

CHAPTER FOUR

Treatment of Generalized Anxiety Disorder

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Theoretical Foundations

Generalized anxiety disorder (GAD) is characterized by excessive, uncontrollable anxiety and worry about a wide variety of events and activities (Whitmore, Kim-Spoon, & Ollendick, 2014). The worry and anxiety associated with GAD are out of proportion to the feared event and typically, in youth, are accompanied by at least one physiological response such as restlessness, muscle tension, irritability, and difficulty sleeping (Whitmore et al., 2014). Worry in children is often conceptualized as repetitive thinking about threatening events happening in the future, the negative outcomes associated with those events, and their lack of ability to cope. Youth with GAD commonly worry about their health, the health of loved ones, school, personal harm, their family, dying, what others think, and social issues such as homelessness (e.g., Muris, Merckelbach, Meesters, & van den Brand, 2002; Weems, Silverman, & La Greca, 2000). DSM-5 has identified worries associated with competence and performance to be the most common among children with GAD (Whitmore et al., 2014). In our clinic, we often see children worrying about such things as taking tests, getting into trouble, or intruders breaking into their homes. Although worry

and anxiety are common experiences in youth, those with GAD find that their worries interfere with their daily lives and cause significant distress, making it difficult for them to go to school, sleep at night, and enjoy time with friends. They often excessively seek reassurance from others or try to do things perfectly as a means to quell their worries. These children experience more somatic symptoms and sleep problems than other clinically anxious youth without GAD (Ginsburg, Riddle, & Davies, 2006; Alfano, Ginsburg, & Kingery, 2007).

GAD typically begins early in life, with prevalence rates estimated between 0.47% and 5.9% (Ford, Goodman, & Meltzer, 2003), but children with GAD are understudied, in part due to the internalizing nature of their symptoms. As a result, there is limited information about the specific etiological or maintaining factors (Kertz & Woodruff-Borden, 2011). Emerging evidence supports the applicability of a metacognitive model of GAD (Wells, 1995; Wells & Carter, 2009) as applied to children's worry and anxiety (Ellis & Hudson, 2010). This model emphasizes the role of metacognitive beliefs in the development and maintenance of GAD. Accordingly, children's positive beliefs about the benefit of the worry, along with negative beliefs about the danger and uncontrollability of worry, are factors that maintain the worry and anxiety (Ellis & Hudson, 2010). For example, children may initially believe that their worrying helps them cope, but as their worrying increases in intensity, they may see worry as harmful to them and feel powerless to influence it, which then leads them to experience more anxiety and distress. This model supports the importance of treatment targeting how children think about their worry in addition to the worry itself. Later in this chapter we illustrate how to approach "thinking about thinking" with youth who may have difficulty understanding such cognitive and abstract concepts.

Preliminary evidence suggests that children who engage in excessive worry also tend to have difficulty tolerating uncertainty, have a negative problem orientation, and attempt to avoid threatening cognitive stimuli (Holmes, Donovan, Farrell, & March, 2014). These factors are thought to play a role in the development and maintenance of GAD (Dugas & Robichaud, 2007). Cognitive-behavioral therapy (CBT) for children with GAD incorporates attention to these factors. In this treatment, children may repeatedly engage in exposure exercises in situations that provoke feelings of uncertainty, helping them to develop new beliefs about their ability to tolerate uncertainty. Children with a negative problem orientation may have the ability to solve problems but doubt their ability to do so because they see problems as threatening and difficult (D'Zurilla & Nezu, 1999). CBT helps children to develop their problem-solving skills, to more realistically appraise problems and their ability to cope, and to successfully implement a problem-solving approach in anxiety-provoking situations. Children further engage in exposures to threatening cognitive stimuli, such

as images of harm, and conduct behavioral experiments to test their negative beliefs about worry.

More general theories of anxiety propose that early family influences and environmental events interact with temperamental vulnerabilities to strengthen or ameliorate children's maladaptive cognitive and behavioral strategies (Chorpita & Barlow, 1998). Some of the better known temperamental vulnerabilities associated with anxiety in youth include behavioral inhibition, negative affectivity, and harm avoidance (Mian, Wainwright, Briggs-Gowan, & Carter, 2011). Research has shown that children as young as 2 years of age who exhibit high levels of behavioral inhibition, a temperamental style characterized by fear and withdrawal in unfamiliar situations, are at risk for developing anxiety disorders (Kagan, Reznick, & Snidman, 1988; Biederman et al., 1990). Harm avoidance, a related temperamental trait, has been found to be associated with GAD in children and adults (Rettew, Doyle, Kwan, Stanger, & Hudziak, 2006). Negative affectivity, a temperamental trait characterized by difficulty being soothed, irritability, negative mood, and intense negative emotional reactions, has been linked to child psychopathology, including anxiety (Sanson, Hemphill, & Smart, 2004). CBT approaches to GAD provide psychoeducation to help children and families understand the role of temperament in their difficulties and how these tendencies can be affected by the use of more adaptive cognitive and behavioral strategies, environmental changes, and parenting practices.

