactions worse by increasing heart rate, causing lightheadedness, numbness in the extremities, and other physiological symptoms that can worsen anxiety.

The purpose of breathing retraining is to help your child gain control over his breathing. In doing so, he will likely be able to decrease other physiological responses to anxiety¹⁰⁹. Just as inefficient breathing can increase physiological symptoms of anxiety (as noted above), learning to breathe efficiently can have the opposite effect, helping to slow down one's heart rate, and helping one feel calmer and more in control.

In educating your child about breathing retraining, his therapist may first teach him about the relationship between breathing and anxiety. Specifically, he may learn that increased breathing in a true emergency or threatening situation can prepare someone for fight or flight (defending oneself or fleeing from a situation). The child will also likely be introduced to the skill before practice begins so that he understands what he will be doing and why. This introduction will likely include the description of what appropriate breathing looks like as well as the rationale and purpose of its use as described in the previous paragraph.

The following is a list of the steps typically used in breathing retraining¹¹⁰:

- ⊗ Place one hand on your chest and one on your stomach.
- ⊗ Breathe in slowly through your nose until your stomach expands.
- ⊗ Exhale slowly through your mouth, allowing your stomach to deflate.
- ⊗ Repeat three to five times.
- ⊗ Increase the amount of time spent conducting the breathing exercise with each practice.
- ⊗ Focus on your body's reaction to correct breathing (feelings of relaxation should become more evident with each practice).

Sample Script of Breathing Retraining...

Today we are going to practice taking deep, relaxing breaths. Let's start by sitting up straight, putting your feet on the floor, and getting comfortable in your chair. Now, I want you to place one hand on your chest and one on your stomach so that you can feel your breath as it goes in and out. Now, I want you to slowly start taking a deep breath in through your nose. Feel the breath going past your chest and into your stomach. Notice that your hand on your stomach rises up as the breath reaches your stomach. Now, begin to breathe out through your mouth, feeling your stomach get smaller beneath your hand. Let's try that again.

In addition to the common steps of breathing retaining, additional techniques may be used to help facilitate learning. For example, metaphors (utilizing visualization) are often used to facilitate correct breathing techniques. Here is a metaphor commonly used to teach this skill¹¹¹:

¹⁰⁹ Ginsburg & Kingery, 2007

¹¹⁰ Kendall & Hedtke, 2006; Silverman & Kurtines, 1996

¹¹¹ Silverman & Kurtines, 1996

Example of a Metaphor...

Imagine that your body is a balloon. As you breathe in, imagine that you are filling up with air just like a balloon. As you breathe out, imagine that you are deflating just like a balloon.

As with the teaching phase of most other skills, modeling can help your child learn how to breathe appropriately. Here is an example of how modeling can be used for this skill¹¹²:

Example of Modeling Breathing Retraining...

Using the “common steps” described above, the therapist puts one hand on her chest and one hand on her stomach. She explains to your child that she is breathing in and imagining a balloon expanding in her stomach. She may even give the balloon a color to help the child visualize it. She then points out that the hand on her stomach is moving outward as she breathes in and, as she exhales, that the same hand is moving back in.

Progressive muscle relaxation (PMR). PMR teaches your child how to relax his muscles. This is important given that muscle tension is often a physiological reaction to anxiety. PMR involves repeated practice of alternating between tensing and relaxing muscle groups throughout the body from head to toe¹¹³.

During the psychoeducational phase, your child may first learn why muscles get tight to begin with. Specifically, he may learn that muscle tension and tightness are common reactions to anxiety given that such reactions can help in dealing with real-threat situations. For example, in a dangerous situation where one would need to either fight or flee, blood goes to the muscles to prepare for running or self-defense. While muscle tension can be helpful in actual life-threatening situations, it is not so helpful when we feel anxious in non-threatening situations (referred to as “false alarms”).

PMR is taught through experiential activities. Early in the teaching of this skill, practice will likely involve progressing through tensing and relaxing all muscle groups so that your child can get the complete experience of this skill. Later on, however, your child will likely focus mostly on muscle groups that he has identified as particularly tense when anxious¹¹⁴. When practicing PMR, your child will generally be encouraged to focus on tensing and relaxing one body part at a time (for example, just the hands)¹¹⁵. When tensing each muscle, it is important that the tension is held long enough so that the child can get a good idea of what a tense muscle feels like. In order to do so, your child may be asked to squeeze with consistent tension for several seconds (one popular manual

¹¹² Kendall & Hedtke, 2006; Silverman & Kurtines, 1996

¹¹³ Ginsburg & Kingery, 2007

¹¹⁴ Kendall & Hedtke, 2006

¹¹⁵ Kendall & Hedtke, 2006

suggests the tension be held to the count of five¹¹⁶) or to gradually squeeze tighter and tighter as time progresses. As your child begins to relax his muscles, he will likely be encouraged to pay attention to the good sensations he feels as he releases the tension. Typical sensations usually include feelings of warmth, relaxation, looseness or tiredness in the muscle. The relaxation phase of PMR should last longer than the tension phase (e.g., to the count of 10) to allow your child enough time to benefit from the relaxed feeling prior to tensing his muscles again. The tension and relaxation of a given muscle will likely be repeated more than once to ensure that your child begins to recognize the difference between tense and relaxed muscles. While the length of time practicing PMR may vary based on the needs of your child, a typical exercise will last around 15 minutes¹¹⁷.

Content Box...

Learning this experiential activity can help you to help your child practice at home. This chapter should assist you in developing an understanding of the basic concepts of this skill but be sure to ask your child's therapist for details about how she is teaching it so that you are able to be consistent with the method she is using.

As discussed with breathing retraining, visualization can also be used to facilitate muscle relaxation. Visualization is an individual technique for relaxation that will be discussed in greater detail below. However, when used with PMR, it can help to enhance one's ability to relax muscles¹¹⁸. There are a few ways that visualization can be used. First, visualization can help enhance the basic instructions of PMR. For example, instead of telling your child to simply squeeze his fist, he may be told to imagine that he is squeezing an orange in his hand and trying to get out all of the juice. He may then be given the instruction to "drop the orange," allowing his hand to relax. Visualization can also be used to imagine what tense and relaxed muscles look like. For example, your child might imagine that a tense muscle looks like a ball or a tight knot. He may then imagine that a relaxed muscle looks long and loose, like spaghetti or jelly. Comparing these sensations and visualizations can help your child to notice the difference between relaxation and tension in practice so that he is better able to detect tension when it is occurring in daily life, to label it as anxiety, and to use that recognition as a cue to use his newly acquired skills in order to release the tension in specific muscles as needed.

Sample Script of PMR...

Today we are going to practice relaxing our muscles. We are going to start at the tips of our toes and work up to the top of our heads, relaxing each of our muscles as we go. When I say go, I want you to squeeze your toes as tight as you can into your feet. Imagine that you are trying to pick up something off the ground with your toes. Squeeze as tight as you can Now, relax. Notice how your toes and feet feel. Are they tired, are they relaxed? Let's try one more time. Squeeze your toes again. Now relax. Do your toes and feet feel more relaxed? Now let's move on to your legs...

¹¹⁶ Kendall & Hedtke, 2006

¹¹⁷ Kendall & Hedtke, 2006

¹¹⁸ Kendall & Hedtke, 2006

As with many other skills your child will learn, the therapist will likely use modeling in order to demonstrate how PMR is supposed to be done. Given that others can readily see the activity of tensing certain muscles in the body, modeling can be particularly effective in helping your child to see exactly what he is supposed to be doing. This is particularly important for those muscles that may seem difficult to tense (e.g., the face muscles). The following is an example of how modeling can be used in teaching this skill:

Example of Modeling for PMR...

In introducing PMR, your child's therapist models PMR beginning with her face and working her way down. She begins by describing what she is doing as she tenses her face muscles (squinting her eyes, raising her cheeks, and wrinkling her forehead). As she does this, she may say out loud to herself, "squeeze tighter, tighter!" Then she says "now relax" and describes what her face feels like as it relaxes (tired, loose). With certain body parts like the foot or the hand, she incorporates visualization (squeezing an object such as a ball or an orange) in order to facilitate the learning process.

Visualization. Visualization, also referred to as "imagery," was first introduced in this chapter as a potential component of breathing retraining. While visualization can certainly be used to enhance relaxation skills including PMR or breathing retaining, it can also be used independently. Visualization requires your child to imagine himself in various states or situations that are peaceful or relaxing¹¹⁹. This can help your child to feel calm and safe during anxious or scary times. Specific to exposure sessions, visualization can also help your child imagine accomplishing a task successfully in order to increase motivation and confidence in his ability to meet the challenges of treatment.

When visualization is first introduced to your child, he will likely be provided with a description of the skill as well as its rationale. This education is particularly important for younger children who may have more difficulty understanding abstract concepts such as visualization.

In teaching visualization, your child may be asked to imagine a time when he felt really calm. Instead of just thinking about the situation, he will likely be asked to recall multiple aspects of it, incorporating all of his senses (i.e., imagining sights, sounds, smells, tastes, and tactile sensations). He may also be asked to identify a particular feeling or set of feelings he experienced in that situation (e.g., calm, relaxed, happy). All of these suggestions can help to make the imagined situation as vivid as possible¹²⁰. Instead of or in addition to visualizing a relaxing situation that he has experienced, your child may be encouraged to think of a new relaxing scenario (e.g., floating in the ocean or on a cloud) as long as he is able to identify a place that is relaxing and safe to him. In addition to using his own imagination, your child's therapist may also provide a script of a relaxing scenario and ask him to imagine being there in order to encourage relaxation. For example, he may be asked to imagine being at the beach listening to the waves,

¹¹⁹ Ginsburg & Kingery, 2007

¹²⁰ Kendall & Hedtke, 2006

seeing the water flowing in and out, smelling the fresh air, and feeling the sand under his feet as he becomes increasingly calm and relaxed. If a script is provided to your child, you will likely be given a copy to read to him when he practices for homework. Alternatively, the script may be recorded so that he can listen to it and practice at home.

Sample Relaxation Visualization Script...

Today we are going to learn to relax by using our imagination. I want you to start by getting comfortable in your chair, placing your feet on the ground, and putting your hands at your sides. If you feel comfortable, close your eyes. Now, I want you to think of the happiest place you have ever been. It could be in your bedroom, it could be at a park, it could be at the beach. Wherever you feel happy and safe. Now I want you to bring that place into your mind. Think about exactly what you see in that place. What do you smell? What do you feel? Can you see it? Can you smell it? Get comfortable in this place. Maybe you want to imagine yourself taking a seat or even lying down. Notice how comfortable you feel in this place, how safe you feel. Let this feeling fill your body and your mind.

Given that visualization skills are not typically visible when implemented, modeling of this skill can be particularly difficult. However, the therapist can still model how visualization is done by saying out loud what she would ordinarily think or imagine in her mind during a visualization exercise in order to help your child get a better idea of what he should be thinking or imagining during such a task. For example, the therapist may tell your child that the most relaxing place for her is in a field full of flowers. She may describe (out loud) that she is walking up to the field and also describe what she notices around her (e.g., the color of the flowers, the scents, the texture of the grass under her feet). She may also describe how, as she walks through this field, she notices that her body feels relaxed and that she feels calm and happy.

Practicing practical application. As part of treatment, your child's therapist will likely guide him through the practical application of skills being taught (e.g., when, where, how). Session time may be spent having your child visualize applying his relaxation skills in real-world, anxiety-provoking situations. However, it is important that your child also learn that full relaxation exercises are not always practical in many "real world" situations¹²¹. For example, it would not be reasonable for your child to take 15 minutes to do a full relaxation exercise when he should be taking an English test. Therefore, session time will likely be spent thinking about situations when the implementation of a complete relaxation strategy will not be practical and developing abbreviated forms of the strategy to be used during such times. Before this is done, the therapist should ensure that your child has a firm grasp on the use of the full skills. Here is an example of what an abbreviated exercise might look like:

¹²¹ Kendall & Hedtke, 2006

Sample of an Abbreviated Relaxation Exercise...

Continuing with the example of taking the English test, instead of doing a full relaxation exercise, your child can opt to take a few breaths to slow his breathing and heart rate or take a few moments to imagine himself in a relaxing spot to calm his anxiety before beginning his test. If he notices his anxiety rising during the test, he can take a few more deep breaths without taking too much time from his test taking.

Typical Homework

When it comes to relaxation, in-session practice is essential for learning skills, but at-home practice is vital for consolidating skills¹²². Below are examples of typical homework assignments that may be assigned during this stage of treatment.

Continued practice with identifying physical signs of anxiety. Mastering relaxation skills requires continued development of the ability to identify the signs of anxiety. In order to continue to develop this skill, your child may be assigned additional activities of writing about anxiety-provoking situations and describing signs that let him know that he is anxious. These assignments are similar to those assigned during Emotion Skills Training (see Chapter 3 for additional details).

Content Box...

Refer to Appendix B page 134 for a sample of a homework assignment from a popular CBT manual that will assist your child in identifying signs of anxiety.

Given that these skills were introduced earlier in treatment, it is likely that your child will have a better grasp on them. Therefore, it is important that independent practice is encouraged. However, if your child is continuing to struggle, refer back to the “What Roles Can Parents Play” section in the “Emotion Skills” chapter for information on how you can assist him.

Identifying tension vs. relaxation. An important part of relaxation skills (particularly PMR), is being able to tell the difference between tension and relaxation¹²³. In order to help your child grasp these differences, workbook or artwork activities aimed at practicing identifying and differentiating these two states will likely be assigned. Typical activities may involve looking at pictures and deciding which represent tension and which represent relaxation, drawing pictures of self or others looking tense or relaxed, or making collages (e.g., one of tense people and one of relaxed people).

¹²² Ginsburg & Kingery, 2007

¹²³ Kendall & Hedtke, 2006

Content Box...

Refer to Appendix B page 135 for a sample of such homework from a popular CBT manual.

Listening to relaxation scripts. As discussed above, relaxation scripts are useful tools that may be used to help your child practice relaxation skills. The therapist may provide your child with a recording of her own voice reading a relaxation script (e.g., PMR instructions, visualizations) or she may provide you with or direct you to a professionally produced recording (e.g., an MP3 file that you can download to your child's iPod). If recordings are not available or you do not own a device that will allow your child to listen to such recordings, the therapist may instead provide a written script that you can read to your child as part of these regular practice sessions.

What Roles Can Parents Play?

As in other components of CBT for child anxiety, there are several important roles that you may play throughout the relaxation component of treatment. Below is a list of some of the typical roles you may play.

