Parent Coaching Anxiety Treatment (PCAT)

6-Session Treatment Study

Clinician Manual

May 2013

Introduction

Parent Coaching Anxiety Treatment (PCAT) is an approach to delivering effective treatment in a time and cost effective manner based on previous work in the treatment of anxiety disorders. The PCAT consists of empirically supported exposure based techniques with the flexibility to allow the provision of different treatment components based on the needs of the patient. Finally, PCAT is consistent with efforts to incorporate parents and family members into the treatment of anxiety disorders. The major difference between PCAT and previous manualized approaches to treating childhood anxiety disorders, is the primary emphasis on teaching the child and parent as quickly as possible to plan and conduct exposures independent of the therapist. To accomplish this goal, the methodology of PCAT is based on other treatments that provide in-session instruction to parents while they are working with their children (i.e., Parent Child Interaction Therapy; PCIT).

Treatment Overview

1. **Objectives**: PCAT is designed to be a time and cost efficient treatment that is flexible to the needs of each individual patient. The treatment is based on available research in the treatment of anxiety disorders. In PCAT, anxiety disorders are seen, as a product of internal/genetic/biological predispositions interacting with the environment. PCAT approaches anxiety as a chronic emotion to be managed, as well as an acute problem to be solved. Thus, PCAT has three primary objectives that need to be met:
    a. Teach the family the cognitive behavioral model of anxiety, its maintenance, and its treatment through exposures.
    b. Provide initial symptom relief through exposure to anxiety causing situations that challenge the child's overestimations of the *likelihood and severity* of feared outcomes.
    c. Allow the child and parent to learn how to plan and conduct exposure-based treatment through hands-on in session experiences.

2. **Mechanism of Action**: The active ingredient in PCAT is thought to be increased self-efficacy to tolerate anxiety and correction of misappraisals of danger through experiential learning.

3. **Pace**: As the agent of change in therapy is exposure with prevention of safety behaviors the job of the therapist is to begin exposure as quickly as possible. The treatment is designed in a series of goals that can be addressed simultaneously to some degree. Some patients may need very little work before beginning exposure, while other may need extensive groundwork. Typically, before beginning exposures the following should be accomplished
    a. The child and parent understand the CBT model of anxiety, its maintenance and why it often does not go away on its own.
    b. The child and parent understand how exposure and removal of safety behaviors are used to decrease anxiety by challenging overestimations of the severity and likelihood of fear events
    c. The therapist and parent understand what situations or objects make the child anxious, what the child fears will happen, and what actions (mental or behavioral) the child takes to avoid or prevent this feared outcome.
    d. The child is ready to begin exposures

    If these can be accomplished during the first session, then exposures can begin in the second session. However, children with a long history of severe anxiety, family conflict, non-compliance, comorbid diagnoses, lack of social skills, or academic difficulties that additional work prior to beginning exposures.

4. **Therapist Characteristics**. Research has shown that both specific techniques and general therapeutic factors positively contribute to therapy outcomes, thus it is important to convey a sense of expertise and understanding of the patient and family, promote confidence, build rapport, and provide an environment that is comfortable, safe, and supportive. PCAT assumes that therapists have a degree in

psychology, social work, or psychiatry with specialized training in child psychopathology and basic therapeutic principles of empathy, reflective listening, and behavior therapy.

In addition to a foundation of strong therapeutic skills there are a number of characteristics that seem especially important for providing exposure therapy with anxious children. One primary difference between behavior therapy and other approaches is the **activity level** of the therapist. The therapist will frequently give the child and family direction and leave the office to complete exposures.

Learning about a child's anxiety and conducting exposures may involve talking about topics that are not usually discussed with children and asking children to do things that we normally would not, such as talking about sexual thoughts or eating potato chips off the floor. To pull this off, therapists need to be **calm, composed and unflappable**. Children are often embarrassed about their symptoms and therapists need to react to them as though they hear these things everyday. We never ask a child to do an exposure that we would not do, so therapists need to **be tolerant and not squeamish** about unpleasant experiences (e.g. touching trash cans, stumbling over your words while asking a stranger for the time).