A number of maladaptive behavioral and cognitive strategies have been identified in youth with anxiety disorders. From a behavioral perspective, children with anxiety disorders such as GAD experience anxiety as highly aversive and typically respond with avoidance of anxiety-evoking and related situations. Avoidance leads to short-term relief, but this relief (negative reinforcement contingency) increases the likelihood of future avoidance and future problems with anxiety (Gosch, Flannery-Schroeder, Mauro, & Compton, 2006). Anxious behavior, such as asking for reassurance or avoiding performance situations, may be positively reinforced, often unintentionally, by attention or rewards from significant others (e.g., parents, teachers). CBT for GAD in children incorporates relaxation training and cognitive strategies to help children manage their physiological arousal, providing an alternative to avoidance as a means to decrease arousal. Therapeutic exposure to anxiety-provoking situations provides children with the opportunity to habituate and develop more adaptive beliefs about threat and their ability to cope. A key component of CBT for child anxiety, contingency management (CM), provides positive reinforcement for approaching previously avoided situations and using adaptive coping strategies. In addition, efforts are made to stop reinforcing maladaptive behaviors such as reassurance seeking and avoidance.

Family influences associated with anxiety in children include parental

psychopathology, parenting style or practices, and parental modeling of anxious behavior and attitudes (Rapee, Schniering, & Hudson, 2009). Children with anxiety are more likely to have a parent with an anxiety disorder than children without anxiety (Burstein, Ginsburg, & Tein, 2010). Parenting styles associated with anxiety in youth include high levels of parental control, particularly control that limits or threatens the child's autonomy (overprotection, overcontrol), and low levels of parental warmth (rejection, criticism, low involvement or emotional support; McLeod, Wood, & Weisz, 2007; Borelli, Margolin, & Rasmussen, 2015). Recent reviews recognize that both the parent and the child play a role in creating a shared dynamic of parenting and childhood anxiety (e.g., Negreiros & Miller, 2014). For example, withdrawn child behaviors may evoke parental overprotection, and parental overprotection may limit the child's independent development. Often related to overprotective parenting and parental anxiety, anxious rearing can be described as encouragement of anxious cognitions and avoidance behaviors in children (Brakel, Muris, Bogels, & Thomassen, 2006). In a study of children with GAD, separation anxiety, and social phobia, parents' expectation of the child's threat bias and child-reported family dysfunction significantly predicted the child's self-reported threat bias (Blossom et al., 2013). Manassis et al. (2014) identified several parenting-related obstacles to treatment success that we have also encountered in our clinic, including parental anxiety, anxiogenic parenting styles, parental frustration with the child, and parents' tendency to inadvertently encourage avoidant coping.

As a means to address these obstacles in CBT for GAD, parents facilitate children's practice of skills (e.g., positive problem orientation, relaxation, positive self-talk) and therapeutic exposure in real-world settings, promoting generalization of skills. Parents are coached by therapists about how to appropriately prompt, encourage, and reinforce the adaptive behaviors (e.g., "brave" behavior), as well as how to withhold reinforcement for maladaptive behavior (e.g., asking for reassurance). Parents are encouraged to model coping skills and positive problem orientation, thus providing a positive example of how to experience anxiety/worry and cope with it. In our work with families, we encourage parental autonomy granting, support for independence, and less parental involvement as a means to increase children's self-efficacy and adaptive functioning.

Assessment

In youth, the assessment of anxiety disorders can be complex. Assessment of GAD in children requires multiple methods (e.g., interview, report inventories) and various informants, such as the child, parents, and teachers. Important areas to emphasize include the nature and intensity of the

anxiety symptoms, as well as the current socialization context (e.g., home and school). Functional behavioral assessment of situations in which the child struggles often yield valuable information as to conditions that trigger and maintain the child's anxiety. Particular antecedents and consequences may be associated with the child's adaptive and maladaptive responses. It is also critical to evaluate skill deficits (e.g., social skills, learning issues) that can underlie child anxiety, as these may need to be part of the focus of treatment. Specific to GAD, the child's perceived self-efficacy, sense of control, intolerance of uncertainty, and problem-solving orientation, as well as estimations about the probability of threat, the dangerousness of situations, and the magnitude of negative outcomes, should be evaluated.

A clear pretreatment picture can serve as the groundwork for effective treatment. Both structured and semistructured diagnostic interviews such as the Anxiety Disorders Interview for DSM-5, Parent and Child Versions (ADIS-5; Albano & Silverman, in press) allow clinicians to do a thorough assessment of mental health disorders. When time limitations preclude administration of the full ADIS-5, clinicians will still find the detailed diagnostic questions helpful in assessing particular disorders and symptoms associated with GAD.

In addition to diagnostic interviews, self-report inventories provide broad information but also information specific to anxiety symptoms. The present discussion will be limited to a few of the most well-known, standardized measures that possess sound psychometric properties. These inventories require only a short amount of time to administer and score, making them highly useful in clinical settings.

Several self-report scales can assist clinicians in discriminating between the various anxiety disorders, depression, and other disorders among children. Two well-respected measures for clinicians to consider include the Multidimensional Anxiety Scale for Children (MASC; March, Parker, Sullivan, Stallings, & Conners, 1997) and the Screen for Anxiety and Related Emotional Disorders (SCARED; Birmaher et al., 1999). The MASC, which has been evaluated favorably in several countries and cultures, offers a GAD index that differentiates children with anxiety disorders from those with depression or no disorders (Villabø, Gere, Torgersen, March, & Kendall, 2012). The MASC also provides information about specific factors of anxiety: physical symptoms, social anxiety, harm avoidance, and separation/panic anxiety. The SCARED is a child and parent report inventory that is consistent with the DSM-IV classification of anxiety disorders. Available for no cost online, this instrument measures several domains, including GAD, panic/somatic, separation anxiety, and school phobia.

