

**TARGETING PARENTAL ACCOMMODATION IN THE TREATMENT OF
YOUTH WITH ANXIETY: A COMPARISON OF TWO
COGNITIVE BEHAVIORAL TREATMENTS**

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ABSTRACT

Parental accommodation refers to the ways in which a parent modifies his/her behavior to avoid or reduce the distress their child experiences. Parental accommodation of youth anxiety is common, and reduction in accommodation is associated with reduced anxiety after treatment. The current study evaluated the efficacy of an adapted cognitive-behavioral therapy program (CBT) designed to address parental accommodation (Accommodation Reduction Intervention; ARI). Sixty children and adolescents (age 7-17) and their parents were evaluated for youth anxiety and parental accommodation before and after 16 weeks of treatment. Thirty youth received ARI and 30 received Coping Cat (CC). Both youth anxiety and parental accommodation were significantly reduced from pre to posttreatment in youth who received ARI as well as those who received CC. No significant difference was found between the two treatment conditions on any measure of anxiety or accommodation. Findings indicate that an adapted CBT that focuses on parent accommodation (ARI) produced favorable outcomes comparable to Coping Cat. Clinical implications and future directions are discussed.

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TABLE OF CONTENTS

	Page
ABSTRACT.....	ii
ACKNOWLEDGEMENTS.....	iii
LIST OF TABLES	v
CHAPTER	
1. INTRODUCTION.....	1
2. METHODS,.....	6
Participants.....	6
Procedure.....	6
Measures.....	7
Treatment.....	9
3. RESULTS.....	12
Preliminary Analyses.....	12
Efficacy of CC-ARI.....	13
Comparison of CC_ARI to CC.....	14
Weekly Trajectory of Accommodation and Anxiety.....	17
4. DISCUSSION.....	19
REFERENCES CITED.....	25
APPENDICES	
A. EXPANDED LITERATURE REVIEW.....	44
B. CC-ARI THERAPIST MANUAL.....	85

LIST OF TABLES

	Page
1. Pretreatment characteristics of sample.....	12
2. ARI pre and posttreatment scores	14
3. ARI and CC posttreatment scores.....	15
4. Effect size of symptom reduction in ARI and CC.....	16
5. Interaction between condition and parent factors on posttreatment anxiety	17
6. Weekly trajectory of anxiety and accommodation.....	18

CHAPTER 1

INTRODUCTION

Anxiety disorders are common and deleterious in youth, affecting between 10% and 20% of children and adolescents (Kessler et al., 2005). Anxiety disorders in youth are associated with numerous functional impairments (Swan & Kendall, 2016) and, if left untreated, place youth at greater risk for anxiety, depression, and substance abuse in adulthood, educational underachievement later in life (Pine, Cohen, Gurley, Brook, & Ma, 1998), and suicidality (Wolk, Kendall, & Beidas, 2015). Cognitive behavioral therapy (CBT) has been identified as a well-established empirically supported treatment for childhood anxiety (Hollon & Beck, 2013), with approximately 60% response rates (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008; Walkup et al., 2008). Despite this success, approximately one-third of youth who receive treatment do not see significant improvement, and some reports suggest that response rates in community settings are even more variable (Wei et al., 2014). Fifty percent of youth treated with CBT for anxiety remain symptomatic after treatment, and one-third of treatment responders relapse in following years (Compton et al., 2004). Given the prevalence of and the impairment associated with youth anxiety disorders, there is public health importance in the development of more efficacious treatments.

One factor found to play a central role in the development, maintenance, and successful treatment of anxiety in youth is *parental accommodation*. In the context of anxiety, accommodation refers to the ways in which parents or other family members act to alleviate the child's anxiety symptoms. Examples of accommodation include changing

family activities or routines so that the child can avoid a feared situation, providing reassurance about a feared stimulus, or allowing a child to sleep in a parent's bed (Flessner et al., 2011; Thompson-Hollands et al., 2014). Less common and perhaps more extreme examples of accommodation include a parent changing his/her work schedule, allowing a child to avoid performances or leave a sleepover early, and staying away from (entirely avoiding) certain places or situations (Benito et al., 2015; Flessner et al., 2011; Thompson-Hollands et al., 2014). Accommodation is common among parents of anxious youth, with 95-97% of parents of anxious youth having endorsed engaging in at least one type of accommodation. Studies have also found a relationship between symptom severity and family accommodation in youth with anxiety disorders, with greater anxiety symptoms associated with greater accommodation (e.g., Lebowitz et al., 2013). See Kagan, Frank and Kendall (2016) for review (Appendix A).

Though accommodation has been linked with symptom severity, research also highlights the positive effect that reduced accommodation may have on treatment outcomes. Decreased parental accommodation has been associated with better youth treatment outcomes for OCD (Merlo, Lehmkuhl, Geffken, & Storch, 2009), and youth with lower pretreatment levels of accommodation showed greater symptom improvements after treatment (Garcia et al., 2010; Rudy, Lewin, Geffken, Murphy, & Storch, 2014). Piacentini and colleagues (2011) found that reduced parental accommodation temporally preceded improvements in OCD-related impairment and severity over the course of treatment. These data, collectively, suggest that decreases in accommodation contribute to symptom improvements in OCD. However, few studies

have explored the role of accommodation in the treatment of anxious youth. One study (Kagan, Peterman, Carper, & Kendall, 2016) found that parental accommodation was significantly reduced from pre to posttreatment for youth receiving individual CBT for anxiety. This study also reported that the reduction in accommodation was significantly associated with the severity of youths' posttreatment anxiety, even when controlling for pretreatment youth anxiety, and that levels of pretreatment accommodation were significantly associated with positive treatment response. A reduction in accommodation has also been associated with receiving CBT for anxiety in youth with Autism Spectrum Disorders (ASD; Storch et al., 2015). Though not yet confirmed, the results are consistent with the notion that accommodation plays an important role in the treatment of youth anxiety, similar to the role it plays in the treatment of OCD.

Recent studies have begun to investigate treatments that specifically target accommodation. In OCD, Positive Family Interaction Therapy (PFIT) was developed to address difficult family interactions (e.g., conflict, blame) and specifically targets accommodation (Peris & Piacentini, 2013). Seventy percent of youth randomized to PFIT were treatment responders compared to 40% of youth randomized to CBT, with both conditions showing a comparable posttreatment decrease in family accommodation. Another targeted accommodation intervention, Supportive Parenting for Anxious Childhood Emotions (SPACE), is a 10-session program that targets the parent-child relationship by teaching parents to withdraw accommodation to address a child's need for parental protection from negative affect. SPACE has been piloted in youth with OCD and has demonstrated a reduction in symptom severity as well as a reduction in

accommodation (Lebowitz, Omer, Hermes, & Scahill, 2014). These findings are consistent with results from a meta-analysis of family involvement in the psychological treatment of OCD that found treatments that targeted family accommodation of symptoms resulted in significant improvements in patient functioning (Thompson-Hollands, Edson, Tompson, & Comer, 2014).

Despite research suggesting that interventions targeting accommodation may help to maximize the beneficial outcomes from CBT, only one study has examined an intervention that directly targets accommodation of youth anxiety. Lebowitz and colleagues (2014) reported an open trial of SPACE with 10 parents of anxious youth. Six of the ten were rated as treatment responders, with an overall significant reduction on measures of anxiety and accommodation. These findings suggest that directly targeting parental accommodation may represent an important component of CBT for anxious youth. To date there has been no study examining a cognitive behavioral intervention that targets parental accommodation and involves anxious youth as well as their parents.

To effectively target accommodation, an intervention must also target and address the factors and causes that underlie it. Accommodation is commonly believed to serve to alleviate parental anxiety and distress about seeing their child unhappy or upset (Caporino et al., 2012). In keeping with this notion, findings indicate that a parent's own avoidance, anxiety, and distress have been associated with increased accommodation (Flessner et al., 2011; Lebowitz, Panza, Su, & Bloch, 2012; Thompson-Hollands, Kerns, et al., 2014), particularly among mothers. Additionally, a study by Kerns et al. (2015) found that maternal difficulties with emotion regulation while their child exhibited

distress mediated the link between maternal anxiety and accommodation. The authors suggest that accommodation may function for the parent as an extrinsic form of emotion regulation when intrinsic strategies have failed. Thus, it is possible that particular parents would especially benefit from an intervention that targets accommodation, perhaps those mothers with high avoidance and anxiety, and difficulty tolerating distress and regulating their emotional response. Thus, research is needed to evaluate the impact of treatments that focus on parental accommodation and provide parents with alternative ways to manage their emotional experience.

The current study evaluated a CBT intervention that targets parental accommodation in youth with anxiety. The intervention is a modified version of Coping Cat (CC) that is augmented with Accommodation Reduction Intervention (ARI). Coping Cat (Kendall & Hedtke, 2006) is a 16-week cognitive behavioral therapy program for children and adolescents that has demonstrated significant reduction in anxiety symptoms (e.g. Walkup et al., 2009). The Coping Cat Accommodation Reduction Intervention (CC-ARI) incorporates specific parent-only sessions that provide psychoeducation about accommodation and provide parents with tools to manage their own emotions when watching their children experience anxiety. We hypothesized that participants in CC-ARI would demonstrate a significant reduction in anxiety and in parental accommodation from pre to posttreatment. Exploratory analyses also compared 30 matched participants who received CC to evaluate whether the targeted intervention (CC-ARI) outperformed the CC treatment, as well as whether pretreatment parental anxiety or accommodation levels are associated with treatment condition and treatment outcome.

CHAPTER 2

METHODS

Participants

Participants were 60 children and adolescents aged 7-17 seeking treatment at the Child and Adolescent Anxiety Disorders Clinic (CAADC) at Temple University and at least one parent. Families were either self-referred or referred from other mental health providers in the community. Youth were eligible for treatment if they met diagnostic criteria for at least one principal DSM 5 anxiety diagnosis (i.e. Generalized Anxiety Disorder, Social Anxiety Disorder, Specific Phobia, or Separation Anxiety Disorder); youth with co-morbid secondary diagnoses were also eligible. Youth were included in the present study if they successfully completed a course of treatment and a posttreatment assessment. Thirty youth received CC-ARI, and a matched sample of 30 youth who completed CC within the past two years served as a comparison condition. Participants who received CC were matched on parent-rated anxiety severity to those who receive CC-ARI.

Parents were mothers, fathers, or other legal guardians, as the family deemed most appropriate. Each family was encouraged to identify one parent to attend all therapy sessions and complete all study measures, though other caregivers were also welcome to attend sessions.

Procedure

Data collection took place as part of treatment for youth receiving services for anxiety. Families completed pretreatment assessments during which diagnosticians

conducted separate diagnostic evaluations with parents and with children using a semi-structured diagnostic interview for anxiety disorder. Parents and youth also completed self-report measures, at pretreatment and weekly throughout treatment (all assessment measures described below). Following treatment, families completed additional questionnaires and youth were reassessed via the same structured diagnostic interview for anxiety disorders. All procedures were conducted with the approval of Temple University's Institutional Review Board.

Measures

Anxiety Disorders Interview Schedule for DSM 5, Parent and Child Versions (ADIS-P/C; Albano & Silverman, in press). Diagnostic status was assessed at pre and posttreatment using the ADIS-P/C for DSM-5. The ADIS assesses a broad range of anxiety, mood, and externalizing behavior disorders in youth and screens for the presence of several additional disorders. The ADIS also addresses age of onset, impairment, and avoidance. The interview has demonstrated inter-rater reliability ($r=.98$ for the parent interview and $r=.93$ for the child interview; Silverman & Nelles, 1988) and retest reliability (e.g., $k=.76$ for the parent interview; Silverman & Eisen, 1992), and has shown sensitivity to treatment effects in studies of youth with anxiety disorders (e.g., Kendall et al., 1997; Dadds, Heard, & Rapee, 1992). Diagnoses were derived separately based on child report and parent report. The composite diagnosis integrates the separate information and was used for entry into the study. A clinical severity rating (CSR) was assigned by the diagnostician for each anxiety diagnosis indicating level of overall severity of the individual diagnosis. CSRs range from 0 (no anxiety) to (8 significant anxiety), with a four or higher indicating a clinical level of

anxiety. The CAADC staff have achieved ADIS-5-P/C inter-rater reliability (>.90).

CGI-I. The *Clinical Global Impression Scale – Improvement (CGI-I; Guy, 1976)* is a seven-point clinician rated scale providing a global improvement score ranging from one (Very Much Improved) to seven (Very Much Worse). Youth were rated by diagnosticians at posttreatment and were deemed positive responders if they received a diagnostician-rated CGI-I of one or two at posttreatment.

The Revised Child Anxiety and Depression Scale - Short Version (RCADS; Ebesutani et al., 2012). The RCADS is a 25-item measure that assesses symptoms of child anxiety and depression on a four-point Likert scale that ranges from zero (never) to three (always). The RCADS has six subscales that measure separation anxiety disorder, social phobia, generalized anxiety disorder, panic disorder, obsessive compulsive disorder, and major depressive disorder, as well as a total anxiety scale that combines all five anxiety scales and a total internalizing scale that sums all six subscales. The total anxiety scale was used in this study. The psychometric properties of the RCADS include internal consistency of the subscales ranges from $\alpha = .78-.88$, and significant correspondence to diagnostic status (Chorpita, Moffitt & Gray, 2005). Parents and children completed the RCADS at pretreatment, posttreatment, and weekly throughout treatment.

Pediatric Accommodation Scale, Parent Report (PAS-PR; Benito et al., 2015). The PAS is a 10-item parent-report measure that assesses the impact of accommodation on the youth and the parent, as well as the frequency of the accommodation behavior. The PAS has three subscales: Frequency (PAS-F), Parent Impact (PAS-PI) and Child

Impact (PAS-CI). All subscales of the PAS were used in analyses. The PAS has demonstrated internal consistency on each subscale (PAS-F $\alpha = .8$, PAS-PI $\alpha = .8$, PAS-CI $\alpha = .76$), and inter-rater reliability ranges from $\alpha = 0.82$ to 1.0. The PAS has demonstrated convergent and divergent validity. Parents completed the PAS at pretreatment, posttreatment, and weekly throughout treatment.

State-Trait Anxiety Inventory – A-Trait Scale (STAI; Spielberger, Jacobs, Russell, & Crane, 1983) is a 20-item self-report instrument that assesses anxiety-related symptoms and behaviors in adults. The STAI A-Trait is a psychometrically sound measure of anxiety, with internal consistencies of $>.80$ (Kendall, Finch, Auerbach et al., 1976). The revised form (eliminating the few items that overlap with depression items) was used. Parents completed the STAI at pretreatment.

Treatment

Participants in both conditions received 16, 60-minute weekly sessions. Both interventions included the core components of CBT for youth anxiety: (1) recognizing somatic reactions and anxious cognitions in anxiety-provoking situations, (2) learning strategies to cope with these reactions (i.e., relaxation; coping self-talk), (3) behavioral exposure, and (4) evaluating performance and self-reinforcement. Both treatments used behavioral training strategies such as modeling, imaginal and *in vivo* exposure, role-play, and contingent reinforcement. To help reinforce and generalize the skills, specific homework tasks were assigned. Parents were engaged as collaborators and consultants to the youth's treatment in both conditions, although the extent and nature of that involvement varied between interventions.

In CC, families received seven sessions of youth psychoeducation, two parent sessions, and seven sessions focused on exposures. The two parent sessions served to orient parents to the program, gather information regarding the youth's anxiety, answer parents' questions, and inform parents of their role in supporting their child's progress in treatment. Parents were included in exposures at the discretion of the therapist. Therapists also conducted a 10-minute check-in with parents at the end of each individual session with the youth. Of note the CC manual allows for flexibility of implementation, giving therapists the ability to focus the intervention as they see fit. The CC manual does not explicitly mention accommodation, either to require or prohibit the discussion. As a result, therapists in the CC condition were free to discuss accommodation with parents as they felt was appropriate. See the Coping Cat therapist manual (Kendall & Hedtke, 2006) for details of this intervention.

In CC-ARI, families received five sessions of youth psychoeducation, four parent sessions, and seven sessions focused on exposures. All skills taught in the seven psychoeducation sessions of CC were covered in the five psychoeducation sessions of CC-ARI. Content of the ARI parent sessions was more specifically prescribed than in the CC manual. All CC-ARI parents were introduced to the concept of accommodation, asked to identify accommodation in their relationship with their child, and taught specific skills to utilize to promote reduction of accommodation. Parents were also taught skills to address their own distress, frustration or anxiety in the context of exposures. Therapists included parents in most exposures and specifically coached parents to reduce accommodation as necessary. See the CC-ARI manual (Appendix B) for details of this intervention.

Adherence to CC-ARI was monitored by weekly progress notes, on which therapists indicated whether they met treatment goals for the session. In addition, sessions were video recorded, and a subset were reviewed by trained coders and assessed for adherence. In addition, a subset of parent CC sessions were reviewed to ensure key elements of CC-ARI were not included in CC sessions.

CHAPTER 3

RESULTS

Preliminary Analyses

All variables were normally distributed (i.e. skewness and kurtosis within acceptable range). Correlations determined that data was determined at random. Adherence to treatment protocols was excellent across both treatment conditions. Across all sessions, therapist reported that 96% of session goals had been met, and independent raters found 94% of session goals to be met. *T*-tests and chi-square tests examined potential differences at pretreatment between participants who received CC-ARI and the matched CC participants. The two conditions were not found to differ on any key demographic or clinical variables examined, including age, gender, race, accommodation, anxiety severity, or primary diagnosis. See Table 1.