Supporter. Your role of providing support and encouragement to your child will remain relatively consistent throughout all components of treatment. It is important that you consistently praise your child for his practice and efforts to help him feel supported and increase his motivation. It is also important that you encourage regular practice as it is vital for getting the full benefit out of relaxation training. As his parent, you can check in with your child to make sure that he is practicing. If he is not, provide encouragement and remind him why relaxation can be so helpful (refer to the rationale described at the beginning of this chapter). You can also remind him of the contingency contract reward that was agreed upon for this practice in order to increase his motivation.

Co-therapist. During the relaxation phase of treatment, you can help with relaxation practice. As mentioned above in the "Typical Homework" section, you can help by reading relaxation scripts to your child to facilitate his practice. If recordings are being used, you can also help by setting up the recordings and monitoring his practice to ensure that he is responding appropriately. In addition, you may record his anxiety ratings before and after the relaxation exercises in order to help him recognize whether or not the skill is working. If you find that your child is struggling with relaxation exercises, see the "Possible Trouble Spots" section below for details on how you can help. Finally, as in most other components of treatment, it is likely that your child will be rewarded for his practice, efforts, and homework completion. It is important that you follow through with the reward agreed upon in the contingency contract to encourage your child's continued efforts.

Possible Trouble Spots

While relaxation skills may seem basic, they can actually be more complicated than expected, particularly for children. For this reason, it is important that these skills are practiced frequently and conducted properly so that they can work effectively. The following will address common trouble spots that may occur during relaxation training.

Doing the exercise incorrectly or struggling with practice. Given that relaxation skills can be challenging to learn, your child may struggle to acquire them. You may find yourself wondering, “How can I tell if my child is struggling?” Perhaps the best way to tell is by observing your child’s practice. Some things you may notice are that your child is trying to use a technique but seems to be doing it wrong or appears to be frustrated (e.g., trying to tense the muscles in his shoulders but he can’t seem to figure out how) or if he is taking a long time to complete a written assignment.

What can you do? If you notice that your child is struggling, there are several steps you can take. First, check in with your child while he is practicing. Praise him for his effort and empathize with the fact that it can be challenging to learn a new skill. At the same time, express confidence that he can do so and remind him that it will help him to learn to control his anxiety (rather than have his anxiety control him). In order to help your child feel more confident in his ability to master these skills, you can ask him to generate examples of other skills he now possesses that were initially challenging for him and required lots of practice. For example, you might remind him that the first time he tried to complete an exposure session (e.g., for a child afraid of bugs, looking at a book of bug pictures), it was very difficult for him, but after practicing he was able to face his fear (e.g., now he can easily look at a picture book of bugs with little or no anxiety). You might also use an example of a skill your child learned that has nothing to do with his anxiety (e.g., learning to ride a bike or learning to play soccer). You could also use your own experience and provide examples specific to the assignment or relaxation skill he is struggling with. For example, when your child is trying to learn to recognize the difference between tension and relaxation, you might remind him of a time when you were tense as well as a time that you were relaxed and describe each situation along with what you felt. You can also use “*Emotional Charades*” or modeling to act out tensed vs. relaxed reactions (e.g., modeling what tense shoulders look like) Refer to the “Psychoeducation” chapter for a reminder on how Emotional Charades works. This can help your child to better identify what tension and relaxation “look like.” If you find yourself unsure about what to do, remember to refer back to this manual and re-read the descriptions of the exercises and/or typical homework assignments. You can also check in with your child’s therapist to re-learn the skill before you help your child.

Your child is not practicing. Developing effective relaxation skills takes practice. As discussed in previous chapters, homework isn’t always fun which can lead your child to feel like he doesn’t want to do “homework” for therapy. The best way to tell if your child is practicing or not is to check in with him to see if he is actually completing written (e.g., writing about anxious situations) and experiential (e.g., breathing, PMR) exercises. Your child may be provided with a homework log to help monitor his

homework completion, which can help you to see if he is completing his work. If he hasn't been provided with one, you can certainly create one to keep track of your child's assignments and then share it with his therapist so both you and she can see his progress.

What can you do? If you notice that your child is not completing assignments or that he is not practicing for the agreed upon amount of time, start by encouraging him to do so. Also, remind him that the rationale for practice is to help him to improve his skills so that he can manage his anxiety. Finally, you can remind him of his contingency reward in order to encourage practice. If you find that your child is still not practicing, inform his therapist so that she can troubleshoot this issue in his next session.

Chapter 6: Cognitive Skills Training

A Brief Description

Cognitive skills training refers to the component of treatment during which your child will learn how to identify, evaluate, and modify cognitions (also called thoughts). Cognitions have two primary dimensions: cognitive content and cognitive process. Cognitive content refers to *what* we think.

Example of Cognitive Content...

Adam's mom tells him that they are going to visit Aunt Elizabeth and Uncle Bob for a few days, Adam thinks, "Uh-oh, they have a dog, I bet he is going to bite me."

Cognitive process refers to *how* we think. The process of how we think is influenced by factors such as our perception, attention, memory, attributions, and problem-solving.

Example of Cognitive Process...

When Adam gets to his Aunt and Uncle's house, he immediately pays attention to all of the threatening things about the dog (e.g., his sharp teeth, his big size, the fact that he is not on a leash) and ignores the non-threatening things (e.g., the fact that he is wagging his tail, the fact that he is gentle with Adam's little brother, the fact that his Aunt has said that the dog is a "sweetheart" who has never bitten anyone).

Cognitive content and processes are central to cognitive skills in CBT given that changing how and what we think can, in turn, change how we feel (including our level of anxiety) and what we do¹²⁴.

How do cognitions relate to anxiety? Cognitions play an important role in increasing or decreasing anxiety. As you may recall from the introductory chapter of this manual, there is a reciprocal relationship between thoughts, feelings, and behaviors. This relationship can be adaptive or maladaptive. Specific to cognitions, thoughts associated with anxiety can be adaptive or maladaptive and can lead to either helpful or unhelpful behaviors.

¹²⁴ Kendall & Hedtke, 2006

Example of an Adaptive Relationship Between Thoughts, Feelings, and Behaviors...

Someone walking alone in a dark alley has the thought, “I need to be very aware of my surroundings,” This thought prepares him to react to bad things that may happen by creating anxiety (feeling) which, in turn, prepares him to fight or flee (behaviors).

On the other hand, thoughts can be unhelpful and lead to anxious “false alarms.” False alarms are anxious reactions when the threat is not real, when the threat is overestimated, or when one’s ability to handle the threat is underestimated. Having unwarranted anxious thoughts and feelings in non-threatening situations can lead to maladaptive behaviors (e.g., avoidance).

Example of a Maladaptive Relationship Between Thoughts, Feelings, and Behaviors...

Sam thinks, “I can’t handle being around clowns,” which leads to him feeling anxious and scared. As a result, he decides to skip his best friend’s birthday party because a clown is going to be there (behavior).

By learning to identify and change maladaptive thoughts to more adaptive and realistic ones, it is possible to decrease anxious feelings and avoidant behaviors¹²⁵.

Example of Changing Maladaptive Thoughts in Order to Change Anxious Feelings and Behaviors...

Sam realizes that he is having a maladaptive thought about clowns and decides to change his thought to one that will help him cope with his fear. He thinks, “I know clowns make me nervous but I really want to go to my friend’s party. I can use my breathing skills and visualization techniques to calm down if I begin to feel anxious at the party.” This makes him feel less anxious and he decides he can handle going to the party after all.

How do we change what or how we think? Maladaptive cognitions can be changed through the process of identifying, evaluating, and restructuring (changing) thoughts that contribute to anxiety as well as by developing coping thoughts and confident self-statements to help manage anxiety-provoking situations. These processes will be address in detail in the “What Will Likely Happen in Sessions” section below.

Purpose of cognitive skills. The cognitive skills component of treatment has many important purposes¹²⁶. These include:

¹²⁵ Kendall & Hedtke, 2006

¹²⁶ Chorpita, 2007; Ginsburg & Kingery, 2007

- ⊗ Helping your child understand the effect his thoughts have on his anxiety.
- ⊗ Teaching your child the common ways of thinking that tend to contribute to anxiety so that he can identify and change them when needed.
- ⊗ Helping your child learn a set of skills (such as positive self-talk, problem-solving, and restructuring common anxious thought patterns) that can increase his self-efficacy, increase his belief in his ability to cope with challenges, and reduce his perception of being overwhelmed.
- ⊗ Ultimately, helping your child to reduce, manage, or better tolerate anxious feelings.

What types of cognitions are most prominent in anxiety? Anxious cognitions generally relate to some sort of threat or danger. These threats or dangers may be physical (“I’m going to get bit”), social (“I’m going to get laughed at”), or psychological (“I won’t be able to handle my anxiety; it will be too much for me to take”). These types of cognitions about threats can lead to real or “false alarm” anxious reactions, depending on the situation.

There are two types of cognitions that tend to lead to “false alarms.” The first type of cognition involves overestimating the probability of threat or danger. In other words, it involves overestimating the probability of a bad thing happening. For example, a child with separation anxiety may think, “If I’m not with my mom, something bad is going to happen to her.” Given that this likely is not true, it is evident that he is overestimating the probability of something bad happening. The second type of cognition involves underestimating one’s ability to cope with or handle situations. In other words, it involves expecting that one cannot handle something or cannot handle it well. For example, a child who is afraid of the dark may think, “I won’t be able to get through a night alone in the dark.”

What cognitions contribute to anxiety? For children with anxiety disorders, cognitions often involve maladaptive thought patterns that increase feelings of anxiety¹²⁷. These thought patterns may be referred to as “Cognitive Errors” or “Thinking Traps”¹²⁸. The following are various types of thought patterns that may play a role in generating or exacerbating anxiety¹²⁹:

Catastrophizing. Catastrophizing involves amplifying or exaggerating the consequences of an event and perceiving oneself as being unable to tolerate it. In other words, it involves taking a situation that is a little threatening where you should be a little cautious and treating it as if it is extremely threatening such that you should escape or avoid it. Also, this same term can be applied to taking a possible negative outcome and regarding it as much worse than it actually is (or as intolerable when in reality, it is distressing but tolerable.)

Example: “If I make a mistake, people will hate me.”

¹²⁷ Chorpita, 2007

¹²⁸ Kendall & Hedtke, 2006

¹²⁹ Kase & Ledley, 2007; Kendall & Hedtke, 2006

All-or-nothing thinking. All-or-nothing thinking also is called “dichotomous” or “black and white” thinking. It involves seeing things in absolute, black and white terms with no “grey area” or middle ground.

Example: “If I make one mistake, I am stupid.”

Negative filtering. Negative filtering also is referred to as “tunnel vision.” It involves focusing only on negative or threatening aspects of a situation while ignoring other information that may make things more manageable or less threatening.

Example: A child thinks, “I can’t handle being away from Mom,” while ignoring the fact that she will not be far from home and will be easily accessible if needed.

Overgeneralizing. Overgeneralizing involves generalizing a specific incident into a pattern. Overgeneralizations often involve the use of the words “always” or “never.”

Example: “Since I wasn’t able to handle being apart from Mom the last time she left, I will never be able to handle it.”

Fortune-telling. Fortune-telling involves making typically-negative predictions about the future without considering real-world evidence.

Example: “I’m going to get up there and mess up.”

Expecting perfection. Expecting perfection involves a child thinking that he has to get everything “just right.”

Example: “I must give this speech without making any mistakes.”

What cognitions help anxiety? Not all cognitions involve unhelpful thought patterns. In fact, there are some thought patterns that can help manage or even decrease anxiety. The following are two types of helpful cognitions.

Positive “self-talk.” Positive self-talk involves positive or optimistic statements children learn to say to themselves to increase self-confidence and willingness to face anxiety-provoking situations. The purpose of such self-talk is to provide your child with a way to encourage himself in difficult situations as well as to remind himself of his capability of facing anxiety and fear.

Example. A child with separation anxiety who feels anxious about leaving his mother for the day may say to himself, “I’m safe here at school” or “Plenty of kids come to school every day without their parents and are ok.” These thoughts serve as encouragement and positive reminders that likely will help decrease his anxiety while he is at school.

Adaptive thinking. Adaptive, realistic, flexible, and balanced thinking can be helpful in counteracting some of the key unhelpful thought patterns related to anxiety (as reviewed above). Adaptive thought patterns include not overestimating the probability of bad things happening, not exaggerating the negative consequences of certain events, and having realistic appraisals of one’s ability to tolerate some distress and to cope with challenging situations.

Example. A child who thinks of reasons why he will be safe or why things likely will turn out ok is using more adaptive thinking than a child who focuses only on danger or threat as well as his inability to cope.

Benefits. The benefits of cognitive skills training for children with anxiety include those described above under the “Purpose of Cognitive Skills” section (e.g., helping your child to understand the effects his thoughts have on his anxiety, teaching him common ways of thinking that tend to contribute to anxiety so that he can change them when needed, helping him to learn a set of skills that can increase his self-efficacy).

Benefits for parents include:

- ⊗ Giving you labels for the common types of thoughts your child may have that increase his anxiety.
- ⊗ Being able to identify when your child’s statements reflect a thought likely to worsen his anxiety and to prompt him to use cognitive skills he is learning in therapy to modify that thought.
- ⊗ Helping you to see that your child is developing skills to manage his anxious thoughts, which can, in turn, decrease your own anxiety.

What is Likely to Happen in Sessions?

Prior to learning cognitive skills, it is important that your child be able to tell the difference between thoughts and feelings. Therefore, the beginning of this phase of treatment likely will focus on helping your child to clarify this difference¹³⁰. Specifically, he will learn that a thought is something that is produced by thinking such as an idea, statement, question, or mental image while a feeling is an emotional state.

Learning about thoughts. Once your child’s therapist feels confident that he understands the distinction between thoughts and feelings, the focus of this phase of treatment will shift primarily to thoughts. Thoughts have many unique characteristics. Thoughts can:

- ⊗ Cover a range of topics including the past, present, and future.
- ⊗ Be helpful, unhelpful, or neutral in terms of their impact.
- ⊗ Vary from being very likely to very unlikely (specific to thoughts involving estimating the probability of something happening or one’s ability to cope with a given situation).

¹³⁰ Chorpita, 2007

- ⊙ Be distorted or realistic.

Modeling. It is likely that your child’s therapist will help him learn about thoughts through the use of modeling. For example, she may say her thoughts out loud so that your child can see what kind of thoughts someone might have. She may also label her thoughts as positive or negative or as helpful or unhelpful so that he can begin to tell the difference. As always, modeling will be gradually faded out as your child works up to stating his own thoughts out loud. It is expected that the therapist will continue to check in with your child to ensure that he is accurately identifying and labeling his thoughts both in session and through his homework. In doing so, she will be able to recognize if he is having difficulty with thought identification and can work with him further to strengthen this important skill if needed.

