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At the time of this publication, Dr. Beidas was a doctoral student at Temple University, but she is now a faculty member at the University of Pennsylvania.

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Abstract

Anxiety disorders are common psychological disorders experienced by youth (Warren & messer, 1999), with reported rates of 10-20% in the general population and primary care settings (Chavira, Stein, Bailey, & Stein, 2004; Costello, Mustillo, Keeler, & Angold, 2004). Anxiety disorders in youth include generalized anxiety disorder (GAD), social phobia (SP), separation anxiety disorder (SAD), specific phobias, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD) (APA, 1994). In this chapter, we focus on treatment for the three youth anxiety disorders: GAD, SP, and SAD.

Disciplines

Cognitive Behavioral Therapy | Mental Disorders | Psychiatry and Psychology

Comments

At the time of this publication, Dr. Beidas was a doctoral student at Temple University, but she is now a faculty member at the University of Pennsylvania.

Chapter 11

Cognitive-Behavioral Treatment for Child and Adolescent Anxiety: The Coping Cat Program

Rinad S. Beidas, MA, Jennifer L. Podell, MA, and Philip C. Kendall, PhD, ABPP

RATIONALE AND DEVELOPMENT OF TREATMENT

Anxiety disorders are common psychological disorders experienced by youth (Warren & Messer, 1999), with reported rates of 10–20% in the general population and primary care settings (Chavira, Stein, Bailey, & Stein, 2004; Costello, Mustillo, Keeler, & Angold, 2004). Anxiety disorders in youth include generalized anxiety disorder (GAD), social phobia (SP), separation anxiety disorder (SAD), specific phobias, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD) (APA, 1994). In this chapter, we focus on treatment for the three main youth anxiety disorders: GAD, SP, and SAD.

Most anxiety disorders do not abate with time and if left untreated are linked to impairments into adulthood. Research indicates that anxious children experience related difficulties

both socially (Strauss, Forehand, Smith, & Frame, 1986; Greco & Morris, 2005) and academically (King & Ollendick, 1989; Van Ameringen, Manicini, & Farvolden, 2003). Additionally, anxiety disorders in youth are associated with psychopathology in adulthood such as subsequent anxiety disorders, depression, and substance abuse (Kendall, Safford, Flannery-Schroeder, & Webb, 2004). The consequences of untreated anxiety disorders in youth highlight the need for early intervention.

Cognitive-behavioral treatment (CBT) combines behavioral strategies (e.g., modeling, relaxation, in vivo exposures, and contingency maintenance) with cognitive strategies (e.g., problem-solving, appraisal of personal abilities and perceived threat). One structured version of CBT for youth anxiety which we have developed and researched is the *Coping Cat Program* which follows a therapist treatment manual (Kendall & Hedtke, 2006a) and uses a client workbook (Kendall & Hedtke, 2006b). This chapter summarizes the main components and strategies of the treatment manual. For added details (e.g., step by step administration procedures, “tips from the trenches”) we recommend consulting the full manual and workbook

(Kendall & Hedtke, 2006a, 2006b; www.WorkbookPublishing.com).

EVIDENCE FOR TREATMENT

CBT for youth anxiety disorders (i.e., the *Coping Cat Program* and variants of it) have been found to be effective in several randomized clinical trials conducted in the United States (Kendall, 1994; Kendall et al., 1997). Additional

evidence for the efficacy of CBT has been provided by researchers in Australia (Barrett, Dadds, & Rapee, 1996), Canada (Manassis et al., 2002) and the Netherlands (Nauta, Scholing, & Emmelkamp, 2003). The results of these trials suggest that approximately 50–72% of children with anxiety disorders (i.e., GAD, SP, and/or SAD) who receive CBT no longer meet criteria for their presenting anxiety disorder following treatment.

Therapeutic gains have also been found to be maintained up to seven years posttreatment. In two followup studies of different samples of anxious youth (3.35 and 7.4 years after treatment), 80–90% of successfully treated children still did not meet criteria for their presenting anxiety disorder (Kendall & Southam-Gerow, 1996; Kendall et al., 2004). Reviews of this literature, applying Chambless and Hollon's (1998) criteria for evidence-based treatments, conclude that CBT for youth with anxiety disorders is efficacious (Albano & Kendall, 2002; Kazdin & Weisz, 1998; Ollendick & King, 1998).

INTRODUCTION TO THE TREATMENT PROTOCOL

The *Coping Cat* (Kendall & Hedtke, 2006a, 2006b) is a 16 session program of CBT for youth (aged 8–13), with GAD, SAD, and/or SP. The therapist manual (Kendall & Hedtke, 2006a) and client workbook (Kendall & Hedtke, 2006b) are used together: the manual guides the treatment, whereas the workbook contains client tasks which correspond sequentially with the treatment.

The *Coping Cat*, as in CBT, represents a synthesis of behavioral and cognitive strategies. Understanding social influences (e.g., family, peer) and the teaching of emotional management skills are also addressed.

The *Coping Cat* has two sections: the first focuses on psychoeducation, whereas the second emphasizes exposure to anxiety provoking situations. The first eight sessions focus on helping the child learn to identify when she is feeling anxious as well as an introduction of strategies to manage or ameliorate anxiety. These strategies are presented to the child as a tool set that she may carry with her and draw from when she is feeling anxious. The strategies include: identifying bodily arousal, engaging in relaxation, recognizing anxious thoughts, and problem-solving. These skills are taught in a sequence that allows the child to build skill upon skill. The last eight sessions focus on exposing the child to anxiety provoking situations (using a fear hierarchy) while using the skills the child has learned in the first eight sessions. Throughout, the therapist is a “coach,” teaching the child the necessary skills and guiding the child to practice the skills.

It is important that the therapist be a ‘coping model’ for the child throughout treatment. A mastery model demonstrates success, whereas a coping model demonstrates the initial problem, a strategy to overcome the problem and then success. The therapist is a coping model by demonstrating anxiety, strategies that help one cope with the anxiety, and then success. The child participates with the therapist in role playing and the child is encouraged to role play scenes alone, practicing newly acquired skills.

Four important concepts are presented to the child in sequence. First, the child is taught to recognize how her body responds to anxiety. Second, the child learns to recognize anxious thoughts and expectations that she might have. Third, the child is taught ways to combat anxious thoughts and expectations through strategies such as problem-solving and coping thoughts. Fourth, the child is introduced to rewarding herself for partial or full success when facing anxiety provoking situations. These four concepts are presented in the education phase of treatment using a mnemonic FEAR, where F = Feeling *F* rightened? E = Expecting bad things to happen? A = Attitudes and Actions that can help and R = Results and Rewards.

After learning the FEAR plan during the psychoeducation portion of treatment, the child embarks upon the exposure tasks to practice the plan during anxiety provoking situations. The situations are individual to each child based on the child's specific anxieties. For example, exposure tasks for a male with social phobia (e.g., meeting a new peer) would be very different than exposure tasks for a female with separation anxiety (e.g., dealing with autonomy from parents). The exposure tasks are sequential: earlier exposure tasks

(e.g., [Session 10](#)) are less anxiety provoking than later exposure tasks (e.g., [Session 15](#)). The last session includes the presentation of a child-created 'commercial' which gives the child a chance to show off the skills she has learned in treatment.