Table 1. Pretreatment characteristics of sample

	Total Sample Mean (SD) or % (<i>n</i>)	ARI	Coping Cat
Age	11.63 (3.02)	11.78 (2.96)	11.50 (3.14)
Gender = Male	58.3% (<i>n</i> =35)	56.7% (<i>n</i> =17)	60.0% (<i>n</i> =18)
Primary Diagnosis (ADIS)**			
Generalized anxiety disorder	68% (<i>n</i> =41)	80.00% (<i>n</i> =24)	56.67% (<i>n</i> =17)
Social anxiety disorder	35% (<i>n</i> =21)	26.66% (<i>n</i> =8)	43.33% (<i>n</i> =13)
Separation anxiety disorder	5% (<i>n</i> =3)	3.33% (<i>n</i> =1)	6.66% (<i>n</i> =2)

Specific phobia	11.67% (<i>n</i> =7)	3.33% (<i>n</i> =1)	20.00% (<i>n</i> =6)
Primary Diagnosis CSR	5.18 (0.68)	5.10 (0.66)	5.27 (0.69)
RCADS-Parent	97.71 (14.23)	98.24 (15.63)	97.18 (13.35)
RCADS-Child	69.45 (12.36)	68.33 (13.02)	70.56 (11.77)
PAS Frequency	8.75 (4.47)	9.47 (4.70)	8.03 (4.18)
PAS Parent Impact	2.36 (2.12)	2.77 (2.46)	1.96 (1.65)
PAS Child Impact	3.22 (2.85)	3.32 (3.34)	3.10 (2.35)

ADIS = Anxiety Diagnostic Interview Schedule; CSR = Clinical Severity Rating; PAS = Parental Accommodation Scale; RCADS = Revised Children's Anxiety and Depression Scale

* $p < 0.05$

**note, may have more than one co-primary diagnosis

Efficacy of CC-ARI

For participants receiving CC-ARI, parent report of youth anxiety on the RCADS demonstrated a significant reduction from pre to posttreatment; $t(27) = 4.74, p < 0.001$, as did youth self-report anxiety on the RCADS; $t(27) = 4.43, p < 0.001$. The highest CSR on the ADIS as rated by diagnosticians was significantly lower following treatment; $t(26) = 4.51, p < 0.001$, with 40% ($n=12$) of participants rated as no longer having diagnostic levels of anxiety. Diagnosticians' ratings of improvement identified 73.3% of youth as treatment responders, with a rating of much improved or very improved on the CGI-I (CGI-I= 1 or 2). The remaining 26.7% ($n=8$) were rated as minimally improved (CGI-I=3), indicating that all participants benefited from the intervention. Parent report on the PAS also demonstrated a significant reduction from pre to posttreatment in the

frequency of accommodation, $t(25) = 5.55, p < 0.001$, parental interference associated with accommodation, $t(26) = 4.23, p < 0.001$, and youth interference associated with accommodation, $t(25) = 3.90, p < 0.001$. See Table 2.

Table 2. ARI pre and posttreatment scores

Measure	Pretreatment Mean (SD)	Posttreatment Mean (SD) or %(<i>n</i>)	t
RCADS-Parents	98.24 (15.63)	87.40 (13.00)	$t(27) = 4.47^{**}$
RCADS-Child	68.33 (13.02)	60.76 (8.72)	$t(27) = 4.43^{**}$
Primary Diagnosis CSR	5.10 (0.66)	4.01 (1.16)	$t(26) = 4.51^{**}$
Treatment Responder (CGI-I)	-	73.3% (<i>n</i> =22)	-
Full Anxiety Remission (ADIS)	-	40% (<i>n</i> =12)	-
PAS Frequency	9.47 (4.70)	4.34 (1.15)	$t(25) = 5.55^{**}$
PAS Parental Interference	2.77 (2.46)	1.44 (1.97)	$t(26) = 4.23^{**}$
PAS Child Interference	3.32 (3.34)	0.96 (1.26)	$t(25) = 3.90^{**}$

ADIS = Anxiety Diagnostic Interview Schedule; CGI-I = Clinical Global Impressions Scale – Improvement; CSR = Clinical Severity Rating; PAS = Parental Accommodation Scale; RCADS = Revised Children’s Anxiety and Depression Scale

*= $p < 0.05$; **= $p < 0.01$

Comparison of CC-ARI to CC

T-tests and chi-square tests examined potential differences at posttreatment between participants who received CC-ARI and the matched CC participants. No significant group differences were found on any posttreatment measure of anxiety,

including the parent-rated RCADS, the child-rated RCADS, or the highest ADIS CSR (all $ps > 0.05$). The number of treatment responders did not differ significantly between treatment conditions, nor did the number of participants without clinical levels of anxiety (i.e., CSR less than a 4 on the ADIS) at posttreatment (all $ps > 0.05$). Similarly, no significant difference was found between treatment conditions on the PAS, including accommodation frequency, parental interference, or youth interference (all $ps > 0.05$). See Table 3.

Table 3. ARI and CC posttreatment scores

Post-treatment measures	Total Sample	ARI	Coping Cat	t or χ^2
RCADS-Parents	88.06 (14.05)	87.40(13.00)	88.74(15.29)	t(53)=0.35
RCADS-Child	62.48 (9.17)	60.76 (8.72)	64.13 (9.44)	t(55)=1.40
Primary Diagnosis CSR	4.10 (1.08)	4.01 (1.16)	4.17 (1.02)	t(55)=0.66
Treatment Responder (CGI-I)	70.0% (n=42)	73.3%(n=22)	66.7%(n=20)	$\chi^2[1]= 0.32$
Full Anxiety Remission (ADIS)	35.0% (n=21)	40% (n=12)	30% (n=9)	$\chi^2[1]= 0.66$
PAS Frequency	4.33 (3.91)	4.34 (1.15)	4.25 (3.94)	t(50)=0.04
PAS Parental Interference	1.07 (1.44)	1.44 (1.97)	1.89 (2.42)	t(52)=0.56
PAS Child Interference	1.67 (2.20)	0.96 (1.26)	1.19 (1.62)	t(52)=0.74

ADIS = Anxiety Diagnostic Interview Schedule; CGI-I = Clinical Global Impressions Scale – Improvement; CSR = Clinical Severity Rating; PAS = Parental Accommodation Scale; RCADS = Revised Children’s Anxiety and Depression Scale

*= $p < 0.05$

Cohens *d* was used compare the effect sizes of the two treatments. The reduction of anxiety on the child and parent report of the RCADS was found to have a medium effect in both ARI and CC, while the reduction of primary diagnosis severity on the ADIS was found to have a large effect in both groups. Regarding the reduction in accommodation, the reduction in frequency of accommodation was large in both treatment conditions. ARI demonstrated a large effect in the decrease of parental interference, and child interference, while CC demonstrated a medium effect. There was no statically significant difference in effect sizes between treatments on any measure examined (all *ps* > 0.05).

Table 4. Effect size of symptom reduction in ARI and CC

	ARI	CC	Z score
RCADS-Parents	0.77	0.62	0.03
RCADS-Child	0.72	0.60	0.05
Primary Diagnosis CSR	1.14	1.26	-0.35
PAS Frequency	1.34	0.97	0.24
PAS Parental Interference	1.01	0.42	0.99
PAS Child Interference	0.88	0.53	0.44

CGI-I = Clinical Global Impressions Scale – Improvement; CSR = Clinical Severity Rating; PAS = Parental Accommodation Scale; RCADS = Revised Children’s Anxiety and Depression Scale

*=*p*<0.05

Exploratory analyses assessed whether baseline parental characteristics interacted with (moderated) treatment condition to affect outcomes. Linear regressions examined pretreatment parental trait anxiety and found no significant interaction with treatment ($p > 0.05$). Similarly, no significant interaction was found between treatment condition and accommodation frequency, parental interference, or youth interference (all $ps > 0.05$). See Table 5.

Table 5. Interaction between condition and parent factors on posttreatment anxiety

	B	B (SE)	t
PAS Frequency x Treatment	-0.58	-1.12 (1.57)	-0.71
PAS Parental Interference x Treatment	-0.18	-0.67 (3.37)	-1.20
PAS Child Interference x Treatment	1.26	3.50 (2.35)	1.50
STAI Parental Anxiety x Treatment	0.00	0.00 (0.49)	0.01

PAS = Parental Accommodation Scale; STAI= State-Trait Anxiety Inventory
 *= $p < 0.05$

Weekly Trajectory of Accommodation and Anxiety

Latent growth modeling explored whether treatment condition influenced the trajectory of the reduction in anxiety, as measured weekly throughout treatment by parents on the RCADS. A chi square test found the model to be a poor fit ($X^2 = 518.81$, $p = 0.00$), with the root mean square error of approximation also indicating poor fit of the model (RSMSEA = 0.18, 90% CI [0.15-0.19]). Treatment condition was not found to be associated with or to predict rate of change (slope = -0.11, $p > 0.05$). Similar results were

found when examining the weekly trajectory of accommodation on the PAS. A chi square test and RMSEA both found the model to be a poor fit ($X^2=317.25$, $p = 0.00$; RSMSEA = 0.11, 90% CI [0.09-0.131]). Treatment condition was not found to be associated with or predict rate of change in accommodation (slope = -0.07, $p > 0.05$). Accommodation intercept and slope were found to be correlated ($r=-0.38$, $p < 0.01$), indicating that those with higher pretreatment accommodation experienced a faster reduction in accommodation across treatment, regardless of condition. See Table 6.

Table 6. Weekly trajectory of anxiety and accommodation

	X^2	RMSEA [90%CI]	Intercept on Treatment Estimate (SE)	Slope on Treatment Estimate (SE)	Slope with Intercept Estimate (SE)
RCADS	518.81*	0.18 [0.15-0.19]	1.58(3.02)	-0.11 (0.16)	-1.41(1.11)
PAS	317.25*	0.11 [0.09-0.131]	1.017 (0.96)	-0.07 (0.06)	-0.38 (0.12)*

PAS = Pediatric Accommodation Scale; RCADS= Revised Children’s Anxiety and Depression Scale

*= $p < 0.05$

CHAPTER 4

DISCUSSION

The present study examined the efficacy of an intervention targeting parental accommodation in the context of individual treatment for anxious youth. Results indicate that youth anxiety decreased significantly from pre- to post-treatment, with a majority of participants classified as treatment responders. Parental accommodation frequency and impact were also significantly reduced from pre to posttreatment. This study is the first to evaluate the CC-ARI and the findings provide initial support for its efficacy. Additional analyses that compared the efficacy of CC-ARI to CC identified that the outcomes were comparable. Together, the findings suggest that the efficacy of CC-ARI is comparable to CC, although it does not outperform it.

Given research findings that suggest an association between reductions in both accommodation and anxiety over the course of treatment for anxiety (e.g. Kagan et al. 2015), there have been a number of calls for interventions that specifically target accommodation (e.g. Rudy, Lewin, Geffkin, Murphy and Storch, 2014). Although a small number of such interventions have been developed, this is the first study to compare an intervention that targeted accommodation with an empirically supported application of CBT. Given results from a meta-analysis that found treatments that targeted family accommodation of symptoms resulted in greater improvements in patient functioning than those that did not do so (Thompson-Hollands et al, 2014), the current findings indicating no difference between conditions are somewhat surprising. However, current research is unclear regarding the amount of focus on accommodation that is necessary. Of

note, Thompson-Holland and colleagues considered “instructions to parents to reduce accommodation” to constitute an intervention that targeted accommodation, a bar met by 83% of the studies included in that meta-analysis. This may indicate that a relatively small focus on accommodation is sufficient to improve outcomes. Given the flexibility of the CC manual, a brief discussion of accommodation is easily incorporated into the two parent sessions. Thus, it may not be accurate to conclude that targeting accommodation did not add to outcomes, but rather to state that even modest efforts to address accommodation constitute effective intervention. It remains unclear what amount and manner of discussion of accommodation is needed to optimize outcomes.

The theory that a small focus on accommodation is sufficient to promote reduction is consistent with findings from our latent growth analyses. Although no significant interaction was found between treatment and accommodation or anxiety slope, a significant association was found between accommodation intercept and accommodation slope. In other words, those participants with higher pretreatment accommodation demonstrated a faster reduction in accommodation across treatment, regardless of condition. Although this change may reflect regression to the mean, it may indicate that among those parents with the most accommodation, even a modest amount of accommodation-focused intervention may be sufficient to promote significant reduction. To our knowledge, this is the first study to examine the weekly trajectory of accommodation over the course of treatment. However, given the poor fit of the model used to examine these questions, no definitive interpretation can be reached. Of note, a previous study examining the trajectory of OCD symptoms every four weeks of treatment

found symptoms to decrease more rapidly in a family-involved treatment, with a marginally faster decline in accommodation in the family-involved treatment (Piacentini et al., 2011). These findings may reflect a difference between the treatment of OCD and anxiety, or they may suggest that a higher level of family involvement is necessary to alter the trajectory of symptom reduction. Future research should aim to further explore the trajectory of the reduction in accommodation and anxiety.

The current study found no difference between interventions on anxiety symptoms at the posttreatment assessment. However, it is possible that differential impact of the interventions would be found when examining other measures of outcomes, such as functional outcomes or maintenance of gains. In fact, the meta-analysis cited above found a relationship between interventions that targeted accommodation and improvements in patient functioning, yet the same study found no such relationship to symptom reduction (Thompson-Holland et al, 2014). This may indicate that teaching parents to reduce accommodation as a part of treatment does not impact the amount of anxiety remaining after treatment, but rather reduces the functional impact of those remaining symptoms. Future studies should examine the relationship between targeted interventions, accommodation reduction, and child functioning.

Similarly, although both interventions demonstrated comparable symptom reduction at posttreatment, it is possible that ARI may represent a promising strategy in assisting families to maintain the gains of treatment over the course of several years. Maintaining a reduction in anxiety symptoms is likely due to ongoing engagement with an “exposure mindset” of approach rather than avoidance. Although therapist-led

exposures may be sufficient to reduce symptoms during treatment, it is possible that parent-involved exposures that focus on the reduction of accommodation are necessary to assist families in acquiring this shift in mindset. For children and adolescents, the involvement of parents and the focus on reducing of accommodation may be key in increasing the longitudinal impact of the intervention. Additional research is needed to explore the impact of ARI at various follow-up time points.

Another area in need of further inquiry is the question of individual characteristics that may identify families that would benefit from a targeted intervention. No significant difference was found between treatment conditions, suggesting that a majority of families benefit from CBT either with or without a specific focus on accommodation. Nevertheless, there is the possibility that a subset of families would benefit from a more targeted intervention, and certain characteristics should be considered as potential moderators. Parental anxiety is one of the characteristics most likely to indicate a family in need of additional, targeted intervention. Although exploratory analyses in the present study found no significant interaction between parental anxiety and treatment condition, there is a body of research associating parental anxiety both with increased accommodation (Lebowitz et al, 2013) as well as with reduced maintenance of gains in youth successfully treated for anxiety (Kendall et al., 2008). Further research is needed to explore the role of parental anxiety, its impact on parental accommodation across treatment, and its function as a potential moderator of outcomes. A number of other parent and youth factors may be associated with a need for targeted focus on accommodation during treatment. For example, potentially important parenting factors

include parental emotion regulation, distress tolerance, and family burden; potentially important youth factors include age, comorbidity, principal diagnosis, and insight (see Kagan, Frank & Kendall, 2016 for a review of relevant factors). These factors should be examined individually and in combination, as certain parent-child profiles may indicate the utility of targeted intervention. There is also a need for research that takes a person-centered approach to examining the impact of ARI on subgroups of families. As latent profile analysis found parental psychopathology and family dysfunction to represent a separate subgroup of anxious youth (Norris, Olin, Gosch et al., 2018), it is possible that such a subgroup may identify those families that would most benefit from a targeted intervention like ARI.

The present findings have important clinical implications. CBT (i.e., Coping Cat) is well-established as an evidence-based treatment for child and adolescent anxiety. Knowing that a variation of CBT that targets parental accommodation has comparable outcomes allows therapists to choose which intervention they deem to be most appropriate for a particular family. In cases where family accommodation seems especially problematic, it will be valuable to have an evidence-based option. Though therapists must currently rely on clinical judgement, future studies should seek to develop empirical guidelines for this decision.

Findings should be considered in light of limitations. First, although sufficient for examining initial efficacy, the sample size limited our ability to explore additional research questions. Second, participants were assigned to either CC-ARI or CC based on the time they sought services rather than randomly assigned to a treatment condition.

That said, participants were matched on level of pretreatment anxiety and no significant difference was found between treatment conditions on any key variable. Despite these limitations, this is the first study to examine the efficacy of CC-ARI, suggesting that it is comparable to traditional CC, although it does not outperform it.

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APPENDIX A
EXPANDED LITERATURE REVIEW

Targeting Accommodation in the Treatment of Youth with Anxiety
Preliminary Examination, May 2017

Anxiety disorders are among the most common mental health problems in youth, affecting between 10 and 20% of children and adolescents (2005). Anxiety disorders in youth are associated with numerous functional impairments (Swan & Kendall, 2016), including impaired academic achievement (e.g. King & Ollendick, 1989), difficulty with social and peer relations (e.g. Chansky & Kendall, 1997), substance use (Lopez, Turner, & Saavedra, 2005) and suicidal attempts and ideation (Rudd, Joiner, & Rumzek, 2004; Wolk, Kendall, & Beidas, 2015). If untreated, anxiety disorders persist into adulthood, placing youth at greater risk for anxiety, depression, substance abuse, educational underachievement later in life (Pine, Cohen, Gurley, Brook, & Ma, 1998) and suicidality (Wolk et al., 2015). Given the prevalence of and the impairments associated with youth anxiety disorders, there is public health importance in understanding how to best treat these debilitating disorders.

Cognitive behavioral therapy (CBT) has been identified as a well-established empirically supported treatment for childhood anxiety (Hollon & Beck, 2013). Approximately 60% of youth respond to CBT in large randomized clinical trials, with

even higher numbers responding to combined treatment with medication (Walkup et al., 2008). Despite the high success rate of CBT, over a third of youth do not see significant improvement, with response rates in community settings that are even more variable (Wei et al., 2014). Fifty percent of youth treated with CBT for anxiety remain symptomatic after treatment, and one third of responders relapse in following years (Compton et al, 2004). Thus it is extremely important to further elucidate factors that may influence treatment outcome in order to facilitate the development of more efficacious treatments.