Thought Bubbles. Another way your child may learn about thoughts is with the use of “thought bubbles.” Thought bubbles are often added to photos or drawings as little bubbles above someone’s head. They can be filled in with various thoughts that illustrate what your child or others may be thinking. By practicing filling in thought bubbles, your child can begin to see how thoughts relate to various situations, feelings, and behaviors¹³¹.

Content Box...

Refer to Appendix B, page 136 for a sample of a “thought bubble activity” from a popular CBT manual.

Learning to change negative or unhelpful thoughts. Changing negative or unhelpful thoughts is often referred to as “cognitive restructuring.” It involves your child changing the thoughts or self-talk he has when those thoughts are unhelpful or maladaptive. Prior to teaching cognitive restructuring, it is important that your child first be able to identify when he is anxious. For a review of this topic, refer to the “Emotion Skills Training” chapter. The remainder of this section will address the steps of learning cognitive restructuring.

Recognizing how thoughts are contributing to anxious emotions. In order to help your child understand how thoughts contribute to anxious emotions and behaviors, his therapist may provide examples using both positive and negative thoughts¹³². These examples can help your child learn which thoughts make him anxious so that he can decide whether or not they contain unhelpful thought patterns. Later in this chapter, we will discuss how your child can change these unhelpful thoughts; but first, let’s look at a few examples that can help your child learn about the impact of positive and negative thoughts:

¹³¹ Kendall & Hedtke, 2006; Silverman & Kurtines, 1996

¹³² Chorpita, 2007

Example of the Impact of Negative Thoughts...

The negative thought: “I’m going to make a fool out of myself if I speak in front of others.

Resulting feelings: Anxiety and fear

Resulting (anxious) behaviors: Biting nails, mumbling, avoiding being around others

Example of the Impact of Positive Thoughts...

The positive thought: “I’m going to do a good job.”

Resulting feelings: Hopeful and happy

Resulting (confident) behaviors: Engagement with others, making good eye contact, speaking clearly

Identifying and evaluating thoughts. Once your child understands the impact of unhelpful thoughts, it is time for him to start identifying and evaluating his thoughts and thought patterns. Identifying and evaluating specific thoughts and unhelpful thought patterns that may be influencing his feelings and behaviors helps your child to recognize if he needs to modify his thoughts to be more realistic or adaptive. Let’s look at some of the common approaches used during this segment of treatment.

Socratic questioning. Socratic questioning, defined as the process of asking a series of open-ended questions for the purpose of encouraging reflection and discovery¹³³, can help your child to broaden his perspective so that he can take a “fresh” or more objective look at his own thoughts. It can also help him to identify if some of his thoughts contain unhelpful thought patterns and unwarranted predictions about the future¹³⁴. Socratic questioning is first guided by the therapist. In other words, your child’s therapist will ask your child a series of questions that can help him to develop insight into his thoughts and how they impact his feelings and actions. Such questions can help your child to recognize if he is overestimating the probability of something bad happening (e.g., “What am I thinking?”, “How likely is it that this is really going to happen?”, “Has this ever happened to me before?”, “Is there any proof that this won’t happen?”, “Is there any proof that it will?”)¹³⁵. It is important to note that your child’s therapist will not just tell him that his thinking contains an unhelpful thought pattern, she will help him to realize it on his own. This will help him to develop the skill of using Socratic Questioning to evaluate his thoughts. Once your child gets comfortable answering these questions, he will gradually begin to internalize (or take in and learn) the skill of Socratic

¹³³ Neenan, 2008

¹³⁴ Chorpita, 2007

¹³⁵ Chorpita, 2007

Questioning until he is ready to begin asking the questions of himself. This skill is referred to as “self-questioning.” Such a skill will help your child to identify, evaluate, and challenge his own thoughts both in and outside of therapy¹³⁶.

Thought records. Thought records are worksheets that your child can use to write down, evaluate, and modify his thoughts¹³⁷. There are a wide variety of thought records available for use in CBT treatment although most of the more complex, multi-column, thought records are intended for use with adults rather than children. Despite this fact, there are simple thought records that may be used with your child. While the therapist may initially help your child complete thought records, it is expected that your child will work up to completing them independently.

Thoughts, feelings, behaviors. A thought record commonly used with children is one that records thoughts, feelings, and behaviors. The purpose of such a thought record is to help your child identify his thoughts and recognize how they are influencing his feelings and behaviors. This thought record typically includes a column for your child to record the situation, a column for him to record his thoughts, a column for him to record his resulting feelings, and a column to record his resulting behaviors.

Example of a Thoughts, Feelings, and Behaviors Thought Record...

SITUATION	THOUGHTS	FEELINGS	BEHAVIORS
I made a mistake during my class speech	“I made a mistake so everyone hates me.”	Sad Anxious	I avoided talking to my friends and other students

Examining the evidence. Often, the evaluation of thoughts is done by learning to “be a detective.” In other words, your child can gather evidence for and against his anxious thoughts in order to determine how realistic they are¹³⁸.

¹³⁶ Silverman & Kurtines, 1996

¹³⁸ Thought record adapted from Greenberger & Padesky, 1995

Example of an “Examining the Evidence” Thought Record...

SITUATION	THOUGHTS	EVIDENCE FOR	EVIDENCE AGAINST
I made a mistake during my class speech	“I made a mistake so everyone hates me.”	I actually made a mistake	Several students told me I did a good job Two of my friends asked me to play kickball after class

As you can see from this example, a thought record that requires your child to gather objective evidence for and against a thought can help him to realize how realistic or unrealistic it really is. This evidence can then be used to help your child develop a more realistic and adaptive thought. Modifying thoughts will be addressed in the next section. For now, let’s talk about another example of a thought record that can help your child evaluate his thoughts.

Probabilities. Sometimes anxious children tend to overestimate the probability of a bad thing happening. A simple thought record can be used to help your child decide whether thoughts about an anxiety-provoking situation or one’s ability to cope with a situation are realistic or if they contain unhelpful thought patterns related to magnifying the probability of a bad thing happening. On such a thought record, your child may be prompted to write down the situation, his anxious thoughts, and then rate how likely he believes it is that these thoughts will come true¹³⁹. He may be asked to use a 0-100 scale or percentages to rate the probability.

As you can see in the example above, when the child initially has the thought, he believes that it is very likely to come true. Later, when we discuss modifying thoughts, we will see how this thought record can be expanded to help your child develop a more probable thought.

¹³⁹ Thought record below is adapted from Chorpita, 2007

Content Box...

Refer to Appendix B page 137 for an example of a probability thought record from a popular treatment manual.

Example of a Probabilities Thought Record...

SITUATION	THOUGHTS	PROBABILITY (0-100)
I need to go to school today which means I have to leave my mom	“If I am away from my mom, something bad is going to happen to her.”	80

Modifying thoughts. Once unhelpful thought patterns are identified and evaluated, your child will learn how to modify these thoughts by developing ones that are more realistic and adaptive. The following are several techniques that can be used to modify unhelpful thoughts.

Thought records. In the previous section, we discussed how thought records can be used to identify and evaluate thoughts. Given that the goal of this phase of treatment is to help your child to develop more realistic thoughts and/or to identify coping thoughts and strategies to use in anxiety-provoking situations, your child likely will be introduced to thought records that include a column that allows him to modify his thoughts or reevaluate his probability ratings.

Examining the evidence. In an effort to help your child develop more balanced or realistic thoughts, it is possible to expand on the “Examining the Evidence” thought record described above. Such a thought record will require that your child consider the evidence to determine whether it suggests that the thought under investigation is true, false, or somewhere in between and then adapt the thought to develop one that is more

consistent with the evidence. Let's expand on the example we used with the shorter "Examining the Evidence" thought record above to see how this can be done¹⁴⁰.

Example of an Expanded "Examining the Evidence" Thought Record...

THOUGHT	EVIDENCE FOR	EVIDENCE AGAINST	NEW THOUGHT
"I made a mistake so everyone hates me."	I actually made a mistake	Several students told me I did a good job Two of my friends asked me to play kickball after class	"I made a mistake but it didn't seem to change the way anyone thinks about me"

Probabilities. Just as "Examining the Evidence" thought records can be used to help develop balanced thoughts, thought records can also be used to adjust your child's expectations of how probable it is that something bad will happen. Specifically, an expanded version of the "Probabilities" thought record above may require your child to consider how probable something actually is by looking at the evidence and then come up with a more adaptive or balanced thought and a new probability rating¹⁴¹.

¹⁴⁰ Example adapted from Greenberger & Padesky, 1995; Note: the "Situation" column in this example has been left off of the thought record to allow for space. Please refer to the "Examining the Evidence" thought record on page 89 to refresh your memory on the situation.

¹⁴¹ Thought record adapted from Chorpita, 2007; Note: the "Situation" column in this example has been left off of the thought record to allow for space. Please refer to the "Probabilities" thought record on page 90 to refresh your memory on the situation.

Example of an Expanded Probabilities Thought Record...

THOUGHT	PROBABILITY	EVIDENCE	NEW THOUGHT	PROBABILITY
“If I’m away from my mom, something bad is going to happen to her.”	80	<p><u>For:</u> One time mom had a car accident while I was at school</p> <p><u>Against:</u> Except for that one time, my mom has been safe when she isn’t with me</p>	“My mom will probably be fine, even when I’m not with her.”	70

Content Box...

Refer to Appendix B, page 138 for a sample of an expanded probabilities thought record from a popular treatment manual.

Socratic questioning/self-questioning. Socratic and self-questioning strategies were introduced in the previous section as techniques commonly used to help children identify and evaluate thoughts. Such questioning can also help your child to modify thoughts to be more adaptive and balanced. Once your child has identified and evaluated an unhelpful thought or thought pattern, he can then ask himself additional questions to modify his thought. Helpful questions may include:

- ⊗ “Is there more evidence for or against this thought?”
- ⊗ “What would a more realistic thought be?”
- ⊗ “What is the real likelihood that this will happen?”

These questions are similar to the questions your child will ask himself on thought records. Asking such questions without a thought record represents a more advanced skill as it requires your child to learn and remember helpful questions to ask when he wants to modify his thoughts.

Decatastrophizing. Another way that Socratic and self-questioning can be used is to help your child “decatastrophize.” Before we explain what decatastrophizing is, let’s take a moment to remember what catastrophizing is. If you recall from above, catastrophizing involves “blowing things out of proportion.” This can occur in a number of different ways. One of the ways in which things can be blown out of proportion is by taking a possible negative outcome and viewing it as much worse (e.g., “horrible,” “intolerable”) than it actually is (e.g., “disappointing,” “distressing but tolerable”). Another type of catastrophizing involves taking a situation that is a little threatening and treating it as if it is extremely threatening such that you should escape or avoid it. Based on this definition, decatastrophizing means taking a possible negative outcome and viewing it with a proportional level of negativity without “blowing it out of proportion.” Decatastrophizing also means taking a situation that is a little threatening and treating it as it is, just a little threatening, without overreacting. Here are some questions your child can ask himself to decatastrophize:

- ⊗ “What’s the worst that could happen?”
- ⊗ “If the worst happened, then what?”
- ⊗ “Are there possible positive outcomes?”
- ⊗ “What’s the best that could happen?”
- ⊗ “If what I fear actually occurs, is it really as bad as I’m making it out to be?”
- ⊗ “How would I cope with it if it does happen?”

Using these questions, your child can determine whether or not he is catastrophizing and then modify the thought to develop a more adaptive and realistic thought. For example, if the catastrophizing thought is, “If I get in the elevator, I’m going to get trapped and suffocate,” the decatastrophized thought could be, “I probably won’t get trapped in the elevator but even if I do, I won’t suffocate because there is plenty of air in the elevator and a button to call for help.” Also, by evaluating whether or not he is catastrophizing, your child can identify what he is most afraid of (e.g., getting trapped in an elevator) which can help him to realize that the fear really isn’t as scary, unmanageable or intolerable as he imagined¹⁴². Even if he determines that it is still scary (as getting trapped in an elevator would be for any child), such questioning can open up the opportunity to identify skills he can use to deal with it. This will be addressed in greater detail in the following section.

Developing coping thoughts. Regardless of whether your child’s reactions to an anxiety-provoking situation represent “real” or “false” alarms, it is helpful for him to learn to focus on what he might be able to do to cope with the situations that he fears. This is particularly helpful when children are catastrophizing because it gets them to focus on what they can do to cope with the situations rather than on their magnified or

¹⁴² Silverman & Kurtines, 1996

exaggerated perceptions of how bad the feared situations would be. This involves modifying thoughts in that your child learns to focus on what he specifically would do to cope with a situation if it should occur. In other words, he is modifying his thinking by shifting his focus to coping thoughts rather than anxious thoughts.

Example of Developing Coping Thoughts...

Juan is anxious about getting stuck in an elevator. After evaluating his thought (“If I get in the elevator, I’m going to get trapped and suffocate”), and modifying it to be more realistic (“I probably won’t get trapped in the elevator but even if I do, I won’t suffocate because there is plenty of air in the elevator and a button to call for help”), he also focuses on developing coping thoughts such as “If I do get trapped, I can press the *Call* button to let someone know and then use my deep breathing to stay calm until help arrives.”

Remembering cognitive skills. As discussed above, Socratic questioning, self-questioning, and thought records can be used to help your child identify, evaluate, and modify his thoughts. However, with all this information, it can be difficult for your child to remember everything he can do to develop more adaptive thoughts. Fortunately, there are strategies your child can learn to help him remember all of this information.

Pneumonic Strategies. “Pneumonic strategies” is a term used for a word where each letter stands for a word or phrase that someone wants to remember. Specific to this treatment, pneumonic strategies are words where each letter stands for a step for dealing with unhelpful thoughts or anxiety-provoking situations. Here are two popular pneumonic strategies used in leading treatment manuals:

STOP¹⁴³

- S-** Identify Signs of anxiety
- T-** List Thoughts that go with it
- O-** Come up with **O**ther thoughts that may be more adaptive
- P-** Praise myself for my efforts

FEAR¹⁴⁴

- F-** Feeling frightened? (Recognizing anxious feelings)
- E-** Expecting bad things to happen? (Recognizing anxious self-talk)
- A-** Attitudes and actions that can help? (Ex. applying coping self-talk)
- R-** Results and rewards (Rating performance and rewarding self)

¹⁴³ Chorpita, 2007; See Appendix B page 140 for a sample of a STOP record.