ISSUES TO CONSIDER WHEN CONDUCTING THE INTERVENTION

Clinicians and researchers have asked and researchers have investigated whether demographic variables (e.g., age, gender, socioeconomic status, comorbidity) affect treatment outcome. Let us consider each.

Age

The *Coping Cat Program* (Kendall & Hedtke, 2006a) is designed/recommended for children ages 7–13. For treatment of anxiety disorders in younger children (ages 4–7), please see the *Kiddie Cat* (Hughes, Hedtke, Flannery-Schroeder, & Kendall, 2005). For treatment of anxiety disorders in adolescents (ages 13–18), see the *C.A.T. Project Manual* (Kendall, Choudhury, Hudson & Webb, 2002). Data reported to date do not indicate that age influences the degree of positive benefit gained from treatment.

Format

The *Coping Cat Program* is an individualized therapy program for the child, with two parent sessions interspersed. Parents serve as consultants and collaborators in the treatment. For those who wish to work within a family therapy framework, with the parents as co-clients in the sessions, please see the family therapy manual (Howard, Chu, Krain, Marrs-Gracia, & Kendall, 2000). For those who wish to treat youth anxiety disorders within a group context, please see the group treatment manual (Flannery-Schroeder & Kendall, 1996).

IQ

The *Coping Cat Program* contains cognitive components that require the child to have at least average cognitive abilities. In our own work, a child is appropriate with an IQ of 80 and above. Please see Suveg and colleagues (in press) for an adaptation of the *Coping Cat* treatment with a cognitively delayed child.

Comorbidity

Most children come to our clinic with multiple anxiety disorders, as well as other forms of psychopathology such as attention deficit hyperactivity disorder (ADHD), and oppositional defiant disorder (ODD). Although comorbidity runs high, comorbid disorders present before treatment do not affect outcomes. In other words, both children with comorbid disorders as well as children without comorbid disorders improved when treated with CBT for their anxiety (Kendall, Brady, & Verduin, 2001; Kendall & Brady, 1995).

Gender and Ethnicity

Two factors that have not been found to affect treatment outcome are gender and ethnicity. CBT for anxious youth produces similar results regardless of gender or race. For example, although there are differences in attrition (Sood & Kendall, 2006), there are no differences in outcomes associated with child gender or ethnicity (Treadwell, Flannery-Schroeder, & Kendall, 1995).

Intake and Screening

The assessment of anxiety disorders in children and adolescents can be a challenging endeavor. Although there is no single universally accepted approach, a multi-method, multi-informant approach is preferred and practiced (Jensen, et al., 1999). Such an assessment involves the collection of information from parents, children, and their teachers, and from a variety of settings, including school, home, and peer interactions. This approach permits a thorough evaluation of presenting symptoms and resulting impairment (Achenbach, 1991; Achenbach, McConaughy, & Howell, 1987).

Clinical Interviews

Interviews are the most common method for assessing anxiety disorders in youth. Numerous interview schedules have been developed and tested. Semistructured interviews for the assessment of anxiety disorders in children and adolescents provide a structured interviewing format, while also allowing for elaboration from informants as judged appropriate by a diagnostician.

We use the Anxiety Disorders Interview Schedule for Children—Parent and Child Versions for DSM-IV (ADIS-C/P; Silverman & Albano, 1997). This semistructured diagnostic interview is administered separately to parents and children. Although targeting anxiety disorders; the ADIS-C/P also assesses mood disorders externalizing disorders, and pervasive developmental disorders, providing information on possible comorbid conditions. Based on the symptoms, distress, and interference reported during independently administered child and parent interviews, the diagnostician assigns a composite Clinician Severity Rating (CSR) ranging from 0–8. CSRs of 0 indicate that no symptoms are present;

CSRs between 1 and 3 indicate subclinical levels of impairment; whereas CSRs between 4 and 8 indicate a diagnosable (clinically significant) level of distress and impairment.

The ADIS-C/P has demonstrated favorable psychometric properties, including excellent retest reliability (Silverman, Saavedra, & Pina, 2001), convergent validity (March, Parker, Sullivan, Stallings, & Conners, 1997; Wood, Piacentini, Bergman, McCracken, & Barrios, 2002), and good inter-rater reliability (Rapee, Barrett, Dadds, & Evans, 1994). The ADIS-C/P has also been demonstrated to be sensitive to treatment-related changes (Kendall et al., 1997; Silverman, Kurtines, Ginsburg, Weems, Lumpkin, et al., 1999).

Although the use of semi-structured interviews is beneficial in diagnosing anxiety disorders in children and adolescents, the lack of concordance between children and parents as informants is a concern (Choudhury, Pimentel, & Kendall, 2003; DiBartolo, Albano, Barlow, & Heimberg, 1998). Specifically, research finds that parent-child agreement on observable, nonschool based symptoms is higher than that for unobservable, school-based symptoms (Comer & Kendall, 2004; Herjanic & Reich, 1982), most likely due to parents having increased access to the former. Parent-child agreement may also be affected by age, as the reliability of child report tends to increase with age, whereas the reliability of parent reports tends to decrease as the child ages (Edelbrock, Costello, Duncan, Kalas, & Conover, 1985). Again, the use of semistructured interviews with parents and children as part of a multi-method assessment, in conjunction with self-report and other-report measures, is recommended.

Child Self-Report Measures

One of the most widely used methods for assessing youth anxiety is a self-report inventory. Numerous self-report inventories exist including the Multidimensional Anxiety Scale for Children (MASC; March et al., 1997), the Screen for Child Anxiety and Related Emotional Disorders (SCARED; Birmaher et al., 1999), the State-Trait Anxiety Inventory for Children (STAIC; Spielberger, 1973), the Negative Affectivity Self-Statement Questionnaire (NASSQ; Ronan, Kendall, & Rowe, 1994), and the Coping Questionnaire (CQ; Kendall, 1994). A selection of these measures is described below.

The MASC (March et al., 1997) addresses a multidimensional conceptualization of anxiety. This scale is a 39-item self-report inventory that assesses youth anxiety by examining four factors: physical symptoms (e.g., tension), social anxiety (e.g., rejection), harm avoidance (e.g. perfectionism), and separation anxiety. The factor structure has been shown to hold for boys and girls as well as for younger and older youth. In addition retest reliability for the MASC has been shown in past studies to be .79 in clinical samples (March et al., 1997) and .88 in school-based samples (March & Sullivan, 1999). Good three-month retest reliability has also been demonstrated (March & Albano, 1998).

The STAIC (Spielberger, 1973) consists of two separate 20-item inventories: the state scale, designed to assess present state and situation-specific anxiety, and the trait scale, designed to assess stability in anxiety across situations. Findings suggest that this measure is useful as a general screening instrument for anxiety (Barrios & Hartmann, 1988).

