Slide 1

Cognitive-Behavioral Treatment of Specific Phobias & Fears

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Slide 2

The NEW ENGLAND JOURNAL *of* MEDICINE

EDITORIALS

Pediatric Anxiety — Underrecognized and Undertreated

Graham J. Emslie, M.D.

Generalized anxiety disorder, separation anxiety disorder, and social phobia are relatively prevalent disorders that affect 6 to 20% of children and adolescents.1 However, these disorders frequently go unrecognized by medical professionals. This is a critical problem, since a younger age of onset and severity of illness result in poor outcomes in adolescents and adults. Furthermore, the failure to identify these disorders early in life leads to increased rates of anxiety disorders, depression, and substance abuse later in life, as well as to educational underachievement.2 In this issue of the *Journal*, the report by Walkup et al. on the Child-Adolescent Anxiety Multimodal Study (CAMS) addresses the need of early treatment for these disorders.

It is important to understand that clinicians did not always consider anxiety disorders among children to be related to adult anxiety disorders. Once similar diagnostic criteria for anxiety disorders were developed for children and adults with the publication of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV),3,4 it was recognized that adult anxiety disorders often have their origins in childhood. For example, "overanxious disorder of childhood," once considered an age-bound condition, was then understood as part of a continuum of generalized anxiety disorder that began in childhood. After generalized anxiety disorder and social phobia were labeled with DSM-IV criteria consistent across the life span, it was clear that early onset, particularly in preadolescents, was an indicator of poor prognosis. In all, the changes in diagnostic categories that stemmed from the DSM-IV criteria have led to increasing awareness of the longitudinal effect of anxiety disorders and have permitted extrapolation of treatments from research in adults to children.

Anxiety disorders may go unrecognized in the pediatric population for several reasons. For one thing, fears and worries are common in healthy children. Normal, developmentally appropriate worries, fears, and shyness can be difficult to distinguish from anxiety disorders. For diagnosis, worries and fears must persist and must lead to impaired functioning. However, even distressing and dysfunctional symptoms are frequently unrecognized because children with anxiety disorders often report only physical symptoms (e.g., headache and stomachache) and are unable to verbalize their internalized symptoms of "worry" or "fear." Furthermore, such reported symptoms are often accommodated by family or school, and the affected child may simply avoid anxiety-provoking situations (avoidant coping). Such overaccommodation strategies may minimize the immediate symptoms yet often lead to increased difficulty in coping with these anxieties later. For example, a child with marked social anxiety may well have substantial difficulties transitioning from elementary school to junior high school if the problem is not addressed. Furthermore, a child with severe social anxiety may have less opportunity to develop the necessary social skills for success later in life because of avoidant coping. Thus, recognizing anxiety disorders in children is the necessary first step in providing treatment that would facilitate learning healthier coping skills.

These issues are central to the CAMS study. Although early randomized, controlled trials demonstrated the effectiveness of the individual treatments (antidepressant medications and cognitive behavioral therapy) used in this study, CAMS compares the two monotherapies, examines their combination, and reveals several interesting findings. First, the two monotherapies were equally

Slide 3

Why Pay So Much Attention to Anxiety?

- Up to 20% of school age children have clinical anxiety
- Negative impact in multiple domains
- "Derailing" from achievement of important developmental milestones (e.g., development of dating skills)
- Educational underachievement (e.g., Woodward et al., 2001)
- Associated with depression & suicidal ideation
- Predicts substance abuse problems & adult anxiety disorders

Slide 4

What About Specific Phobias Specifically?

- Up to 10% of community samples
- Personal, academic, & social distress
- Predict adult phobias
- Associated w/ anxiety, mood, & substance abuse down the road
- Early treatment may therefore serve a preventative role

Slide 5

Differentiating Specific Phobias from Normative Childhood Fears

- Timing
- Intensity
- Duration of fearful response
- Functional impairment
- Consider in the cultural and family context

Slide 6

Differentiating Specifica Phobias from Other Childhood Disorders

- Children with phobia and OCD may fear dogs, but the fear may extend to items touched by the dog in OCD
- Children with phobia and OCD may fear getting sick, but those with OCD may have a more elaborated fear network & varied methods of avoidance
- Children with phobia and PTSD may fear certain situations, but those with PTSD often fear triggering memories
- If fear is centered on fear of catastrophic consequences of physical sensations, panic disorder may be present

Slide 7

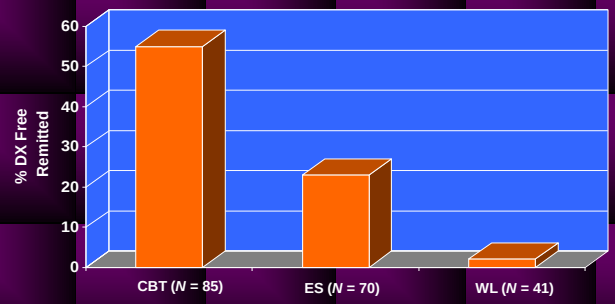
Phobia Treatment Outcome

- Little in the way of pharmacotherapy data
- Multiple studies attest to CBT's efficacy & durability
- Until recently the CBT trials were WL comparisons (Ollendick et al., 2009)
- Treatment can be conducted efficiently – sometimes in a single extended session!
- Phobias studied include animal, natural, insects, dental & situational phobias