¹⁴⁴ Kendall & Hedtke, 2006

Learning problem-solving. Problem-solving is a step-by-step process to deal with “real-life” problems and for managing anxiety-provoking situations¹⁴⁵. It is taught for use with a broad range of anxiety-provoking and non-anxiety-provoking situations¹⁴⁶. It is likely that both you and your child will learn problem-solving skills during treatment. Your involvement in this phase of treatment will prepare you to work with your child to solve problems, particularly those related to anxiety, which may be more difficult for him to solve¹⁴⁷.

Problem-solving is an important component of this phase of treatment. By improving his ability to problem-solve, your child will be able to cope with or solve problems more effectively, his perceived ability to cope with life’s challenges will increase, and as a result, his anxiety will decrease¹⁴⁸.

The following is a list of common problem-solving steps¹⁴⁹. These steps can be modified or simplified depending on your child’s age and cognitive ability¹⁵⁰.

1. Describe the problem.
2. Identify goals for the solution.
3. Generate alternative solutions (also called “brainstorming”).
4. Evaluate the alternatives.
5. Based on evaluation of alternatives, identify the one that seems the best.
6. Put the best strategy into action.
7. Evaluate the success of the outcome.

In order to demonstrate how the steps of problem-solving can be used, let’s look at an example:

¹⁴⁵ Ginsburg & Kingery, 2007

¹⁴⁶ Kendall & Hedtke, 2006

¹⁴⁷ Silverman & Kurtines, 1996

¹⁴⁸ Chorpita & Southam-Gerow, 2006

¹⁴⁹ Chorpita & Southam-Gerow, 2006

¹⁵⁰ Kendall & Hedtke, 2006

Example of Problem-Solving Steps...

Billy realizes that he lost his sister's toy and decides to use problem-solving steps in order to solve his problem.

- 1) Describe the problem: I lost my sister's toy that I borrowed without asking.
- 2) Identify goals: I need to find my sister's lost toy.
- 3) Generate alternative solutions:
 - a. I could look by myself.
 - b. I could tell my sister and ask her to help me find the toy.
 - c. I could tell Mom what happened and ask her to help me find it.
- 4) Evaluate Alternatives:
 - a. If I look for the toy myself, no one will know I lost it so they won't get mad at me right away. However, the more people that help me look, the more likely it is that we will find it. Also, I know I took the toy to my friend's house so I need someone to drive me there to look.
 - b. If I tell my sister, she could help me look. However, telling my sister may end up making her mad in which case she probably won't want to help me. She might also tell Mom which could get me in trouble.
 - c. If I tell Mom, she could help me look at home and, if we don't find it, she can drive me to my friend's house so we can look for it there. However, telling Mom may get me grounded for taking something that wasn't mine.
- 5) Identify the alternative that seems best: Asking Mom for help will probably be the best since two sets of eyes are better than one and she can give me a ride to my friend's house to look for the toy if we need to.
- 6) Put the best strategy into action: Mom and I searched for the toy at home as well as at my friend's house.
- 7) Evaluate the outcome: Fortunately, I found the toy right where I left it at my friend's house. Using the problem-solving steps helped me to find my sister's toy and also helped me to make this scary situation less scary.

Pneumonic strategies. Just as there are pneumonic strategies for remembering cognitive restructuring skills, there are also strategies for remembering the steps to problem-solving. Here is an example of such a strategy¹⁵¹:

SOLVE:

S: Settle down

O: Own my problem

L: List solutions

V: Vote for one solution after deciding on the pros and cons of each

E: Engage in the one solution that seems best, evaluate the outcome and repeat the steps as needed

¹⁵¹ Ginsburg & Kingery, 2007

Problem-solving practice. Problem-solving practice will occur both in and outside of the therapy room. In session, the therapist likely will have your child begin by practicing problem-solving with hypothetical or imaginary situations. This approach will produce less anxiety for your child, which will make it easier for him to learn the skills. Later, once your child has developed a strong foundation in problem-solving, he will then begin to apply it to actual problems that he has faced or will face in his life. Given that practice is important to the development of effective skills, problem-solving is often assigned as homework so that your child can apply his new skill to real life situations. Both in and outside of session, your child likely will be encouraged to begin by applying problem-solving to less challenging problems and then progress to more challenging ones¹⁵².

Making an action plan. An action plan is a strategy for coping with anxious situations¹⁵³. Developing an action plan can help your child with solution development in problem-solving or at any time when he needs to take an active step in managing his anxiety. This can help your child to feel prepared to deal with a range of anxiety-producing situations or other problems he may face. For example, he can learn speaking skills to reduce further his fear of public speaking or learn to use relaxation skills to manage his bodily reactions to anxiety.

Learning about evaluation and rewards. After your child has utilized one of his cognitive skills, it is important that he evaluates his experience and receives rewards for his efforts as appropriate.

Evaluation. Evaluation involves examining the progress made with specific skills or practice sessions and deciding how successful they have been (e.g., how well did he restructure his thoughts or use his problem-solving skills)¹⁵⁴. Evaluation typically involves asking a series of questions about performance. Typical questions include:

- ⊗ “Was I successful?”
- ⊗ “How anxious do I feel?”
- ⊗ “Am I more or less anxious than before I used the skills?”
- ⊗ “How would I rate my level of anxiety?”

Evaluation is typically taught to your child through modeling by the therapist. She will model asking these questions to your child so that he can learn how to evaluate his performance. She will then invite him to practice evaluation along with her. Once your therapist feels confident that he knows how to answer these questions, she will encourage your child to use self-evaluation where he asks himself these questions and decides how successful he was.

¹⁵² Kendall & Hedtke, 2006

¹⁵³ Silverman & Kurtines, 1996

¹⁵⁴ Kendall & Hedtke, 2006

Example of Self-Evaluation...

Alan has been working on his fear of dogs. He identifies that he often has the thought, "I am not safe around dogs." He evaluates this thought and decides that it involves "negative filtering" since he has only experienced one negative incident with a dog (when his neighbor's dog lunged at him while barking angrily) while his other interactions with dogs, which he realizes he hasn't been paying attention to, have been positive (friendly dogs that he walked by on the street, positive experiences he had with dogs in the past). As a result, he decides it would be appropriate to change his thought to, "Even though I had one bad experience with a dog, most dogs seem safe and even friendly so I should be ok around dogs." He also thinks of an action plan for managing his anxiety around dogs. He decides it would be helpful if he learns the appropriate way to pet a dog and if he remembers to ask the owner for permission before approaching the dog so that he is more likely to have safe interactions with dogs.

Rewards. Rewards are things that are given to your child when he or someone else is pleased with the work he has done¹⁵⁵. Rewards should be given for effort (in order to encourage continued practice towards success) as well as for accomplishment. The rewards your child receives for his work should be planned out ahead of time so that he knows what he is working towards when he is practicing. This likely will involve developing a list of rewards that are fitting for specific skills (see the "Psychoeducation" chapter for a reminder of how contingency management is done). It is important that the rewards fit the task (e.g., small rewards for small efforts, big rewards for accomplishing difficult tasks). This will help to motivate your child to continue facing increasingly anxiety-provoking tasks. Rewards are usually given initially by your child's therapist or you. However, your child will eventually learn how to give self-reward. This can take the form of positive self-talk (telling himself "Good job!" or "I knew you could do it!") or selecting an item off the reward list by himself instead of being given one by you or the therapist. Working up to independent evaluation and reward is all part of helping your child to master CBT skills and, thus, to master his anxiety. Let's continue with the example of Alan above in order to see how self-reward can work:

Example of Self-Reward...

We saw how Alan used cognitive restructuring to help reduce his anxiety and to develop an action plan to use around dogs. He then took a walk around the neighborhood with his mother in order to try out his new action plan and was able to use his new skills to interact with his friend's dog (who his mother knew was friendly). After he got home from his walk, he evaluated himself and decided he did a good job using his skills to cope with his anxiety around his friend's dog. He was sure to tell himself that he did well by saying, "I knew you could do it!" He then looked at his rewards list to see what he earned for using these skills and was glad to see that he earned extra game time after dinner.

¹⁵⁵ Kendall & Hedtke, 2006

Typical Homework

Homework and practice are vital parts of helping your child to acquire and consolidate cognitive skills. Below is a list of some typical assignments that may be given while your child is learning cognitive skills.

Completing thought records. As you learned above, thought records can be helpful for identifying, evaluating, and modifying thoughts. They can also help your child to recognize the impact his thoughts are having on his feelings and behaviors. There are various forms of thought records that may be assigned to your child (just listing his thoughts in a given situation; listing thoughts, feelings, and behaviors; listing thoughts and probabilities; examining the evidence)¹⁵⁶. Given that we have already discussed several thought records in detail above, we will not elaborate further here. When your child is assigned a thought record, refer to the sections on thought records above for details on what exactly he is being asked to do.

Practicing changing cognitions. The purpose of homework geared toward changing cognitions is to help increase your child's ability to evaluate his thoughts, to determine if they are unrealistic or unhelpful, and, where indicated, to learn to restructure the thoughts to be more realistic, helpful, or adaptive. There are several different types of assignments that may be given to help your child learn this important skill.

Thought bubbles. Thought bubbles, first introduced above, can often be used to help children practice changing cognitions. Your child may be asked to gather or draw pictures of characters or real people that are in anxiety-provoking situations. Once he gathers the pictures, he can assign thoughts (written in thoughts bubbles drawn or pasted onto the picture) to each person or character describing what they may be thinking. Next, he can evaluate the thoughts to determine how realistic or helpful they are and then change the thoughts (by creating new thought bubbles) to be more adaptive¹⁵⁷. He may replace the original thought or use the "double bubble" technique where he uses two bubbles for one person, assigning one bubble for the original thought and the other for the modified thought.

"In vivo" practice. While practice on paper can help your child build the skills of cognitive restructuring, it is also important that he learn to apply these skills in "real world" situations. For that reason, practicing evaluating and changing cognitions in real anxiety-provoking situations and/or during exposure sessions is particularly important. The use of cognitive restructuring in a "real world" situation is illustrated above in the example involving Alan.

Making coping cards. Coping cards can be used to provide your child with a way to remind himself of his coping skills. This will be particularly important when treatment comes to an end. Your child may be asked to create one or several cards

¹⁵⁶ Chorpita, 2007; Kendall & Hedtke, 2006

¹⁵⁷ Kendall & Hedtke, 2006; Silverman & Kurtines, 1996

containing tools to manage anxious thoughts¹⁵⁸. The cards may list positive coping thoughts that your child can tell himself in anxiety-provoking situations, the list of problem-solving steps, or one or several of the mnemonic strategies described above. Once your child has created these cards, you can help him by getting them laminated or by helping him to think of a place to keep them so that they are accessible when he needs them. Alternatively, your child may decide to make his coping cards electronic (e.g., creating them on his phone, iPad, or computer) which may make the cards even more accessible to him.

Practicing evaluation and reward. Practicing evaluation can help your child to see how well his new skills are working for him. Also, getting rewards from others as well as giving rewards to himself for his effort and success reinforces the use of his new skills. There are many ways that your child can practice evaluation and reward. For example, he may be asked to draw a cartoon strip or create a short story to demonstrate someone coping with anxiety and then evaluating and rewarding himself. This is a good first step before your child practices evaluating and rewarding himself “in the real world.” Evaluations and rewards can be used with any other homework assignment or practice your child does throughout the day. He may practice evaluation and reward by writing them out (adding columns for each skill to a thought record), by saying them out loud (where you can listen and make sure he is conducting evaluations and giving rewards correctly), or eventually, by internalizing these skills and conducting evaluations and rewards in his own mind.

Content Box...

Refer to Appendix B, page 139 for a sample of an assignment geared towards evaluating and rewarding performance.

What Roles Can Parents Play?

As in other components of CBT for child anxiety, there are several important roles that you may play throughout the cognitive skills component of treatment. Below is a list of some of the typical roles you may play.

Co-therapist. Given that there are many skills for your child to learn during this phase of treatment, you will have many opportunities to play the co-therapist role to help your child acquire and consolidate his skills. In order to help your child learn new skills, it will be important for you to know what cognitive skill(s) he is learning each week so that you can be prepared to help him if needed. If you haven't been given the opportunity to speak to your child's therapist about the cognitive skills he will be learning, call her for an appointment. You can also use this manual to get more details about these skills and how you can help your child with them.

Learning to identify and change unhelpful thought patterns. In order to help your child with this skill, make sure that you know the common unhelpful thought

¹⁵⁸ Kendall & Hedtke, 2006

patterns (described above). In order to help your child learn this skill, you can provide examples of your own thoughts that may contain unhelpful thought patterns to help your child identify his own patterns correctly. For example, as your child works to identify overestimating the probability of bad things happening, you may tell him about a time when you were starting a new job and you thought if you made even one mistake, your boss would fire you right away. You could also use an example from your child's experience to help him learn this important point (like when he expected that no one would like him on his new baseball team but came home with three new friends the first day).

Helping your child learn probabilities. Learning probabilities can be difficult, particularly for younger children. You can help your child to decide how probable it is that a certain event or feared situation will happen by modeling how you would use this skill. Continuing with the example of your work experience above, you can ask your child how probable he thinks it is that you would be fired for making one mistake, particularly when you were just starting a new job. He likely will say a low probability (0-20) although if he says a high one, you can help him to understand why this estimate is inflated. Assuming he estimates the probability correctly, praise him for recognizing that you were overestimating the probability of a bad thing happening. Then, ask him to help you to come up with a more realistic thought, ("It's expected that people will make some mistakes as they are just learning a new job; If I make a mistake at work, I likely will just be given some help so that I am less likely to make the same mistake again").

Learning to problem-solve. When your child is learning problem-solving, you can help him to understand how to use this important skill by providing him with examples and going through the steps together. Prior to helping your child with problem-solving, it will be helpful if you familiarize yourself with the steps described above. Once you feel that you understand the steps, pick a problem from you and your child's shared experience and practice problem-solving the situation together.

Example of Assisting your Child with Problem-Solving...