In addition to assessing anxiety in general, it may be helpful to evaluate specific aspects of anxiety. The Severity Measure for Generalized Anxiety Disorder—Child Age 11–17 (10 items; Craske et al., 2013), the Penn State Worry Questionnaire for Children (14 items; Chorpita, Tracey,

Brown, Collica, & Barlow, 1997), and the Intolerance of Uncertainty Scale for Children (27 items; Comer et al., 2009; Read, Comer, & Kendall, 2013) enable clinicians to easily monitor key GAD symptoms over time, as they contain only a few items and are available online for no cost (for a fuller review of worry and intolerance of uncertainty measures, see Ginsburg & Affrunti, 2013). Another measure sensitive to change over time, the Coping Questionnaire (CQ; parent and child versions; Kendall, 1994), assesses the child's ability to manage three anxiety-provoking situations that are identified based on interview data. The child and parent rate the child's ability to cope with each on a 7-point scale (1 = "not at all able to help myself" to 7 = "completely able to help myself feel comfortable"). The Revised Fear Survey Schedule for Children—Child and Parent Versions (FSSC-R; Ollendick, 1983) allows clinicians to identify a child's specific fear sensitivities, providing information as to the focus of child worries. Another critical outcome measure is based on the development of a hierarchy of anxiety-provoking situations specific to each child. Standardized ratings of child anxiety and avoidance for each hierarchy item provide a means of monitoring improvement over the course of treatment.

Treatment

A strong research base supports the use of CBT for the treatment of anxiety, including GAD, in youth. Numerous randomized clinical trials (RCTs) have established the effectiveness of CBT for treating children with anxiety disorders, with 55–65% of treated youth no longer meeting criteria for an anxiety disorder following treatment (e.g., Dadds, Spence, Holland, Barrett, & Laurens, 1997; Kendall et al., 1997; Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Short, Barrett, & Fox, 2001; Walkup et al., 2008; Hudson et al., 2009). A few promising GAD-specific CBT protocols have been developed that place additional emphasis on the cognitive factors associated with worry, sleep problems, and perfectionism (e.g., Clementi & Alfano, 2013; Payne, Bolton, & Perrin, 2011). An RCT of the No Worries! Program, a group treatment for children with GAD, has provided evidence to support the efficacy of this approach (Holmes, Donovan, Farrell, & March, 2014; Holmes, Donovan, & Farrell, 2015), but there is need for further RCT evaluations.

Perhaps one of the most researched CBT protocols for treating anxiety in children, the Coping Cat program, combines a variety of behavioral strategies such as *in vivo* exposure tasks with cognitive strategies such as problem solving to help children cope with their anxiety (Podell, Mychailyszyn, Edmunds, Puleo, & Kendall, 2010). The program consists of 16 sessions that are described in a detailed therapist manual. The accompanying child workbook includes child-friendly activities for the child to complete

during and between sessions. The Coping Cat Parent Companion (Kendall, Podell, & Gosch, 2010) provides parents with psychoeducation about anxiety and their child's treatment program. The goal of Coping Cat is to teach children to recognize signs of anxiety and learn strategies to cope with anxiety-provoking situations. The program focuses on building skills to cope with anxiety (e.g., coping self-talk, problem solving) followed by practice using the coping skills through exposure to anxiety-provoking situations.

We have found specific strategies helpful when applying the Coping Cat protocol to GAD. Given the abstract nature of the cognitive components of GAD in youth, we find it beneficial to externalize the cognitive process by helping children create a character that incorporates their maladaptive cognitions, such as a "worry bug" or the "what if? monster." We find that youth can better recognize "thinking traps" and "talk back" to their maladaptive cognitions in this form. *In vivo* exposures may target perfectionism (e.g., handing in homework half completed), dealing with uncertainty (e.g., changes in family plans), and breaking rules/getting in trouble (e.g., running in the halls). To modify worry schemas, children may create a story or picture of the feared event (e.g., someone breaking into their home) and then add a ridiculous twist generated by the child (e.g., the burglar transformed into a unicorn bringing jelly beans to the child). As the child repeatedly reviews the story or picture, the emotional state associated with the cognitive content of the worry shifts, and anxiety tends to dissipate. To address being consumed with worries all day, we have children set a special "worry time" of 10 minutes each day. They may make a "worry box" in which they place a list of their worries and spend 10 minutes each day reviewing the worries with a parent. When they have a worry during the day, they acknowledge it and either physically or mentally put it in the "worry box" for review during the designated worry time. Often, when worry time rolls around, they have forgotten the worry or find it less distressing. Thus we encourage some strategic use of attention modification and mindful awareness but not suppression or avoidance of the fears underlying the worry. In addition to *in vivo* exposures, children with GAD frequently benefit from imaginal exposures to target abstract worries and fears of harm. For example, children suffering from GAD may worry about a death in the family or family financial problems. In these types of situations, imaginal exposure tasks asking the child to describe the situation in detail and discuss the fear can be beneficial (Kendall et al., 2005). The following case example illustrates a number of the aforementioned strategies in treating GAD in children.