Assisting children to face their fears requires a delicate **balance between urging the patient to engage in treatment and empathizing with his or her distress**. Therefore therapists need to be respectful, understanding, encouraging, explicit, and challenging (Rabavilas et al, 1979). Therapist must be observant of the child's and family's reactions and emotional state in order to properly balance, providing comfort and pushing the child to complete difficult tasks. Providing exposure therapy requires a concerted effort to tolerate one's own emotional distress, as well as **confidence with the treatment approach**, which comes with understanding the research and experience with providing exposure-based treatment. To be successful, the therapist needs to be seen as trustworthy by the parents and child. Finally, although exposures by definition need to include feeling anxious and uncomfortable, there is no reason that treatment can't be fun. Therapists are strongly encouraged to use their own **humor and creativity** during treatment, especially surrounding exposures.

5. **Who attends each session?** PCAT assumes that both the child and parent will be in attendance the majority of the time. This structure is consistent with the philosophy of PCAT that children will make faster and more lasting progressive if they have a coach at home to help them practice managing anxiety. Thus, the therapist approaches each session with the goal of encouraging the child and parent to work as independently as possible. There are times when it is necessary to meet individually with the child or parent and older adolescents may prefer to conduct therapy alone. However, we believe that everyone can benefit from having a home coach or support person and PCAT has been successfully implemented with older adolescents in addition to younger children.

6. **Termination.** The decision to terminate is made collaboratively among the child, parent, and therapist. Because there is substantial variability in the manner in which treatment ends, this section describes and ideal termination. Treatment is expected to typically last between 6 and 10 sessions. The most straightforward indication that treatment is close to completion is when the child and parent describe a decrease in symptoms and impairment to the extent that they feel treatment is no longer necessary. Hopefully this verbal report will correspond to anxiety ratings falling in the "not a problem" to "a small problem" range. Before termination the child should have habituated to the most challenging exposure on the fear hierarchy, as well as, designed and conducted an exposure (with parents) outside of the session, without the therapist's assistance. It is not necessary for the child to have completed as exposures on the hierarchy; in fact it may be preferable for the family to address some on their own after therapy has been discontinued.

   In general, termination can occur after the following three objectives have been meet:

   a. The child and parent have a thorough understanding of the cognitive behavioral model of anxiety, its maintenance, and its treatment through exposures.
   b. The child has obtained sufficient symptom relief through exposure to anxiety causing situations and can identify overestimations of the *likelihood and severity* of feared outcomes.
   c. The child and parent feel confident that they can plan, execute, and learn from exposure to anxiety provoking situations that may arise.

   Finally, a repeat assessment should be conducted to thoroughly evaluate the patient's progress.

Treatment Goals

Goal #1. **Therapeutic alliance: Become a team**. A strong foundation of rapport, trust, and safety is essential to successful treatment. Research suggests that what are often called non-specific factors play an important role in all treatment. This is no different in exposure based treatment for anxiety disorders. In this treatment children are being asked to work hard and complete scary tasks. To be successful they need to feel safe and supported and have a therapist they can trust. It is very important to note that the goal is to *begin* developing a therapeutic alliance, not to have one firmly established. Specifically, therapy can continue to Goal #2 before this process is "complete."

Within PCAT that therapeutic alliance is primarily established through the conduction of the other therapy goals (e.g., Assessment, Psychoeducation). It is expected that the therapist spend some time with the **child individually during the first session** in order to allow the child to speak freely outside of the parents' presence. It is assumed that therapist will engaged in some "small talk" with the patient during each session, particularly the first assessment and treatment sessions. This consists of asking the child about his hobbies and engaging in conversation that is interesting to the patient. The extent of this interaction depends on the child, but the baseline assumption is that this is intermingled with the other goals. Specific efforts to develop rapport through long conversations, games, or structured activities are only utilized if the therapist feels they are having a particularly difficult time establishing rapport. There are plenty of opportunities to develop rapport while focusing on beginning exposures as quickly as possible, such as: a) during assessment of impairment discuss what fun activities anxiety prevents the child from doing, b) have the child teach his/her parents the CB model after s/he has learned it from you, give lots of praise, c) appropriately self-disclose your own fears, and most importantly d) through your questions, nonverbal communication, tone of voice, words, and explanations, convey interest in the child, compassion for their pain, optimism for improvement, and a sense of humor.