- 1) Describe the problem: Your child and his friends needs to be picked up from soccer practice (it's your turn to do carpool) but you have a doctor's appointment at the same time.
- 2) Identify goals: You and your child identify the goals of getting him and his friends home from practice and making sure that you get to your doctor's appointment.
- 3) Generate alternative solutions:
 - a. We could ask Dad to help out with carpool.
 - b. We could change the doctor's appointment.
- 4) Evaluate Alternatives:
 - a. Asking Dad could be good because then there is no need to cancel the appointment. However, Dad has to work and may not be able to make it on time.
 - b. Canceling the appointment would be good because then you can still do carpool but what if they don't have another appointment for a long time?
- 5) Identify the alternative that seems best: Calling Dad and asking him if he can help.
- 6) Put into action the best strategy: You and your child call Dad together and ask him if he can leave work in time to make it to soccer practice.
- 7) Evaluate the outcome: Dad said "yes" and was able to make it on time. You made it to your doctor's appointment too so everything worked out.

A final note on helping your child with cognitive skills. As you are helping your child to learn these important skills, you want to be careful about giving him the answers. For example, if your child says, "I'll never get better" (an example of fortune-telling), you don't want to say, "I think you are doing some 'fortune-telling'" as this would lead to a missed opportunity for your child to learn to identify his own unhelpful thought patterns. Instead, you can say, "I wonder what your therapist would say if you told her that?" or "I wonder if you might be using an unhelpful thought pattern?" These questions will help to empower your child to figure out what is going on with his thoughts on his own.

Providing rewards. As your child's parent, you are often the primary source of rewards. There are several ways that you can reward your child. First, you can provide him with praise for his efforts to use a skill. You can also praise him for his accomplishment in successfully using a skill. Finally, you can praise him for evaluating himself correctly. As you are providing praise, remember to be concrete by saying exactly what you are praising him for and why. For example, if your child uses positive self-talk, you can say, "I am really proud of you for using positive self-talk when you were feeling anxious around our neighbor's dog." In addition to providing verbal praise, you can also provide tangible rewards as previously discussed. While you will be the primary source of rewards early on, the goal is for your child to be able to provide self-rewards. The more experienced he gets with using his skills, the more you should fade out providing tangible rewards (while still praising his efforts and accomplishments) and encourage him to self-reward¹⁵⁹.

¹⁵⁹ Silverman & Kurtines, 1996

Possible Trouble Spots

Cognitive skills can be difficult to learn. Not only can you not see them on someone's face like you can an emotion, they are also not as easy to practice as other skills like relaxation. Given that these skills can be difficult, it is important that your child learn them correctly in order to make lasting changes to his anxiety. Below are some of the common trouble spots that may arise during this phase of treatment.

Your child is having difficulty identifying thoughts. In order to utilize cognitive skills, your child must be able to identify his thoughts. If he cannot identify the thoughts, he can't figure out what he needs to change¹⁶⁰. You will be able to realize if your child is having difficulty identifying his thoughts if he is having trouble filling out thought records, thought bubbles, or other tasks involving identifying thoughts. Your child might also express difficulty with identifying his thoughts during exposure sessions or other tasks that require thought identification.

What can you do? If you notice that your child is having difficulty identifying his thoughts, start by letting him know that this skill can be difficult. Next, you can model the skill by providing him with an example of labeling your own thoughts or inner dialogue. Alternatively, you could use books, videos, or comic strips depicting thoughts experienced by characters when they are anxious.

Your child fears talking about his anxious thoughts. Talking about anxious thoughts can make your child feel anxious which can, in turn, trigger more anxious thoughts and feelings. Therefore, he may fear talking about his anxious thoughts¹⁶¹. If his anxiety keeps him from talking about his anxious thoughts, he won't be able to see that they may not be as scary as he thinks, will not identify the need to restructure them, and will not develop these important skills. The best way to notice if your child is experiencing fear of talking about his anxious thoughts is to observe his homework and practice. He may not be completing his homework assignments or not engaging fully in the restructuring process. You may also notice that he has a strong anxious reaction to identifying cognitions.

What can you do? If you notice that your child is scared to talk about his anxious thoughts, you can let him know that it is tough to talk about things that make you anxious. You can then encourage him by reminding him that the more he practices facing and challenging his thoughts, the less anxiety-provoking they will become. You can help him work up to talking about his anxiety by taking smaller steps towards this goal. Start by talking about your own anxiety so that he can see that talking about anxious things isn't that scary. For example, you may tell him, "I often feel anxious that I will say something silly at the PTA meeting and that other people will laugh at me." You can also help him to find safer ways to start talking about his own anxiety. For example, you can ask him to write his thought down on a thought record instead of saying it out loud. He could also draw himself as a cartoon and use a thought bubble to write the anxious

¹⁶⁰ Chorpita, 2007

¹⁶¹ Chorpita, 2007

thought. These small steps will help him eventually work up to talking about his anxious thoughts.

Your child doesn't "believe" his coping thoughts. Part of cognitive skills is coming up with coping thoughts to help manage anxiety. Unfortunately, just because your child can identify coping thoughts that he "could" or "should" have doesn't mean that he will believe them. Of course, coping thoughts can only be helpful if he believes what he is telling himself. You may notice that he doesn't believe his coping thoughts if you hear doubt in his voice or if he is making dismissive remarks regarding the alternative thoughts. You may also notice that the strategies he is using are not reducing his anxiety, indicating that something may not be being done correctly.

What can you do? Your child's therapist should be checking in with him frequently to ensure that he is identifying coping thoughts he believes in and/or doing things to help him believe more strongly in the coping thoughts or alternative thoughts that he does identify. You can help by doing the same thing. You know your child best so use your instincts to decide whether or not your child is really "buying in" to the coping thoughts. For example, if your child is "thinking out loud," does he say the coping thoughts with conviction or does he seem to be simply "going through the motions" and saying the words without really believing them? Also, you can check in with him and encourage him to share his struggles with you. If he is having difficulty, brainstorm with him other coping thoughts that are more believable to him. You can talk about ways to make alternative or coping thoughts more credible and then do an "experiment" to try out an alternative thought and see if it comes true. For example, if the coping thought is "I will feel less anxious if I've learned the skills for public speaking," your child can learn some effective ways to speak in front of others (e.g., making good eye contact, speaking slowly and clearly) and then use these skills the next time he has to speak in class. By using his newly learned skills, your child likely will realize that he does feel less anxious and will, therefore, feel more confident about his new coping thought.

Chapter 7: Planning for the Future and Relapse Prevention

Brief Description

Planning for the future and relapse prevention are an essential steps in the final stages of CB treatment¹⁶². They occur after your child has acquired the various skills that have been discussed throughout this manual. At this point, your child likely has experienced significant improvement in the anxious symptoms that initially brought him to treatment, and he is now ready to manage his anxiety on his own.

While CBT is typically a successful treatment, it does not get rid of anxiety completely (nor is it intended to). Therefore, as your child moves towards the end of treatment, it is important that he remembers that some anxiety is natural and expected for everyone, particularly during stressful times. For example, it is common for children to experience some anxiety before a test or before a performance. In order to maintain treatment gains and continue to make additional gains after therapy is over, it is essential that your child prepares for the future and learns how to recognize and handle the inevitable return of anxiety¹⁶³.

Goals. This final phase of treatment (which typically lasts between one and several sessions, depending on the needs of your child) has a number of important goals that will prepare your child for what lies ahead. These goals are:

- ⊗ To review the gains that your child made during treatment.
- ⊗ To help your child take credit for these gains and attribute them to his efforts.
- ⊗ To review and practice target skills, particularly those that proved to be the most helpful for your child.
- ⊗ To emphasize the need for continued practice.
- ⊗ To promote reasonable expectations with respect to your child's future experience with anxiety (e.g., that it is natural for anxiety to occur).
- ⊗ To develop plans for managing unavoidable reoccurrences of anxiety in the future.

Refer to the “What is Likely to Happen in Sessions” section below to learn more about how each of these goals is accomplished.

Benefits. There are many important benefits of this final phase of treatment.

Benefits for your child include:

- ⊗ Providing him with the opportunity to review skills learned throughout treatment¹⁶⁴.

¹⁶² Linares-Scott & Feeny, 2006

¹⁶³ Silverman & Kurtines, 1996

¹⁶⁴ Ginsburg & Kingery, 2007

- Helping him to consolidate knowledge through the review process.
- Recognizing gains he has made and attributing those gains to his own efforts.
- Taking credit for and developing pride in his accomplishments.
- Increasing his confidence by reminding him about how much he has learned.
- ⊙ Helping him to prepare to handle the return of some anxiety.
 - Helping him to recognize when to use his newly acquired skills to manage his anxiety independently.
 - Empowering him by showing him that he is now capable of handling his anxiety on his own.
 - Giving him the opportunity to predict possible setbacks and to plan how to handle them.
 - Teaching him how to notice if and when his anxiety is increasing to the point that he needs to ask for help.

Benefits for parents include:

- ⊙ Reminding you of what your child has learned.
- ⊙ Teaching you how to help him consolidate the knowledge he has gained.
- ⊙ Increasing your feelings of pride in your child by helping you to recognize how far he has come with regard to managing his anxiety.
 - Helping you to recognize how your efforts contributed to the gains he has made.
- ⊙ Preparing you to help your child in the future.
 - Learning about possible setbacks and what to do when they occur
 - Increasing your confidence in your own ability to help your child through future struggles.

What is Likely to Happen in Sessions?

Reviewing progress. As noted above, one of the first goals of this final stage of treatment is for your child to review the progress he has made¹⁶⁵. His therapist will emphasize that the progress he has made in therapy is due to his own efforts. It is essential that he understand that it was he, not the therapist, who made the changes that led to the decrease in his anxiety. This knowledge will help him to develop confidence in his ability to manage anxiety without the therapist and without therapy in the future.

Identifying strengths and useful skills. Your child has learned many skills throughout therapy. While all of them may have been useful to him in one way or another, there are probably certain skills that he found to be particularly helpful. These skills are the ones that likely will be the most applicable in future anticipated and unanticipated anxiety-provoking situations. In order to identify these skills, your child and his therapist will review all the skills he has learned and then work together to select which ones were the most helpful for him and which ones he liked the most.

¹⁶⁵ Chorpita, 2007

Once your child identifies the skills that are the most useful to him, he can develop a “tool kit” of these skills that can be used when he becomes anxious in the future¹⁶⁶. This “tool kit” can take many forms. One form, used mostly for older children, is a “mental tool kit.” This type of tool kit can be developed by verbally reviewing the skills your child will use in the future so that they are fresh in his mind. Whenever he is feeling anxious, he can “reach” into his “mental tool kit” and pull out one of his skills to use to decrease or cope with his anxiety. Alternatively, your child may develop a “physical tool kit.” This type of tool kit may be a list, a collage, or an actual kit (e.g., a shoe box) including words, descriptions, or items that will remind your child of his skills. Such a concrete “tool kit” may be beneficial for younger children and for those that may have a difficult time remembering their skills when they are feeling anxious.

Example of a “Tool Kit”...

“MY TOOL KIT”

- 1) Imagine being at my favorite place (at the beach).
- 2) Take some slow, deep breaths (balloon exercise).
- 3) “Be a detective” with an “examining the evidence” thought record (the extra records are in mom’s desk).
- 4) Use the **FEAR** steps (**F**eeling frightened, **E**xpecting bad things to happen, **A**ttitudes and actions that can help, **R**esults and rewards) to deal with an anxiety-provoking situation.

Maintaining gains. Your child’s therapist will emphasize the importance of continued practicing of his skills in order to maintain his gains¹⁶⁷. She may explain to him that he needs to practice to keep his CBT skills “fresh,” just like he would with a sport or an instrument, or else he may become “rusty”¹⁶⁸. Your child will be encouraged to continue to utilize his skills on a daily basis either by practicing them in order to keep his skills “fresh” and applying them to anxiety-provoking situations.

¹⁶⁶ Kase & Ledley, 2007

¹⁶⁷ Chorpita, 2007; Silverman & Kurtines, 1996

¹⁶⁸ Chorpita, 2007

Planning for the future. Once your child has reviewed his progress in treatment, it is time to begin making plans for the future¹⁶⁹. These include how your child is going to maintain existing gains (addressed above), how he is going to make further progress, how he can tell if he is having a setback, and what to do if setbacks occur.

Setting goals for the future. While maintaining gains is essential, it is also important that your child learn that work and progress do not stop when treatment ends. In planning for the future, your child and his therapist will consider the skills he needs to keep developing as well as the situations that he needs to continue facing. These skills and situations may be written out in list form so that you and your child can remember what he needs to continue working on.

In the spirit of encouraging your child to keep making treatment gains, his therapist will ask him to continue to approach, rather than avoid, situations that he responds to with “false alarm” anxious responses. This proactive stance will enhance his ability to manage anxiety in these situations even after treatment is over. In addition to approaching anxiety-provoking situations, your child will also be encouraged to keep confronting the anxious cognitions he still struggles with so that he can make further progress in managing his anxiety with cognitive skills. Anxious cognitions may be written on a list to help your child remember what he needs to work on. Your child will be encouraged to add to this list as needed in the future.

Anticipating situations that may cause anxiety in the future. An important part of maintaining gains and setting goals for continued progress is anticipating future situations that may cause an increase in anxiety for your child. Planning ahead for potential anxiety-provoking situations can increase your child’s confidence in his ability to handle these (or similar situations) when they occur. During session, your child and his therapist will spend time brainstorming possible situations that likely will occur in the future that may cause him anxiety. They can then identify steps he can take to deal with each situation. Typical steps may include identifying anxious thoughts, feelings, and behaviors; evaluating and modifying thoughts; implementing a relaxation strategy, problem-solving; and/or developing action plans. Let’s look at an example of how these steps may be applied:

¹⁶⁹ Kase & Ledley, 2007

Example of Anticipating and Planning for Future Anxiety-Provoking Situations...

Aaron, who has struggled with performance anxiety, predicts that he may have an increase in anxiety when he performs in his end-of-the-year school play in five months.

Predicted thoughts: “I’m going to mess up.”
“If people laugh at me, I won’t be able to handle it.”

Predicted feelings: Anxiety, fear

Predicted behaviors: Making mistakes, avoiding the performance

Cognitive Skills:

- 1) Evaluating thoughts for possible unhelpful patterns (overestimating the risk of something bad happening, catastrophizing/underestimating his ability to cope)
- 2) Modifying thoughts: (e.g., “I may mess up but most people make some mistakes so it is unlikely that people will laugh at me.”)

Coping Behaviors:

- 1) Action plan: Using establish skills
 - a. Take a few deep breaths
 - b. Use positive self-talk (e.g., “I can do this!”)
- 2) Action plan: Developing new skills
 - a. Learn public speaking skills (e.g., good eye contact, speaking clearly)

Identifying and dealing with setbacks. As previously mentioned, the goal of therapy is not to remove all anxiety but to help your child learn how to cope with the inevitable experience of anxiety in the future¹⁷⁰. In helping him to learn how to cope with anxiety, he first will need to learn what anxiety will “look like” when it returns.