Slide 8

CBT for Specific Phobias in Youth

(ITT Outcomes, *N* = 196)

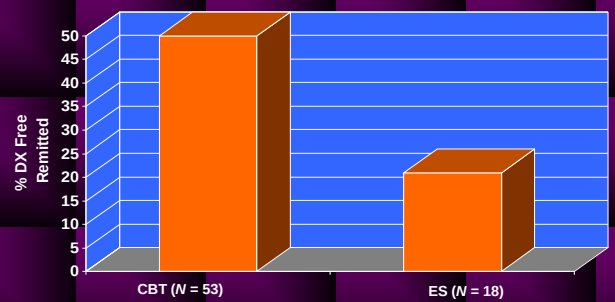


Ollendick et al. (2009), *Jnl Consul Clin Psych*

Slide 9

CBT for Specific Phobias in Youth: Follow-up

(ITT Outcomes, *N* = 196)



Ollendick et al. (2009), *Jnl Consul Clin Psych*

Slide 10

Assessment

- Parent-child diagnostic interviews (e.g., ADIS)
- Self-report measures (e.g., Spider Phobia Questionnaire, Fear Survey Schedule)
- Behavioral observation
- Parent & teacher reports
- Self-monitoring and parent-monitoring prior to and during exposure to fear-relevant cues (e.g., insects)

Slide 11

Stylistic Considerations

- Therapist as coach
- Focus on “choosing to be anxious”
- Teaching child to treat their own anxiety
- Use of humor
- “Fun time” in therapy
- Providing treatment outside of the office

Slide 12

CBT Session Structure

• Review homework sheets	~ 5 min.
• Skill exercise for given session	> 40 min.
• Fun activity - reward for effort	~ 10 min.
• Bring MAF in to discuss session	~ 5 min.

Slide 13

Psychoeducation

- Discussion of cognitive, behavioral, and physiological symptoms of anxiety
- Critical role of negative reinforcement
- Rationale and description of CBT "tools"
- Emphasis upon skill building
- Defining the role of the family
- Find out what the child can do already

Slide 14

A Simplified Theoretical Approach

"Blah, blah, blah, do the thing you're afraid of,
Blah, blah, blah, the more you do it, the easier it gets."

Gwen Franklin, age 6, to her father, 2001

Slide 15

Climbing the Exposure Hierarchy

Slide 16

What is a Hierarchy?

Slide 17

Low

Slide 18

Medium

Slide 19

High

Slide 20

Low

Slide 21

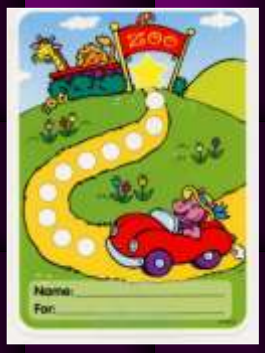
Medium

Slide 22

High

Slide 23

Rewarding Efforts: Key Element to Any Program



Slide 24

Early CBT Sessions

- Begin with only moderately distressing situations
- "Ticker-tape parades" for early successes
- Coaching and encouragement in dropping overt and covert avoidance behaviors
- Trouble-shooting and planning future exercises together
- Encouraging patience on family's part

Slide 25

Homework Typically Includes:

- Graduated exposure to feared situations
- Instructions to use skills to support exposure
- Following through on rewards for effort
- Consider any adjustments that need to be made to the fear and avoidance hierarchy

Slide 26

Moving Up the Hierarchy

- Build on past successes from earlier sessions
- Encourage patient to choose from among equivalent situations for next exposures
- Note changes in impairment & decreased symptoms to highlight improvement
- Prepare patient and family to “reach the summit”

Slide 27

Confronting the Greatest Fears

- Encouragement and praise for efforts
- Repeated and prolonged exposure to feared situations
- Continued reminders to “use toolkit”
- Confront fears in multiple contexts

Slide 28

Relapse Prevention & Wrapping Up

- Review of progress & future challenges
- Discussion of lapse *vs.* relapse
- Reinforcement of patient's new-found knowledge to combat phobic anxiety
- Relationship between anxiety & stress
- Ongoing contact & booster sessions

Slide 29

LESSONS TO BE LEARNED

- Anxiety is transient
- Avoidance strengthens fear; exposure weakens it
- Exposure is necessary for habituation
- Anxiety in *anticipation* of exposure may be higher than anxiety during *actual* exposure
- Feared consequences highly unlikely to occur – use exposure to disconfirm these

Slide 30

Working with Anxious Children in School Settings

- Some anxiety problems can be managed successfully in the school environment without referral for specific outpatient treatment
- Other anxiety problems require referral but the school staff can still play an important role
- In either case, the goals in school are to reduce avoidance and facilitate use of more adaptive coping strategies

Slide 31

When Is It Time to Do More?

Slide 32

To Refer, or Not to Refer?

- How do you know when it's time?
  - If distressing or interfering and cannot be managed at school or home
- When to refer?
  - The longer a problem goes on the harder it may be to treat
- Where to refer?

Slide 33

Contact Us

Child & Adolescent OCD, Tic, Trich & Anxiety Group (COTTAGe)

- Visit us online at:

www.med.upenn.edu/cottage

- To refer a patient or to schedule an appointment, please call:

215 ● 746 ● 3327