Readiness Is Key in Cognitive-Behavioral Therapy

Children with anxiety symptoms must first understand how the treatment works to benefit.

BY DAMIAN McNAMARA
Miami Bureau

MIAMI — Clinicians can help children and adolescents with cognitive, physical, and behavioral symptoms of anxiety through cognitive-behavioral therapy. However, readiness for treatment must first be established, according to a presentation at the annual conference of the Anxiety Disorders Association of America.

"The better you can get a child to understand some of the concepts behind the treatment, the more they will be engaged," said Aureen Pinto Wagner, Ph.D., a child psychologist at the department of neurology at the University of Rochester (N.Y.).

Readiness for treatment is a key to success with cognitive-behavioral therapy (CBT), Dr. Pinto Wagner said. Do not confuse readiness with motivation, however. "Everyone at some level is motivated. Readiness is the ability to channel that desire to get well into the action to get well," Dr. Pinto Wagner said.

CBT, particularly the exposure therapy component, may seem counterintuitive to patients with anxiety and to their parents. So educate patients and families about how CBT works, and the reasons why testing the reality of fears by facing them can be beneficial, Dr. Pinto Wagner suggested. "When children understand the concepts, there is an 'Aha' moment."

Assure anxious children that they will not be forced to do anything they don't want to do, Dr. Pinto Wagner suggested. Instead, clinicians should tell the patient that they will act as a guide.

Sometimes children still do not engage. A bit of role reversal might help, Dr. Pinto Wagner said. For example, she consulted with a child who was fearful of vampires. She assured him that vampires are not real, but the child said everyone told him that, and it did not help. "I told him that I was afraid of roller coasters. I asked him how to get over my fear," she said. "He told me to go ride them. I said no, I was afraid of falling out. He suggested that I ride the kiddy coaster … I said: 'Aha, you've helped me with my fear; now let's work on yours.' "

A person attending the meeting asked what to do about a pediatric patient who remains recalcitrant. "I ask them if they want to participate in the treatment. I tell them to go home and think about it, and to let me know," Dr. Pinto Wagner said. "In some ways I give up the control, but then 95% of the time kids will come back and say they want to do it."

The goal with CBT is to change or modify the anxiety triad of thoughts, physical arousal, and behaviors. An overestimation of danger, expectation of the worst outcome, and a "sense of uncontrollability" are common cognitions. A pounding heart, sweating, tension, disturbed sleep, and hypervigilance are physical symptoms. Safety checks, reassurance-seeking, escape, and avoidance are common behaviors.

"CBT teaches children that they can take back control of how they think and how they feel," Dr. Pinto Wagner said.

Realistic thinking, self-instruction training, and problem-solving strategies can help alleviate anxious thoughts, Dr. Pinto Wagner said.

Socratic thinking is one approach. The clinician asks systematic questions to guide the child to arrive at a desired conclusion on his own. For example, ask a child what she would first think about if she heard a noise at the window. Eight out of 10 children would say a burglar, she said. Then ask them what else it could be—could it be a tree rubbing against the window? "The point is, it's the same noise at the window, and depending on how they think of it, they will feel differently."

Mathematics and probability can help some children. "Kids like to use math to get perspective on their fear," Dr. Pinto Wagner said.

She cited the example of a girl with school refusal. When asked why she did not want to go to school, she might reply that she does not want to be away from her mother. The clinician might ask about her specific fears. She states she is afraid her mother will get into a car accident while driving her to or from school. Then ask how many times her mom has driven to school. Do the math together to figure out how many days over how many years, Dr. Pinto Wagner advised. Then ask how many accidents she has had during that time to demonstrate how low the probability is.

"Acknowledge that bad things do happen, but they happen rarely, compared to the level of their fear," Dr. Pinto Wagner said.

Less mature children may not be able to engage in Socratic thinking, however. "For younger children, we use self-instruction training," Dr. Pinto Wagner said. Self-instruction teaches a child to recognize anxious self-talk and replace it with calming thoughts.

Another tactic is to invoke support from a favorite superhero. Ask the child: "What would Michael Jordan say to you? What would Kim Possible do in this situation?"