In addition to the self-report measures used to assess many of the general symptoms of anxiety, other self-report measures have been developed to specifically evaluate cognitive content, schemas and processes that have been implicated in the maintenance of anxiety (e.g., Ingram & Kendall, 1986, 1987). These measures include the NASSQ (Ronan et al., 1994) and the Coping Questionnaire (CQ: Kendall, 1994). The NASSQ examines the cognitive content of anxious children by measuring their self-talk. It measures the frequency of occurrence of negative self-statements on a 5-point scale and consists of separate items for younger and older children. The measure has been found to have good retest and internal reliability and to be sensitive to changes due to treatment (Kendall et al., 1997). The CQ assesses the child's perception of her ability to cope in stressful, anxiety-provoking situations, using three child-generated stressful situations. The CQ-C is sensitive to treatment gains (Kendall, 1994; Kendall et al., 1997).

Self-reports allow for a cost-effective examination of anxiety symptomatology. However, results from self-reports with children must be interpreted with caution for several reasons. Such measures may not adequately capture fears specific to the individual child (Kendall & Ronan, 1990), preventing the individualization of treatment. In addition, self-report instruments do not often account for developmental variability in comprehension—i.e., younger children may not be able to understand the questions posed or their corresponding response scales. Anxious children may respond in a socially desirable manner due to fear of negative evaluation, calling into question the validity of their self-report responses. The measures described herein may be less

troublesome because each has a corresponding parent report form, which can be used in conjunction with child self-report.

Parent and Other-Report Measures

In addition to parent reports on the parent versions of child self-report measures just described (e.g., MASC-Parent, CQ-Parent), the impact of the child's anxiety on daily functioning can be assessed using the Child Anxiety Impact Scale-Parent Version (CAIS-P; Langley, Bergman, McCracken, & Piacentini, 2004). The CAIS-P measures functioning in a variety of domains and is comprised of three subscales: school, social, and home/family. The CAIS-P has demonstrated good internal consistency and construct validity, and results indicate that it is a useful measure of the impact of anxiety on child functioning (Langley et al., 2004).

The Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983; Achenbach & Rescorla, 2001) is a parent rating scale (118-items) that assesses behavioral problems and social and academic competence. Although the CBCL does not differentiate between specific anxiety disorders, it discriminates between externalizing and internalizing disorders and provides information on the child's participation in social activities and peer interaction. The CBCL has been shown to effectively discriminate between youth with internalizing and externalizing disorders (Seligman, Ollendick, Langley, & Baldacci, 2004; see also Aschenbrand, Angelosante, & Kendall, 2005).

The Teacher Report Form (TRF; Achenbach & Rescorla, 2001) is a version of the CBCL designed for completion by teachers. The TRF allows for assessment of the child's

classroom functioning and is useful in contrasting the child's behavior at home and at school. The TRF is particularly useful when assessing children whose primary concerns revolve around social interaction, classroom performance, or evaluation by peers. As with the CBCL, the TRF does not provide diagnostic clarity in regard to different subtypes of anxiety disorders.

The use of parent-report or other-report measures in the assessment of anxious children has some limitations. As described in Comer and Kendall (2004), parents or teachers may not be fully aware of the extent of the child's anxiety symptoms. Many of the child's observable anxiety symptoms may occur outside of parents' visibility, such as at school or when interacting with peers. Parents who are prone to anxiety themselves may also be more likely to over-report their child's anxiety symptoms (see Frick, Silverthorn, & Evans, 1994). Conversely, some parents may be likely to under-report symptoms either because they are unaware of the extent of the child's anxiety symptoms or they are concerned with providing socially desirable responses. Again, we recommend a multi-method assessment procedure that compiles information collected from various sources.

THE TREATMENT MANUAL

The *Coping Cat Program* (Kendall & Hedke, 2006a, 2006b) is an integrated cognitive behavioral treatment for youth with anxiety disorders, specifically GAD, SP, and SAD. The program incorporates exposure tasks, relaxation training, and role plays with an added emphasis on the child's cognitive information processing associated with her anxieties. The

overall goal of the program is to teach youth to recognize signs of anxiety and use these signs as cues for the use of anxiety management strategies.

The treatment manual (Kendall & Hedtke, 2006a) describes CBT components such as psychoeducation, relaxation training, building a coping model, problem solving, contingent reinforcements, modeling, exposure tasks, and weekly homework. All are integrated within sessions of the 16 session treatment.

Psychoeducation

The psychoeducation component helps youth identify and discriminate their own (and others') emotional states. Many youth with anxiety experience physical symptoms, such as stomachaches or headaches, which they may attribute to an illness (as opposed to anxiety). Through psychoeducation youth are taught to discriminate when their somatic symptoms (i.e. headache) may be due to anxiety or illness by looking at the context in which these symptoms occur (i.e. only before reading aloud in front of the class). Other emotions are identified, named, and skills in their recognition are taught.

Relaxation

Practice in relaxation teaches youth to develop awareness and control over their own physiological and muscular reactions to anxiety. This procedure involves tensing and relaxing various muscle groups in order to allow the child to perceive sensations of bodily tension and to use these sensations as cues to begin relaxation. This increased awareness of somatic

reactions to tension enables the child to use the aroused physical state as a warning signal to start the relaxation procedure.

Building a Coping Template

Throughout the program, youth are coached on how to think about anxious arousal. This involves the identification and modification of maladaptive self-talk, along with building a new way to view situations. The goal of building a new template for thinking is not that perceptions of stress will disappear, but that the formerly distressing perceptions and arousal, when seen through a coping template, will serve to prompt the use of coping strategies.

Problem Solving

The overall goal of problem solving is to teach children to develop confidence in their own ability to help themselves meet daily challenges. Children are shown that problems are part of everyday life and they are encouraged to inhibit their initial impulses (e.g., avoidance behavior). Problem solving involves helping the child define and formulate the problem into a workable situation with goals and alternatives. The therapist models brainstorming by generating both pragmatic and even improbable solutions. The child then evaluates the advantages and disadvantages of each solution—and is soon better equipped to select alternative solutions to problems.

Contingent Reinforcement

Reinforcement focuses on facilitating responses through reward. Many anxious children have unjustly critical beliefs

and through contingent reinforcement the therapist emphasizes the importance of rewarding oneself for effort and partial success. Reinforcement provided contingent upon effort and nonavoidance help to modify and reduce anxious behavior.

Modeling

Modeling appropriate nonanxious behavior in anxiety-provoking situations is a main task for the *Coping Cat* therapist (see Nelson & Kendall, 2007). Through various role-plays the therapist models behavior appropriate to anxiety-provoking situations.

Exposure-Based Procedures

Exposure tasks involve placing the child in a fear-provoking situation, either imaginary or in vivo, helping her to acclimate, and providing opportunities for the child to use coping skills. The therapist works with the child to design a hierarchy of exposure tasks and the child gradually makes his or her way through the exposure tasks going from low anxiety provoking situations to high anxiety provoking situations. It is important that the child is able to have some degree of success in each exposure in order to build a sense of self-confidence and mastery.

A Feelings Thermometer (aka the Subjective Units of Distress [SUDS] rating) is a tool that the child uses to rate her anxiety on a scale from 0–8 during an exposure task. Please see the *Coping Cat* manual (Kendall & Hedtke, 2006a) for more details.