One important component that has received considerable attention is the role that parents play in the treatment of their children. Parents are believed to play an important role in the development and maintenance of anxiety in youth (e.g. Ginsburg, Siqueland, Masia-Warner, & Hedtke, 2004). Yet despite the impact of parenting factors on anxiety in youth, research has yielded mixed results regarding the impact of parental involvement in treatment (see Wei & Kendall, 2014, for review). Some have argued that the difference across specific interventions as to the nature of the involvement may account for these findings. Others have suggested that key parenting factors must be targeted in treatment for maximal benefit (Wei & Kendall, 2014). One such key factor to target may be parental accommodation.

In the context of anxiety, accommodation refers to the ways in which parents or other family members act to alleviate the child's symptoms. Examples of parental accommodation include changing family activities or routines so that the child can avoid a feared situation, providing reassurance about a feared stimulus, or allowing a child to

sleep in a parent's bed (Flessner et al., 2011; Thompson-Hollands et al., 2014). Accommodation is common among parents of anxious youth, with 95-97% of parents of anxious youth having endorsed engaging in at least one type of accommodation (Benito et al., 2015; Lebowitz et al., 2014a; Thompson-Hollands et al., 2014). The presence of parent accommodation has also been linked to more severe levels of child anxiety (Kagan, Frank, & Kendall, in press). Although parental accommodation may be well intentioned, it is in direct conflict with the emphasis that exposure-based therapy places on reducing avoidance and tolerating discomfort (Peterman, Read, Wei, & Kendall, 2015; Thompson-Hollands, Edson, Tompson, & Comer, 2014). Indeed, research has found that higher levels of pretreatment parental accommodation significantly predicts reduced gains in youth anxiety following treatment (Kagan, Peterman, Carper, & Kendall, 2016).

Research exploring parental accommodation in the context of anxiety in youth is a relatively new area of inquiry. This paper reviews the existing literature regarding the parental accommodation in anxious youth, drawing on the literature of accommodation in childhood OCD to highlight areas in need of future investigation. It then reviews the key literature on parental involvement in the treatment of child anxiety, concluding by considering how, in light of these two areas of inquiry, parental accommodation might be most effectively targeted in the treatment of child anxiety.

Accommodation in Youth with Anxiety

Accommodation was initially investigated in the context of adult OCD (e.g. Calvocoressi et al., 1995) with the vast majority of relatives of adult patients with OCD reporting that they provide some form of accommodation. Research demonstrates

that accommodation is also common among family members of youth with OCD and anxiety. Though the majority of research on family accommodation has been conducted within the context of OCD, recent efforts have focused on explaining the role of accommodation in youth anxiety disorders. Several recent efforts have developed and validated new measures of family accommodation in youth anxiety, providing information about the nature and frequency of accommodation in this population. A few studies have begun to examine the role of accommodation in the treatment of anxious youth. The following section reviews the existing literature, first by establishing what is known about accommodation in youth with OCD, and then by reviewing what research has explored these questions in youth with anxiety.

Before reviewing the literature, a note about terminology is warranted. When speaking of youth with anxiety, the terms *family accommodation* and *parental accommodation* are used interchangeably. Family accommodation was the initial term developed in the context of adult OCD, and was intended to capture accommodation by both spouses and parents. The term was carried into the research of youth with OCD, though research focused almost exclusively on accommodation by parents. Similarly, in families of youth with anxiety, the study of accommodation rarely captures accommodation by siblings or other family members besides parents. The term *parental accommodation* is therefore generally more accurate, but is less commonly used. In this review, as in the literature more broadly, both terms will be used to refer to the same construct. In those places where additional research on the broader accommodation in a family may be warranted, this will also be noted.

Prevalence and Presentation

Family accommodation was first studied in adults with OCD, with 88.2% of caregivers accommodating adults with OCD at least once a month, though a significant portion endorsed more frequent, even daily, accommodation (Calvocoressi et al., 1995). Numerous subsequent studies have supported these findings in pediatric samples. In the Pediatric OCD Treatment Study (POTS I), for example, 96 youth age 7-17 youth received treatment for OCD; of these, 99% reported engaging in accommodating behavior (Flessner, Freeman, et al., 2011). Accommodation is frequent as well as common, with the majority of parents reporting that they provide accommodation at least once a day (Flessner, Freeman, et al., 2011; Futh, Simonds, & Micali, 2012; Peris et al., 2008). Two kinds of accommodation are reported by parents of youth with OCD: participation in compulsions, such providing objects needed for a ritual, and avoidance of triggers, such as avoiding going places because of the child's OCD (Flessner, Sapyta, et al., 2011).

Research findings indicate that accommodation is similar in families of youth with anxiety disorders as it is in youth with OCD. One study of treatment-seeking school age children in the US and Israel found that 97.3% of parents endorsed at least one type of accommodation behavior (Lebowitz et al., 2013). The frequency of this accommodation varied from monthly to daily, with 45.3% of parents providing daily reassurance and 30.7% of parents participating daily in anxiety-related behaviors. Another study by Benito and colleagues (2015) also found a substantial majority of parents of clinically anxious youth aged 5-17 to endorse at least one form of

accommodation in the past week, with 95.5% endorsing accommodation on a self-reported measure, and 97.1% endorsing accommodation in a clinician rated interview. In this sample, 97.1% of parent reported providing accommodation in the past month and 71% reported facilitating avoidance in the past week. A third study by Thompson-Holland and colleagues found similar rates in youth 4-18. As in OCD, two aspects of family accommodation have emerged in parents of youth with anxiety: participation in the youth's symptoms, and modification of family routine (Lebowitz et al., 2013). Both types of are common in youth with anxiety (Lebowitz et al., 2014b), with providing reassurance and facilitating avoidance among the most common forms of parental accommodation reported (Benito et al., 2015).

Approximately 70-80% of parents of youth with anxiety disorders report experiencing distress as a result of their accommodation, also noting that their accommodation is associated with impairment for their child at home and at school (Benito et al., 2015; Lebowitz et al., 2013). However, parents also report negative consequences in those instances that they do not accommodate, including exacerbation of the child's anxiety, or the child becoming abusive (Lebowitz et al., 2013). In contrast, 65% of youth with anxiety disorders report that they feel less anxious when their parents accommodate, with only 25% endorsing the belief that their parents should accommodate them less (Lebowitz, Scharfstein, et al., 2014a). When child and parent ratings of parental accommodation are compared, agreement is good on items capturing the presence of accommodation, but poor for items capturing maternal distress and consequences of accommodation (Lebowitz, Scharfstein, et al., 2014a). This discrepancy

suggests that children are less aware of the impact of parental accommodation than of the presence of the accommodating behaviors themselves.

Overall, research on parental accommodation in parents of anxious youth suggests that accommodation is similar in terms of prevalence and presentation in youth with anxiety and OCD. Indeed, in the one study that made an initial comparison (Lebowitz, Scharfstein, and Jones, 2014b), the findings indicated that maternal accommodation is highly prevalent in youth age 7-17 meeting diagnostic criteria for anxiety or OCD, with no significant difference on any specific accommodation items. In contrast, mothers of youth who did not meet diagnostic criteria reported significantly less accommodation and distress, suggesting that, although accommodation may function differently in non-clinical populations, it is likely similar across clinical groups (Lebowitz et al., 2014b).

Symptom Severity and Functional Impairment

Studies characterizing families seeking treatment for youth OCD report that accommodation is related to increased OCD symptom severity and functional impairment (Bipeta, Yerramilli, Pingali, Karredla, & Ali, 2013). Research has indicated that compulsion severity was one of two significant predictors of the magnitude of family accommodation (Flessner, Freeman, et al., 2011; Peris et al., 2008). Parents are also likely to report higher levels of accommodation for youth who are taking medication, which may be a proxy for symptom severity (Peris et al., 2008). Studies have found that family accommodation mediated the relationship between OCD symptom severity and functional impairment (Bipeta et al., 2013; Caporino et al., 2012; Storch et al., 2007), though all were cross-sectional studies and as such did not establish temporal precedence

in the mediational relationship. Nonetheless, this suggests that family accommodation may be a mechanism through which OCD symptom severity can result in greater impairment, though further research is indicated.

In the context of the treatment of OCD, accommodation is also associated with symptom severity. Accommodation has been associated with treatment-resistant OCD (Storch et al., 2008) and low in-session adherence (Morgan et al., 2013; Storch, et al., 2010; Storch et al., 2010). There is also a relationship between apprehension about treatment and accommodation, with parents of youth who are more reluctant about treatment likely to provide increased accommodation (Selles, Rowa, McCabe, Purdon, & Storch, 2013).

Studies have also found a relationship between symptom severity and family accommodation in youth with anxiety disorders, with higher accommodation associated with greater anxiety (Lebowitz et al., 2013). This association with symptom severity is strongest with clinician-rated family accommodation (as compared to parent-report), suggesting that parents may have more limited understanding of their own accommodation (Benito et al., 2015). Lebowitz and colleagues (2014b) reported a significant correlation between symptom severity and overall accommodation in mothers of youth with both anxiety and OCD, but failed to find a similar relationship in the control group. Thus, it is possible that when parents are less responsive to their parent's anxiety and do not accommodate, a clinical level of symptoms does not emerge (Lebowitz et al., 2014b).

Treatment Outcome

Though accommodation has been linked with symptom severity, research also highlights the positive effect that reduced accommodation may have on treatment outcomes. A study by Merlo, Lehmkuhl, Geffken, and Storch (2009) found that decreased accommodation was associated with better treatment outcomes, even after controlling for pretreatment OCD severity. Garcia et al. (2010) also found that youth with lower levels of accommodation showed greater improvements after treatment for OCD. Similarly, in a study examining predictors of treatment response to intensive treatment of pediatric OCD, (Rudy, Lewin, Geffken, Murphy, & Storch, 2014) family accommodation was identified as a predictor of posttreatment symptom severity. A study by Piacentini et al. (2011) examining treatment for youth with OCD, found that reduced parental accommodation temporally preceded improvements in OCD-related impairment and severity. These data, collectively, suggest that decreases in accommodation contribute to symptom improvements. Other studies have shown a reduction in family accommodation following weekly (Waters, Barrett, & March, 2001) and intensive CBT for OCD (e.g. Storch et al., 2007; Storch et al., 2010; Whiteside et al., 2014).

Few studies have explored the role of accommodation in the treatment of anxious youth. One study (Kagan et al, 2016) found that parental accommodation was significantly reduced from pre- to post-treatment for youth receiving individual CBT. The findings indicated that the reduction in accommodation was significantly associated with the severity of youths' post-treatment anxiety, even when controlling for pre-treatment youth anxiety, and that levels of pre-treatment accommodation was significantly associated with treatment response. A reduction in accommodation has also been

associated with receiving CBT for anxiety in youth with Autism Spectrum Disorders (ASD). Using Behavioral Intervention for Anxiety in Children with Autism (BIACA; Wood et al., 2009), Storch and colleague's (2015) study of 24 youth with ASD and anxiety found accommodation to be associated with pretreatment symptom severity, as well as with posttreatment anxiety reduction. Though preliminary, these results are consistent with the notion that accommodation plays an important role in the treatment of youth anxiety, similar to the role it plays in the treatment of OCD.

Recent studies have specifically investigated treatments of OCD that target accommodation. Peris and Piacentini (2013) compared Positive Family Interaction Therapy (PFIT) and CBT for 20 youth with OCD and their families. PFIT addresses difficult family interactions (e.g., conflict, blame) and specifically targets accommodation. 70% of youth randomized to PFIT were treatment responders compared to 40% of youth randomized to standard CBT, with both conditions showing a comparable posttreatment decrease in family accommodation. In another intervention study, Lebowitz and colleagues (2013) evaluated Supportive Parenting for Anxious Childhood Emotions (SPACE), a 10-session program to help parents reduce accommodation. SPACE targets the parent-child relationship by teaching parents to withdraw accommodation to address a child's need for parental protection from negative affect. The pilot evaluation found that both OCD symptom severity and family accommodation were reduced significantly at posttreatment. Lebowitz and colleagues (2014) also targeted accommodation in a family-based treatment for preschool age children with OCD. Again, OCD symptoms improved significantly and family

accommodation was significantly lower at posttreatment and at follow-up. These evaluations provide promising preliminary evidence for the beneficial gains that may result from treatments for OCD in youth that target accommodation. These findings are consistent with results from a meta-analysis of family involvement in the psychological treatment of OCD. That report (Thompson-Hollands, Edson, Tompson, & Comer, 2014) noted that treatments that targeted family accommodation of symptoms resulted in significant improvements in patient functioning. Taken together, research suggests that interventions targeting accommodation will likely maximize beneficial outcomes.

At present, only one study has examined an intervention that directly targets accommodation of youth anxiety. Lebowitz and colleagues (2014) reported an open trial of SPACE with 10 parents of anxious youth age 9-13. Six of the ten were rated as treatment responders, with an overall significant reduction on measures of youth anxiety and accommodation. This finding suggests that directly targeting parental accommodation may represent an important option for anxious youth who refuse treatment, though replication is needed in a larger sample of youth. To date there has been no study that examined an intervention targeting parental accommodation that involves anxious youth as well as their parents. Given the prevalence of individual CBT for anxious youth, further studies are needed.

Associated Factors

Accommodation is well established in families of youth with anxiety, as well as those with OCD, but a number of questions remain about the nature of this relationship. The development of youth anxiety is a complex, multi-determined processes, and

numerous factors may interact to contribute to the maintenance of symptoms. Recent research has begun to examine potential factors that may be associated with the development and maintenance of family accommodation. The following section explores a variety of child and parent factors that have been explored by recent research.

Principal diagnosis. Research has explored differences in family accommodation across youth with anxiety disorders. Accommodation has been found to be highest in youth age 4-18 with generalized anxiety disorder (GAD) and separation anxiety disorder (Sep) (Thompson-Hollands et al., 2014). The prevalence of accommodation in Sep is somewhat expected given the inherent involvement of parents in the presentation of Sep. Accommodation may be high in GAD because GAD comes with intolerance of uncertainty and increased need for reassurance—both pulling for accommodation (Thompson-Hollands, et al., 2014). Accommodation of social anxiety disorder was rated as less frequent, but more impairing. Another study by Benito and colleagues (2015), however, reported no difference in accommodation across specific diagnoses, although it is possible the study was not fully powered to detect differences between diagnostic groups. Further research is needed to fully explore the question of diagnostic differences in accommodation.

Comorbidity. Co-occurring problems, often considered a reflection of more severe psychopathology, may influence the amount of parental accommodation that is provided. In a study by Lebowitz and colleagues (Lebowitz et al., 2013), the youth's total number of diagnoses was significantly associated with accommodation. Similarly, comorbid internalizing problems (e.g., depressive disorders) were associated with higher

levels of accommodation in youth with OCD, (Storch et al., 2012; Wu, Lewin, Murphy, & Geffken, 2014), a finding that has recently been replicated in youth with anxiety (Benito et al., 2015). Such findings could suggest that accommodation leads to decreased feelings of self-worth, though it may also indicate that parents are more likely to provide accommodation when children experience the combination of both anxiety and depression. In contrast, general internalizing symptoms in youth with ASD and anxiety had no association with accommodation (Storch, Zavrou, et al., 2015).

Child externalizing problems are significantly and positively associated with accommodation in OCD (Caporino et al., 2012; Morgan et al., 2013; Storch et al., 2007; Wu et al., 2014). Indeed, externalizing symptoms have been found to mediate the association between symptom severity and accommodation (Wu et al., 2014). Relatedly, youth with OCD who were described as dysregulated received more accommodation than youth with OCD who were not dysregulated (McGuire et al., 2013).

The findings of several studies of youth with OCD point to a coercive cycle involving youth disruptive behavior and parental accommodation, which may explain the increased presence of accommodation when co-occurring problems are identified (Lebowitz, Vitulano, & Omer, 2011; Storch, Lewin, Geffken, Morgan, & Murphy, 2010). Youth are reported to use physical violence or aggression, verbal abuse, and other forms of disruptive behavior, to coerce family members into assistance with rituals or the avoidance of anxiety-provoking situations. In this way, parents are forced to engage in accommodation, leading to high levels of parental distress and helplessness (Lebowitz et al., 2011) and higher levels of accommodation (Lebowitz, Scharfstein, et al., 2014b).

Children who have rage attacks may force parents to provide accommodation, leading to greater OCD-related impairment and severity in the long term and in turn, contributing to the maintenance of the coercive cycle.

The results linking externalizing problems to accommodation are not consistent with studies among youth with anxiety, where findings did not indicate a significant association between accommodation and the presence of an externalizing disorder (Benito et al., 2015; Storch, Salloum, et al., 2015). It is unclear if this discrepancy represents some underlying difference in the underlying characteristics of accommodation in OCD and anxiety. Of note, parents of youth with anxiety and OCD both report oppositional behavior when they do not accommodate their child's anxiety, suggesting concerns about exacerbating externalizing problems often serve as a motivation for accommodation in both disorders.

Age. Child age has been investigated in association with accommodation, but the results are mixed. Some data indicate that age was not associated with accommodation of anxiety in youth (Lebowitz et al., 2013) or OCD (Flessner, Freeman, et al., 2011). Another study (Thompson-Hollands, Kerns, et al., 2014) found a significantly greater range of accommodation in the parents of younger children, though the associated interference did not differ. Some have speculated that parent accommodation would be greater for younger children, as parents of younger children may be less aware of what represents a developmentally inappropriate level of accommodation (Thompson-Hollands, Kerns, et al., 2014). Alternatively, accommodation may have a greater scope in younger children because parents have more areas of interaction (Masten, Faden, Zucker,

& Spear, 2009), whereas accommodation may be less likely in adolescence because parents expect greater independence and capability from older children. Given mixed findings, developmental research is indicated to explore the emergence and maintenance of accommodation.

Child insight. Child insight, or awareness and understanding of one's symptoms, may be associated with accommodation. Bipeta and colleagues (2013) categorized 35 treatment-naïve youth with OCD as having either high or low insight. Children in the low-insight group were found to have greater levels of accommodation from family members compared to children in the high-insight group. Parents of children with lower insight reported providing higher levels of accommodation (Storch et al., 2009) but, as the authors noted, the direction of this finding is unclear. It may be more difficult to reason with children with low insight, leading to greater levels of accommodation. Alternatively, children who receive high levels of accommodation may become less aware of the negative impact of their symptoms and appear to have lower self-awareness. Insight has not yet been explored in relation to accommodation of youth anxiety, but given the similarity in presentation between accommodation in youth with anxiety and OCD, it is an important area of inquiry.