The end goal is to have the child be willing to answer your questions, share his/her reactions, follow your directions, and verbalize a willingness to try to do exposures.

Goal #2. **Functional Behavioral Analysis (FBA): Become an expert on the child's anxiety symptoms.** The objective of this step is to learn about the child and his or her anxiety. You do not have to complete a thorough assessment as this was part of the initial consultation, but you need get to know the child as a person (e.g., interests and activities) and conduct a FBA. The FBA including obtaining a detailed understanding of a) the objects and situations that lead to the child feeling scared, anxious, or worried, b) what thoughts the child has about the situations, or what s/he is afraid will happen, c) what the child does in response to these thoughts in order to prevent feared outcomes and/or reduce his fear, and d) what parents and others in the child's life do in response to his/her fear.

Goal #3. **Psychoeducation: Turn the child and parent into experts on the treatment of anxiety**. Once you are comfortable that you understand the child's symptoms, the next step is to provide psychoeducation on anxiety disorders and their treatment. The goal is to help the child and parent develop an understanding of a) the cognitive behavioral conceptualization of anxiety and its maintenance, b) how treatment through exposures works, and c) a three step plan for designing and learning from exposure (i.e., identify fear, evaluate degree of danger, take action). This process is intended to have a number of effects: a) provide informed consent to the child and parent about what treatment will entail; b) de-stigmatize anxiety disorders by presenting them as a normal outcome of a sensitivity to anxiety and learning from experience; c) instill a sense of hope in the child and parents that improvement is obtainable; d) de-mystify the child's symptoms to help them feel more empowered. Typically this information is presented one time and then reviewed in the next session with the therapist encouraging the child to be the teacher. The child need not "master" this information at this point as breaking the anxiety cycle through exposure will be the recurring theme of treatment. You can move on to the next goal if the child and parent understand the material. The goal for the end of treatment is for the child to say that the way to manage anxiety is through "Facing your fears."

Goal #4. **Fear Ladder: Creating an individualized treatment plan.** The combination of you functional behavioral analysis and the introduction of the family to the cognitive-behavioral theory of anxiety results in the creation of a fear hierarchy. Fear hierarchies do not need to be an exhaustive list of the child's fears and should included approximately 10 items. An effective fear ladder should include: a) something that is easy enough to do tomorrow, b) something that is more difficult than what the child is expected to do in daily life (biggest fear), and c) enough steps to get from a to b without taking big leaps. If there are multiple sources of anxiety (e.g., fear of the dark, social phobia) it is typically helpful to create separate ladders. However, separate themes with in generally area (e.g., OCD contamination and intrusive thoughts) can be combined together. In general, the therapist should use his or her judgment to create a parsimonious, yet thorough treatment guide.

Goal # 5. **Exposure: The road to mastery.** Once you have a fear ladder based on the shared understanding of the child's symptoms, and the parent and child are familiar with the CB theory of anxiety and exposure therapy it is time to begin exposure. There are four components to conducting exposures that are discussed here: 1) Proceeding up the ladder, 2) Teaching parents to be exposure coaches, 3) Evaluating success and progress, and 4) additional techniques.

1) **Proceeding up the ladder**: Once the child is ready to do exposures select an easy one from the child's fear hierarchy. Completing an exposure involves three tasks: set-up, exposure, debriefing.
    a. The **set-up** involves: a) working with the child to pick an object or situation, b) getting a rating of the child's fear level, c) learning from the child what they are afraid will happen, c) discussing how likely it would be for that to happen and (if necessary) how bad it would be if it did, and

d) reviewing what we expect to happen (i.e., nothing bad, anxiety decreases over time). The therapist usually needs to be directive to help the patient stay focused on **one problem at a time** (rather than switching between topics or addressing each week's crises) and encourage them to pick **increasingly challenging situations**.

b. **During the exposure**, while the child is confronting the feared situation the therapist's jobs are to: 1) get SUDS rating periodically (every 2 minutes or so depending on the exposure), 2) ensure that the child is not doing any safety behaviors including distraction, 3) be supportive of the child's efforts, especially when anxiety increases during the initial part of the exposure, 4) direct the child's attention and learning to the fact that their anxiety is decreasing merely because they are waiting it out, that the feared outcome did not occur, and that they can handle the anxiety and what happens, and 5) keep the child focused on the anxiety.

c. **Debriefing** consists of a) praising the child for his or her effort and successfully completing the exposure, b) focusing attention of the fact that what they were afraid of did not happen, or that they handled what did happen, c) focus attention on the fact that anxiety decreased just with passage of time, d) if anxiety remained high, focus on the fact that they were able to manage it.