Case Example

Robert was a 7-year-old Caucasian boy who entered treatment after an assessment using the Anxiety Disorders Interview Schedule for DSM-IV

(ADIS-IV; Silverman & Albano, 1996) confirmed diagnoses of GAD, separation anxiety disorder, and major depressive disorder, past episode in full remission. GAD was identified as the problem area of most concern. At the time, he lived in a major metropolitan area with his mother, father, and younger sister. His main worries concerned harm to himself. Robert worried excessively about burglars, murderers, and crime at night and was fearful of the “downtown” city area because “bad people” lived there. He also expressed worry about the future. For example, whenever he saw graffiti, he worried that he would grow up to do graffiti and “other bad things.” Robert would check the locks on the doors and the alarm system multiple times every night. Additionally, Robert worried excessively about world affairs and would become fearful upon overhearing crime stories on the news. His worries caused him difficulty concentrating and sleeping, as well as irritability.

At pretreatment screening, Robert’s total MASC score of 56 fell in the high average range, and his mother’s MASC rating of 47 fell in the average range. His score of 15 on the Children’s Depression Inventory (CDI; Kovacs, 1992) indicated a mild level of symptoms. Consistent with GAD, he endorsed items related to trouble sleeping, as well as worrying about aches and pains. Of note, he indicated that he was sure that bad things would happen to him, that he hated himself, and that he was not sure if anyone loved him. Robert indicated on the Coping Questionnaire (Kendall, 1994) that he had difficulty helping himself cope when he worried about his parents going out at night, when he worried about burglars, or when he worried that he had done something “bad.” Finally, on the Children’s Global Assessment Scale (CGAS; Shaffer et al., 1983), a numeric 1–100 scale used by clinicians to rate overall functioning (with 100 as optimal functioning), Robert was assigned a CGAS of 52, indicating that he had noticeable problems in numerous areas.

Robert was treated using the Coping Cat protocol (Kendall & Hedtke, 2006). Skills taught included somatic management, relaxation training, cognitive restructuring, and problem solving, followed by graded exposure tasks to practice acquired coping skills in situations involving the feared stimuli. Throughout the program, Robert learned to recognize, manage, and effectively cope with his anxiety. During the first eight sessions, the Coping Cat protocol uses the acronym of FEAR to describe the plan that children are taught to better cope with their anxiety. Each letter represents a step in the program, described herein as they unfolded in the skill-building phase with Robert. In addition, Show-That-I-Can (STIC) tasks serve as between-session assignments to bridge what was learned in session to the outside world (and thus consolidate treatment gains). Studies have shown that therapeutic homework assignments, frequently used in CBT, facilitate significant improvements (Burns & Spangler, 2000; West, Dozois, & Marcus, 2007; Hudson & Kendall, 2005). Time is spent at the beginning of each session reviewing the STIC task and reinforcing its completion.

Skill-Building Phase (Sessions 1–9)

Session 1: Building Rapport and Treatment Orientation

The goals of the first session are to orient the child and parents to the program, introduce and assign the first STIC task, and build rapport while encouraging the child's participation. In the first session, Robert presented as energetic, talkative, and occasionally hyperactive. The therapist first discussed with Robert and his mother the goals and structure of therapy and invited an open dialogue regarding any questions, comments, or concerns. The therapist then met with Robert alone and encouraged him to play a game of reciprocal questions so that they could get to know one another. The therapist discussed with Robert his overall goals of not being so stressed at nighttime and feeling safer in general. As DiGiuseppe (1989) points out, discussing a child's end goals in the beginning of therapy, rather than focusing on more specific session goals, is one way to build rapport. Robert was then asked if he would like to pick out a game to play. Robert came up with a drawing game to teach the therapist that he would choose to play at the end of every session as a sort of tradition for the remainder of treatment. The drawing game represented a reward for his work in each session. Helping the child to identify and create rewards early on in treatment is beneficial later when conducting exposures.

Session 2: Identifying Anxious Feelings

Children suffering from anxiety lack awareness of their ability to alter their emotions and the confidence to manage anxious experiences (Southam-Gerow & Kendall, 2000; Suveg & Zeman, 2004). The second session of Coping Cat is dedicated to building this awareness by teaching the child to identify and recognize anxious feelings while continuing to normalize the experience. The therapist first talked with Robert about how different feelings have different expressions in our bodies that can serve as clues for when we begin to feel bad. The following discussion took place:

THERAPIST: OK, Robert, you mentioned your sister was feeling sick last week. If she didn't tell you she was sick, how could you tell?

ROBERT: Well, she was lying on the couch curled up.

THERAPIST: Hmm. So her body seemed very still and lazy. Why, do you think?

ROBERT: Because she didn't feel well and was probably tired or something.

THERAPIST: I think that's probably right! What did her face look like, Robert?

ROBERT: It looked sort of sad, I guess.

THERAPIST: So what her face and her body looked like told you a lot about how she was feeling, even if she didn't tell you out loud she was sick?

ROBERT: Yep.

THERAPIST: So could those things be like clues to how a person is feeling?

ROBERT: I think so.

THERAPIST: Great! Now let's pretend we are detectives, Robert, and use these clues. Do you have a dog at home?

ROBERT: Yeah, my dog Mickey!

THERAPIST: Great! When Mickey's tail is wagging and his ears are perked up and he is prancing around the kitchen, how do you think he feels?

ROBERT: Happy!

THERAPIST: Sure! And how can you tell when Mickey is scared?

ROBERT: His tail goes between his legs, and his ears go down sometimes, and if it's a person he's scared of he usually barks to tell us.