Parent psychopathology. One parent factor often investigated in relation to accommodation is the degree of parental psychopathology, particularly parental anxiety. Parental anxiety has been implicated in the development and maintenance of child anxiety, and has also been demonstrated to reduce the maintenance of gains in youth successfully treated for anxiety (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg,

2008). Indeed, high levels of parent anxiety interferes with the development of a parent's own coping skills (Ginsburg et al., 2004) and anxious parents often model anxious thoughts and behaviors to their children (Whaley, Pinto, & Sigman, 1999). Children of anxious parents may be more likely to develop maladaptive beliefs about the nature and manageability of anxiety, and the provision of parental accommodation would reinforce these beliefs. For example, youth with anxiety disorders are more likely than non-anxious peers to have parents who support anxious interpretations and avoidant strategies (Barrett, Rapee, Dadds, & Ryan, 1996). This suggests that parental anxiety may play a key role in accommodation.

Research findings indicate that accommodation is predicted by parental anxiety (Flessner et al., 2011; Storch et al., 2008), and increased parental anxiety has been associated with increased accommodation in youth with anxiety (Lebowitz et al., 2013) and youth with OCD (Frank et al., 2014). Thompson-Hollands and colleagues (2014) found that mothers' symptoms of anxiety and stress were related to the extent of maternal accommodation of youth with anxiety, as well as the amount of associated impairment, though no such association was found for fathers. Similarly, Futh et al (2012) found accommodation for youth with OCD was correlated with stress and anxiety as measured by the Depress Anxiety and Stress Scale in mothers, but not fathers. A parent's own avoidance has also been found to be positively correlated with accommodation of their child's anxiety (Flessner, Freeman, et al., 2011; Futh et al., 2012), and a study by Jones and colleagues (2015) found maternal accommodation to mediate the relationship between symptoms of anxiety in mothers and youth, although this was a cross-sectional

study and thus did not establish temporal precedence. Additionally, one study found accommodation frequency moderated the link between maternal and child anxiety (Kerns, Pincus, McLaughlin, & Comer, 2015). Taken together, these results suggest that maternal anxiety in particular plays a key role in parental accommodation of youth anxiety. Accommodation may even play a crucial role in the transgenerational transmission of anxiety. For example, anxious mothers may be more likely to accommodate their child's fears, promoting avoidance that may ultimately lead to increased anxiety in the youth. However, further research is needed to provide elucidation into the nature of that relationship.

The degree of association between accommodation and parent depression has been studied, but the findings are inconsistent. One study reported that increased parental depressive symptoms were associated with a greater parent-reported impact of accommodation (Benito et al., 2015) but other studies have found no association between accommodation and parental depression (Thompson-Hollands et al., 2014) Where found, accommodation was associated with depression in mothers but not fathers (Futh et al., 2012), a finding that is in keeping with findings highlighting the influence of maternal over paternal anxiety. Additional research should examine the role of parental depression, as well as other forms of parental psychopathology that have not yet been explored.

Parent emotion regulation. Emotion regulation, a broad term encompassing the way an individual experiences and responds to both positive and negative emotions (Gross, 2015), may contribute to parental accommodation. One study by Kerns and colleagues (2015) found that maternal difficulties with emotion regulation while their

child exhibited distress mediates the link between maternal anxiety and accommodation. The authors suggest that accommodation may function as an extrinsic form of emotion regulation on the part of the parent when more intrinsic strategies have failed. Such mothers may particularly require other tools to regulate their emotional response in order to reduce their accommodation. Future research should explore the role of emotion regulation in fathers of anxious youth, as well as the impact this has on the reduction of accommodation over the course of treatment.

Family burden. Accommodation may adversely affect parents, siblings, and other caregivers. The burden of caring for and accommodating a child's disorder has been studied in OCD in particular. A significant parental emotional burden has been found for those caring for a child with OCD (de Abreu Ramos-Cerqueira, Torres, Torresan, Negreiros, & Vitorino, 2008; Peris et al., 2008), with parents also reporting negative affect and distress emerging from the effort required to accommodate their child's symptoms (Futh et al., 2012). Of note, the distress associated with accommodation is described as less severe than the distress associated with facing the unwanted experiences that occur when a parent does not accommodate (Lebowitz, 2013).

Several studies support a reciprocal relationship between accommodation and family burden in families of youth with OCD. Storch and colleagues (2009) found that parents of children with OCD report being notably distressed about their child having OCD, and that this was associated with OCD symptom severity, impairment and accommodation. These findings are consistent with the notion that parents who are distressed by their child's OCD may accommodate in an attempt to minimize both the

child's and their own distress. Unfortunately, the act of providing accommodation may then, somewhat paradoxically, increase overall parental distress. Parents of children who have not responded to first-line treatments for OCD report particularly high stress related to providing accommodation (Storch et al., 2008). Barrett, Rasmussen, and Healy (2000) demonstrated that siblings of children with OCD also provide accommodation and are more distressed, anxious, and depressed than siblings of children who do not have OCD. Treatment can reduce the burden associated with OCD (Paula Barrett, Healy-Farrell, & March, 2004), perhaps in part due to a reduction in accommodation (Ginsburg, Burstein, Becker, & Drake, 2011).

Family burden has not been studied extensively with regard to youth anxiety. However, Lebowitz and colleagues (Lebowitz et al., 2013) reported that 76% of parents endorsed experiencing distress when accommodating, and this accommodation was associated with parent-rated impairment at home and in school. A majority (70.7%) of parents reported experiencing distress as a result of accommodation and 85.3% of parents reported negative consequences in those instances that they do not accommodate, including exacerbation of the child's anxiety (73.3%), or the child becoming abusive (56%; Lebowitz et al., 2013). Accommodation may function as an attempt to reduce family burden (parent and child distress), though it ultimately maintains it.

Limitations of current research. Research has only begun to explore the relation between various and parent and child factors and the presence of accommodation, and a word of caution is warranted about these findings. Although the data have been presented here separately by construct, the majority of results reported come from a few,

comprehensive studies examining a number of correlates of accommodation. Such studies offer an exploratory look at a wide number of variables, but must be followed with additional studies with direct hypotheses testing. The research on accommodation in youth is relatively new, and has not yet reached this stage. This may explain some of the inconsistent findings on these questions.

Other concerns about this research include limitations in the diversity and composition of the samples. Though these few studies have all examined youth of a wide range of ages (e.g. 4-18, 7-17), they have primarily looked at Caucasian youth from affluent families (e.g. 78.9% white, 35% annual income over \$100,000; Thompson-Hollands, Kerns, et al., 2014). In addition, despite investigating the correlates of family accommodation, these studies primarily investigated mothers, with samples that range from 57% mothers (Thompson-Hollands, Edson, et al., 2014) to 93% (Benito et al., 2015). Given findings that suggest difference between mothers and fathers on some variables of interest, it is important to replicate all findings in independent samples of both mothers and fathers separately. Similarly, the majority of these studies have been conducted in treatment-seeking samples, primarily recruited at anxiety specialty clinics. Accommodation may be different in different settings, and further studies should examine youth in community settings with both clinical and subclinical levels of anxiety.

Despite these limitations, it is clear that numerous parent and child factors interact to form well-established patterns of parent-child interactions that may make the reduction of accommodation more difficult. Though the factors considered here have primarily been discussed in isolation, it is likely that a full developmental model will incorporate a

wide range of factors. Future studies should examine the relationship between various parent and child factors and accommodation in order to better elucidate the development, function and maintenance of parental accommodation.

Future Directions

The literature on accommodation in youth with anxiety supports the idea that accommodation is not a preferred parent strategy, and that the sequelae of accommodation are negative and include both parent and sibling distress. Research also indicates that effective treatment for anxiety in youth may require assessing accommodation and directly addressing accommodation throughout the course of treatment. Yet despite the growing number of studies in recent years that have examined accommodation in youth with anxiety, a number of important questions remain for future investigation.

Potential associated factors. As reviewed above, a growing body of literature explores associated factors that may contribute to the presence of accommodation in families of youth with OCD and anxiety. However, the research is relatively new, and several important potential factors have yet to be examined. In the following section, I consider a variety of parent and child factors that may contribute to the development and maintenance of accommodation. For each factor, the current research regarding the relationship of the factor to anxiety is explored, with speculation as to how this might contribute to accommodation.

Child Emotion Regulation. Anxious youth exhibit increased emotional reactivity and poor emotion management, and are more likely than non-anxious peers to experience

negative emotions intensely (Suveg & Zeman, 2004). Anxious youth are less likely to employ strategies such as cognitive reappraisal as frequently or effectively as peers (Carthy, Horesh, Apter, Edge, & Gross, 2010). Child distress significantly predicts parental accommodation, such that parents are more likely to accommodate when children exhibit a high level of distress (Settipani & Kendall, 2013): thus, poor emotional regulation represents a plausible risk factor for increased accommodation. Among youth meeting diagnostic criteria for anxiety, those with difficulties in emotion regulation may exhibit increased distress when presented with anxious stimuli in treatment, triggering ongoing parental accommodation. Conversely, children with excellent emotion regulation may demonstrate resilience in spite of other risk factors. However, no research to date has explored the relationship of a youth's emotion regulation to the presence of parental accommodation.

Child Temperament. Given the transactional relationship between children and parents, child temperament is a potentially relevant factor in the development and maintenance of anxiety in youth. One temperament, behavioral inhibition (BI), may be associated with increased parental accommodation. BI, which is characterized by a fearful response to novelty and avoidance of social interaction, has been identified as an early risk factor for childhood anxiety (see Ginsburg et al., 2004 for review). BI may lead to a higher arousal in unfamiliar situations, which may in turn lead social withdrawal (Ginsburg et al., 2004; McDermott et al., 2009). Given the stable nature of temperament, BI may illicit increased and ongoing accommodation, as parents come to view their child

as “unable” to tolerate unfamiliar, stressful situations and reduce expectations accordingly.

Child temperament is generally believed to lead to difficulties only in the context of certain environments (Bates, Pettit, Dodge, & Ridge, 1998). In many cases, child temperament has been found to interact with parenting behaviors, and a similar interaction may occur in the case of parental accommodation of child anxiety. For example, overprotective parenting moderates the association between child temperament and anxiety, with temperamentally fearful children more likely to exhibit social withdrawal and anxiety when their mothers exhibited higher levels of overprotection (Coplan, Arbeau, & Armer, 2008; Degnan, Henderson, Fox, & Rubin, 2008). The same may be true for accommodation, with parental accommodation serving to facilitate the development of anxiety disorders in behaviorally inhibited youth. At this, however, time no studies have examined how child temperament relates to accommodation.

Parenting Style. A broad set of parenting behaviors and practices are hypothesized to create an emotional climate for the parent-child relationship (Jeffrey J. Wood, McLeod, Sigman, Hwang, & Chu, 2003), and may have an effect on parental accommodation. Parents of youth with anxiety and OCD are more likely than parents of non-anxious children to use overprotective style emphasizing parental control behaviors (Hudson & Rapee, 2001; McLeod, Wood, & Weisz, 2007), and this style is believed to play a central role in the development and maintenance of child anxiety (Wood et al., 2003). Behaviors typical of an overprotective parenting style include intrusive parental involvement and low child autonomy in age-appropriate activities, both of which restrict

the child's opportunities to independently master their distress (McLeod et al., 2007; Wei & Kendall, 2014).

Some have argued that accommodation may be seen as a piece of a larger overprotective parenting style (Thompson-Hollands, Kerns, et al., 2014). Parental control and over involvement are certainly consistent with the behaviors involved in providing accommodation. Though excessive parental involvement is typically well intentioned, if parents provide too much support for their child in the face of anxiety-provoking stimuli, this will reinforce the child's avoidance and fear by depriving the child of the opportunity to encounter the feared stimulus. Furthermore, such behavior instills a lack of confidence in the parent's belief in the child's ability to encounter the feared stimulus or situation, which also encourages avoidance (Affrunti & Ginsburg, 2012).

In contrast, some studies have found that permissive parenting increases the risk of internalizing problems (e.g. Williams et al., 2009). This finding may be because such parenting allows behaviorally inhibited children to *avoid* anxiety-provoking events rather than to face them (Affrunti, Geronimi, & Woodruff-Borden, 2014). Permissive parents may allow their children to do anything necessary to avoid anxiety-provoking situations, such as leaving school early and skipping obligations due to anxiety. Bögels and Brechman-Toussaint (2006) resolve these seemingly contradictory theories by suggesting that there is a curvilinear relationship between parental control and child anxiety, and a similar relationship may exist with accommodation.

Parental Distress Tolerance. Another parent factor that may be associated with increased family accommodation is low parental distress tolerance. Parents of anxious children have been shown to display increased avoidance, and have limited ability to tolerate their children's distress (Tiwari, Podell, Martin, Mychailyszyn, Furr, & Kendall, 2008). This may suggest that parents who can least tolerate their child's distress are mostly likely to facilitate avoidance by accommodating. In keeping with this hypothesis, high accommodation is associated with high maternal distress in treatment-seeking samples (Thompson-Hollands, Kerns, et al., 2014), though no study to date has explored the specific role of paternal distress tolerance. Additionally, child distress significantly predicts family accommodation, with parents reporting more accommodation when the child shows a high level of distress relative to low level distress (Settipani & Kendall, 2013). It is thus possible that factors such as a parent's *perception* of their child's distress, as well as their willingness or ability to tolerate it, are closely tied to parental accommodation. These parents with low tolerance for their child's distress may also be particularly motivated by the negative reinforcement of the accommodation cycle, leading to increased accommodation in the future. Though the construct of parental distress tolerance plausibly links several findings on the role and function of accommodation, no study has directly its role in the development and maintenance of family accommodation of anxious youth.

There may be a number of additional factors that contribute to the development and maintenance of parental accommodation in the families of youth with anxiety. Others such factors may serve as buffers against risk, assisting families that might

otherwise be likely to accommodate in finding more adaptive coping strategies. Continued exploration of these and other factors that may be associated with accommodation will serve to advance our understanding of the complex, dynamic system that gives rise to parental accommodation, ultimately leading to more efficacious interventions to reduce it.

Direction of the association between anxiety and accommodation. Another area that requires further research is the direction of the association between youth symptoms and parental accommodation. In many cases, a youth's anxiety symptoms may develop and then elicit accommodation, which in turn maintains the problem. A reduction in accommodation is associated with a reduction in symptoms, but the direction of this association is not yet known. In one study of OCD, reduced parental accommodation was shown to temporally precede improvements in OCD-related impairment and severity (Piacentini et al., 2011). A similar pattern may be observed in the families of youth with anxiety, but no study to date has examined these questions of temporal precedence in a sample of anxious youth. In parent-focused treatments, however, interventions that target accommodation have led to a reduction in symptoms (e.g. SPACE program; Lebowitz et al., 2014). Thus, successful reduction of accommodation may frequently precede – or even be necessary for – a reduction in child anxiety.

However, the majority of parent-child reactions have a reciprocal relationship, and it is likely that the relationship between the reduction in parental accommodation and youth anxiety is reciprocal as well. Perhaps in some cases, particularly those treatments that do not directly address accommodation, a reduction in youth anxiety is followed by a

reduction in accommodation. Needed studies include an examination of the timing of the emergence of accommodation and symptomology, as well as the trajectory of accommodation and symptoms across treatment in order to determine a causal relationship. Collecting weekly measures of anxiety and accommodation will allow researchers to more accurately examine the trajectory of change and the relationship between these variables.

Measurement issues. As interest in accommodation has grown, a number of measures of accommodation have been developed and evaluated. There are currently three measures of family accommodation in youth with anxiety: The Family Accommodation Scale – Anxiety (FASA; Lebowitz et al., 2013), the Family Accommodation Checklist and Interference Scale (FACILIS; Thompson-Hollands et al., 2014) and the Pediatric Accommodation Scale (PAS; Benito et al., 2015). Although the existing measures have psychometric properties that support their use, there are broader issues pertinent to the construct of accommodation that require attention.

One question regarding measurement pertains to who is the ideal reporter of parental accommodation. Most accommodation measures include a parent report, as parents are often thought to be best suited to report on behaviors occurring within the family. Although collecting parents' perspectives is important, their perspective may also be limited (De Los Reyes et al., 2015). And while parents may have difficulty providing objective ratings of their accommodation, or may be unfamiliar with the construct of accommodation, parent and clinician reports have been found to be significantly correlated on the Pediatric Accommodation Scale (PAS and PAS-PR; Benito et al.,

2015). Interviewer-administered measures may provide the most complete and accurate picture of family accommodation, but it may not be feasible for such a time-intensive measure to be implemented. In contrast, the therapist seeing the youth/parents may be suited to report on family accommodation and how it changes over time. Though a therapist provides a useful perspective, no therapist-report measure of accommodation has been developed to date.

Another question regards who provides the accommodation being reported. Existing measures define the construct of accommodation narrowly, using the phrase “family accommodation” but predominantly refer to accommodation by parents. Although other family members may indeed accommodate, there is limited research on the role of family members other than parents. Only the PAS (Benito et al., 2015) addresses accommodation in other family members, with one question on sibling accommodation. Future research should consider sibling accommodation, as well as the accommodation of extended family members.

Despite the focus on parental and family accommodation, accommodation may occur beyond the family. Teachers and school staff may accommodate anxiety symptoms, and may even be directed to do so through Individualized Education Plans. Peers may also accommodate friends with anxiety, particularly among adolescents. There are not currently any measures or studies that examine the extent and provision of accommodation in schools or among peers. Future studies should aim to capture the full range of accommodation a youth is experiencing, as well as the potential impact parental

accommodation may have on the range and type of accommodation a youth comes to expect in other domains.