Show That I Can (STIC) Task

STIC tasks are weekly homework assignments to be completed outside the therapy setting. They provide the child with an opportunity to practice the skills learned in session. The child is rewarded for STIC task completion.

THE TREATMENT MANUAL WITH CASE ILLUSTRATIONS

To help bring the *Coping Cat Program* (Kendall & Hetdke, 2006a) to life, ¹ we introduce two fictitious youngsters, Katie and Matt. As we describe each of the 16 sessions, we illustrate the treatment using Katie and Matt.

Katie, a 7-year-old female diagnosed with separation anxiety disorder, is afraid that bad things will happen to her mother and these worries are so distressing that she has difficulty being away from her mother for even brief periods of time. Katie attends first grade and makes multiple trips to the nurse's office with complaints of stomach and headaches. She calls her mother almost daily from school to check on her and Katie's mother reports that she picks Katie up from school early because of these physical complaints about once a week. Katie also has difficulty sleeping by herself and her mother sleeps with her most nights. Recently Katie has been invited to go on play-dates at friends' houses but she refuses to go without her mother. During intake, Katie had difficulty being in the interview room without her mother.

Matt, a 12-year-old boy, was diagnosed with social phobia. He is easily embarrassed, and afraid that others will laugh at

him when he interacts with them. He fears reading aloud in class, joining in a conversations, talking on the phone, asking questions, or speaking to strangers. Matt's distress impairs his social function; it gets in the way of his making/keeping friends. His distress is highly impairing to Matt, and gets in the way of his making/keeping friends. When Matt is faced with a social situation, he perspires and has difficulty maintaining eye contact. His heart beats very quickly and he finds it difficult to breathe. Matt expects that those around him will laugh at him if/when he speaks.

Session 1: Building Rapport

A main goal of the first session is to build rapport and get to know each other. The child-therapist relationship is important. We recommend that the first part of the session not focus on the child's anxiety—the time is best used by getting to know one another. Once that has been accomplished, the therapist can spend time introducing the child to an overview of the program. For example, the therapist can share logistics with the child (e.g., how often the two will meet) and discuss goals for the program. Time can be spent explaining to the child that the first eight sessions focus on recognizing anxiety, and the later sessions focus on knowing what to do about feeling anxious. Once the therapist has introduced the program, it is important for the child to feel free to ask any questions. This encourages the child's participation in the treatment, and puts an emphasis on the therapist and child being a collaborative 'team' working together.

At the end of the session the child is assigned an easy STIC task (homework) from the *Coping Cat Workbook* (Kendall &

Hedtke, 2006b) and a reward is planned for completing the task. To illustrate, let's take a look at Matt's first session.

Matt enters the therapy room with his eyes cast downward. He sits hesitantly in a chair, and waits—what is going to happen? The therapist invites Matt to make himself comfortable and to look around and see if there are any interesting games that he would like to play. Matt searches the room and finds some video games. The therapist lets Matt know that they will save time (e.g., the last ten minutes) to play Super Mario Kart together. The therapist thanks Matt for coming and they engage in a “getting to know one another game” (asking each other questions). During this period, the therapist sees Matt start to relax.

After spending the first half hour getting to know one another, the therapist introduces Matt to some of the logistics of the *Coping Cat Program*. She lets him know that he will be coming in weekly, and that they are going to be doing some team work. Matt has told her that he worries about reading out loud in class, and the therapist tells Matt that they will be working on some skills that can help kids when they are feeling worried or scared. She tells him that in the beginning, they will simply focus on figuring out *when* he is worried—later on they will work on what to do about feeling worried. The therapist makes it a point to laugh and be comfortable with Matt, and to be encouraging when he talks or asks questions.

Matt is assigned a STIC task (Remember my name), and the therapist and Matt spend the last ten minutes playing Super Mario Kart (as promised).

Session 2: Identifying Anxious Feelings

The aim of this session is to help the child identify different feelings—to distinguish anxious or worried feelings from other feelings. To do this there is discussion about how different feelings have different physical expressions. The therapist and child collaborate to list various feelings and their corresponding physical expressions (in the *Coping Cat Workbook* pp. 6 and 8). Relatedly, they work to identify the child's own somatic responses to anxiety. Once the child understands that different feelings correspond to different expressions, the therapist works with the child to normalize the child's own experience of fears and anxiety. The therapist serves as a coping model by disclosing a time when the therapist felt anxious and how she handled it. The child and therapist discuss the child's own anxiety, including the types of situations that provoke anxiety, and the child's responses in the anxiety-provoking situation.

The therapist introduces the Feelings Thermometer—used to determine which situations are more anxiety provoking for the child (see the therapist manual for details). The therapist and child construct a fear hierarchy or fear ladder using the ratings from the Feeling Thermometer. Katie's [Session 2](#) is an illustration. Just to refresh our memory, Katie is our seven year old female with SAD.

Katie is hesitant to be in the therapy room without her mother. After a review of what is going to happen and a firm and confident reminder that her mother will be in the next room, Katie is able to stay alone with the therapist. The session

begins with a review of the STIC task and Katie and the therapist discuss the “feeling-great” situation that Katie recorded in her Coping Cat workbook. The therapist talks with Katie about how different feelings have different physical expressions. Katie and the therapist play a game, using pictures from magazines, to label pictures of people showing different emotions. Katie and the therapist identify certain facial or physical expressions (e.g., a smile, a clenched fist) that match to certain emotions (e.g., feeling happy, feeling angry). They discuss the idea that all people feel anxious at times and the purpose of the program is to help Katie learn to recognize when she is feeling anxious and how to make herself feel better.

Katie and her therapist start to construct a hierarchy of anxiety-provoking situations by categorizing the things Katie is afraid of into easy, medium, and challenging categories. Katie identifies being in the therapy room without her mother as a medium fear and going to a birthday party where her mom drops her off and leaves as the most challenging fear.

Before the session ends Katie is assigned a STIC task to complete at home—she is to record one anxious experience and one nonanxious experience in her Coping Cat workbook.

Session 3: What’s That Your Body Is Saying?

This session emphasizes teaching the child to identify how her body responds to anxiety. A variety of techniques are used, culminating in the “F” step of the FEAR plan.

To begin, the child and therapist review the STIC task and an appropriate reward is given. If the child didn't do the STIC task, they do it then, together. Next, the therapist spends some time talking about somatic feelings that might occur when someone is feeling anxious, such as heart racing or an uneasy stomach. The child and therapist talk about different bodily sensations that may occur when an individual is faced with an anxiety provoking situation. Once the child is able to name some somatic responses that might occur, the child and therapist practice identifying these responses (via coping modeling and role-playing). The pair practice identifying somatic responses in various anxiety provoking situations, starting with the least anxiety provoking situation. When the child displays comfort identifying somatic feelings, it's time to introduce the "F" step. The "F" step stands for: Feeling Frightened?

At the end, the child is reminded that the next meeting will be with her parent(s). A STIC task is assigned based on tasks covered in the *Coping Cat Workbook* and a game is played to end session on a fun note.

When Matt comes in today, he is feeling slightly less anxious than last time—he is beginning to learn the ropes. The therapist and Matt start the session by reviewing Matt's STIC task.