Relaxation and interoceptive exposure are CBT techniques that can allay physical symptoms of anxiety. "Relaxation training is the most common approach in kids but also the least effective," Dr. Pinto Wagner said. "Some kids might need it when they are very worked up, but in general this only works with mild anxiety in kids who get anxious occasionally. I use it in about 10% of the kids I work with."

Exposure is the most potent technique for overcoming anxious behaviors, Dr. Pinto Wagner said. "I tell patients [that] to overcome your fear, you must face your fear. Do the things you are afraid to do, and stop the avoidance and escape." From exposure, patients habituate and get to test the reality of their fear. "Because 99.9% of it does not come true, it gives them an ability to invalidate their fear," she added.

Rather than use a flooding approach, take little steps toward gradual exposure in children, Dr. Pinto Wagner advised. "It's more natural and less frightening for kids. Start with almost ridiculously easy things. Experience easy success and build confidence. If you go too far, the child gets scared, and you have to backtrack. "

Any child can relate to the metaphor of riding a bicycle, Dr. Pinto Wagner said. "I tell children [that] facing their anxiety is like riding up a big hill. You may want to quit and go back down, which is escape and avoidance. But if you keep going, you will get to the peak of your anxiety and then you will be able to coast downhill on the other side." ■

Special CBT Protocol Improves Anxiety in Young Children

BY DAMIAN McNAMARA
Miami Bureau

MIAMI — A cognitive-behavioral therapy program designed for children aged 4-7 years significantly improves anxiety symptoms over 6 months, according to a randomized, controlled trial.

Many pediatric cognitive-behavioral therapy (CBT) programs are geared toward older children and teenagers. The typical age range is between 8 and 14 years, for example.

"But anxiety disorders have an earlier onset than age 8," Dina R. Hirshfeld-Becker, Ph.D., said in an interview at her poster at the annual conference of the Anxiety Disorders Association of America.

"People thought for a while that CBT was not suitable for younger children. They thought kids did not have enough perception into their cognition and would not be compliant enough with their homework," said Dr. Hirshfeld-Becker, who serves as director of anxiety research in the pediatric psychopharmacology program at Massachusetts General Hospital, Boston.

However, the findings of this study counter that perception. Dr. Hirshfeld-Becker and her associates assessed 65 children. All but one had a DSM-IV anxiety disorder; the other child was at high risk for anxiety.

A total of 71% had multiple anxiety diagnoses. More than half of the children had a parent with an anxiety disorder, and 20% had comorbid oppositional defiant disorder.

Mean age was 5 years, 54% were female, 80% were white, and 88% came from intact families.

The researchers randomized 35 participants to CBT treatment—up to 20 sessions over 6 months—and an additional 30 to a monitoring-only group as a control.

The CBT protocol is called "Being Brave: A Program for Coping With Anxiety," adapted from the Coping Cat program for children aged 8-13 years developed by Philip C. Kendall, Ph.D., at Temple University in Philadelphia.

The first six sessions are a parent-only module, during which time parents learn anxiety management and how to coach their children to cope in feared situations. A child-parent module for an additional 8-13 sessions incorporates effective techniques for preschoolers with phobia analogs, in vivo exposure, modeling, and reinforced practice. A final session for parents is designed to maintain gains and continue progress.

"We teach relaxation exercises and coping self-statements like, 'I'm a brave boy,' and that can help," Dr. Hirshfeld-Becker said.

All attempts at success are rewarded, for example, with stickers or extra time with the parent. "We do graded exposure therapy, but we make it fun."

A total of 58 children completed the study. At 6 months, a blinded clinician rated 70% of the 30 CBT completers as having much or maximal improvement on global ratings of improvement for anxiety compared with 32% of the 28 control group completers.

An intent-to-treat analysis yielded similar findings: 60% achievement with CBT, vs. 30% for controls.

"I was happy the improvement rates they showed were comparable to CBT protocols in older kids," Dr. Hirshfeld-Becker said.

Initially, parents expressed concern with the graded exposure component of CBT, Dr. Hirshfeld-Becker said. "Parents might expect the kid is going to suffer, but they come to respect their children when they show resiliency."

The CBT protocol helped parents as well, Dr. Hirshfeld-Becker added. "I was surprised the parents tended to benefit as well as the child." ■