Value of accommodation in school. According to federal guidelines, schools are mandated to provide reasonable accommodations to maximize each student's academic potential. Such accommodations are viewed favorably, thought to enhance the accessibility of schools. It is clear, however, that despite the widespread societal belief that accommodations are desirable, this is not always the case for youth with anxiety. Rather than promoting increased independence and functioning, such accommodations prevent the youth from improving their functioning. These educational accommodations fail to consider the long-term implications of accommodation, and may include steps to be taken that are contraindicated for optimal treatment of anxiety. For those youth who do not have access to treatment, such accommodations may indeed be necessary; yet when possible it may be more ideal to assist the youth in slowly approaching feared situations in order to learn to live without these forms of assistance.

The question remains as to what extent providing accommodation is advisable in school settings. It is plausible that, at least in some cases, accommodations promote a continuation of a status quo in which a youth is not pushed to develop new abilities. Following treatment research findings, it may be indicated to gradually provide youth with skills and structure to engage with difficult situations rather than allowing the youth to permanently avoid them. However, it is also probable that there are areas in which youth with anxiety may require temporary or even ongoing accommodations. Therefore,

future studies should evaluate the function and potential long-term effects of accommodation for anxious youth in a variety of school settings.

Accommodation in adulthood. The primary focus of this review has been on youth, but there are clear implications regarding long-term negative outcomes if accommodation is not addressed early. Research on accommodation among adults with OCD indicates that accommodating behaviors are not unique to children and frequently continue into adulthood (e.g. Amir, Freshman, & Foa, 2000). Yet only one study has examined accommodation in adults with anxiety. Zaider, Heimberg & Iida (2010) demonstrated that, among married couples, a wife's anxiety was significantly associated with relationship dissatisfaction, not just globally but on a day-by-day basis. Moreover, the wife's anxiety was also correlated with her husband distress, particularly among those husbands who reported frequent accommodation of anxiety (Zaider et al., 2010). These findings suggest that accommodation continues into adulthood, affecting the quality of key relationships. Future studies should further explore the role of accommodation in anxious adults, as well as examining the impact and trajectory of parental accommodation later in life.

Targeted intervention. The literature on accommodation in youth OCD and anxiety suggests that effective treatment for anxiety in youth may require assessing accommodation and directly addressing accommodation throughout the course of treatment. Interventions to reduce accommodation can be efficacious (e.g. Lebowitz, Scharfstein, et al., 2014b), but the existing findings are only preliminary. In anxiety in particular, only one open trial of 10 youth has explored the efficacy of targeting

accommodation in a parent-focused intervention (Lebowitz, Omer, et al., 2014). Further developing and evaluating interventions that specifically target accommodation, particularly in primarily child-focused treatments, is a needed next step.

Research identifying the function of accommodation may enhance efforts to most effectively target and reduce accommodation. Commonly, the function of accommodation is to alleviate parental anxiety about seeing a distressed child (Caporino et al., 2012), but other functions may include minimizing the child's disruption in public or fulfilling parental tendency toward over involvement. Studies are needed to explore parent and child reactions to the provision or withdrawal of accommodation and to examine the function of accommodation for each family member. This understanding will facilitate the development and implementation of interventions that specifically target and address the factors and causes that underlie accommodation, ultimately leading to treatments that may benefit a wider range of anxious youth.

Nearly all parents of anxious youth accommodate, but many demonstrate a reduction over the course of standard CBT for youth anxiety. Thus, it is plausible that interventions that specifically target accommodation may not be necessary for all families that accommodate. Future research should consider if there are specific parent or child factors that identify families that will most benefit from a targeted intervention. For example, there may be a level of accommodation above which parents require focused intervention. Alternately, a more complex profile made up of a variety of parent and child factors may identify those in need of additional focus. For example, research indicates a link between a parent's own avoidance, anxiety, and distress have been associated with

increased accommodation (Flessner, Freeman, et al., 2011; Lebowitz, Panza, Su, & Bloch, 2012; Thompson-Hollands, Kerns, et al., 2014) and that maternal difficulties with emotion regulation mediate the link between maternal anxiety and accommodation (Kerns et al., 2015). It is thus possible that parents with high avoidance and anxiety, coupled with difficulty tolerating distress and regulating their emotional response, would particularly benefit from a targeted intervention. Additional research should aim to enhance our understanding of which families might most benefit from targeted treatment.

Parent Involvement in the Treatment of Anxiety in Youth

Interventions that are designed to target parental accommodation as a way to enhance anxiety reduction in youth are not the first to consider involving parents in the hopes of improving treatment outcomes. A number of studies have examined the effect of involving parents in the treatment of child anxiety. Findings have been mixed, however, leading to uncertainty as to how to best involve parents in treatment (see Wei & Kendall, 2014 for review). The inconsistent nature of these findings has led to the conclusion that the differences in format and content of these interventions may account for some of the variation in outcome (e.g. Barmish & Kendall, 2005). Some have speculated that variation in how to structure parental involvement accounts for inconsistent findings, as some interventions incorporating the entire family while others focus on parent-only sessions. Others have highlighted variation in the key components of parent intervention, raising questions about the specific purpose of parental involvement. Others have suggested that only certain families are in need of parent-involved interventions, advocating that interventions target specific families to optimize outcomes. The

following section briefly reviews each of these questions and considers what they might indicate about the best way to maximize outcomes in the targeted treatment of parental accommodation.

Structure of Treatment

Parents may be involved in a primarily child-focused intervention for youth anxiety in more than one way. Early studies of parent involvement primarily chose to simply add additional parent-only sessions, in addition to the individual child sessions standard to that intervention. The first controlled study, conducted by (Barrett, Dadds, & Rapee, 1996), compared individual CBT (Coping Cat) to CBT plus a modified behavioral family intervention that taught parents to manage their own anxiety, reward coping behavior and reduce excessive anxious behavior. The combined intervention exhibited superior outcomes at the end of treatment, as well as at 6 and 12 month follow up. Other studies have examined the impact of family therapy, rather than parent-only sessions. In these interventions, parents are brought into the room while their child learns and practices skills. An early study, also by Barrett and colleagues (1996) found individual CBT and family based-treatment did not differ in the percentage of children who were diagnosis free at posttreatment or at follow up. While these results might seem suggest the superior efficacy of parent session over family sessions, a study by Mendlowitz and colleagues (1999) found no significant difference between family CBT, individual CBT and parent CBT. However, the difference between these two different forms of parental involvement warrants additional consideration.

This variation in the structure of parent-involved treatments is understandable, given the lack of research examining the optimal role for parents in treatment. Kendall (2012) suggests that parents may be involved as *consultants*, providing information about their child's anxiety and input into the direction of treatment; they may be *co-clients*, if treatment aims to identify and address ways parents may be maintaining their child's anxiety, or as *collaborators*, assisting in the implementation of treatment components. Different interventions take different approaches, but little empirical evidence exists on this question. When parents are conceptualized as collaborators joint family sessions may be necessary to facilitate a transfer of control from the therapist to parent as the youth's primary coach. Yet when parents are conceptualized as consultants, individual parent sessions may be indicated to allow parents to speak candidly about their concerns. Similarly, when parents are conceptualized as co-clients, individual sessions may be needed to ensure parents receive sufficient individual attention to identify and address ways they may be contributing to their child's anxiety. More research is needed to examine these questions, in order to develop our understanding of optimal role parents can play in treatment.

A targeted treatment of parental accommodation might reasonably be structured in a number of ways. SPACE, the only accommodation focused intervention for youth with anxiety and their families, is made up entirely of sessions with the parents alone, rather than involving youth directly in treatment. In contrast PFIT, which was developed to target accommodation in the families of youth with OCD, supplements typical child-focused exposures with family sessions that target family dynamics such as

accommodation. There is need for an intervention that targets accommodation by involving both parents of and youth with anxiety, and research should explore which of these different treatment structures are most effective in targeting accommodation.

Key Components of Treatment

Existing interventions vary not just in terms of structure and format, but also in terms of the purpose of parental involvement (Wei & Kendall, 2014). The goal of involving parents in treatment typically falls within three broad categories: (a) addressing ways parents can enhance their child's use of new skills (b) teaching parents techniques to manage their own anxiety and (c) reducing other family factors associated with anxiety in youth. Given the very different intentions treatments have for parental involvement, it is not surprising that the underlying components of treatment greatly vary between interventions. Yet to date no research has directly examined how this variation in purpose and content influences outcomes.

Nearly every parent and family intervention directly addresses ways parents can facilitate and enhance the youth's employment of skills gained in treatment. For example, most interventions entail some component of psychoeducation, typically educating parents about the causes and maintaining factors of anxiety in youth, as well as explaining the rationale behind CBT (Wei & Kendall, 2014). Many programs also focus on removing parental reinforcement of youth anxiety (Barmish & Kendall, 2005). Parents are encouraged to minimize attention to anxious behaviors and to provide their child with rewards and praise for brave behavior (Ginsburg & Schlossberg, 2002). In many interventions, parents are also taught to identify maladaptive parenting behaviors that

may be contributing to their child's anxiety, and replace them with parenting strategies that promote independence and coping (e.g. Bodden et al., 2008; J. Wood, 2006). Other interventions involve parents in the completion of homework assignments, particularly exposures, in the hopes of increasing compliance with a key element of treatment (Wei & Kendall, 2014). Most programs also emphasize relapse prevention, working with parents to maximize the maintenance of gains over time (Ginsburg & Schlossberg, 2002; Wei & Kendall, 2014).

Some programs go a step further than educating parents about how to manage their child's anxiety, and also teach parents techniques to manage their own anxiety. Some implementations do this by including parents as a part of family session that teach the youth CBT techniques, and encourage parents to utilize these skills to apply to their own anxiety (e.g. Philip C. Kendall et al., 2008). Other interventions have individual parent sessions in which parents are encouraged to engage in cognitive restructuring of their own beliefs about their child and their child's anxiety, replacing these maladaptive cognitions with more constructive ones (e.g. Bodden et al., 2008). Many programs also emphasize the importance of parental modeling of coping, teaching parents to model the calm, brave behavior they wish to see in their children (e.g. Philip C. Kendall et al., 2008). Some treatments ask parents to specifically face and cope with situations that make them anxious as an important part of their child's treatment (e.g. Bodden et al., 2008).

Research has identified numerous factors that are associated with increased anxiety in youth, and some interventions target these factors in an effort to improve youth

treatment outcomes. Programs may aim to reduce family conflict (Barmish & Kendall, 2005), for example by teaching collaborative problem solving techniques (Greene et al., 2004). Others aim to improve communication skills by replacing negative communication styles (e.g. criticism, interrupting) with positive alternatives (Ginsburg, Silverman, & Kurtines, 1995). Breinholst and colleagues (2012) speculate that those interventions that target empirically supported and theoretically relevant parent factors have the greatest impact, though they note that even this hypothesis is not universally supported by the current literature.

In developing a parent-involved treatment to target accommodation, all three of these strategies bear consideration. Addressing ways parents can facilitate their child's gains through skills practice and exposures is certainly necessary. This might include psychoeducation about the rationale of CBT, the importance of exposure, and as well as the role of accommodation in maintaining anxiety in youth. Indeed, SPACE emphasizes the importance of psychoeducation, as well as teaching parents ways to change the targeted parental behavior of accommodation, as a key to reducing youth anxiety (Lebowitz, Omer, et al., 2014). Given research that links accommodation to parental distress (Kerns et al., 2015), it is likely that a successful targeted intervention will also work directly with parents to provide cognitive restructuring, relaxation and other coping skills for parents to facilitate their reduction in accommodation. Finally, it is possible that other family factors such as conflict and communication style lead to increased accommodation, and it may be necessary to address other maintaining factors to maximize gains.

Targeting Specific Families

It can be speculated that involvement may not be necessary for all parents of youth with anxiety problems. Specific family characteristics may indicate which families are in need of parent-involved interventions. Several studies have examined whether parental involvement is particularly warranted in anxious youth with anxious parents. A study by Cobham and colleagues (1998) examined the benefit of family versus individual child therapy for anxious youth with and without parental anxiety. This study found that youth with anxious parents did particularly well with family therapy, while youth without anxious parents did well in both treatment conditions. Similarly, Kendall and colleagues (2008) found no overall difference between individual and family CBT, but found family CBT to outperform individual when both parents had anxiety. Another study by Cobhman et al (2010) compared youth who received 10 sessions of individual CBT to those whose parents also received four additional parent management sessions. This study found no significant difference between conditions among youth with anxiety, but found greater efficacy of the additional parent sessions among youth with anxious parents. (Bodden et al., 2008) reported both individual and family CBT to be less efficacious if parents were anxious, though individual CBT did outperform family CBT for all youth. Taken together, these results suggest that parental psychopathology represents a risk factor for reduced treatment gains that may be mitigated by increased parental involvement in treatment.

Parental anxiety has received the most attention, but it is only one such factor that may indicate the need for parental involvement in treatment. Parental involvement may

also be warranted in those cases that specific parental behaviors require increased direct intervention beyond what is typically offered in child-focused interventions (Ginsburg et al., 2004). Over-protection has been proposed as likely indicator of families in need of an intervention with additional parental components (Wei & Kendall, 2014), and accommodation is likely another such factor.

As noted earlier, however, nearly all parents of anxious youth accommodate, but many demonstrate a reduction over the course of standard CBT for youth anxiety. It is possible that extensive involvement in treatment may not be necessary for all parents who accommodate. Perhaps only those with high levels of accommodation need be involved in treatment, or an interaction may exist with other parent factors such as parental anxiety or over-protection, such that parents with high levels of accommodation and anxiety most benefit from involvement in treatment, in order to maximize their child's gains. These questions remain open for further investigation, and may shape the development of targeted interventions.

Though research has yielded mixed results regarding the impact of parental involvement in treatment, targeting key parenting factors may be necessary to optimize outcomes, particularly in those cases that parental behaviors require increased direct intervention (Ginsburg et al., 2004). Given emerging research supporting the increased efficacy of interventions that target parental accommodation, it is clearly one such key parent factor. As additional targeted interventions are developed for accommodation, research should continue to explore the different options and variations in parent-

involved treatment. This additional data will further our efforts to optimize the integration of parents into the treatment of anxious youth.

Conclusion

The present review of the literature on accommodation in youth with anxiety indicates that accommodation is associated with increased symptom severity, parent and sibling distress, and reduced treatment gains. Taken together, this information suggests that accommodation contributes to the development and maintenance of anxiety in youth, and should be targeted throughout treatment. Research on accommodation among adults indicates that accommodating behaviors are not unique to children and frequently continue into adulthood (e.g. Amir, Freshman, & Foa, 2000), further highlighting the importance of early, targeted intervention.

The present review also examined key questions raised by the literature on parental involvement in the treatment of child anxiety. Despite many years of research, much remains unknown about the most effective ways to target parents in treatment. Areas of variation were highlighted and considered for the implications to a parent-involved intervention that targets parental accommodation in anxious youth. Given wide variation in structure, goal and population of interventions involving parents, it is not surprising that the impact on treatment outcomes varies widely as well. As further interventions targeting parental accommodation are developed, examined, and compared, we will develop a better understanding of the key elements in an effective parent-involved intervention.

Although research examining accommodation in the context of youth anxiety is relatively new, existing research suggests it has much in common with accommodation in families of youth with OCD. Although many crucial questions remain for future investigation, accommodation can be operationalized and the data are fairly consistent: persistent accommodations of the features of anxiety in youth is not advisable. Given that exposure is a key process in the successful remediation of anxiety, and given that parents are often involved in the treatment of their children, it is reasonable to suggest that accommodation be targeted and addressed.

APPENDIX B
CC-ARI THERAPIST MANUAL

Therapist treatment manual for

Cognitive-Behavioral Therapy
for Anxious Children
Accommodation Reduction Intervention

CC+ARI

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This therapist treatment manual is an augmentation of the *Coping cat therapist manual* (Kendall & Hedtke, 2008), with adjustments made to address parental accommodation. The concept of supportive parenting addressing in session 5 is adapted from the SPACE manual (Leibowitz & Omer, 2015).

Session 1: Getting to Know You and Identifying Feelings

Conducted with: The child

Purpose:

Get to know one another and explain basic information about the treatment. Begin to gather information about situations that make the child anxious and the child's reactions to signs and feelings of anxiety. Normalize feelings of fear and anxiety.

Goals:

1. Build rapport
2. Orient child to the program
3. Encourage/support the child's participation
4. Introduce the concept that different feelings have different physical expressions
5. Normalize the experience of fears and anxiety
6. Review the child's anxious experience
7. Assign an initial simple Show-That-I-Can (STIC) task
8. Engage in fun end-of-session activity.
9. Check in briefly with parents

Tasks

1. Build rapport

It is essential that the therapy not move too quickly, because anxious children are often avoidant, generally fearful or wary, and typically not familiar with our inquiries about their feelings, thinking, or self-talk. Rapport between the anxious child and the therapist is critical to the success of the therapy, and it is certainly worthwhile to devote ample time to the establishment of a trusting relationship between the child and therapist.

➤ **Opening conversation**

The first 10-15 minutes are for opening conversation: no focus, no threat.

The therapist asks the child to make himself¹ at home, look around the room, try any of the toys or games he'd like, and encourages the child to suggest a fun activity for the end of the hour/session. The therapist has suggestions of possible activities if the child has difficulty naming one. When the child has become somewhat involved and has selected an activity for the end of the session, the therapist can then agree in a manner something like the following: "Ok, that would be fun to do. Let's be sure to save 10 minutes to do that together." The therapist checks a watch and notes the time. Trust is

¹ To increase readability, the pronoun "she" will be used to refer to the therapist and the pronoun "he" will be used to refer to the client.

built on reliable recall of the “deal” and sticking to it.

- Get to know each other
To introduce the therapist’s need to gather information, and the idea that this information is important to the therapist, play a “Personal Facts” game (you can use pp. 1-2 in the Coping cat workbook as a guide). In this game both the child and therapist supply answers to the same questions, such as “What is your middle name?” “How old are you?” “How many brothers and sisters do you have?” etc. In addition, including questions about favorite TV shows, videogames, music, heroes, and superheroes can provide information that will be helpful later in the treatment. After giving answers, the therapist and child playfully quiz each other on the answers, with a small prize going to the players (i.e., provide a reward for participating in question answering). It is important that the therapist recall the information accurately, as this information is one of the child’s first attempts to share personal data with the therapist. It is suggested that the therapist be comfortable with the child’s asking personal information and with providing answers to appropriate questions.