They then focus on today's session: Identifying somatic expressions of anxiety. The therapist talks about possible bodily expressions of anxiety such as sweating, or getting red in the face. Funny, exaggerated examples make both laugh. The therapist asks Matt to think about possible ways someone might respond when anxious. Matt mentions having his heart

beat quickly when he has to read in front of his class. Together, they discuss what kinds of somatic feelings they have during low anxiety provoking situations, medium anxiety provoking situations, and high anxiety provoking situations. This helps Matt zero in on what his body is telling him when he is feeling nervous. The therapist acts as a coping model for part of the session by letting Matt know what happens to her when she feels anxious. She introduces this process of learning to listen to your body as the “F” step.

At the end of session, Matt is reminded that next session will be with his parent(s). The therapist checks with Matt about any information he shared with her that is off limits (not to be discussed with parents). A STIC task is assigned for Matt’s next session and they play Super Mario Kart together for five minutes.

Session 4: First Parent Meeting

The goal of the first parent session is to facilitate parental cooperation and collaboration with the program, and to gather parent input. The therapist and parent(s) meet without the child to provide the parent(s) the opportunity to discuss any concerns they may have and to consider specific ways that the parent(s) can be involved in the program. The parents serve as consultants (i.e., provide the therapist with information about the child) and as collaborators (i.e., help with implementation of the program). During this parent session the therapist provides additional information about the program and gathers information about the parents’ own understanding of anxiety. Let’s turn back to Katie for an example.

The therapist meets with Katie's mom because Katie's dad is unable to attend. The therapist briefly outlines the treatment program and explains Katie's involvement so far and what will happen in the remainder of treatment.

Katie's mom has lots of questions about the things that Katie is going to be required to do and asks the therapist if she can sit in during the sessions so that she can help her daughter. The therapist recognizes that Katie's mother has been supporting/maintaining Katie's anxious avoidance (e.g., picking her up from school early). Katie's mom may not understand that although she is trying to help, her involvement in this way hinders Katie's progress. The therapist uses this opportunity to discuss with Katie's mom her own anxiety as well as the ways that she can be involved in treatment to help Katie. The therapist talks with Katie's mom to learn more about situations where Katie becomes anxious.

Session 5: Learning How to Relax

Prior to embarking upon the main goal of [Session 5](#) (learning to relax), it is useful to briefly discuss the parent session with the child. Let the child know that her parents are very proud of her, and allow the child to ask any questions that may come up about the parent session. After discussing the parent session with the child, review the STIC task from [Session 3](#) and reward the child.

Review the "F" step as you introduce the main topic of today's session: relaxation. The therapist may suggest to the child that when she is feeling anxious, her body gives her

signals or cues. These signals may be associated with tension, which can be reduced by relaxation. The therapist explains relaxation, as well as useful ways to bring about this feeling. For example, deep breathing, progressive muscle relaxation, and relaxation aids such as relaxation CDs. It is useful to practice relaxing with the child (with the therapist as a coping model).

Once the child understands how to help herself become more relaxed, the therapist and child collaborate to identify when relaxation may be useful. For example, it is unlikely that the child can engage in full progressive muscle relaxation each time she is feeling anxious. However, the child may recognize that taking a few breaths and relaxing certain muscle groups might be useful. To end the session, the STIC task is assigned, and the therapist and child take a few moments to play a fun game or activity. Let's turn to Matt and see how he learns to relax.

When Matt arrives his therapist talks to him about last week's parent session. She tells him that his parents are very proud of him and support him every step along the way. Time is left for Matt to ask questions. After this, they go over Matt's STIC task and Matt trades in his points for a small soccer ball.

Today, the therapist is introducing relaxation as a technique for Matt to use when he feels anxious. She talks to him about how sometimes, when he has to speak in public or read aloud, his body gets tense. He agrees. She links this to the "F" step (Feeling frightened?) of the FEAR plan. The therapist explains that Matt's body provides cues when he is feeling nervous and they are signals for him to relax. The therapist

asks Matt to imagine a situation where he is feeling relaxed and then to imagine a situation where he is feeling tense, and to compare the feelings.

Next, they practice deep breathing. The therapist asks Matt if he wants to turn down the lights—he does, and sits comfortably on a bean bag chair. She asks him to take a deep breath and then let it out slowly, focusing on how his body feels. They do this together a few times. She highlights to Matt how her body feels and how his might feel after taking deep breaths. She gives Matt a copy of his own relaxation tape, with the therapist's voice to help him practice these skills at home. They practice these skills together and then Matt's parents join. Matt is asked to teach relaxation to his parents.

At the end of the session, the therapist assigns Matt his STIC task from the Coping Cat Workbook, and they play a game of Super Mario Land together.

Session 6: Identifying and Challenging Anxious Self-talk

Session 6 introduces the role of personal thoughts and their impact on anxiety. The therapist uses pictures with blank thought bubbles to generate thoughts that might occur with different feelings. Through exercises in the *Coping Cat Workbook* (pp. 22–24) the child provides thoughts that could accompany various events. The therapist and child discuss self-talk, and the therapist facilitates the connection between thoughts and anxious feelings. Importantly, they work together to discriminate anxious self-talk from coping self-

talk. The therapist models coping self-talk. During this session the “E” step of the FEAR plan is introduced. Expecting bad things to happen? The child and therapist practice coping self-talk using the first two steps in the FEAR plan.

Katie and the therapist begin their session by reviewing the STIC task from last week. Katie reports that it was hard for her to relax when she was thinking about being away from her mom but after she listened to her relaxation tape at home two times she was able to relax.

Katie and the therapist discussed the anxious and nonanxious situations that Katie wrote about in her *Coping Cat Workbook* and the therapist called Katie’s attention to the expectations and thoughts she reported in these situations. The therapist talks with Katie about the idea that thoughts are connected to feelings. Katie and the therapist work on a thought bubble exercise in Katie’s workbook and during this exercise the therapist helps Katie differentiate between anxious self-talk and coping self-talk.

The therapist introduces the “E” step (Expecting bad things to happen) of the FEAR plan and helps Katie start to pay attention to what she is expecting might happen when she is anxious. Katie and the therapist practice coping self-talk and review the “F” and “E” steps of the FEAR plan. Katie is assigned a STIC task and the session ends with a game of Connect Four, one of Katie’s favorites.

Session 7: Attitudes and Actions I Can Take to Help Myself Feel Better!

At the beginning, the therapist and child review the STIC task assigned in the *Coping Cat Workbook* and the child is rewarded appropriately. At this point it is also helpful to discuss the child's use of relaxation over the past few weeks. The therapist and child engage in a brief relaxation exercise and review the "F" and "E" steps. The therapist reminds the child that F and E allow the child to recognize how her body responds to anxiety and to recognize expectations that she may have about the situation.

The next step introduces the child to how she may change her reactions so that she may proceed even when feeling anxiety. The "A" step stands for Attitudes and Actions that can help. Now that the child recognizes anxious arousal and thoughts, she can begin to deal with them. This session focuses on problem solving as a tool to deal with anxiety. Problem solving is a process. First, the child identifies what is making her feel anxious. Second, the child speculates what she might do to make the situation less anxiety-provoking. Third, the child identifies possible solutions that make sense. Last, the child selects the solution which makes the most sense, and proceeds.