Exposures continue until the child has completed all the items on the ladder, including addressing their greatest fear. Additional items can be added or addressed as needed.

2) **Teaching Parents How to be Exposures Coaches**.

a. It is often helpful, but not necessary to conduct the first exposure with the child alone, outside of the parent's company. This strategy 1) allows for more control over the exposure, 2) provides more social expectations on the child to fight anxiety, 3) prevents parents anxiety or difficulties from being visible to the child, 4) prevents parents and child from participating in any reassurance activities that would interfere with the exposure.

b. After the therapist and child have completed one successful exposure, the next task is to teach the child and the parents to do exposures on their own. This process involves gradually transferring the responsibilities for planning, leading, and debriefing exposures from the therapist to the parent. Ultimately, the goal is to transfer responsibility to the child, but PCAT assumes that all children will benefit if their parents know how to plan and run an exposure. To accomplish this transition the therapist uses written material, modeling, shaping, direct instructions, feedback, and praise. However, PCAT assumes that the family will be better off if they are given the chance to **generate the solutions themselves**. This process not only improves their ability to design exposures, but also increases their confidence that they can continue this work outside of the therapist's presence.

c. One **concrete approach to transferring control** is to have the parents take charge of one aspect of the exposure, such as recording, and then have the therapist complete the rest. Additional steps that the parent can

successively take over include planning the exposure, gathering anxiety ratings, giving encouragement, providing prompts to focus on learning, and debriefing. The end goal is for the parents and child to feel capable and confident in planning, conducting, and learning from exposures. The process will be different for each family, and some will need less assistance than others. The end goal is for the parent and child to conduct exposures in the session with minimal input from the therapist.

d. **Generalizing** principles from exposure to a broader approach to child anxiety often requires direct emphasis by the therapist. Therapists should encourage parents to approach anxiety causing situations in general the same way they approach exposures: 1) remain warm and calm, 2) encourage the child to be as independent as possible, 3) help the child break the task into manageable steps, 4) pay attention to and reward the child's efforts to face his or her fears, 5) remove attention from anxious behavior, and 6) do not accommodate anxious avoidance.

In addition to in-session exposure, the family must be instructed to complete exposures at-home between appointments. The importance of at-home exposure cannot be overemphasized, as without home practice, it is unlikely that the child will have sufficient experience to habituate or to generalize his or her gains to new situations. Parents are included in treatment and taught to be exposure coaches to increase the likelihood that at home exposure will be completed. These exercises are also opportunities for the parent to improve his or her coaching skills. Families should be encouraged to conduct at least one exposure per day for 20 to 30 minutes. Homework should initial focus on repeated the exposures done in session. As the treatment progresses, the family should be encouraged to practice a number of exposure items including ones that have not been addressed in session.

3) **Evaluating success and progress: Clearing the road for exposure.** The first two components assume that the family is ready to participate in exposure. However, this needs to be evaluated by the therapist before beginning exposures and re-evaluated throughout the process of moving up the fear ladder. This component is presented last to emphasize that many if not most children will be ready to begin exposures without additional interventions. However, if a child/family is unwilling to begin or continue exposures, is not progressing with exposures, or has another pressing issues these should be addressed. The following sections outline responses to the more common obstacles to exposure therapy.

   a. Non-compliance. Some children especially younger children or those with oppositional traits may be resistant to participating in exposure. The steps for encouraging compliance with parent request's to complete exposures are:

      i. *Internal motivation*. It is assumed that children want to decrease their anxiety symptoms. If the child is not completing exposure the first step is to examine the exposure plan to make sure that the

requested exposure is not too difficult or not appropriate in other ways, e.g. not applicable to the child's fears, lack of social skills.