THERAPIST: That's exactly right, my dog does those things too when she is scared! Those are all good clues that tell us how they are feeling.

Following this discussion, the therapist helped Robert make a "feelings dictionary." Robert looked through magazines and cut out pictures of faces with various emotions on them. He then demonstrated an ability to identify different feelings by pasting them on a blank sheet of paper and labeling the emotion underneath. The therapist spent a few minutes with Robert beginning to construct his fear hierarchy, a chart that delineates and ranks his feared situations. Robert's hierarchy included items related to separation and safety fears (e.g., that mom or dad will be shot or stabbed when they are running an errand, that a serial killer will come into the house at night). Robert came up with his own Subjective Units of Distress (SUDs) scale (Wolpe, 1969) with numbers 1–1,000, using increments of 100 to rate his distress. The fear hierarchy and SUDs ratings were discussed throughout Sessions 1–9 to prepare for the exposure phase.

Session 3: Identifying Somatic Responses to Anxiety

The third session discusses specific somatic reactions to anxiety, practices identifying them, and introduces the "F" step in the FEAR plan. The therapist normalized Robert's experience of fears by using a false fire alarm analogy to help him understand that physical symptoms of anxiety can be clues to tell him when he is becoming worried or afraid.

THERAPIST: Has the fire alarm ever gone off at school before?

ROBERT: Yes.

THERAPIST: And was it loud?

ROBERT: It was so loud I thought my ears were going to fall off!

THERAPIST: Wow, that's loud! How were you feeling when the fire alarm went off? Were you feeling anything in your body?

ROBERT: Well it really surprised me at first and my heart started beating really, really fast, like bum-bum, bum-bum, like out of my chest!

THERAPIST: I bet! You know, the first step in the FEAR plan is what letter, do you think?

ROBERT: "F"?

THERAPIST: That's exactly right! The "F" step is first, and it stands for "Feeling frightened?" Sometimes when we are feeling frightened our bodies tell us first. The first alarm might make your heart go "bum-bum" because your body realizes there might be danger, even before you've had a chance to think about it! But fire alarms go off for all sorts of reasons, right? They might go off because someone pulled it, or because it's broken, or even for a fire drill just for practice, and is there danger in any of those situations?

ROBERT: Probably not.

THERAPIST: Right! But your body still reacts like there is, and it makes you feel really scared for a minute, right?

ROBERT: Right.

THERAPIST: So sometimes our worry or anxiety is the same way. We might feel scared even when there is no danger, sort of like a false alarm. We're going to practice in here how to figure out when the false alarm is happening so you don't think you're in danger when it's really safe. One way to tell a false alarm is by paying attention to those clues in your body.

The therapist then used a body cutout activity to assist Robert in identifying his own signals or clues for when he is feeling nervous. The therapist traced Robert's body and helped Robert identify and label the cutout. For example, Robert talked about how his heart raced sometimes when he thought about murderers. The therapist asked Robert to show this on the cutout, and he colored a heart where his chest was and wrote, "heart drumming-bum bum bum" next to it. The therapist then helped Robert practice how to use these somatic responses as clues to his worry by using role-playing techniques. Specifically, the therapist employed the "tag-along" procedure (Ollendick & Cerny, 1981) by first acting out her own example of being afraid of a big dog at the park. The therapist pretended to step out the front door and, as she was journeying to the park, identified different clues (e.g., "I can feel my heart getting faster"). Robert used

a recent example of a ride on a roller coaster; he acknowledged different parts of the experience during which he felt escalating bodily sensations (e.g., waiting in line with butterflies in his stomach, heart pounding on the ride). The therapist encouraged Robert to be aware of what his body was telling him in the coming week as part of his STIC task.

Session 4: First Meeting with Parents

The fourth session is a parent-only meeting dedicated to providing further information about treatment, addressing parents' questions and concerns, gathering additional information about the child's functioning, and discussing ways the parents can be involved in treatment. The therapist sensitively discussed common cycles of parent-child interactions that develop with anxious children and asked the parents if they had ever engaged in similar interactions. The parents were encouraged to monitor their behavior over the week to see whether they noticed inadvertent accommodations that might be playing a role in maintaining Robert's anxiety, worry, and avoidance. They were also asked to monitor their own modeling of anxiety and avoidance of anxiety-evoking situations, as well as other variables related to GAD (e.g., intolerance of uncertainty, worrying, overcontrol, rejection). Robert's parents were already implementing many positive and supportive techniques to help Robert manage his anxiety. However, it should be noted here that many parents of anxious children have anxieties themselves, and clinicians should be prepared to handle parents who are unaware that they are modeling poor coping strategies, are negativistic in parent-child interaction styles, or are simply conveying an excess amount of worry and accommodation regarding their child's anxiety. An important function of the parent sessions can be to teach parents how to effectively manage their child's anxiety and their own anxieties instead of inadvertently maintaining them through the avoidance cycle. Normalizing the tendency for all parents to want to protect their children from distressful situations can facilitate this conversation.