The first use of problem solving should be easy and least anxiety-provoking. The therapist can begin with a problem that is concrete and relevant to the child, and show the child how to apply the problem solving process. The therapist slowly builds to practicing problem solving in more and more anxiety provoking situations.

Towards the end, homework is assigned and the therapist and child engage in a fun activity. Let's take a look at Matt in [Session 7](#).

Matt and the therapist began by going over the STIC task and discussing Matt's use of relaxation over the past week. Matt let the therapist know that deep breathing helped him before he had to ask a friend about a homework assignment. It didn't help him as much when he had to read out loud in class. The therapist and Matt discuss possible reasons why this might be the case.

Next, the therapist reviews the "F" and "E" step with Matt by asking him to describe what they stand for. She introduces the idea that now that he knows how to make sense of his body and mind, he can learn how to cope with anxiety. She explains about the "A" step, which stands for "Attitudes and actions that can help." To illustrate the "A" step, the therapist discusses the process of problem solving. The therapist models problem solving by discussing a nonthreatening situation. She gives the following example: "You've misplaced your jacket somewhere at school. How would you try and find it?" She then thinks through this situation with Matt. Then, Matt tries to problem-solve a few different situations, including some that are anxiety-provoking situations.

To end the session, Matt is assigned his STIC task, and the therapist and Matt play a game of Jenga.

Session 8: Results and Rewards!

Session 8 introduces the last step of the FEAR plan: “R” Results and rewards. The child is introduced to the concept of rating performance and rewarding oneself for effort. The therapist talks about self-reward and the pair discuss the concept of self-rating and being satisfied with one’s effort.

The child and therapist collaborate on a list of rewards (e.g., going to the movies with friends, getting a new book or game) and specify what is required to earn the rewards. The therapist serves as a coping model by describing a situation where she experiences some distress but was able to cope with the anxiety, rate herself, and then give herself a reward. Before the end of session the child and therapist identify a stressful situation and apply the FEAR plan to get them through it.

The therapist informs the child that the next part of the treatment program involves practicing the skills that have been learned so far. The child and therapist will practice using the FEAR steps in situations where the child might be anxious or worried. The child is assured that the practice will happen gradually, starting with a situation that makes the child a little nervous. It is important to let the child know that the goal of treatment is not to remove all of the child’s anxiety but to help the child identify it and cope with the anxiety. The therapist informs the child that she will experience some anxiety during these practice sessions but by going through the FEAR steps the child will be able to manage the anxiety. Let’s now turn back to Katie.

Katie and the therapist begin by reviewing the STIC task from session 7. They discuss the plan of action that Katie has been working on when she is faced with an anxiety (e.g., being in school without her mom or sleeping in her bed alone). The therapist introduces the final step in the FEAR plan “R”—Results and rewards. The therapist talks with Katie about how people reward themselves when they are pleased with something they have done. Katie and the therapist create a list of rewards (e.g., stickers, time reading with mom) and identify scenarios in which Katie can earn rewards (e.g., making it through the school day without going to the nurse’s office).

Katie and her therapist practice making self-ratings through role-plays. They review the steps of the FEAR plan and together create a FEAR card for Katie to keep with her when she is anxious. Katie and her therapist review Katie’s fear hierarchy which includes walking into session without mom, having one day at school where she doesn’t call her mom from the nurse’s office, sleeping in her bed alone for one night, and finally attending a party without her mom.

The pair discuss that the next part of treatment involves practicing the things that Katie has learned. The therapist explains to Katie that she may feel anxious during the practice tasks but she can use the FEAR plan to help her get through them. The therapist tells Katie that she is going to meet with her mother again next time and asks Katie if there is anything that she doesn’t want the therapist to talk about with her mother. The therapist assigns Katie a STIC task and at the end of session they read a few pages in a book that Katie brought from home.

Session 9: Second Parent Session

The second parent session provides an opportunity for the parent to learn more about the exposure tasks part of treatment. The therapist explains that these tasks provide opportunities to make sure the child practices the skills that have been learned.

Specifically, the therapist explains the rationale behind exposure tasks. The parents are reminded that the goal of treatment is not to “cure” anxiety, but to reduce the amount of distress experienced in previously anxiety provoking situations. This is accomplished through the repeated practicing of the FEAR plan in anxiety provoking situations. Parents are introduced to the idea that the child will likely feel some initial anxiety during the exposure tasks, and that this is beneficial because when the child applies her new skill set and experiences success, the anxiety is reduced and this improves her confidence and reduces anxiety in general.

Once the therapist has covered the key points regarding the exposure tasks, the parents are given an opportunity to ask questions. It is useful to encourage the parents to suggest situations in which they have noticed their child becoming anxious. Finally, the therapist may want to solicit the parent’s assistance in the planning of exposure tasks at home. Let’s see how Matt’s parents fare in [Session 9](#).

Today’s session is dedicated to introducing Matt’s parents to the exposure tasks portion of his treatment. Both parents are able to attend, and they arrive on time. The therapist begins by spending some time catching up, and then outlining the

remainder of treatment. She highlights that Matt now has a way to cope with anxiety in social situations and that he will get to practice. By facing his anxiety he will gain mastery over his fears and lessen his anxiety in the future.

The therapist introduces the idea that exposure tasks are the best way for Matt to practice his new skills, and that it is normal for him to feel initial anxiety in these situations. At this point, Matt's mother interjects and asks if he is going to feel very upset. The therapist lets his mother know that the exposure tasks move at a very gradual pace, and that they will start with the least provocative one. Matt's father asks if Matt will be cured and the therapist tells Matt's father that the aim of the treatment is not to cure anxiety, because we all experience anxiety at one time or another, and in fact it can have an adaptive function. However, treatment is going to bring Matt's anxiety down to a normative level so that he can participate in social situations without feeling excessive distress.

Finally, the therapist asks if there are any particular situations that the parents can think of in which Matt needs practice. They volunteer reading aloud, calling friends on the phone, and joining in on conversations. The therapist tells Matt's parents that she may be involving them in some of the planning of exposure tasks and encourages them to call if they have questions or concerns.

Session 10: Facing Your FEAR: Low Anxiety-Provoking Situations

Session 10 involves “practice” (an exposure task) using the FEAR plan in a low anxiety situation. It is important for the child to have at least partial success.

The therapist and child talk about how the focus will shift from learning about thoughts and feelings to practicing coping in different situations. The therapist and child pick a low anxiety-provoking situation and practice using the FEAR plan through an imaginal exposure. Together they write out the child’s FEAR plan for the specific situation in the *Coping Cat Workbook* (p. 44) and walk through all the steps during the imaginal exposure task. The child is asked for ratings on the Feelings Thermometer at different times during the imaginal exposure.

Once the child has walked through her FEAR plan in an imaginal exposure task, the child and therapist move to an in vivo exposure task (going into the real situation). They review relaxation exercises to remind the child that relaxation (i.e., taking a few deep breaths) can be a first response to feeling anxious.