2. Orient child to the program

- Give a brief overview of the program (e.g., meeting each week) and create the sense that this program is a joint effort between the therapist and child.
- Provide a review of the reasons for the program (“Helps some kids with...”).
- Mention the goals for treatment, including being able to identify anxious feelings, recognize anxious thoughts, and use appropriate coping strategies. These ideas are introduced as “knowing when you’re anxious” and “knowing what to do about it”—with the focus of the first few sessions on “knowing when you’re anxious,” followed by sessions that will focus on “knowing what to do about it.”
- The child is told that the several meetings will be held with his parents. The therapist reassures the child that she will not share during the parent session personal information he has disclosed. For example, the therapist asks the child “Is there anything you don’t want me to talk about”? The therapist informs the child that she is interested in what his parents think about the treatment and how they can be of help.

3. Encourage/support the child’s participation

- Invite the child’s questions about the treatment and re-open the invitation periodically until the child begins to share his questions and concerns.
- Stress to the child that information from his point of view is very important. Ask the child to tell some stories of fun activities, family trips, or school events that were particularly enjoyable. Reward participation, encourage verbalization, and ask easy-to-answer questions.
- Point out that different people see things differently (Provide concrete examples such as “A brick wall that is very tall to a child may be small to a full-grown and tall man.” “A tasty treat for one person may be the cause of

an upset stomach for someone else.”). Emphasize that we’re interested in “What you see and think about various situations.”

4. Introduce the concept that different feelings have different physical expressions, including anxiety

- Discuss the idea that people’s bodies can do different things in response to different feelings, and that different facial expressions and postures are clues to their feelings. The therapist can have the child list as many feelings as he can think of in the Coping cat workbook (p.5), and try to assess which feelings the child is most comfortable talking about.

5. Normalize the experience of fears and anxiety

- Initiate a discussion to reassure the child that all people have fears and anxieties (including adults who are admired as brave or labeled as heroes) and that the purpose of this program is to help him learn to recognize distress and cope with it effectively. We ALL feel anxious at various times, but some of us are better than others at knowing what to do when it happens. Some of us are better at “regulating” the emotion, like adjusting the volume on the radio. The skills to deal with anxiety can be learned. The purpose of the program is to help the child learn and use the skills to manage anxious feelings

6. Review the child’s anxiety

- If child is willing, discuss the specifics of the child’s anxieties, including the types of situations that provoke anxiety, the child’s reactions to anxiety (somatic and cognitive), and the child’s response in the anxiety-provoking situations.
- If appropriate, begin constructing a brief hierarchy of the situations that seem to provoke anxiety in the child. To record this information, the therapist and child use either the situation cards found on pages 74-76 of the Coping cat workbook or the “fear ladder” found on page 77 of the Coping cat workbook. The decision as to which method to use can be made collaboratively. For young children, categorizing fears into “easy,” “medium,” and “challenging” may be a more simplistic and understandable procedure than building an actual hierarchy using the fear ladder. Regardless of the method chosen to document the child’s fears (situation cards or fear ladder), the therapist takes note of which aspects of the different situations seem to be particularly easy and troublesome for the child. Be as specific as possible regarding the situations. For example, vague language is not preferred (e.g., “going to school”). Instead, enter specific situations such as “taking a math test at school” or “eating in the cafeteria.”
- For children who are not yet comfortable discussing their anxiety, this area is not pushed.

7. Assign an initial simple Show-That-I-Can (STIC) task

- To introduce out-of-session activities, the child is told that Show-That-I-Can (STIC) tasks are assigned and reviewed at each meeting. For the first STIC task, give the child the Coping cat workbook and ask him (a) to bring the workbook to the next session and (b) to write in it a brief example of a time

when he feels really great—not upset or worried. The child is asked to focus on what made him comfortable and what he thought at that time. To help the child understand the assignment, the therapist provides an example of a time when she felt really great and describes what she thought. Then the child is given a chance to do the same.

- The child is told that he can earn 2 points (or stickers for younger children) at the next meeting to be entered in the “bank” on page 72 of the Coping cat workbook for having completed the STIC task. The points earned are used to purchase rewards periodically during the program (after Sessions 4, 8, 12, and 16). The child can select the rewards he wants to earn and enter them in the “reward menu” on page 73 of the Coping cat workbook. Options for rewards after Sessions 4 and 8 can be small toys, books, or games. The rewards available after Sessions 12 and 16 are social rewards such as time spent playing a computer game with the therapist or going out for ice cream.

7. Engage in fun end-of-session activity

- After the session content has been addressed, take 5-10 minutes to play a game or engage in an activity (e.g., looking up something on the internet, telling funny stories, talking about episodes of favorite T.V. shows) that was selected with the child at the beginning of the session. Engaging in a fun activity serves several purposes. Foremost, it’s fun! When a child views therapy as a potentially fun and a positive experience, he will be more likely to want to attend subsequent sessions and engage in session activities. Also, engaging in the fun activity that had been selected at the start of the session shows the child that that the therapist “follows-through.” helping to establish trust. Finally, playing a game or engaging in a fun activity at the end of session is a reward for the child’s attendance and effort in the session.

8. Check in briefly with parents

- For the last 5-10 minutes of session, check in with the child's parents. Provide a brief overview of the program and goals. Explain that the first two sessions are primarily with the child to build rapport, but that parent and therapist will also be meeting regularly.
- Ask parent to complete a chart tracking their child's anxiety and their own response to it.

STIC Tasks:

- **Child:** A Time I was Happy in workbook
- **Parent:** Anxiety Chart

Session 2: Identifying Anxious Responses & Relaxation

Conducted with: The child

Purpose: Identifying Anxious Responses & Relaxation

Help the child identify his own specific somatic responses to anxiety. Review recognizing the somatic cues that indicate that the child is tense and anxious. Introduce relaxation training and its use in controlling tension associated with anxiety.

Goals:

1. Build rapport
2. Review STIC task from Session 1
3. Discuss specific somatic reactions to anxiety
4. Introduce the “F” step
5. Introduce the idea of relaxation and practice relaxation techniques
6. Develop the child’s awareness of how and when relaxation might be useful
7. Practice relaxation
8. Assign STIC task
9. Check in Briefly with parents

Tasks

1. Build rapport

- If the child needs to settle down or ask questions, or if additional time needs to be spent on building rapport, a brief game is played or a fun activity is shared with the child.

2. Review STIC task from Session 1

- Discuss the feeling-great situation that the child experienced during the intervening days and recorded in the Coping cat workbook, particularly focusing on the different pleasurable aspects. The therapist asks how the child felt, what the child thought about, and how the child acted. It is unlikely that the child will be able to fully describe such a situation. This limitation, however, can be noted as it may be informative about which aspects of the therapeutic program will need more or less attention and effort. Reward points or give stickers for effort--even modest participation (shaping).
- If the child did not complete the STIC task from Session 1, the therapist is not punitive, but (a) spends time at the start of the session to complete the task and (b) explores why the child was unable to complete the task (e.g., child did not understand assignment, child forgot to complete assignment). The therapist asks the child to think back over the week and to talk about his experiences with the therapist’s probing. For any session that the child does not complete the previous week’s STIC task, the therapist and child begin by completing the STIC task in session.

3. Discuss specific somatic reactions to anxiety

- Introduce the variety of somatic feelings that are associated with anxiety including butterflies in the stomach, heart beating fast, flushing of the face, trembling, etc., by telling a story about people caught in an anxiety provoking situation and how each one feels during the experience.
- Ask the child to identify the kinds of somatic responses he has heard about, or that he experienced when in an anxiety-provoking situation. If the child is not able to be specific, suggest that he imagine himself in a safe and neutral situation, imagining how his body feels. The therapist then describes a situation, which is anxiety-provoking for the child, and again asks him to describe how his body feels. Ask the child to describe what his body felt in the anxiety-provoking situation which he did not feel in the safe, neutral situation. This effort is intended to make the somatic signs of anxiety more apparent and clear. Describing the experiences of other people can also help.

□

4. Introduce the “F” step

- The therapist introduces the child to the idea of a 4-step coping plan, called the FEAR plan. The first step, the “F” step is:

Feeling Frightened?

E

A

R

As part of the “F” step, the child distinguishes anxious feelings, monitors his somatic responses associated with the anxiety, and asks himself, “Am I feeling frightened?” “How does my body feel?”

5. Introduce the idea of relaxation and practice relaxation techniques

- Deep breathing
Dim the lights in the room and have the child find a comfortable position (e.g., lying on a couch, lounging in a bean bag). Tell the child that you will be doing an exercise to help him learn to relax and ask the child to close his eyes. The first relaxation skill to be introduced is deep breathing. The child is told to take a deep breath and try to make his stomach expand (like blowing up a balloon), then to let it out slowly, focusing on how his body feels as the air comes out. The procedure is repeated 3 to 5 times. Ask the child to focus on how his body feels after taking a few deep breaths, noticing the relaxed feelings and suggesting that this is one quick way to help feel relaxed. Suggest that this idea (“taking a deep breath.”) may be quite useful as a first coping strategy in an anxiety-provoking situation.
- Progressive muscle relaxation
Again ask the child to tighten his fist to the count of 5 and then relax it to

the count of 5, focusing on the relaxed warm feeling in his hand, following it into his arm and continuing to follow it as it works its way through his body. Continue the relaxation exercise, focusing on the two or three muscle groups which the child has identified (or the therapist has noticed) as the areas in which the child experiences tension.

It is wise to limit the number of new muscle groups that are to be introduced to two or three. The exercise lasts approximately 15 minutes, as it is unlikely that the child will be able to focus on the activity any longer. The therapist may choose to use the Feelings Thermometer (SUDS rating) to track the progress of the child's relaxation.

➤ Relaxation materials/aids

To help children begin to identify the difference between how their body feels and looks when it is tense versus when it is relaxed, the exercises on pp. 17-19 of the Coping cat workbook are used.

When practicing relaxation skills, a script which puts the exercises in a story-like scenario (e.g., Koeppen, 1974) encourages participation and practice for younger children. For the older child, see Ollendick and Cerny's (1981) relaxation script. Also, the I Can Relax! CD for Children (The Child Anxiety Network, 2001) is a useful tool and fun way to introduce relaxation procedures.

In addition, the therapist, using her own voice, records the relaxation procedures and emails or provides the child with a copy take home so that he can practice his relaxation skills on his own. On the recording, the therapist "walks" the child through the relaxation procedures such as deep breathing and progressive muscle relaxation.

6. Develop the child's awareness of how/when relaxation might be useful

- Explain that relaxation training exercises are done to help the child realize what it feels like to be tense or relaxed and to help to relax more quickly. Explain that under real life anxious circumstances he usually won't have the opportunity to do a thorough relaxation exercise, but probably could take a few deep breaths and concentrate on relaxing those muscle groups that he has come to recognize he tends to tighten when anxious.

7. Practice relaxation

- The therapist can describe an anxiety-provoking scenario and models recognition of anxious feelings and accompanying tension by talking about her somatic responses. Be a coping model! Demonstrate coping by modeling the unwanted stress (and thoughts) and then using the deep breaths and relaxing. Describe carefully what is being done. The child tags along with the therapist during a similar sequence, or the child can role-play a similar sequence while the therapist only provides prompts as needed.

- The therapist can also suggest the child “show-off” these new skills to his parents. The parents are invited into the session and the child or therapist briefly explains the rationale for relaxation training. The therapist invites the parents to participate if they wish and with the child repeats the exercise script (the child demonstrates relaxation).

8. Assign STIC task

- Remind the child about the STIC task and review the idea of using the Coping cat workbook he was given in Session 1 as a journal to record his experiences. Or, if needed, the events can be recorded. This method allows for more immediate recording.
- For the following session, ask the child to record in his Coping cat workbook one anxious experience and one non-anxious experience, describing what happened, how the child knew he was anxious, how he felt, and what he thought.
- The therapist also explains the need for daily relaxation practice, describing the ability to relax as a skill to be learned, not something that can be done automatically. The child is asked to do the breathing and muscle tightening and relaxing exercises introduced during the session. When appropriate, parents are asked to assist in helping the child find a time and place to practice. If there are siblings, the child could choose to have them join in the practice or he could choose a private place and/or headphones to practice with his CD/tape. The goals are to (a) practice at least once a day for several days and (b) write about 2 anxiety-provoking situations including any thoughts and somatic cues he identifies.
- Take a few minutes to engage in a fun activity at the end of the session.

8. Check in briefly with parents

- Check in with parents to see how week went. Briefly review anxiety log, and praise parents for completion.
- Therapist provides brief explanation of a functional behavior analysis, explaining that every behavior has antecedents and consequences that reinforce the influence likelihood that the behavior will occur in the future. Walking through examples from the previous week, therapist briefly introduces the idea that parents’ reactions before and after their child’s anxious behavior may provide important information.
- Ask parent to complete a second anxiety log tracking the ABCs of their child’s anxiety, including their own response to it.
- Next week is first parent session. Discuss feasibility of both parents/relevant key caregivers being involved in treatment. Therapist may wish to reach out by phone to invite parents who have not been involved thus far.

STIC Tasks:

- **Child:** A Time I was Nervous in workbook
- **Parent:** Anxiety Log

Session 3: First Meeting with Parent

Conducted with: The parents

Purpose: Orient parents to treatment program. Explain parents' role in treatment, introduce the idea of accommodation, answer parent questions.

Goals:

1. Provide additional information about treatment, and how the parents will be involved in the program
2. Introduce the idea of accommodation and the role it plays in maintaining anxiety.
3. Learn more about the situations in which the child becomes anxious and ways parents accommodate.
4. Provide parents an opportunity to discuss their concerns
5. Assign parental accommodation chart

Tasks

1. Provide additional information about treatment, and how parents will be involved in the program.

- The therapist outlines the treatment program and explains where the child is in treatment and what will happen next. Parents' questions are invited and answered. The therapist reminds the parents that the first segment of the treatment is learning skills and that reduction in anxiety is not anticipated until the child begins to learn to apply coping skills during the second half of the treatment.
- The therapist also explains that another important focus of treatment is providing *parents* with skills that they can use to better manage their child's anxiety. The therapist explains the idea that parents cannot directly control child's behavior, but that parenting behavior is a powerful tool to change child's behavior – and one we can actually control. If necessary, parents will also learn how to handle their own distress, frustration or concern in the face of their child's anxiety.

2. Introduce the idea of accommodation, and the role it plays in maintaining anxiety.

- The therapist normalizes the tendency for parents to want to protect or reassure their child or allow their child to avoid stressful situations. However, parents are also informed about the "dangers of avoidance" by explaining that, over the long term, avoidance actually maintains anxiety. The therapist draws a graph representing the typical habituation curve, in order to demonstrate how anxiety reduces naturally over time. Introduce idea of avoidance as an "escape route" which helps children immediately reduce anxiety in the moment, but helps to maintain the cycle overtime. Discuss how demonstrates how avoidance maintains anxiety.
- Therapist introduces the concept of **accommodation**: ways a family "gives in" to a child's anxiety - for example by allowing a child to avoid a stressful situation, reducing expectations, or providing excessive reassurance. In other words, accommodation is the set of behaviors that a family does to help a child feel less anxious. The therapist returns to the habituation graph, and highlights the function of accommodation as an "escape

route” or “safety blanket.” The therapist explains the way in which accommodation reduces anxiety in the moment, but maintains anxiety in the long term by reinforcing the child’s avoidance (because anxiety goes down) and the child’s belief that he cannot handle the situation.

- The therapist explains that, as a part of treatment, parents will be taught alternatives to accommodation, mentioning that this has been shown to help reduce a child’s anxiety. The therapist clearly emphasizes that they are not blaming the parent for their child’s anxiety, while also explaining that parents do have the power to help shape future behavior and influence the outcome of treatment.

3. Learn more about the situations in which the child becomes anxious and the ways the parent accommodates

- Using what has been learned in sessions to date, the therapist talks generally about her impressions of situations that are troublesome for the child and of the child’s typical somatic and cognitive responses to anxiety. She invites the parents to share their impressions.
- Discuss parental reactions to anxiety, including anger, distress, accommodation, etc. Explore current parental roles at home (e.g. is one parent the one who typically soothes the child while the other typically sets boundaries). The therapist explains that many parents feel torn between protecting their child from anxiety and demanding their child be self-sufficient, which often leads to inconsistent parenting across different situations. Parents are informed they will be taught to support their child in facing his fears in a slow, consistent manner as treatment progresses.

4. Provide parents an opportunity to discuss their concerns

- Invite parents to discuss their concerns about the child or about other factors that could affect the child’s difficulties and ability to benefit from the treatment. With open-ended questions, the therapist invites the parents to provide any additional history or current information which they feel will be helpful to the therapist in understanding the child.
- Explore parental reactions to the idea of reducing accommodation, and address concerns about difficulty, feasibility, and effectiveness. Reduction of accommodation is key, and parental attitude can be a central barrier to that reduction. It is important that the therapist takes the time to fully explore the parents’ reaction to reducing accommodation, and both normalize and address any concerns that arise.

5. Assign homework.

- Ask parents to complete parental accommodation chart to track instances and extent of parental accommodation during the coming two weeks until the next parent session.

STIC Tasks:

- **Child:** no new assignment
- **Parent:** Accommodation chart

Session 4: Identifying & Challenging Anxious Self-Talk

Conducted with: The child

Purpose: Introduce the function of personal thoughts and their impact on response in anxiety provoking situations. Help the child begin to recognize his self-talk (expectations, automatic questions, and attributions) in anxious situations. Help the child begin to develop and use coping self-talk. Review relaxation training.

Goals:

1. Acknowledge the parent session
2. Review STIC task from Session 2
3. Introduce the concept of thoughts (self-talk)
4. Discuss self-talk in anxiety-provoking situations (anxious self-talk)
5. Differentiate anxious self-talk from coping self-talk
6. Introduce the “E” step
7. Practicing coping self-talk
8. Assign STIC task
9. Brief check-In with the parents

Tasks

1. Acknowledge the parent session

- Mention to (remind) the child that you met with his parent(s) as planned, and will be doing so throughout treatment. Reassure him that you could tell that his parents really care about him and that they are proud of his efforts. Encourage any questions the child may have about your meeting with his parents. Explain to the child that his parents, assuming it is OK with him, will be invited in for the last part of today’s session so they can see how he is learning the new skill of relaxation and so they can help set up an opportunity for him to practice at home.