Session 5: Relaxation Training

The focus of the fifth session is on reviewing muscle tension as it relates to other somatic sensations of anxiety and on teaching relaxation. To begin, the therapist prompted Robert to imagine a time when he felt relaxed and to explore how his body felt. Then the therapist asked Robert to imagine again the roller coaster example used in the previous session and used imaginal techniques to help him remember how his body felt. A comparison was then made regarding how it felt to be relaxed rather than tense. The therapist also helped Robert externalize these bodily sensations of fear by helping him describe these feelings verbally, and he came up with "the

Incredible Hulk taking over” as a description of his feelings. Externalizing and labeling anxiety creates a common language between therapist and child and, as a result, might help children to better conceptualize these feelings and related cognitions. The therapist first introduced relaxation techniques by practicing some belly breathing with Robert. Robert had initial success with this and expressed that it helped his body feel calmer. The therapist then had Robert practice tensing and relaxing his body to further exaggerate the difference, using Koeppen’s (1974) script for progressive muscle relaxation for children. The following is an excerpt from the script that was applied in this session with Robert:

THERAPIST: OK, Robert, we just talked about feeling tense versus feeling relaxed. We agreed that feeling relaxed is much better, and we usually feel tense when we are stressed out or afraid of something. Now that we know how to notice when the Incredible Hulk is taking over, we can use relaxing activities to make him go away so that you can feel relaxed again. It’s hard to be afraid when we feel really relaxed, right?

ROBERT: Right. I wish I felt relaxed and happy all the time. That would be easy.

THERAPIST: Well, sometimes we just need to practice things so they can become easier for us, right? So let’s practice relaxing our muscles. With enough practice, relaxing will just happen naturally, on its own!

ROBERT: OK.

THERAPIST: OK. Sit comfortable in your chair and take some deep, belly breaths. Plant both feet on the floor and let your arms hang loose. You can close your eyes if you’d like. Are you ready to begin?

ROBERT: I’m ready.

THERAPIST: OK, here we go. Remember to keep breathing and try to pay attention to your body. Pretend you have a whole lemon in your left hand. Now squeeze it hard. Try to squeeze all the juice out. Feel the tightness in your hand and arm as you squeeze. Now drop the lemon. Notice how your muscles feel when they are relaxed. Take another lemon and squeeze. Try to squeeze this one harder than you did the first one. That’s right. Real hard. Now drop the lemon and relax. See how much better your hand and arm feel when they are relaxed.

The same process is repeated with the right hand and arm, followed by a section for arms and shoulders, jaw, face and nose, stomach, and legs and feet. The therapist then had a discussion with Robert about different times he could practice and use these new skills. He identified nighttime as when he felt the most stressed. Robert was given the opportunity at the end of the session to explain and show his mother these new skills, and

the therapist gave Robert's mother a recording of the therapist reading the script so that Robert could continue to practice his relaxation skills at home each night.

Session 6: Identifying Anxious Self-Talk and Learning to Challenge Thoughts

Prior to beginning Session 6, relaxation was reviewed to consolidate gains, and Robert reported that he had done well with practicing along with the recording each night and that it had become a part of his bedtime routine. The goals of Session 6 are to introduce the concept of self-talk, to differentiate anxious self-talk from coping self-talk, and to introduce the "E" step in the FEAR plan.

To begin, Robert viewed cartoon characters in specific situations who were feeling different feelings and tried to guess what they were thinking (i.e., what was in their "thought bubble"). For example, one situation in the workbook involves two children who are going ice skating. One child has never skated before; the other is a skilled skater. Robert and the therapist discussed differences in the characters' feelings and thoughts to help Robert understand that "expecting that something bad is going to happen" is often associated with feeling anxious, while thinking that one can cope or have fun is often associated with positive feelings. The therapist explained that the next step in the FEAR plan, the "E" ("expecting") step, is to learn to feel better by changing anxious self-talk to coping self-talk. Utilizing the tag-along technique, the therapist practiced with her own example before guiding Robert through the process:

THERAPIST: Okay, Robert, let's try using one of your examples with the "E" step. We've been talking a lot about how it makes you nervous and scared when Dad goes out at night to run errands. Should we use that?

ROBERT: Sure.

THERAPIST: OK, great. So what happens when Dad gets ready to go out?

ROBERT: I get scared and, well, I usually ask him not to go, but it doesn't work. Then he goes out anyway, and I get upset.

THERAPIST: Would you say the Incredible Hulk takes over?

ROBERT: Oh, yeah.

THERAPIST: What would the Incredible Hulk's thought bubble say when Dad goes out?

ROBERT: He's thinking "Dad's going to get shot at the grocery store and die."

THERAPIST: OK, so you tried to get Dad to stay home, and he went out anyway. Are you feeling frightened? What's happening in your body?

ROBERT: Yes. My heart is pounding, and I'm crying.

THERAPIST: OK, so you did the "F" step and you know you're feeling frightened, maybe you're trying to take belly breaths and relax, but the Incredible Hulk is getting stronger, and you're starting to get more scared, and you keep thinking that Dad is going to get shot. Remember that the "E" step means "Expecting bad things to happen"? Let's go through the "E" step questions and pretend we are detectives gathering evidence. First, "Do I know for sure this is going to happen?"

ROBERT: Well, no, not for sure. I'm just afraid of it happening.

THERAPIST: OK, has it happened before, or has it happened to anyone you know?

ROBERT: Not to anyone I know, but I hear it in the news a lot, and I know it's happened near where I live.

THERAPIST: OK, but not to anyone you know.

ROBERT: No.

THERAPIST: So how likely do you think it is that it will happen to Dad?

ROBERT: Probably not that likely, but there's a lot of bad people and murderers out at night.