The return of anxiety typically takes two forms: lapses and relapses¹⁷¹. *Lapses* are minor setbacks that are likely to happen during times of stress. This kind of return of anxiety is expected and inevitable and does not represent the return of your child’s anxiety disorder. Having a lapse does not mean that your child has lost all the progress he has made¹⁷². In fact, he already has all the skills he needs in order to rebound from such a setback¹⁷³. On the other hand, *relapses* occur when a significant amount of anxiety returns and leads to significant distress and impairment in your child’s daily life. This type of anxiety may indicate that your child’s anxiety disorder has returned and that

¹⁷⁰ Chorpita, 2007; Kendall & Hedtke, 2006; Silverman & Kurtines, 1996

¹⁷¹ Chorpita, 2007

¹⁷² Silverman & Chorpita, 1996

¹⁷³ Chorpita, 2007; Ginsburg & Kingery, 2007; Kase & Ledley, 2007

booster sessions (sessions designed to refresh or enhance skills) or additional therapy may be needed.

Once your child is able to tell the difference between a lapse and a relapse, it is time for him to learn how to recognize warning signs of each. His therapist may tell him that he will recognize that he is having a *lapse* if he notices that situations that caused him little to no anxiety at the end of treatment now cause him more anxiety. This anxiety should be managed relatively easily by following the steps discussed in the “Anticipating Situations that May Cause Anxiety in the Future” section above. On the other hand, your child may notice that he is having a *relapse* if situations that caused him little or no anxiety at the end of treatment now cause him significant anxiety and distress and that this anxiety is interfering with his daily activities and relationships. He may also recognize the return of old anxious thoughts, feelings, behaviors, and/or physical symptoms and an inability to manage these reactions with existing skills. Your child’s therapist will help him to understand that relapses are not uncommon and that they do not mean that he has lost all of his progress. At the same time, she will help him to understand how important it is that he let you know that he is having difficulty managing his anxiety so that you can help him get the assistance that he needs.

How will therapy end? Once your child has reviewed his progress and made plans for the future, it is time for him to say goodbye to therapy and to his therapist. The ending of treatment is sometimes referred to as “termination.” It can occur in several ways depending on the needs of your child¹⁷⁴. One possibility is that the frequency of your child’s sessions (e.g., once a week) will remain constant and the therapist will end treatment on his last regularly scheduled session (though it is possible that one or more planned or unplanned “booster” sessions may occur a number of weeks or months following this session) . Another possibility is that treatment will be gradually phased out. For example, your child’s therapist may move to having therapy every other week and then once a month before she officially ends treatment. These gradual termination approaches can be particularly helpful in increasing your child’s confidence and belief in his ability to manage anxiety on his own. They can also help him to come to his own conclusion that he no longer needs treatment. The decision of how to terminate likely will be decided by the therapist, and she should let you and your child know ahead of time when termination will occur. If you have questions or concerns about her decision, do not hesitate to ask for an explanation.

Time to celebrate. The ending of treatment is a time to celebrate your child’s accomplishments and progress. His therapist likely will make this a unique day by planning a fun activity or having special snacks. She may also ask you and your family to join in for the last part of the session for an “award ceremony” where your child will receive a certificate for his achievements¹⁷⁵. Such celebrations can be helpful in further developing your child’s pride in his accomplishments.

¹⁷⁴ Chorpita, 2007; Kendall & Hedtke, 2006

¹⁷⁵ Kendall & Hedtke, 2006

Emotional goodbyes. While the ending of treatment is celebratory, it can also be emotional. For this reason, your child’s therapist should spend time talking with him about saying goodbye. It will be important for your child to understand that therapy is ending, not because he did something wrong or because the therapist no longer wants to spend time with him, but because he has gained the skills he needs to handle his anxiety on his own. Given that your child has likely worked with his therapist for some time and that she has undoubtedly served as an invaluable source of knowledge and support, it is expected that your child will feel sad about saying goodbye. In order to help your child cope with his emotions, his therapist likely will empathize with his feelings by letting him know that saying goodbye can be hard and by letting him know that she will miss him too¹⁷⁶. At the same time, she will remind him of how far he has come and how confident she is that he can handle his anxiety on his own.

Dealing with your own emotions. Just as your child may be sad about saying goodbye to his therapist, you too may have feelings about saying goodbye. This is perfectly natural given that she has helped your child so much and also likely has been a source of support for you. If you are having feelings about saying goodbye, it is important that you have the opportunity to share them with the therapist. While saying goodbye can be difficult, it is essential that both you and your child understand that once treatment ends, it is expected that you will not continue to have a relationship with the therapist unless your child re-engages in therapy.

Typical Homework

Even though your child will not necessarily be learning new skills during this final phase of treatment, he still will receive homework assignments that will help him to consolidate his existing skills and to develop pride in the work that he has done. Below are examples of typical homework assignments that may be assigned during this stage of treatment.

Reviewing progress. As previously discussed, an important goal during this phase of treatment is for your child to review and consolidate his skills. In order to accomplish this goal, your child may spend time writing about the skills he has learned (perhaps by making a list or by journaling). He also may write about the progress he has made during treatment.

Content Box...

Refer to Appendix B, page 141 for a sample of homework that may be assigned to your child to help him review the progress he has made.

Developing a tool kit. Developing a tool kit can be a great way for your child to review the skills he has learned while also creating a means of remembering these skills so that he can use them when needed. Developing such a kit can empower your child by helping him to realize that he has the tools to manage his own anxiety. As described above, this tool kit can be a “mental tool kit” or a “physical tool kit” (a list, a collage, or

¹⁷⁶ Silverman & Kurtines, 1996

an actual kit). The kit may contain a list of learned skills, helpful reminders of steps to take for exposure tasks, relaxation scripts and recordings, or pictures of “happy places.”

Continued practice of learned skills. As previously mentioned, your child likely will be encouraged to continue practicing learned skills in order to further enhance his ability to manage his anxiety. Even as treatment ends, previously assigned homework involving practice of thought records, exposure tasks, or relaxation skills may be assigned during this stage of treatment in order to help your child further consolidate these skills.

What Roles Can Parents Play?

It is expected that you will be included in the final stage of treatment as it is important that you too refresh your memory of the many skills your child has learned. Being involved in this stage of treatment also creates the opportunity for you to learn how best to respond to future lapses when your child experiences an increase in anxiety. Additionally, your involvement will allow you to learn warning signs of relapse and what to do when this occurs¹⁷⁷. Furthermore, this is an opportunity for you to provide feedback to the therapist on the therapy process and to ask any questions you may have about the treatment or how to best help your child in the future. In addition to gaining this important information, there are several roles you can play during the final stage of treatment. Below is a list of some of the roles you may play.

Supporter. Your provision of support for your child is vital at all stages of treatment. However, it is particularly important at this stage given that children often can be fearful of terminating treatment (e.g., “I can’t do this on my own”). In addition to providing encouragement for regular practice of learned skills and consistent praise for your child’s accomplishments, you also can support your child as he deals with the difficulties of transitioning out of therapy. See the “Possible Trouble Spots” below for more information on how to help your child through this difficult time.

Co-therapist. Once your child ends treatment, you will likely continue to assist your child as he works on further mastering his skills. For this reason, you want to be sure to gather whatever information and support you need from the therapist prior to the ending of treatment so that you can serve in this role.

Helping to maintain treatment gains. Helping your child to maintain treatment gains will include encouraging him to continue using his skills on a daily basis, particularly when he is feeling anxious. You can help by monitoring his practice to ensure that he is using his skills correctly given that, over time, he may get “rusty” (e.g., taking shallow breaths instead of breathing deeply into his stomach and). If you notice that your child is getting “rusty,” you can rely on information you gained through therapy and this manual to remind him of the appropriate use of his skills.

While monitoring your child’s practice is important, it also is essential that you remember to provide him with increased autonomy so that he feels increasingly confident

¹⁷⁷ Kendall & Hedtke, 2006

in his ability to manage anxiety on his own¹⁷⁸. For example, if your child is feeling anxious and asks you what to do, instead of providing a direct answer you can say, “Which of your skills do you think would be the most helpful?” or “Why don’t you have a look at your tool kit and see what might help you to cope with this situation?” In doing so, you will empower your child by allowing him to decide for himself what he needs to do in order to manage his anxiety.

Encouraging further development. Recall that, prior to ending treatment, your child and his therapist will identify the areas where he may need continued skill development¹⁷⁹. You should familiarize yourself with this information prior to the end of treatment. If you are unclear about what skills your child needs to work on or how he will continue to work on them, be sure to speak to his therapist for clarification. In addition, you can ask your child’s therapist for copies of blank practice records and other materials used in therapy so that you have a supply available for your child’s continued practice.

Noticing when a lapse or relapse may be occurring. As your child’s parent, you likely will be the first person (perhaps besides your child) who will notice if he is experiencing a lapse or a relapse. Below are some tips on how to tell if lapses or relapses are occurring as well as information on what to do.

Lapses. If your child is having a lapse, there are several things that you might notice. For example, he may experience an increase in physiological symptoms of anxiety (e.g., stomach aches, sweating) or he may begin making more anxious statements than usual (e.g., “I don’t think I can handle being around Bobby’s dog.”). You also might notice that some of his previous anxious behaviors have returned (e.g., nail biting or carrying a security blanket or toy more often).

Relapses. If your child is having a relapse, he is experiencing high levels of anxiety that are likely causing significant distress and interfering with his social or academic functioning. Therefore, it likely will be easy for you to notice if he is having a relapse. Things you might notice include high levels of anxiety, statements reflecting frequent negative thoughts, increased physiological symptoms, obvious avoidance of anxiety-provoking situations, increased difficulty in school, or avoidance of social situations. You also may notice, that despite his efforts to use his skills, he is unable to decrease his anxiety.

It can be upsetting to realize that your child is having a lapse or relapse. Nonetheless, it is important that you remain calm for your child. Remember that the return of some anxiety is something that you and your child have learned to expect so have confidence that you both have the ability to manage it successfully. In approaching your child, adopt a “matter-of-fact,” non-worried tone of voice. In the case of a *lapse*, remind him that some anxiety is normal and that the point of treatment was not to make all of his anxiety go away. Find out from him what he is anxious about and ask him what skills from his tool kit he might be able to use to manage his anxiety. If he does not come

¹⁷⁸ Kendall & Hedtke, 2006

¹⁷⁹ Kendall & Hedtke, 2006

up with something, ask him to get his “tool kit” (if it is physical) so that you can go through it with him and decide together what he might be able to use to manage his anxiety. If it is a “mental tool kit,” encourage him to write out his skills so that you can look at them together and decide what he can do. In the case of a relapse, let your child know that you will handle this together and that you will contact the therapist to schedule a booster session or to have a re-evaluation for continued treatment. Remember, if you want to help your child overcome his lapse or relapse, show confidence in him- it’s contagious!

Possible Trouble Spots

There are a number of possible trouble spots that may arise during this final stage of treatment. The following will address many of the common trouble spots that may occur.

Attributing his gains to the therapist. It is common for children in therapy to attribute their improvement to the therapist rather than to themselves¹⁸⁰. For this reason, it is vital that your child understand that he is responsible for his improvement. You may notice that he is attributing his gains to the therapist if he is making statements like, “I can’t do this without her” or “I am better thanks to [therapist’s name].”

What can you do? Your child’s therapist should address this issue prior to termination. However, you can help reinforce this point by providing specific praise to your child for his accomplishments. For example you may tell your child, “I am really proud of how hard you have worked in therapy.” You also may say, “Look at all the new skills you have learned!” or “I am proud of how well you have managed your anxiety.” In making these statements, you will be attributing treatment gains to your child, which will help him to do the same.

Fear of ending therapy. While children may often be reluctant to begin therapy, it is common for them to get used to it and even enjoy it over time. It is also common for children to become attached their therapists. As a result, they may be fearful of ending therapy or sad about the loss of their relationship with the therapist.

What can you do? As discussed previously, your child’s therapist will address such termination issues with your child. However, you can help by normalizing this difficulty for your child. For example, you can tell him, “It is natural to have a tough time with change” or “It’s normal to have a hard time saying goodbye to someone you feel close to.” You also can remind your child that he has internalized (or taken in) all the skills from therapy so a part of it (and of the therapist) will always stay with him, and he now has the skills to master his anxiety on his own.

Expecting anxiety to go away permanently. As previously mentioned, the point of treatment is not to get rid of anxiety completely. However, it is possible that your child expected that, by the time treatment is over, he would be free of anxiety.

¹⁸⁰ Chorpita, 2007

What can you do? If you notice that your child appears disappointed about still having some anxiety, normalize this reaction. At the same time, remind him why having some anxiety is natural and even necessary. For example, you can say to him, “Wouldn’t you like to be able to still feel some anxiety if it means it will help you to prepare to handle real threatening situations?” As always, continue to encourage him to approach, rather than avoid anxiety-provoking situations so that that your child can continue to gain mastery over his anxiety.

Closing Comments

Just as your child has come to the end of his treatment, you have reached the end of this manual. You are to be congratulated for your hard work and dedication to the well being of your child. Now is a great time for you to reflect on your own progress and gains. Through this process, you have learned about the nature of anxiety disorders as well as the CBT approaches typically used to treat the symptoms of anxiety. You also have learned how you can help your child manage his anxiety by using important skills both during and after treatment. This information has prepared you not only to help your child maintain his gains long after treatment is over but also to notice if your child is having a lapse or a relapse so that you are able to take the necessary steps to help him. Remember to return to this manual as needed for reminders and for guidance. Also, see Appendix A for additional resources including helpful websites and self-help books that you can use to further enhance your ability to help your child manage his anxiety.

APPENDIX A
Additional Resources

Additional Resources

Manualized Treatments for Anxiety Disorders:

1. Chorpita, B.F. (2007). *Modular cognitive-behavioral therapy for childhood anxiety disorders*. New York: Guilford Press.
2. Kendall, P.C. & Hedtke, K.A. (2006b). *The coping cat workbook: Second Edition*. Ardmore, PA: Workbook Publishing.
3. Silverman, W.K. & Kurtines, W.M. (1996). *Anxiety and phobic disorders: A pragmatic approach*. New York: Springer.