Katie and the therapist begin by talking about how much Katie has improved in terms of coping and managing her anxiety as well as rewarding herself for her progress. Katie reported that she went to the nurse’s office today because she had a stomachache but when she got there she was able to use her FEAR card. After doing some deep breathing and having a glass of water she returned to the classroom without calling

her mom. The therapist praises Katie for her success at school and rewards her with a sticker of one her favorite characters, Ariel, from the Little Mermaid.

The therapist explains to Katie that today they are going to work on practicing the FEAR plan by imagining a situation that might make her a little anxious, such as having Katie imagine staying alone in the therapy room with the lights out for two minutes.

Katie and the therapist develop a FEAR plan for coping with the task and decide on a reward to be given for completing it. Katie and the therapist first practice the FEAR plan while imagining the situation. The therapist has Katie close her eyes and pretend that she is in the room alone. Katie explains the FEAR plan to the therapist saying that first she is going to ask herself if she's feeling frightened, what she is expecting might happen, what actions she can take, and how she will reward herself. Katie is able to successfully describe all the steps of the plan and completes the imaginal exposure task.

Katie and her therapist prepare for the in vivo exposure task. Throughout both the imaginal and in vivo exposure tasks Katie rates her own anxiety using the Feelings Thermometer. Katie is able to stay in the therapy room for two minutes with the lights out and as a reward Katie and the therapist find a comfortable spot to sit and read a chapter from the Little Mermaid. Before Katie leaves she completes a brief relaxation exercise and she and the therapist plan an exposure task for the next session. Katie is assigned a STIC task to review and to practice the FEAR plan in at least one anxious situation over the coming week.

Session 11: Facing Your FEAR: Low Anxiety-Provoking Situations

This session continues exposing the child to low anxiety-provoking situations. Session begins by reviewing the STIC task and the child is rewarded appropriately.

In this session the child practices coping with distress in several low anxiety-provoking situations. To prepare for each, the therapist and child develop a FEAR plan and record it in the *Coping Cat Workbook*. Once a FEAR plan is designed, the child role-plays its use in session. Finally, the child actually participates in the exposure task while using the FEAR plan. The child and therapist provide a rating of the child's anxiety and, after the exposure task, the child receives the planned reward.

The last part of session is to plan the exposure task for the next session (there will be an increase in difficulty) and the STIC task is assigned.

Matt comes in today feeling nervous about continuing the program. Last session, Matt and the therapist planned that the exposure for this week will be calling his grandmother on the phone. Using the phone is anxiety provoking for him because he worries about being unintelligible, not knowing what to say, or saying something stupid. He feels more comfortable calling his grandmother than phoning a friend.

Session begins with reviewing last weeks STIC assignment. Then the therapist and Matt begin preparing for calling his grandmother on the phone. They come up with a FEAR plan

for this exposure, thinking through all the steps. Matt identifies that his body may be sweaty, and that he is worried that his grandmother may not be able to understand him. He comes up with the coping thought that his *grandmother will still care about him even if she is unable to understand him*, and problem-solves that he can repeat himself if he needs to. His reward will be spending time showing the therapist his latest book report (for which he received an A).

After designing the FEAR plan Matt practices calling his grandmother on a pretend phone. After this, it is time to actually give her a call. He picks up the phone and calls her, and gives the therapist SUDS rating before he makes the phone call, during each minute of the phone call, and after the call. Before beginning, his SUDS rating is very high (5), and it spikes even higher after the first minute. As he speaks to his grandmother about his day and gradually begins to immerse himself in the conversation, his SUDS ratings diminish. At the end he reports a SUDS rating of 1.

Matt and the therapist discuss what went well and what he might try in the future. Matt receives his reward—they share time reviewing his excellent book report. The pair plan the exposure task for [session 12](#), and the STIC task is assigned.

Session 12: Facing Your FEAR: Moderate Anxiety-Provoking Situations

In [session 12](#) the FEAR plan is applied in both imaginal and in vivo situations that produce moderate levels of anxiety for

the child. The therapist prepares for the imaginal exposure task by describing the chosen situation and collaborating with the child to develop a FEAR plan for it: Make the imaginal situation as real as possible. As a coping model the therapist (acting as the child) models thinking through the situation out loud using the FEAR plan. The child then creates a FEAR plan for a slightly different situation with the therapist prompting the use of the FEAR plan. Following the imaginal exposure task, its time to prepare for and engage in in vivo exposure tasks. The child and therapist prepare for these by developing a FEAR plan (please see [p. 53](#) in the *Coping Cat Workbook*), thinking through what might and might not happen and preparing for several likely aspects of the task. The therapist and child negotiate a reward for completion/effort. Let's check in on Katie and see how [session 12](#) unfolds.

Katie and the therapist start [session 12](#) by reviewing the STIC tasks that Katie was assigned. Together, they discuss two anxious experiences that Katie exposed herself to during the week and Katie describes how she coped with them and how she rewarded herself. Katie tells the therapist that this week she had four days where she didn't go to the nurse's office. Katie explained to the therapist that there were some days where she wanted to go to the nurse's office to call her mom but she was able to use her FEAR plan. Katie told the therapist that she had a stomachache because she was feeling frightened not because she was really sick. She told herself that bad things wouldn't happen if she didn't go to the nurse and as a reward she was able to stay in class where the students were working on their art projects, one of Katie's favorite activities. The therapist praised Katie for her effort using the FEAR plan and rewarded her with stickers.

Katie and her therapist discussed the practice situation that they were going to do today. The therapist spoke with Katie's mom during the week to arrange for her collaboration. For this task, Katie will go out to the waiting room and her mom will not be there (Katie's mom will actually be in another room down the hall). First Katie and the therapist practice, where Katie imagines what it would be like to walk into the waiting room and not know where her mom is. She takes the therapist through the steps of the FEAR plan, and they then undertake the real exposure task. Katie provides SUDS ratings throughout. Her SUDS rating is initially very high but as she goes through the steps of the FEAR plan her ratings decrease. Following this, Katie is rewarded and she and her therapist discuss the experience of the exposure task. Katie reports some new confidence, but also expresses concern that because of this confidence her mom may feel unwanted. Katie and the therapist discuss this, make sense of it (mom wants you to be confident) and comfort each other.

Session 13: Facing Your FEAR: Moderate Anxiety-Provoking Situations

This session begins by reviewing the STIC task and rewarding the child appropriately, and the session continues with practicing the FEAR plan in moderate anxiety-provoking situations. Together, the therapist and child come up with a FEAR plan that addresses the exposure task that was generated in [Session 12](#). Prior to participating in the exposure task, the child practices with the therapist using imaginal exposure. Subsequently the child engages in the task and

provides SUDS ratings. The child is rewarded for participation. The session ends by planning the next exposure task (a high anxiety-provoking situation) and the assigning of a STIC task. It is useful to mention to the child that there are only three sessions left, to mention the idea of the commercial, and to prepare her for the idea that she will be doing things on her own. Let's go to Matt's [Session 13](#).

Matt comes to session ready to engage in the planned exposure task. He has been having good success and is eager to move forward.