2. Review STIC task from Session 2

- Initiate a discussion with the child about the anxious experiences he described in his Coping cat workbook. Discuss these anxious experiences thoroughly, but particularly focus on the somatic responses that were experienced. If the child has not clearly described or has difficulty recalling somatic feelings associated with the two experiences, use an imaginal role play to help the child identify the physical expressions of his worried and anxious feelings.
- Discuss the child’s experiences when practicing relaxing, noting the parts that went well and those that did not. Initiate a discussion with the child about his experiences recording the anxiety-provoking situations during the intervening days. Focus on anxious and non-anxious somatic feelings (to reinforce the skills from Sessions 3 and 5). Listen for any suggestion from the child of thoughts or expectations associated with these experiences and, in age-appropriate terms, call them to his attention. Reward the child with 2 points as appropriate. If the STIC was not completed, do it with the child at

the start of the session.

3. Introduce the concept of thoughts (self-talk)

Suggest to the child that now he knows when he becomes anxious, and that there are some thoughts that probably occur along with the feelings.

- Thought-bubble activity
Show cartoons with empty bubbles (see pp. 22-24 in the Coping cat workbook). Together with the therapist, the child fills in the possible thoughts for different cartoons. The cartoons portray fairly simple scenes in which the character's thoughts are likely to be fairly obvious and include a number of different types of feelings.
- Self-talk in low-stress (concrete) situations
The therapist describes some fairly concrete and non-stressful, or slightly stressful, situations (e.g., "your pencil falls on the floor" or "your mother is serving broccoli for dinner and you hate broccoli"). The child is asked to give some samples of thoughts that would accompany these events (i.e., "What would be in your bubble?"). The child thinks of a situation and describes what thoughts might occur to someone else who just experienced that situation.

4. Discuss self-talk in anxiety-provoking situations (anxious self-talk)

- Using cartoons (or magazine pictures) to present characters in low-anxiety provoking situations (select a cartoon/picture of specific interest to the child), the therapist suggests possible thoughts that the character might have and then asks the child to make similar suggestions for other cartoons/pictures. The therapist makes a connection between the thought "something bad is going to happen" and anxious feelings.

5. Differentiate anxious self-talk from coping self-talk

- Again, present cartoons (or magazine pictures) depicting a character in a low-anxiety-provoking situation, but this time ask the child to help think of thoughts that (a) would lead the character to experience more distress (i.e., anxious self-talk) and (b) would help the character to reduce distress (i.e., coping self-talk). Using this example, the therapist introduces the idea of coping self-talk, or thoughts that help people reduce distress in anxious situations. The therapist and child discuss how the character might change his behavior depending on the way he thought about what had happened: The child and therapist change the "talk" in the thought bubble and have the end result of the cartoon sequence/picture change accordingly.

6. Introduce the "E" step

- Introduce the child to the second step to the "E" step: Expecting bad things to happen? Feeling Frightened?

Expecting Bad Things to Happen?

A
R

Explain that as part of the “E” step, the child monitors his thoughts associated with anxiety and asks himself, “What is my self-talk?” “What am I expecting to happen?” Illustrate how if someone is thinking negative thoughts, the person can then attempt to reduce his distress through changing the self-talk to coping self-talk. Inform the child that the other 2 steps in the FEAR plan will be learned in later sessions.

7. Practicing coping self-talk

- Practice using the first 2-steps in the FEAR plan
The therapist models, and the child tags along, practicing the “E” step and monitoring thoughts in increasing anxiety-provoking situations, going through the following questions:

Feeling frightened?

- Ask myself:
Am I feeling anxious? What’s happening in my body?

Expecting bad things to happen?

- Ask myself:
What is my self-talk? What am I expecting to happen?
 - Gather evidence for the thought (be a detective!):
Do I know for sure this is going to happen? What else might happen? What has happened before? Has this happened to anyone I know? How many times has it happened before?
 - Having collected all the evidence:
How likely is it to happen? What is a coping thought I can have in this situation? What is the worst thing that could happen? What would be so bad about that?
- Discuss "thinking traps"
Encourage the child to be a detective and look for thinking traps that can trick people into feeling anxious before they have had a chance to collect evidence.
 - **Walking with blinders**
Only seeing the negative and overlooking the good in a situation [Race horses wear “blinders” to see straight and not be distracted in a race]
 - **The repetitor**
If it happened once it is always going to happen that way

- **The catastrophiser (or the pessimist)**
Always thinking the ‘worst ever’ is going to happen
 - **The avoider**
Staying away from situations you think are scary without trying first
 - **The mind reader (or fortune-teller, using the “crystal ball”)**
Jumping to conclusions about a person/thing/situation without the facts
 - **The shoulds (having ”the shoulds” is like having “a cold”)**
I SHOULD always be perfect. I SHOULDN’T make mistakes.
 - **The perfectionist**
Setting expectations that are too high: Perfection is not a human option.
- Make a “coping card”
Encourage the child to make a card of potential coping thoughts and/or good prompt or “detective” questions to take with him into anxiety-provoking situations. For younger children, a card with an image to represent their coping thought may also be useful.

8. Assign STIC task

- During the next week, the child is asked to record in the Coping cat workbook two situations in which he felt anxious and pay special attention to his thoughts. Remind the child to practice listening to his relaxation CD/tape and to record his experiences.
- At the end of the session, take a few minutes to play a game or engage in a fun activity.

9. Check in briefly with parents

- The therapist reviews the idea of modeling with the parents, and emphasizes the importance of modeling brave behaviors rather than anxiety and avoidance. The therapist empathizes the difficulty of handling the distress the parent may feel in light of the child’s reaction, and suggests that relaxation exercises can be helpful for parents as well in these moments.. Therapist provides a "grown-up" version of the relaxation exercises to practice during the week.
- Parents are reminded to complete accommodation chart for next session.

STIC Tasks:

- **Child:** Workbook and relaxation exercises
- **Parent:** Relaxation exercises, accommodation chart

Session 5: Reducing Accommodation

Conducted with: The parents

Purpose: To further explore the role and extent of accommodation in the family, and to help parents understand the importance of accommodation reduction.

Goals:

1. Review accommodation chart
2. Create a list of current accommodations
3. Discuss ways (other than accommodation) to respond to a child's anxiety
4. Address parents concerns about reducing accommodation
5. Assign accommodation chart

Tasks:

1. Review accommodation chart

- Therapist reviews the accommodation chart with the parents, normalizing the examples parents have noticed during the week. The goal of this initial review is for the therapist to gain more understanding of the parents' responses to the child's anxiety, as well as to begin helping parents to see the role their actions play in maintaining the cycle of anxiety. Positive feedback is provided to parents for completion and insight.
- If a parent raises a suggestion about how they might begin to reduce accommodation immediately, the therapist can provide support in helping the parent to do so. Otherwise, parents are not expected to begin reducing accommodations at this point in treatment, as specific ways to reduce accommodation will be discussed in future sessions.

2. Create a detailed list of current accommodations.

- Therapist reviews the idea that most parents play a role in helping their child cope with anxiety, and explains that one of the goals of treatment is to help a child begin relying on himself. The therapist reminds parents of the function of accommodation as an “escape route,” and restates that a primary goal of treatment will be to help parents identify and reduce accommodations.
- Using the accommodation chart as a jumping off point, the therapist and parents work together to create a detailed list of current accommodations. Therapists are encouraged to probe for expected or typical accommodations parents have not identified.

3. Discuss other ways to respond to a child's anxiety

- The therapist introduces idea of *supportive* parenting, in which a parent labels their child's anxiety and expresses confidence in the child's ability to face their fears. This approach is contrasted with *protective* parenting, in which a parent helps a child avoid scary situations in attempt to reduce anxious distress, or *demanding* parenting, in which a parent minimizes a child's distress in an attempt to encourage bravery. Supportive parenting acknowledges the child's experience, while also encouraging them to act in more adaptive ways.
- To promote supportive parenting rather than accommodation, parents are taught the **LEMUR** acronym, a parenting parallel to the child's **FEAR** plan.

- **Label a child's anxious feelings:** parents label their child's emotions and encourage a child to use his new skills
- **Express empathy and compassion for the child:** parents express empathy for the child's anxiety, without rushing to accommodate or minimize the child's distress
- **Model calm, non-anxious behavior:** parents monitor their own distress or frustration, and model the behavior they wish their child to practice
- **Use your skills:** parents employ relaxation and coping thoughts to handle their own distress or frustration
- **Reward brave behavior:** parents provide praise and rewards for desired behavior

4. Address parents' concerns about reducing accommodation, including disagreement between parents.

- Many parents have views that conflict with the therapist – or even one another - about how to handle a child's anxiety. For example, one parent may be overly accommodating while the other is overly demanding. If necessary, the therapist works with these families to understand that treatment requires an integration of the “nice” parent's desire to emphasize with the child's distress and the “firm” parents' desire to reduce accommodation.

5. Assign accommodation chart.

- An updated accommodation chart is introduced, with a column for parents to track their use of their own skills. Ask parents to complete updated accommodation chart to track accommodations in the next two weeks. The therapist should be clear that parents are not expected to immediately reduce all accommodation, nor remember all **LEMUR** steps. A more modest initial goal is developed with the family. In many cases, parents can begin practicing a single step in isolation. For example, some parents may wish to begin expressing empathy rather than frustration, or modeling calm rather than anxious behavior.

STIC

- **Child:** no additional task
- **Parent:** Accommodation chart

Session 6: Coping and Problem Solving Skills

Conducted with: The child

Purpose: Review the concept of anxious self-talk and reinforce changing anxious self-talk into coping self-talk. Introduce the concept of problem solving and develop and use problem solving strategies to better manage anxiety. Review relaxation training.

Goals:

1. Review STIC task from Session 4
2. Review and discuss the first two steps in the FEAR plan
3. Introduce the “A” step
4. Introduce the idea of problem solving
5. Practice problem solving
6. Assign STIC task
7. Check in briefly with parents

Tasks

1. Review STIC task from Session 4

- Discuss with the child the anxious experiences he described in his Coping cat workbook. Focus the discussion on how the child knew he was anxious and what his anxious self-talk was, using a modified version of the “triple column” procedure. Three columns headed “Situation,” “Feelings,” and “Thoughts” are written, leaving space for adding a fourth column. During the discussion, the therapist writes the information in the appropriate column, thereby helping the child organize his thoughts about his experiences. A fourth column entitled “Actions” is added, and possible alternative actions which might be related to different entries in the “Thoughts” column are entered. Reward the child for effort and cooperation with two points or stickers, as appropriate. If the STIC was not completed, do it with the child at the start of the session.
- Discuss the child’s experiences during the week practicing relaxation, noting both the times that went well and those in which he experienced difficulty. Take a few minutes to do a relaxation training exercise. Discuss the child’s experiences using relaxation as a first response when becoming anxious, and expand on the idea of a quick relaxation exercise such as a few deep breaths and relaxing the muscles he tends to tighten.

2. Review and discuss the first 2 steps in the FEAR plan

- The therapist summarizes the two previously introduced steps by reminding the child that now he realizes that his body responds with certain feelings when he is becoming anxious, and that there is anxious self-talk. Use an experience that was recorded in the four-column procedure as an example and encourage the child to think of other examples.
- Suggest to the child that he can begin to take steps to change his responses in an anxious situation. Recognizing the responses his body has to anxiety and identifying anxious self-talk are the first two steps in learning to proceed in a situation in spite of feeling anxious.

□

- The therapist suggests to the child that when he is in an anxious, worrisome situation, it will be easier to manage his anxiety if he knows what steps to follow. Encourage the child to generate the first two steps based on his work thus far. These steps are explained below in a general way, but are phrased in the child's own language. Write the first two steps on a black/whiteboard for the child to refer to throughout the session.

Feeling frightened?

- Ask myself:
Am I feeling anxious? What's happening in my body?

Expecting bad things to happen?

- Ask myself:
What is my self-talk? What am I expecting to happen?
- Gather evidence for the thought (be a detective!):
Do I know for sure this is going to happen? What else might happen? What has happened before? Has this happened to anyone I know? How many times has it happened before?
- Having collected all the evidence:
How likely is it to happen? What is a coping thought I can have in this situation? What is the worst thing that could happen? What would be so bad about that?

3. Introduce the "A" Step

- The therapist introduces the child to the third step to coping with anxiety in the FEAR plan, the "A" step:

Feeling Frightened?

Expecting bad things to happen?

Attitudes and actions that can help

R

The therapist explains to the child that that in addition to recognizing his anxious feelings and self-talk, he may find it helpful to take some action that will help change the situation so he can proceed despite his anxiety. The final step in the coping plan will be learned in Session 8.

4. Discuss the concept of problem solving

- Describe the problem-solving steps
The therapist explains that problem solving helps to develop a plan for coping with the anxiety (This plan will be specific to the type of situation and the child's particular preference for strategies that are helpful to him).

Discuss the problem solving process by describing for the child how to develop an idea for changing something, using the following steps:

Step 1 Define the problem: What is the anxious situation?

Step 2 Explore potential alternative solutions (be careful not to evaluate yet!): What might someone do to make this situation less fearful?

Step 3 Evaluate the potential alternative solutions: Which solutions are feasible alternatives? Do any alternative solutions NOT make sense or are any NOT feasible?

Step 4 Select the preferred alternative: What might be one of the best things to do? What is the preferred solution?

This presentation will have to be modified to accommodate the child's developmental level, particularly in terms of the language and cognitive ability. Some children will be able to understand and comprehend the ideas as presented, but the language level will have to be lowered. For young children, the procedure may simply have to be taught by example and practice.

5. Practice problem solving

- Apply problem solving to nonstressful situations
To demonstrate how to use this method of developing an idea, begin with a simple, non-stressful problem which is concrete and real for the child (e.g., "You've lost your shoes somewhere in your house. How might you go about trying to find them?"). As necessary, the therapist models the process of exploring the alternatives and selecting the preferred alternative first.

If needed, therapist then sets up another very concrete situation and will again model this process, but this time the child is encouraged to participate in the problem-solving process by contributing suggestions and evaluating them for the best one. Throughout this exercise, the therapist takes care to emphasize that this skill takes much practice and that the child should not expect to be good at it right away.

- Practice under conditions of minimal anxiety
Practice the same process in low anxiety-provoking situations. Again, the therapist models problem solving first and then invites the child to tag along. As always, the child is encouraged to contribute his own scenarios to be acted out, but the therapist is also prepared with relevant situations if the
- Practice under conditions involving greater anxiety
The problem solving activity is applied to higher anxiety-provoking situations, again using therapist modeling and child tag-along procedures as needed until the child can think through a situation with too many therapist prompts.

6. Assign STIC task

- During the next week, the child is asked to record in the Coping cat workbook two situations in which he felt anxious and pay special attention to his thoughts. Remind the child to practice listening to his relaxation CD/tape and to record his experiences.
- At the end of the session, take a few minutes to play a game or engage in a fun activity.

9. Check in briefly with parents

- Check in with parents to see how the past week went. Briefly review accommodation log, and praise parents for completion and progress. If parents have struggled to implement LEMUR as discussed, provided brief feedback. Parents are assured that new skills take time and effort, and can be informed that the bulk of next week's session will be devoted to working on any issues that may have arisen. Assign additional accommodation chart.

STIC Tasks:

- **Child:** FEA in workbook
- **Parent:** Accommodation chart

Session 7: Parental Emotions & Skills

Conducted with: The parent

Purpose: To teach parents skills to respond to their own distress in the face of their child's anxiety. Practice using LEMUR in common situations that arise regarding the child's anxiety, and discuss ways to handle difficult behaviors the child may exhibit.

Goals:

1. Review parental accommodation chart
2. Introduce "U" skills
3. Practice using LEMUR
4. Discuss way to handle difficult behaviors such as emotional and behavioral outbursts.
5. Assign homework

Tasks:

1. Review parental accommodation chart

- Therapist reviews the accommodation with the parents, praising parents for completion and progress. Attempts to use **LEMUR** are reviewed, and challenges that arose are discussed.

2. Introduce "U" skills.

- Review the U step.
Therapist reminds parents of the **U** step in **LEMUR: Use your skills**. Similar to the **A** step in the **FEAR** plan ("Attitudes and Actions that Can Help"), parents can draw on both relaxation and helpful "coping thoughts" to assist them in reducing accommodations. Encourage parents to "check in with your own emotions," and explore their common reaction to their child's anxiety (frustration, distress, embarrassment, concern). Explicitly discuss the way this emotion may influence the desire to accommodate. Many parents may already have personal strategies that help them handle negative emotions, either around their child's anxiety or in other settings (e.g. when I am frustrated I go for a run or take a bath). Discuss what parents already find helpful, and problem-solve around barriers to using these skills in relation to their child's anxiety.
- Teach parents to develop "coping thoughts" and employ relaxation techniques. Parents are asked to check in with the "self-talk" they may have when their child is anxious. Therapist works with parents to develop appropriate adaptive responses or coping thoughts. Parents are encouraged to check in with their self-talk when they notice the desire to accommodate and employ a relevant coping thought in response. Help the parent practice developing coping thoughts in a variety of common situations.

If necessary, the therapist can suggest common possibilities. Some parents may feel anxious or guilty about their child's anxious response, and have thoughts such as "I can't/shouldn't push him any more". These parents may want to employ thoughts like "even though he's upset he'll be okay," "giving in doesn't help him" or "the more we practice the easier this will get." Other parents may feel frustrated or angered by their

child's anxious response and have thoughts such as "I'm so frustrated he can't just do this." These parents may want to use thoughts like "the anxiety is control right now, not him" or "I'm teaching him to help himself."

Some parents may additionally find relaxation techniques helpful. For most parents, deep breathing will be more useful than progressive muscle relaxation. Others may want to employ a moment of mindfulness in which they excuse themselves to focus on return to a calmer state. Teach appropriate techniques to parents, and discuss when parents will employ their new skills.