Self-Help Books for Parents¹⁸¹:

1. Dupont-Spencer, E., Dupont, R.L., & Duppont, C.M. (2003). *Anxiety Cure for Kids: A Guide for Parents*. New Jersey: John Wiley & Sons, Inc
2. Rapee, R.M, Spencer, S.H., Cobham, V., Wignall, A., & Lyneham, H. (2008). *Helping Your Anxious Child: A Step-by-Step Guide for Parents, Second Edition*. Oakland: New Harbinger.
3. Last, C.A. (2006). *Help for Worried Kids: How Your Child can Conquer Anxiety*. New York: Guilford Press.
4. Chansky, T.E. (2004). *Freeing Your Child From Anxiety: Powerful, Practical Solutions to Overcome Your Child's Fear, Worries, and Phobias*. New York: Broadway Books.

Useful Websites Related to Child Anxiety:

1. The Child Anxiety Network: www.childanxiety.net
2. Temple University's Child & Adolescents Anxiety Disorders Clinic:
www.childanxiety.org
3. Anxiety Disorders Association of America: www.adaa.org
4. American Academy of Child and Adolescent Psychiatry: www.aacap.org
5. Child Anxiety Center: www.childanxietycenter.com

¹⁸¹ These self-help books can be purchased at local book stores and on-line retailers (e.g., Barnes and Noble, Borders). They can also be purchased at a discounted price (new and used) at amazon.com

6. UCLA Anxiety Disorders Research Center:
<http://anxiety.psych.ucla.edu/anxresources.php>
7. Association for Behavioral and Cognitive Therapies: <http://www.abct.org/sccap/>

APPENDIX B

Sample Homework Assignments

S.T.i.C. Task - Session 2

Write about two situations that happened to you this week. One situation should be a time when you felt really nervous, scared, or worried. The other situation should be a time when you felt relaxed. Remember to describe the situations, what you were thinking, and what you were feeling.

I was nervous, scared, or worried when _____

I was relaxed when _____

Watch someone else this week. It can be someone in your family, or a friend, or a TV character. How can you tell what this person is feeling if they don't tell you?

Name of other person: _____

Situation: _____

The other person's feeling: _____

What did you see that was a clue to the other person's feelings?



Continuous Practice Record

Goal: Each time you practice, take ratings every _____ minutes. Stop after _____ minutes or when your rating comes down to a _____.

Start Date: _____

Day _____

Item _____



Day _____

Item _____



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¹⁸³ Guilford Press; Modular Cognitive Behavioral Therapy for Childhood Anxiety Disorders, (2007); page, 243; Chorpita, B.F.; Original copyright notice: 2010; With kind permission of Guilford Press.

reward menu

reward	Number of points or stickers



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¹⁸⁴ Workbook Publishing; The Coping Cat Workbook, Second Edition, (2006); page 73; Kendall, P.C. & Hedtke, K.A.; Original copyright notices: 2010; With kind permission of Workbook Publishing.

★ **Feelings Role Play: Can You Guess What I'm Feeling?**

Try and show your feelings using only your face and body. No words! You can do it! See if your therapist can guess what you are feeling.

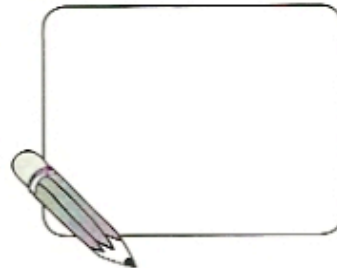
★ **If I were in this situation I'd feel...**

Read the following stories and write in a feeling that you might have.

1. Your best friend comes running up to you on the playground. Your friend says, "Let's go play!"

What feeling would you have?

Draw a face to show that feeling.



2. This week you and your class did a pretty good job on your assignments and were very well behaved and the teacher decided that you could all go on the school trip to the zoo. But on the day of the trip it is raining so the trip to the zoo is cancelled.

What feeling would you have?

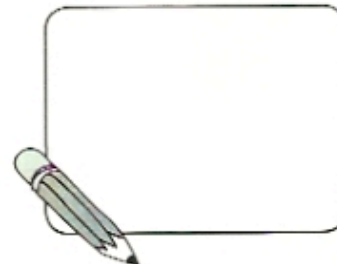
Draw a face to show that feeling.



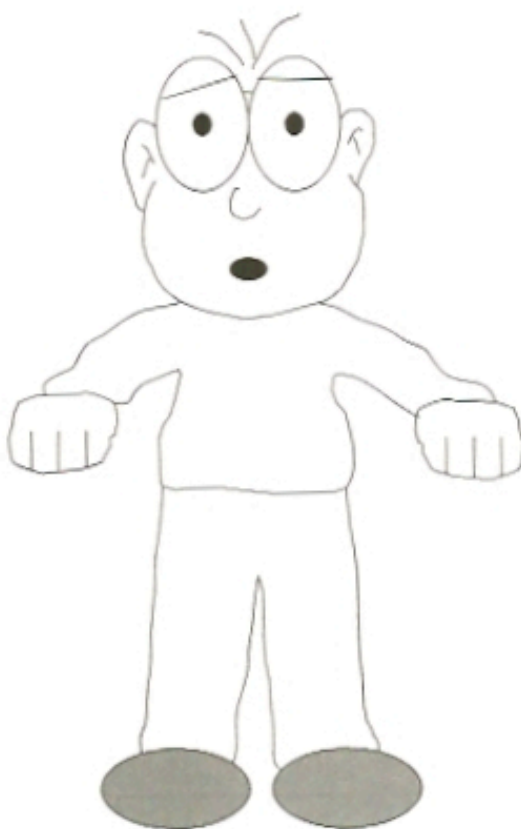
3. You are at home and your parents are outside. You are the only one in the house — you hear a noise in the other room.

What feeling would you have?

Draw a face to show that feeling.



Feelings



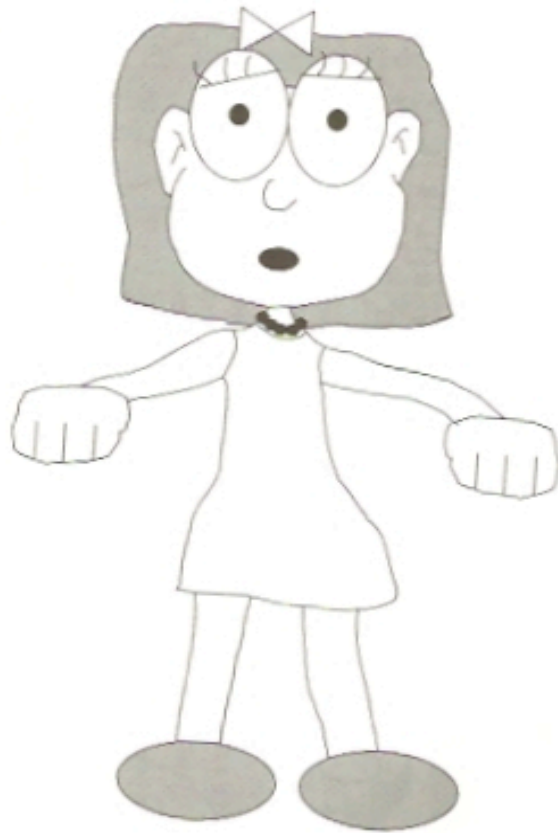
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¹⁸⁶ Guilford Press; Modular Cognitive Behavioral Therapy for Childhood Anxiety Disorders, (2007); page, 222; Chorpita, B.F.; Original copyright notice: 2010; With kind permission of Guilford Press.

Feelings



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SESSION 3: HOW DOES MY BODY REACT?

Today we're going to talk about the ways our bodies might react when we feel nervous. For example, as a cat, I show that I'm scared when my fur stands up. When I'm frightened, I feel like a Scaredy Cat.



Sometimes being afraid is OK - there are times when everyone is a little bit afraid. But, there are other times when we don't have to be afraid. When I keep my cool, I feel like I can cope with whatever comes my way. I'm a Coping Cat.



activities menu

★ How do my family members show that they're scared?

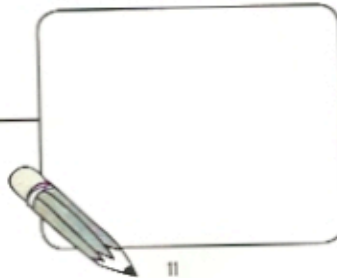
When people are scared, they can notice that their bodies give them clues or hints that they are scared. Think of a time when a family member or a friend of yours was scared. What ways could their bodies tell them that they were scared? Write them in the spaces below.

1. _____

2. _____

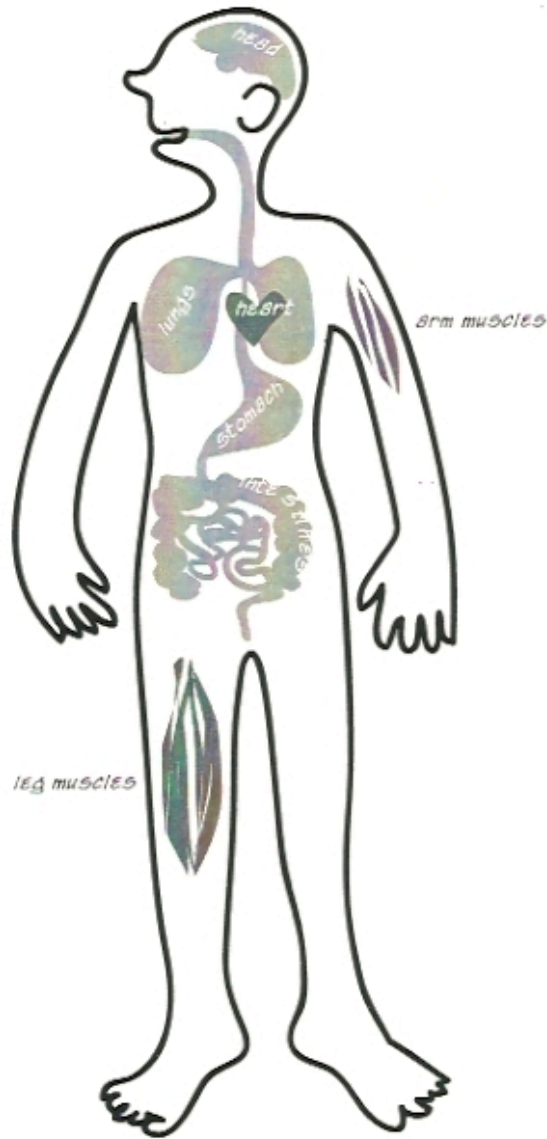
3. _____

Draw a picture of a person who is feeling scared or worried.



★ How do our bodies tell us we're anxious?

Look at the drawing of the human body below. Which part of your body gets a funny feeling when you feel nervous or worried? Draw a circle around it and describe how it feels.



★ Let's answer some questions about how our body reacts

Sometimes there are several different reasons that could explain your feelings and how your body is reacting. Read the following situations and circle the number of the reason you think is the most likely why the person in the story feels the way he/she does.

Marina was very hungry, so she ate the tuna fish that had been in the fridge for several weeks. A few hours later her stomach hurts.

Why do you think her stomach hurts?

1. The tuna fish was spoiled.
2. Somebody punched her.
3. She's worried about a test.



Terry is about to give a book report in front of his class. He notices that he feels sweaty.



Why might he feel that way?

1. He ran to school earlier that morning.
2. It's a hot day outside.
3. He's nervous about speaking in front of the class.

The last time Chris went to the dentist, he had to have a shot that hurt a little bit. Six months later he's in the dentist's waiting room again. When the dentist calls him to come and sit in the dentist's chair, Chris feels his heart beating really fast.

What could have caused his heart to beat so fast?

1. He swam in a race right before he went to the dentist.
2. He drank too much soda pop.
3. He was worried about what might happen with the dentist.



The answers to these three questions can help us to understand how our bodies give us clues. In Marina's situation, an upset stomach could result from any of the three reasons listed; but since we know that she ate very old tuna fish, we can be confident that the tuna fish upset her stomach. Keep in mind, though, that if her food was OK, a very important test could make her stomach upset.

Terry could be feeling sweaty because the air temperature is hot. However, if it is a cool day and if he hasn't been running within the last half hour, then his speaking in front of the class might be the cause of his sweating. Running, hot temperatures, and stressful circumstances all can make us sweat.

Chris felt nervous and he identified it when he noticed his heart pounding. He was worried about pain.



How do we know what someone is feeling?

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See if you can figure out how they are feeling.



This person feels _____



How do you know?

Write why you think they are feeling that way.



This person feels _____



How do you know?



This person feels _____



How do you know?



This person feels _____



How do you know?

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Here are things you can feel when you are scared. Draw a line to match the word with the feeling in the picture

blushing

sweaty

butterflies

racing heart

shaky

out of breath

dizzy



(3 of 9)

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NAME: _____

DATE: 7/8/04

0 1 2 3 4 5 6 7 8

Not scared of at all/
Never stay away from

A little scared of/
hardly ever stay away from

Scared of/
Sometimes stay away from

Very scared of/
Usually stay away from

Very, very, very scared of/
Always stay away from

		How Scary (0-8)
Scariest	<u>calling girl on phone</u>	<u>8</u>
	<u>asking girl for her phone number</u>	<u>7</u>
	<u>talking to girl when she's in group</u>	<u>6</u>
	<u>talking to girl when she's alone</u>	<u>5</u>
	<u>similiar talking w/ new people</u>	<u>4</u>
	<u>talking to new people at party</u>	<u>4</u>
	<u>talking/asking waiter/waitress</u>	<u>3</u>
	<u>asking for directions</u>	<u>2</u>
	<u>phone calls</u>	<u>2</u>
Least scary	<u>going to market alone</u>	<u>1</u>
	<u>saying hello (greetings)</u>	<u>1</u>

Figure 5.1. Hierarchy for child with Social Phobia (Social Anxiety Disorder).

Contract Number 2
 Session Number 4

Parent-Child Contract

Let it be known that on this Fri day, the 17 of
(day of week) (date)
Dec in the year 1993, a contract between
(month)
 _____ and mother/father _____
(child's name) (parent's name)
 concerning the child's fear of animals was signed, witnessed
(event / object)
 by Dr. Silverman.
(therapist's name)

The above parent and child hereby agree that if _____
(child's name)
 successfully pets a cocker spaniel in cage
(exposure task)
at pet store for 5 minutes

then she will receive a chocolate ice cream cone.
(reinforcement child will receive) (one scoop)
 This task is to be done by the child Wed, and the parent is
(when)
 to give child the above mentioned reward Wed.
(when)

Figure 5.3. Contract for a child with a Specific Phobia of dogs and cats.

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¹⁹⁴ Springer/Kluwer Academic Publishers; Anxiety and Phobic Disorders: A Pragmatic Approach, (1996); Chapter 5, page 67, Figure 5.1; Silverman, W.K. & Kurtines, W.M.; Original copyright notice: 2010; With kind permission of Springer Science and Business Media.