ii. *Rewards*. If internal motivation is not sufficient the therapist should work with the family to increase incentives for participating in exposures. This includes praise, special activities, and point systems.

iii. *Consequences*. If rewards are not sufficient, the therapist should consider implementing mild consequences. For instance, exposures can be treated like homework that must be completed before other fun activities such as watching TV or playing games. In addition, the therapist may need to help the parents use other behavior modification techniques such as time-outs, or logical consequences, e.g. additional preparation exercises for non-compliance with planned exposure.

b. Comorbidity.

i. *Depression*. Mild symptoms of depression, especially if secondary to anxiety, should be monitored to see if they respond to anxiety relief. More severe symptoms that interfere with treatment should be addressed through adjunctive treatment, such as behavioral activation.

ii. *Skill deficits*. Some children may require instruction on appropriate behavior, especially social skills, before some exposures.

c. Family issues:

i. Family circumstances involving abuse, neglect, or severe conflict need to be addressed immediately. If a child is in danger or the home situation is unsafe this needs to be addressed.

ii. Parent-child conflict does not rule out the use of PCAT. In fact, parents and children who tend to argue, particularly about anxiety situations, are likely in more need of a strategy that helps them work together. If parent or family conflict appears to be the cause of anxiety, or to be the most pressing problem this should be addressed first. If parent or family conflict appears to result from the anxiety disorder or is less acutely pressing than the anxiety disorder, the family should be encouraged to "rally around anxiety treatment."

iii. Other parent factors can effect anxiety treatment. The principles of differential attention are taught through learning to be an exposure coach. However, some parents may need additional instruction on ignoring anxious behavior and attending to the child's efforts to work on anxiety constructively.

4) **Additional Techniques**.

a. **Relaxation strategies** are generally not taught in PCAT. They are likely unnecessary and may at times become safety behaviors or present a mixed message about the benign nature of somatic symptoms of anxiety. Exceptions are if the child needs instructions for normal breathing in

contrast to hyperventilation or if a child has significant stomach pain, nausea, or vomiting related to anxiety.

b. **Cognitive restructuring.** Cognitive change is a necessary aspect of exposures. In order for children to benefit from exposures they need to pay attention to and learn from their experience. However, it is not clear that independent cognitive restructuring exercises are necessary for cognitive change and symptom relief. All children are introduced to the basic concepts of observing their anxiety and the outcomes of exposures, likelihood and severity estimations. However this is generally done with a brief introduction during the psychoeducation on anxiety and then repeatedly reinforced during exposures.

Goal #6. **Preparing for the future**. The final step of treatment is preparing the family to continue managing the child's anxiety without regular appointments with the therapist. Teaching the child and the parent to conduct exposures on their own gives them the tools to apply the process to new symptoms that arise in the future. However there are a few items that need to be completed to solidify this aspect of treatment: 1) discuss lapse vs. relapse, that is the family should expect anxiety to return at times, particularly during increased stress (i.e. a lapse), but that does not mean it will become a significant problem (i.e., relapse); 2) allow the family to address some symptoms on their own during or after treatment (not the most difficult items); 3) consider spacing sessions farther apart (2 or 4 weeks, 4) have the family brainstorm how they would address a variety of new symptoms, and 5) establish a plan for future contact with the therapist.

Session by session guide

Session #1:

In session: Psychoeducation, being fear ladder

Homework: Encourage child to try and replace avoidance with approach (parents encourage, but not require), review psychoeducation, think about items for fear ladder

Session #2:

In session: Review psychoeducation, continute fear ladder, (if time-introductory exposure)

Homework: Encourage child to try and replace avoidance with approach (parents encourage, but not require), repeat low-level exposure, review psychoeducation and fear ladder

Session #3:

In session: Exposure with parents recording

Homework: Repeat exposure daily

Session #4:

In session: Exposure with parents helping to set it up

Homework: Choose 1 or 2 items to work on with daily exposure

Session #5:

In session: Exposure with parent assistance through out

Homework: Choose 1 or 2 items to work on with daily exposure

Session #6:

In session: Exposure with parent taking lead

Homework: Choose items to work on with daily exposure, including an item not addressed session