THERAPIST: Do you think we could try to use some coping thoughts and see if that helps the Incredible Hulk calm down? Who knows, maybe it might help.

ROBERT: I guess.

At this point the therapist helped Robert brainstorm different coping thoughts that he could believe in. He came up with "Dad will probably be fine and will be home soon." The therapist helped Robert make a coping card with this thought on it to remind him. Although Robert seemed to be able to come up with alternative coping thoughts to use, he did not feel confident regarding his ability to use them in stressful situations. The therapist helped Robert practice in situations that were likely to come up and encouraged him to try in the next week.

Session 7: Reviewing Anxious and Coping Self-Talk and Developing Problem-Solving Skills

The goals of Session 7 include introducing the "A" step and teaching problem-solving skills. At the beginning of Session 7, Robert said that he had continued to work on his relaxation skills at home and that he tried to use coping thoughts as well, although he was still experiencing significant distress at night. The therapist practiced the "F" and "E" steps with Robert in session before moving on, and he was encouraged to continue practicing these skills. Problem solving was taught through a red–yellow–green light

game that the therapist created. The following transcript serves to illustrate the session:

THERAPIST: Do you remember what letter we are learning in the FEAR plan today?

ROBERT: The “A” step?

THERAPIST: That’s right. The “A” step stands for “Action planning.” Sometimes when we are feeling frightened, relaxation might help a little, and gathering the evidence might help, too, but we still might be scared after trying those things. That’s what happened to you this week, right?

ROBERT: Yeah, I did everything we practiced, but it didn’t really work.

THERAPIST: That’s OK! We still have a couple more things to learn. So far we’ve learned to know how to do things with our feelings and thoughts. Today we’re going to play a game to practice problem solving, so that when you feel stuck after trying those things, you know how to make a plan and do something about it. Sound good?

ROBERT: Sounds good.

THERAPIST: Cool, OK, so we’re going to take a pretend problem to play the game with first. Pretend you wake up for school in the morning, and you can’t find your shoes. The bus is coming, and your mom is yelling at you to hurry up. The first step in problem solving is to brainstorm—that means to think of all the possible things you could do, even if they seem silly or like a bad idea. Let’s see how many we can think of together in the next 3 minutes. Ready? Go.

The therapist and Robert created a list that included items such as “wear different shoes,” “go to school with no shoes,” “go to school late,” and “ask mom to help me look.” Next, the therapist went through the list with Robert and asked, for each one, “What would happen if I did this?” and “How would I feel if that happened?” After that, Robert colored each one red, yellow, or green depending on whether he thought it was a bad idea, an OK idea, or a great idea. The green choices were combined to make an action plan, with the yellow being the backup plan. Afterward, Robert created an action plan using the same steps for his stressful situation of his dad going out at night. Once an action plan was created, it was added to his coping card for use over the following week.

Session 8: Introducing Self-Evaluation and Self-Reward and Reviewing Skills

Session 8 is spent reviewing skills already learned and explaining the “R” step (“ratings and rewards”), as well as preparing to transition into the exposure phase of treatment. The therapist summarized for Robert the first

three steps of the FEAR plan: recognizing his fearful feelings, recognizing and replacing his anxious self-talk with coping self-talk, and taking action to help change the situation and get the power back. Then she introduced the idea of rating his performance and rewarding himself for effort and for staying in the situation even when he was afraid. The therapist used the example of teaching a dog to roll over on command by rewarding the dog for each little step he takes. The dog is rewarded for sitting, then lying down, then turning on his side, and then flipping over. Like us, dogs learn things in pieces and with practice. When we make a good effort, a reward can motivate us to try even harder next time. The therapist emphasized that rewards were for trying hard, not just for when we do things perfectly. The therapist then used different examples relevant to Robert's life to help him practice deciding whether or not he thought he should be rewarded in different situations and what rewards he might receive. The therapist and Robert made a "FEAR plan ID card" that summarized the steps so that he could carry it with him during exposures. They practiced the plan using several examples: riding a roller coaster, Robert's dad going out at night, and Robert sleeping in his own bed. The therapist discussed the process and rationale for upcoming exposure exercises. She explained that he would likely experience some fear or anxiety, much like he already did, but that with practice his anxiety would go down, and he would start to feel better. Prior to the end of the session, Robert expressed anxiety about not wanting therapy to end. After validating Robert's feelings, the therapist helped Robert label this "anxious thought," identify thinking traps (e.g., negative fortune telling), and problem-solve how to cope with the situation. At this time, Robert also continued to express harm-to-himself and harm-to-others concerns, but he seemed motivated to try exposure challenges to help decrease these fears.

Session 9: Second Meeting with Parents

The ninth session is a parent session focusing on preparation for the exposure tasks that come next in treatment. The therapist reviewed the rationale and process for the exposure phase, and then she and Robert's parents collaboratively developed a hierarchy of anxiety-provoking situations for upcoming exposures. She discussed what they might expect over the coming weeks, the things they could do at home to best support exposures (e.g., providing appropriate prompts, encouragement, and rewards), and problem-solved potential obstacles to treatment.