S.T.i.C. Task - Session 5 - CONTINUED

Describe two times you were nervous or scared this week. Write down the situation and how your body felt, and then give the situation a rating using your rating scale.

Situation 1

I was nervous, scared, or worried when _____

Feeling frightened?

My body reacted by: _____

RATING:

Situation 2

I was nervous, scared, or worried when _____

Feeling frightened?

My body reacted by: _____

RATING:

¹⁹⁵ Workbook Publishing; The Coping Cat Workbook, Second Edition, (2006); page, 21; Kendall, P.C. & Hedtke, K.A.; Original copyright notices: 2010; With kind permission of Workbook Publishing.

★ Tense or relaxed?

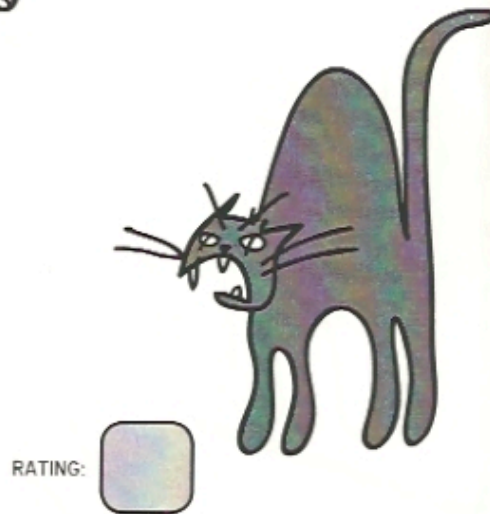
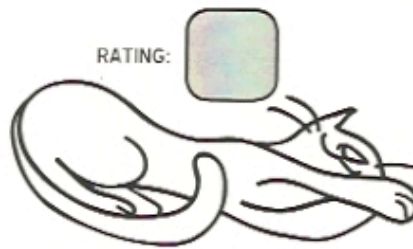
Sometimes we can also notice when other people feel tense by the way their bodies work. Look at these pictures below. Can you rate how relaxed the cat feels? Under each picture note how tense or relaxed the cat is: place a "1" if the cat is relaxed, or if the cat is tense, put a "4".

1 = relaxed

2

3

4 = TENSE!





SESSION 6: WHAT AM I THINKING?



In this session we're going to talk about the kinds of thoughts that people have in different situations. For example, if I won a catnip mouse at a raffle drawing, I would probably think "I'm so excited; I can't wait to play with it!" These thoughts are "talking to myself," so sometimes I call them self-talk.

activities menu

★ What's in the thought bubble?

This is a cartoon drawing of the Lincoln Memorial, a statue to memorialize one of the great Presidents of the United States. We call the balloon over his head a "thought bubble"—it's where the cartoon character's thoughts go. His thought bubble is empty. What might he be thinking? Take a minute to think, then turn the page for what he might be thinking.



Two-Column Thought Record

When you have a nervous thought, write it in the column on the left, and then rate how likely you think it is to come true. Remember to write your thought as a prediction or a guess about what will happen in the future.

Thought?	How likely is it? (0 to 100%)

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Five-Column Thought Record

When you have a nervous thought, write it in the column on the left, and then rate how likely you think it is to come true. Next, write down an alternative thought and proof that you think it is true. Finally, re-rate how likely you think your original nervous thought is, considering the proof you came up with.

Thought?	How likely does it feel? (0 to 100%)	Alternative Thought?	Proof?	How likely is it really? (0 to 100%)

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★ **Make your own FEAR plan card.**

Now that we have learned all four of the FEAR steps, turn to page 79. Cut out the card that you find on that page. On the card, write the four steps for coping with anxiety. Decorate the card any way you like. You can refer to this card whenever you feel anxious and need to remind yourself of the steps to use.



★ **A coping character.**

When I'm coping with a tough situation, it helps me to think of a storybook or cartoon character who would handle the situation well. I can think about how that person would cope and that gives me an idea of how I should try to cope. I'd like you to think of a character from a comic strip, book, or TV show that would help you to feel calm. If you can't think of anyone, make up a character. Describe your character on the lines below.



YOUR S.T.i.C. Task FOR next time...

1. Record two situations in which you felt anxious and you used the steps we've learned to help yourself cope with anxiety. Describe how you rated yourself on how well you've coped. Also describe how you rewarded yourself for coping with the situations. Be sure to reward yourself for partial success, not just for total success.
2. Show the card that you made to a parent and explain the steps to them.





STOP Record

If you feel Scared, write down where and when it happened over on the left. Then write any scary Thoughts that you had. In the next column, put any Other thoughts you could have that are less scary. Remember to Praise yourself at the end!

Scared? (where and when)	Thoughts?	Other Thoughts?	Did you Praise yourself?

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What I Took Back from Anxiety



Handwriting practice lines consisting of ten horizontal lines.

Handwriting practice lines consisting of ten horizontal lines.

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References

- Abramowitz, J.S., Deacon, B.J., Whiteside, S.P. (2011). *Exposure therapy for anxiety: Principles and practice*. New York, NY: Guilford Press.
- Albano, A.M., Chorpita, B.F., & Barlow, D.H. (1996). Child anxiety disorders. In Mash, E.J. & Barkley, R.A. (Eds.), *Child Psychopathology*. (pp. 196-241). New York, NY: Guilford Press.
- Albano, A.M. & Kendall, P.C. (2002). Cognitive behavioral therapy for children and adolescents with anxiety disorders: Clinical research advances. *International Review of Psychiatry, 14*, 129-134. doi: 10.1080/09540260220132644.
- American Academy of Child and Adolescent Psychiatry. (2007). Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 46*(2), 267-283. doi: 10.1097/01.chi.0000246070.23695.06
- Barlow, D.H. (2002.) *Anxiety and its disorders: The nature and treatment of anxiety and panic, 2nd edition*. New York, NY: Guilford Press.
- Barrett, P.M. & Ollendick, T.H. (2004). *Handbook of interventions that work with children and adolescents: Prevention and treatment*. New York, NY: John Wiley & Sons.
- Brown, A.M., Deacon, B.J., Abramowitz, J.S., Dammann, J., & Whiteside, S.P. (2007). Parents' perceptions of pharmacological and cognitive-behavioral treatments for childhood anxiety disorders. *Behavior Research and Therapy, 45*, 819-828. doi: 10.1016/j.brat.2006.04.010
- Cartwright-Hatton, S., McNicol, K., & Doubleday, E. (2006). Anxiety in a neglected population: Prevalence of anxiety disorders in pre-adolescent children. *Clinical Psychology Review, 26*(7), 817-833. doi: 10.1016/j.cpr.2005.12.002
- Cartwright-Hatton, S., Roberts, C., Chitsabesan, P., Fothergill, C. & Harrington, R. (2004). Systematic review of the efficacy of cognitive behavior therapies for childhood and adolescent anxiety disorders. *Journal of Clinical Psychology, 43*(4), 421-436. doi: 10.1348/0144665042388928
- Chorpita, B.F. (2007). *Modular cognitive-behavioral therapy for childhood anxiety disorders*. New York, NY: Guilford Press.
- Chorpita, B.F. & Southam-Gerow, M.A. (2006). Fears and anxieties. In E.J. Mash and R.A. Barkley (Eds.), *Treatment of childhood disorders (3rd ed.)* (pp. 271-335). New York, NY: Guilford Press.

- Compton, S.N., Kratochvil, C.J., & March, J.S. (2007). Pharmacotherapy for anxiety disorders in children and adolescents: An evidence-based medicine review. *Psychiatric Annals*, 37(7), 504-517.
- Costello, E.J. & Angold, A. (1995). Epidemiology. In March, J.S. (Ed.), *Anxiety disorders in children and adolescents*. (pp.109-124). New York, NY: Guilford Press.
- Ginsburg, G.S. & Kingery, J.N. (2007). Evidence-based practice for child anxiety disorders. *Journal of Contemporary Psychotherapy*, 37(3), 123-132. doi: 10.1007/s10879-007-9047-z
- Greaves-Lord, K., Ferdinand, R.F., Sondejker, F.E., Dietrich, A., Oldehinkel, A.J., Rosmalen, J.G., Ormel, J., & Verhulst, F.C. (2007). Testing the tripartite model in young adolescents: Is hyperarousal specific for anxiety and not depression? *Journal of Affective Disorders*, 102 (1-3), 55-63. doi: 10.1016/j.jad.2006.12.009
- Greenberger, D. & Padesky, C.A. (1995). *Mind over mood: Change how you feel by changing the way you think*. New York, NY: Guilford Press.
- Grisel, J.E., Rasmussen, P.R. & Sperry, L. (2006). Anxiety and depression: Physiological and pharmacological considerations. *Journal of Individual Psychology*, 62(4), 397-416.
- Hammerness, P., Harpold, T., Petty, C., Mendard, C., Zar-Kessler, C., & Biederman, J. (2008). Characterizing non-OCD anxiety disorders in psychiatrically referred children and adolescents. *Journal of Affective Disorders*, 105(1-3), 213-219. doi: 10.1016/j.jad.2007.05.012
- Hannesdottir, D.K. & Ollendick, T.H. (2007). The role of emotion regulation in the treatment of child anxiety disorders. *Clinical Child and Family Psychology Review*, 10(3), 275-293. doi: 10.1007/s10567-007-0024-6
- Hedtke, K.A., Kendall, P.C., & Tiwari, S. (2009). Safety-seeking and coping behavior during exposure tasks with anxious youth. *Journal of Clinical and Child and Adolescent Psychology* 38 (1), 1-15. doi: 10.1080/15374410802581055
- Kase, L. & Ledley, D.R. (2007). *Anxiety disorders*. Hoboken, N.J.: John Wiley & Sons.
- Kendall, P.C. & Choudhury, M.S. (2003). Children and adolescents in cognitive-behavioral therapy: Some past efforts and current advances, and the challenges in our future. *Cognitive Therapy and Research*, 27(1), 89-104. doi: 10.1023/A:1022542814822
- Kendall, P.C. & Hedtke, K.A. (2006). *Cognitive-behavioral therapy for anxious children: Therapist manual*. Ardmore, PA: Workbook Publishing.

- Kendall, P.C. & Hedtke, K.A. (2006b). *The coping cat workbook: Second Edition*. Ardmore, PA: Workbook Publishing.
- Kendall, P.C. & Suveg, C. (2006). Treating anxiety disorders in youth. In Kendall, P.C. (Ed.), *Child and adolescent therapy* (pp. 243-294). New York, NY: The Guilford Press.
- Kendall, P.C. & Treadwell, K.R. (2007). The role of self-statements as a mediator in treatment for youth with anxiety disorders. *Journal of Consulting and Clinical Psychology, 75*(3), 380-389. doi: 10.1037/0022-006X.75.3.380
- Mahoney, G., Kaiser, A., Girolametto, L., MacDonald, J., Robinson, C., Safford, P., & Spiker, D. (1999). Parent education in early intervention: A call for a renewed focus. *Topics in Early Childhood Special Education, 19*(3), 131-140. doi: 10.1177/027112149901900301
- Maldonado-Duran, M.J., Lubin, S., Manguia-Wellman, M. & Lartigue, T. (2002). Latino families in the perinatal period: Cultural issues in dealing with the health-care system. *Great Plains Research, 21*, 75-100.
- Nauta, M.H., Scholing, A., Emmelkamp, P.M.G., & Minderaa, R.B. (2003). Cognitive-behavioral therapy for children with anxiety disorders in a clinical setting: No additional effect of a cognitive parent training. *Journal of American Academy of Child and Adolescent Psychiatry, 42*(11), 1270-1278. doi: 10.1097/01.chi.0000085752.71002.93
- Psychogiou, L., Daley, D., Thompson, M.J., & Sonuga-Barke, J.S. (2008). Parent empathy: Associations with dimensions of parent and child psychopathology. *British Journal of Developmental Psychology, 26*(2), 221-232. doi: 10.1348/02615100X238582
- Rosenberg, D.R., Banerjee, P., Ivey, J.L., & Lorch, E.R. (2003). Psychopharmacology of child and adolescent anxiety disorders. *Psychiatric Annals, 33*(4), 273-278.
- Schieffelbein, V.L. & Susman, E.J. (2006). Cortisol levels and longitudinal cortisol change as predictors of anxiety in adolescents. *The Journal of Early Adolescents, 26*(4), 397-413. doi: 10.1177/0272431606291943
- Silverman, W.K. & Kurtines, W.M. (1996). *Anxiety and phobic disorders: A pragmatic approach*. New York, NY: Springer.
- Silverman, W.K., Pina, A.A., & Viswesvaran, C. (2008). Evidence-based psychosocial treatments for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child and Adolescent Psychology, 37*(1), 105-130. doi: 10.1080/15374410701817907

- Southam-Gerow, M.A. & Chorpita, B.F. (2007). Anxiety in children and adolescents. In Mash, E.J. & Barkley, R.A. (Eds.), *Assessment of childhood disorders (4th ed.)*. (pp. 347-397). New York, NY: Guilford Press.
- Suveg, C., Roblek, T.L., Robin, J., Krain, J., Aschenbrand, S., & Ginsburg, G.S. (2006). Parent involvement when conducting cognitive-behavioral therapy for children with anxiety disorders. *Journal of Cognitive Psychotherapy: An International Quarterly*, 20(3), 287-299. doi: 10.1891/jcop.20.3.287
- Verduin, T.L. & Kendall, P.C. (2003). Differential occurrence of comorbidity within childhood anxiety disorders. *Journal of Clinical Child and Adolescent Psychology*, 32(2), 290-295. doi: 10.1207/S15374424JCCP3202_15
- Walkup, J., Albano, A.M., Piacentini, J., Birmaher, B., Compton, S.N., Sherrill, J.T., ...Kendall, P.C. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *The New England Journal of Medicine*, 359(26), 2753-2766. doi: 10.1056/NEJMoa0804633
- Weems, C.F., Zakem, A.H., Costa, N.M., Cannon, M.F., & Watts, S.E. (2005). Physiological response and childhood anxiety: Association with symptoms of anxiety disorders and cognitive bias. *Journal of Clinical Child and Adolescent Psychology*, 34(4), 712-723. doi: 10.1207/s15374424jccp3404_13
- Wood, J.J, Chiu, A.W., Hwang, W. Jacobs, J., & Ifekwunigwe, M. (2008). Adapting cognitive-behavioral therapy for Mexican American students with anxiety disorders: Recommendations for school psychologists. *School Psychology Quarterly*, 23(4), 515-532. doi: 10.1037/1045-3830.23.4.515