To begin, the therapist and Matt review the STIC task from [session 12](#), and Matt is rewarded appropriately. Next, Matt and the therapist develop the FEAR plan for the agreed upon exposure task for today—Matt will be reading a passage from a book in front of two members of the clinic staff. He anticipates that he will turn red, and expects that they might laugh at him if he mispronounces a word. However, his coping thought is that it is not likely that he will mispronounce a word since he has read the passage several times. And, even if he mispronounces something, it's no big deal. His reward will be getting ice cream with his therapist.

Matt practices reading the passage to his therapist and they discuss the FEAR plan. Matt is asked to describe how he is feeling while he practices.

Matt and the therapist go to a room where there are two clinic staff members whom Matt has never met before. He stands in front of them and reads a three minute passage. Afterwards, Matt and the therapist discuss how it went. Even though Matt turned a little red at first, and had a few anxious thoughts

while reading, he was able to get through it (thinking coping thoughts). Although Matt felt anxious initially during the exposure, he soon felt calmer and was very proud of himself for going through with it.

To end, Matt and the therapist congratulate each other, and then plan the exposure task for [session 14](#) which will be among the highest on his fear hierarchy. He is also assigned a STIC task.

Session 14: Facing Your FEAR: High Anxiety-Provoking Situations

[Session 14](#) applies the skills for coping with anxiety in imaginal and in vivo situations that produce high levels of anxiety in the child. Just as in previous exposure tasks, the child and therapist prepare by developing a FEAR plan. During the imaginal exposure the therapist uses props to help create a situation of high anxiety and encourages the child to describe a situation that she can role play with minimal help from the therapist. Before the real exposure task, the therapist is careful to ensure that the child includes a plan to ensure success. The therapist remarks on specific aspects of the situation that might generate anxiety and the child, who is the new expert, walks the therapist through the FEAR plan. The child provides SUDS ratings and is rewarded for both effort and completion. Let's see how Katie does in a high anxiety-provoking situation.

Katie and the therapist begin session by reviewing the STIC task and Katie is rewarded for practicing the FEAR plan during anxious experiences that occurred during the week: (1)

Katie's mom was late to pick her up from school one day (this had been arranged as an exposure task) and (2) Katie was able to stay in the house while her mom went to the store. Katie and the therapist prepare for today's exposure task which entails going for a walk around the office building with only the therapist, seeing mom and waving to her, but going back to the clinic without running up to mom.

Katie and the therapist practice the FEAR plan and the therapist helps Katie to identify aspects of the situation that may generate anxiety. Katie describes her feelings, somatic sensations, and self-talk regarding the upcoming task. Katie provides SUDS ratings before, during and after the exposure task and is rewarded for her effort. Katie and the therapist plan exposures for the remaining sessions with the help of Katie's mother. The therapist reminds Katie about the "commercial" that she can produce in the final session. The therapist explains that the commercial is something to show others what she has learned and to teach them about managing anxiety.

Session 15: Facing Your FEAR: High Anxiety-Provoking Situations

Session 15 continues to engage the child in exposure to situations that cause anxious distress. The session begins with a review of the STIC task. Additionally, the therapist and child discuss ideas for the commercial.

Most of session is spent preparing and engaging in the exposure task. The therapist and child prepare for it by designing a FEAR plan. Finally, the child engages in the

planned exposure task. The therapist and child discuss the child's performance afterwards and the child is rewarded. A last exposure task is planned for [session 16](#).

It is important to discuss the end of treatment. The therapist lets the child know that the next session is the last one, and remarks on the child's progress to date. To introduce this idea, it is useful to briefly summarize what the child has learned over the past 15 weeks, and to communicate confidence in the child's new abilities. Finally, the therapist assigns the last STIC task. In between this session and the last, the therapist gathers materials needed for the commercial. Let's check in on Matt.

To begin, Matt and the therapist review the STIC task. Unfortunately, Matt had a death in his family, was busy almost every night, and wasn't able to complete his STIC task. The therapist and Matt complete the STIC task together. Next, Matt and the therapist brainstorm ideas for the commercial. Matt says that he would like to do something involving basketball, so the therapist agrees to have a basketball hoop and a basketball on hand for the last session.

Most of the session today is spent on the exposure to a high anxiety-provoking situation. Matt and the therapist prepare for one of the situations highest on Matt's fear hierarchy: calling a classmate on the telephone. Matt and the therapist begin by talking about the FEAR plan for this particular exposure. They discuss how Matt's body might be feeling, what he might be expecting, and actions he can take to make himself feel better. They agree that his reward is staying up late this weekend (this was agreed upon by his parents prior to session).

After practicing with his therapist, Matt reports being ready to call a friend, Timothy. Although his SUDS rating is high, he picks up the phone and makes the call. The call goes through and he spends about five minutes on the phone with his friend. When he gets off the phone, he has a triumphant grin on his face, and is very excited that he was able to do it. The therapist and Matt discuss what was easier for him and what was more difficult. Together, they plan the last exposure, which will be reading aloud to a group of six people, including some who will be disinterested and some who will not understand what he is saying.

The therapist reminds Matt that the program will be completed soon. She tells him how proud she is of him and lets him know that she thinks he is ready to be on his own at school and at home. They talk a bit about Matt's feelings toward ending treatment. He is excited to be able to do activities that he wasn't able to do before, but he is sad about ending. She tells him that in a few months, she'd love him to call her on the phone and let her know how he is doing, and he agrees.

Session 16: Primetime!

Congratulations! You made it. The goal of the last session is to have a final practice using the FEAR plan and to allow the child the pleasures of “producing” a commercial. The commercial is where the child client celebrates and teaches others about the program and her successes. Prior to this session the therapist prepares the room for taping the commercial. The commercial should be fun and should be a

celebration of how far the child has come since the beginning of treatment.

After the commercial is filmed, the parents are invited to watch the commercial and the child, who is now the expert, reviews and explains the FEAR plan/acronym. It is important for the therapist to note that the child has made great gains, but there may be areas in need of improvement and that there will be times that are difficult in terms of coping with anxiety. In commemoration of the child's completion of the program she receives an official certificate of completion. Let's check in on Katie.

Katie enters the clinic by herself and explains to the therapist that her mom dropped her off and is parking the car. The therapist is exuberant, and praises Katie for coming into the clinic by herself. Katie explains that even though she was nervous about walking in without her mom she used her FEAR plan and was able to do it.

Katie and the therapist run through one final imaginal and in vivo exposure task and then Katie starts her commercial. Katie, with the help of her mother, has written a song about the FEAR plan—and the song is to the tune of *The Little Mermaid's* "Under the Sea." Katie practices parts of the song for the therapist and then she sings it though. Katie and the therapist show the recording to her mother. Katie, the therapist, and her mother review Katie's progress and discuss treatment termination. The session ends with a shared pizza to celebrate the gains.

Notes

1. We recommend that anyone interested in treating an 7–13 year old anxious child consult the therapist manual (Kendall & Hedtke, 2006a) and accompanying client workbook (Kendall & Hedtke, 2006b). For teens, see the related *C.A.T. Project* treatment materials. For more information about the printed materials and the training videos and DVDs, visit the website at www.WorkbookPublishing.com. For more information about the Child and Adolescent Anxiety Disorders Clinic (CAADC), visit our website at www.childanxiety.org.

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