Exposure Phase (Sessions 10–16)

Exposure serves as the main focus of in-session and between-session work in Sessions 10–16. One potential therapeutic mechanism underlying

exposures is habituation to the feared stimuli coupled with response prevention, which in turn leads to long-term corrective learning (Barlow, 2014; Foa & McNally, 1996). It is hypothesized that once the client repeatedly stays in the feared situation without being allowed to engage in known safety behaviors, a corrective experience occurs that helps the client realize that he or she is capable of coping and successfully dealing with the feared stimuli and that it is unlikely that the feared outcome will occur. Another theoretical slant focuses on the new learning that occurs following exposure: The child learns that the feared catastrophe doesn't happen. The Coping Cat protocol is flexible in that multiple areas of stress can be targeted at once, depending on therapist discretion. At the beginning of Robert's exposure phase, the therapist, Robert, and his mother collaboratively decided to first target Robert's fear of guns, as well as sleeping in his own bed. At the time, Robert was sleeping on the floor of his bedroom every night by the door, where he could see into his sister's room. He was fearful of sleeping in his own bed, which was next to a window, because he thought someone would point a gun through the window and shoot him. For Robert's first *in vivo* exposure, he looked at a picture of a gun for 10 seconds, then again for 15 seconds. During the exposure, he rated his fear using the SUDs rating scale that he previously created (100–1,000). His first week of at-home exposures involved continuing to look at this picture for increasing amounts of time, as well as lying in his bed for 1 minute the first night, adding a minute each night. The therapist explained to both Robert and his parents that exposures are meant to be flexible, emphasizing the importance of at least attempting to complete the exposures and of rewarding these attempts.

When beginning exposures, it can be helpful to assign easier exposures so that the child does not become overly fearful and overwhelmed by the process. Over sessions, the therapist and child move up the fear hierarchy, making exposures incrementally difficult. Encouraging the family to take initiative and be creative at home during this process can ensure that successes are strung together more quickly. In Robert's case, the family reported that Robert found the initial exposure plan easy, so they had altered the length of time Robert did each challenge to make them more difficult. In fact, Robert had a lot of initial success with sleeping in his own bed and with looking at different pictures of guns (the therapist had emailed the pictures to Robert's mom). During the next session, his SUDs ratings before, during, and after each exposure were charted so that Robert could identify for himself the pattern of fear: at its highest before the challenge and progressively going down until it was over. *In vivo* exposures included watching YouTube videos of guns being shot at a gun range and listening to the sound. The therapist expressed satisfaction with Robert's efforts and encouraged him to keep it up. In addition, the therapist consistently checked with Robert's mom to make sure that Robert was being

rewarded for completing his challenges as planned. Robert's next challenge sheet was created collaboratively on the computer. They decided to keep building on prior exposures while adding in the challenge of his father going out for errands at night. For example, the first night, Robert would do an activity with his mom while his dad went out for 5 minutes, then 10 minutes the next night, then 20 minutes the next, followed by playing with his sister (not bothering his mom) while his dad went out for 10, then 15, then 20 minutes.

During the exposure phase, we continued to practice examining Robert's thoughts and how they related to his anxiety. More and more, Robert developed adaptive thoughts along with his new relaxation skills to help him cope successfully with anxiety. Robert quickly stopped checking the locks on the doors and the alarm system. Robert began to experience success with his exposures and was rewarded for his efforts. He displayed less intense reaction to guns, graffiti, and people living in the city and thus did not become as upset by them or think of them as harmful. His avoidance and associated safety behaviors of clinging to his mom and engaging in behavioral outbursts or crying decreased. By the time therapy terminated, Robert was sleeping in his own bed every night. He reported that he no longer believed the world was a dangerous place but more realistically expressed feeling that he and members of his family would be safe as long as they were careful and looked out for each other.

At posttreatment, Robert's total MASC score of 39 and his mother's rating of 28 both fell in the low range. His CDI score of 8 suggested that he was experiencing minimal depressive symptoms. Posttreatment data on the coping questionnaire suggested that both Robert and his mother felt that Robert was much more in control of his coping abilities. They indicated that he was very much able to help himself cope if he worried about his parents going out at night, if he worried about burglars, or if he worried that he had done something "bad." At posttreatment assessment, Robert was assigned a CGAS of 80, which means he was experiencing no more than minor impairment in functioning in school, at home, and with peers. He expressed normal emotional distress in response to life stressors, which occasionally resulted in behavioral outbursts, but these were brief and transient, and, in general, Robert was functioning well.

Mediators and Moderators of Outcome

As CBT has been found helpful in treating children with anxiety, researchers are beginning to explore potential moderators and mediators of outcomes. Studies to date indicate that race, ethnicity, and gender do not appear to differentially influence outcome (Treadwell, Flannery-Schroeder, & Kendall, 1995). A few studies suggest that children who are more active

and involved with the treatment tend to have better outcomes (e.g., Chu & Kendall, 2009). Some studies have found a relationship between treatment response, decreases in negative automatic thoughts, and increased perceived control over anxiety, consistent with the CBT model (e.g., Kendall & Treadwell, 2007; Muris, Mayer, den Adel, Roos, & van Wamelen, 2009). Gains in coping efficacy have been found to mediate treatment improvement in anxiety symptoms (Kendall et al., 2016). In our experience, involvement can be fostered by helping the child learn through activities and play—teaching through discovery versus didactic instruction. There is evidence that therapists who are more collaborative and empathic, who follow the Coping Cat manual, and who implement the treatment in a developmentally appropriate way have better treatment outcomes (Podell et al., 2013). Such findings speak to the need to maintain fidelity with treatment procedures being sensitive to children's emotional and developmental needs when implementing treatment for child GAD.

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