- Develop a key "mantra" to reduce accommodation.
Some parents may feel overwhelmed by the number of new instructions they are being asked to remember when their child is anxious. For these parents, a simple mantra may be developed to capture the most crucial aspect of **LEMUR**. For example, a parent who tends to rush to reassure and relieve her child's anxiety may want to use the mantra "help him help himself," while another who tends to snap in frustration may settle on "validate the anxiety to encourage bravery." The selected mantra is a direct response to the emotion or thought that most frequently leads the parent to accommodate.

3. Practice using LEMUR

- Using common examples of the child's anxiety, the therapist and parents discuss how the parents can respond. If time permits, the therapist and parents role-play a difficult scenario to allow the parent a chance to practice their skills. Practicing in session allows the parents to develop familiarity with the skills and language they will be employing in place of their typical accommodations.

4. Discuss ways to handle difficult behaviors such as emotional and behavioral outbursts.

- The therapist and parents discuss any difficult behavior expected around an exposure tasks. For children who exhibit disruptive behavior, time is dedicated to how to handle this behavior without maintaining accommodations.
- Disruptive behavior can be seen as a part of the anxious response (fight or flight). Parents are taught the idea of disengagement – or planned ignoring – as an alternative to excessive reassurance and other forms of accommodation. The therapist explains that paying attention to a behavior or emotion increases the behavior, while removing attention reduces it. Therefore, providing excessive attention to a child's anxiety can increase it, whether that anxiety manifests in behavioral outbursts, complaining about an exposure, or repetitive questions. Parents are taught to avoid reassurance, suggestions and lectures; instead, parents can use **LEMUR** to help themselves remain calm while waiting patiently for their child's anxiety to decrease. Parents are encouraged to notice and praise any reductions in anxious behavior, and provide increased attention to all brave behaviors.
- Discuss with parents how and when they might apply planned ignoring around exposures (e.g. labeling anxiety, answering anxious question once, waiting calmly until anxiety has reduced and then reiterating reward the child can earn). Review appropriate limits to set during planned ignoring (e.g. limiting violent, destructive, or unsafe behaviors).

5. Assign homework.

- Parents are again asked to pick a single aspect of **LEMUR** and to begin practicing (e.g. remaining calm, labeling emotions). The therapist can suggest an appropriate goal, given their knowledge of the child's progress in treatment thus far, and parents are also encouraged to indicate which aspects they would like to begin practicing. An additional accommodation chart is provided for parents to track progress.

STIC

- **Child:** No new assignment
- **Parent:** Accommodation chart, including use of **LEMUR**

Session 8: Self-Evaluation and Self-Reward & Putting the FEAR Plan together

Conducted with: The Child

Purpose: Introduce the concept of evaluating or rating performance and rewarding yourself based on effort and performance. Review all previously introduced skills by formalizing the 4-step FEAR plan for the child to use when feeling anxious and practicing its use in non-stressful situations.

Goals:

1. Review STIC task from Session 7
2. Introduce the “R” step
3. Discuss the concept of self-rating and reward
4. Practice making self-ratings and rewarding oneself for effort
5. Review the FEAR plan
6. Construct or review the fear hierarchy and discuss exposure tasks
7. Assign STIC task
8. Meet briefly with parents.

Tasks

1. Review STIC task from Session 7

- Initiate a discussion about the child’s experience during the intervening days. Have the child describe his experience developing a plan of action when faced with an anxious situation--be sure to encourage and support even partial successes. Remind the child that mastering these skills requires lots of practice. Reward him for his effort and cooperation with points, as appropriate. If the STIC was not completed, do it with the child at the start of the session.
- Discuss the child’s experiences during the week practicing relaxation, noting both the times that went well and those in which he experienced difficulty. Discuss the child’s experiences using relaxation as his first response when becoming anxious, and expand on the idea of a quick relaxation exercise such as a few deep breaths and relaxing the muscles he tends to tighten.

2. Introduce the “R” step

- The therapist introduces the child to the final step to coping with anxiety in the FEAR plan, the “R” step: Results and rewards
Summarize for the child the first three steps of recognizing his anxious feelings, recognizing his anxious self-talk and applying coping self-talk, and taking some action that will help change the situation. Introduce the idea of rating his performance and rewarding himself for efforts to cope and to stay in a situation despite his anxiety.

3. Discuss the concept of self-rating and reward

- Describe self-rating and rewards

The therapist begins the discussion by describing a reward as something that is given when you're pleased with the work that was done. Give examples of reward using a story about teaching a dog a trick: If the dog learns the trick, he gets a reward such as a dog biscuit, a pat on the head, or something else he enjoys. But the whole trick isn't learned all at once—it takes gradual steps that get closer and closer to the complete trick. If a puppy has trouble learning a trick, his trainer tries again and again until he gets it right. Emphasize the point that in the beginning the master might reward the puppy for doing part of the trick and that the puppy is rewarded each time he does something right.

Extend the concept to people by talking about “bosses” at work and evaluation and rewards (or another similar example that the child suggests) and discuss how a person feels after a reward or after being punished.

Introduce the idea of self-rating by describing how a child can decide whether or not he is satisfied with his own work. Suggest that people can rate themselves and reward or punish themselves for their own behavior. Provide concrete examples, drawn from your knowledge of the child's own experiences. For instance, for a Little Leaguer, “Imagine that you hit a single that scored a run and helped your team win the game. Were you successful at what you tried to do? How would you feel? What would you do afterwards? What would you be thinking about?” Be sure to point out that it would not be reasonable to expect to get a hit every time you are at bat (e.g., best hitters bat 1 for 3; average .330), and not always getting a hit is not justification to punish yourself. All that is asked is that one tries his best. Do the same for a scenario in which the child is not successful, so has no reward.

- Make a list of possible rewards for the child
Discuss with the child appropriate reward sizes (not too big), point out that rewards work best when they are immediate, and encourage a mix of material (e.g., trading cards) and nonmaterial (reading a book) rewards. Introduce the idea of social reward, such as going to a movie with friends or playing a game with someone. Potential rewards are entered on p. 37 of the Coping cat workbook or into the “reward menu” on p. 73 of the workbook.
- Illustrate the use of self-rating and reward with examples (see p. 38 of the Coping cat workbook). Present a scenario in which a child copes successfully with a fairly simple problem and rates himself positively (let the child steer the discussion whenever there is interest and involvement). Introduce the idea that how you feel afterwards indicates how you rated your performance—positive or negative. If you feel badly, chances are you were

disappointed in your performance, but if you feel happy afterwards, you were probably happy with your efforts. Use the scenario to illustrate this idea by focusing on how the child feels afterwards. Also present a scenario in which a child has to face a more difficult situation where his actions can have little impact on solving the problem, but where he can nevertheless feel good or bad about his thoughts and responses to the situation. Discuss the difference to help the child see that it is possible to rate himself positively in spite of an unfavorable outcome that was beyond his control.

- Present the idea of a “Feelings Barometer”
Using the Feelings Barometer (p. 78 of the workbook), the child measures his own rating of his/her effort/performance. The therapist models self-rating and uses the Feelings Barometer regarding a situation of her own. The therapist then presents a scenario and the child imagines himself in that scenario, and uses the Feelings Barometer to rate his effort/performance.

4. Practice making self-ratings and rewarding oneself for effort

- Therapist as a coping model
The therapist provides a coping model by describing at least one scenario in which she experienced some distress, did not automatically solve the problem, but nevertheless successfully coped with the anxiety, positively rated herself, and gave herself an appropriate reward. Examples of rewards considered might include telling herself she did a good job, writing about the accomplishment in her journal, sharing it with a friend, or spending time on a favorite hobby.
- Role-play
The therapist and child role play a scenario involving an anxious situation that is coped with successfully (not perfectly), using the “tag-along” procedure as necessary. Examples of possible self-rewards are included. Finally, the child role plays a similar scenario with less of the therapist’s guidance. Remember that it’s not enough to talk about these issues; provide the opportunity for real practice by orchestrating in role-play activities.
- Cartoon strips
The therapist presents the child with a cartoon strip in which the character attempts to cope with an anxiety-provoking situation and is successful. By the way, it is a good idea to have cartoon strips prepared ahead of time. The child is asked to fill in the thought bubbles.

The therapist can introduce a cartoon strip in which the character attempts to cope with an anxiety-provoking situation, but is only partially successful. The child is asked to fill in the thought bubbles. The therapist uses this opportunity to emphasize to the child that when he rates his own

performance, he is likely to find both successes and things that could have been done better--people rarely do everything entirely correctly. Emphasize to the child that he can reward himself for effort and for progress—not just the times when he does something correctly. Focus on the idea that no one does everything perfectly and not doing something 100% correctly does not mean that you punish yourself (e.g., Michael Jordon shot 49%, lifetime shooting average).

The therapist describes at least one scenario in which the character does something well but would like to do other things better, demonstrating selfreward for partial success (perfection is not needed for reward). The child is encouraged to participate with the therapist in role playing a similar scenario.

The therapist then describes a scenario in which the character copes well with his anxious feelings, but the outcome is negative despite his best efforts, demonstrating self-reward for successful use of the 4-step plan even in the case of negative results.

5. Review the FEAR plan

- The therapist and child review the concepts in the 4-step FEAR plan and create a “FEAR Plan ID”—a pocket/wallet-sized index card such as the one on p. 79 of the workbook. The first letters of each FEAR step is emphasized in some colorful way. The child decorates the card creatively and personalizes the card with coping thoughts, possible rewards, etc. The therapist provides the crayons, markers, and stickers, laminates the card, and gives the child the card to carry with him.
- The FEAR acronym makes recall of the steps easier and facilitates successful coping. Children are encouraged to use the FEAR acronym during the sessions. If the child wants to be more creative, or has difficulty with the FEAR acronym, encourage him to generate his own acronym to remember the steps.
- The therapist presents a somewhat stressful situation and then uses the FEAR acronym to help talk herself through the situation. The child and therapist participate together in a different scenario using the tag-along procedure (if necessary) and, finally, the child role plays his way through situations that are increasingly anxiety-provoking for him.

6. Construct or review the fear hierarchy and discuss exposure tasks

- The therapist informs the child that the next session involves practicing the skills that have been learned. “We’ll go places and do things.” The following information may need to be discussed with the child:
 - **The FEAR steps will be practiced in situations in which the child feels anxious or worried** (i.e., the situations identified on the situation

cards/fear ladder in the Coping cat workbook). Practicing these steps in situations that provoke genuine anxiety allows the child to see that he can cope and to find out that what he thought was going to happen in the situation is unlikely to happen.

- **The practice will be carried out in a gradual way.** The child will start practicing in situations that make him only a little anxious (i.e. the Easy situation cards/bottom of fear ladder). Step by step we'll move up to approach some tougher situations (i.e. the Medium and Challenging situation cards/higher entries on the fear ladder). Once the child builds some confidence, we can try even tougher situations.
 - **The aim of the treatment is not to remove the child's anxiety** all together but to reduce it to a normal level and to be able to manage it. It's like turning down a radio volume from a high volume of 10 to a normal volume of 2—the radio is still on, the volume is just lowered.
 - **The child will experience some anxiety when practicing his skills,** but this is to be expected and is OK. The more he practices facing these situations the less anxious he will feel, and the more his mastery and confidence will build.
 - **The fear steps need to be practiced repeatedly.** Facing situations that make the child feel anxious will be practiced over and over again. Practice will take place almost until the child feels bored with the situation rather than anxious. The practice is done both in and out of session.
 - **Depending on the exposure task, the child may need to stay in the situation for a certain duration of time.** The aim of an exposure task is for the child to realize that he can cope with the situation and that what he thought was going to happen is not likely to happen. If he gets out of the situation too quickly, then he hasn't experienced that he can cope and the next time he enters the situation he will feel the same or even more anxiety.
- Using the situation cards or fear ladder in the Coping cat workbook (pp. 74-77), the therapist and child brainstorm a list of practice situations that are specific to the child's fears/worries. For example, a child with performance anxiety could be asked to read a poem to the therapist. In order to adequately design an exposure task, it is essential to ascertain the child's feared outcome in each situation. For example, designing an in-vivo for a child who is anxious at school because he is afraid he will have to answer a question in class will involve the child actually being asked a question and using the FEAR steps to cope with the experience. In this case, just

practicing going to school will not allow the child to face the real situation. It is important to be as specific as possible when designing a hierarchy (see a list of exposure task suggestions in Kendall et al., 2005a).

- The therapist and child plan the first exposure task for Session 10, choosing something from the ‘easy’ cards or at the bottom of the fear ladder.

7. Assign STIC task

- Ask the child to record in his workbook two anxious situations that he experienced and to focus on self-rating and reward: whether he rated himself on partial success or just for total success, his feelings afterward, and what he used to reward himself.
- The child is also asked to explain the FEAR acronym to a parent, using the FEAR plan ID if needed. This experience helps the child understand the coping plan and also provides the parents with an understanding of the plan.
- At the end of the session, take a few minutes to play a game or engage in a fun activity.

8. Briefly check in with parents

- Briefly review how child’s anxiety was this week, and how parents have been employing **LEMUR** this week.

STICK

- **Child** - workbook
- **Parent** – continue practicing **LEMUR**

Session 9: Preparing Parents for Exposures

Conducted with: The parents

Purpose: Discuss parents' role during exposures, and address any additional questions or concerns.

Goals:

1. Review parental accommodation chart
2. Provide additional information about the second half of treatment (i.e., exposure tasks)
3. Discuss parents' role during exposures, including reducing accommodation
4. Provide parents an opportunity to discuss their concerns
5. Assign homework

Tasks

1. Review parental accommodation chart

- Therapist reviews the accommodation with the parents, praising parents for completion and progress. Attempts to use elements of **LEMUR** are reviewed, and challenges that arose are discussed.
- Because **LEMUR** is an essential element of treatment, if parents report difficulties or that they did not use it, the therapist takes the time to role-play key its use in key situations that may arise.

2. Provide additional information about the second half of treatment (i.e., exposure tasks)

➤ Provide a brief outline of the remainder of the treatment program and briefly explain the purpose and features of the second half of treatment. Explain that the child will be practicing the skills that he has learned. As presented to the child in Session 8, the following information is also presented to the parents. Parents' questions/concerns are invited and answered. Of note, though the term "exposure" is primarily used in this manual, the term "challenge" is generally used with children and parents.

- **The FEAR steps will be practiced in situations in which the child feels anxious or worried** (provide examples to parents of possible exposure tasks, both imaginal and in-vivo). Practicing these steps in situations that provoke genuine anxiety allows the child to see that he can cope and to find out that what he thought was going to happen in the situation is unlikely to happen.
- **The practice will be carried out in a gradual way.** The child will start practicing, with the therapist, in situations that make him only a little anxious. Step by step he, along with his therapist, will approach some tougher situations. Once the child builds some confidence, he can try even tougher situations.

- **The aim of the treatment is not to remove the child's anxiety** all together but to reduce it to a reasonable level and for the child to be able to manage it.

It's like turning down a radio volume from a high volume of 10 to an average

volume of 4—the radio is still on, the volume is just lowered.

The child will experience some anxiety when practicing his skills, but this is to be expected and is OK. The more he practices facing these situations the less anxious he will feel and the more his mastery and confidence will build.

- **The fear steps need to be practiced repeatedly.** Facing situations that make the child feel anxious will be practiced over and over again. Practice will take place until the child feels bored with the situation rather than anxious. The practice is done both in and out of session.
- **Depending on the exposure task, the child may need to stay in the situation for a certain duration of time.** The goal of practicing is for the child to use his new skills and to realize that he can cope with the situation and that what he thought was going to happen is not likely to (didn't) happen. If he gets out of the situation too quickly, then he hasn't experienced that he can cope and the next time he enters the situation he will likely feel the same or even more anxiety.

- After explaining the rationale behind the use of exposure tasks, the therapist acknowledges that this portion of the treatment may invoke some anxiety for the child before a reduction in anxiety is observed (i.e., anxiety may go up a bit before it comes down). Spend time with the parents discussing this process with them.

3. Discuss parents' role in exposures, including reducing accommodation.

- Review supportive behavior and **LEMUR** with parents. The therapist discusses with the family which of these steps may be difficult, and the way they can work well with the **FEAR** plan to assist parents in conducting exposure and reducing accommodation at home.
- The first few exposures are also discussed, and therapist and parent work together to identify any accommodations that will need to be reduced to maximize the success of the exposures. The therapist and parents discuss the emotional and logistical considerations necessary to help the parent effectively reduce accommodation and support their child through initial exposures, and the skills the parent will employ to do so.

4. Provide parents an opportunity to discuss their concerns

- The therapist invites the parents to discuss their concerns about the child or about the child's participation in the second half of treatment, particularly

the exposure tasks. With open-ended questions, invite the parents to provide any additional history or current information which they feel will be helpful in understanding the child and constructing useful exposure tasks. Specific concerns about reducing accommodations and using new skills are elicited and addressed.

5. Assign homework

- Encourage parents to continue practicing steps of LEMUR at home.

STIC

- **Child** - workbook
- **Parent** – continue practicing **LEMUR**

Session 10: First Exposure

Conducted with: Parent and Child

Purpose: Practice the coping plan (i.e., the FEAR plan) under low anxiety-provoking conditions, either imaginal or in-vivo. Guide parent to reduce related accommodations.

Goals:

1. Meet with parents to discuss exposure and tasks their role.
2. Review STIC task from Session 8 with parent and child
3. Review the idea of progressing from learning new skills to practicing new skills
4. Practice using imaginal and/or in-vivo exposure in low anxiety-provoking situations
5. Plan an exposure task(s) for Session 11
6. Assign STIC task

Tasks

1. Meet with parents to discuss exposure tasks and their role

- The therapist begins the session by checking in with the parents. The day's exposure task is introduced and the parents' reaction is discussed. Parents' role in the exposure task is addressed directly. For early exposures, parents are invited to simply watch, while employing their own skills to minimize their distress. Parents are also asked to monitor and minimize any accommodations, including excessive reassurance.

2. Review STIC task from Session 8

- Initiate a discussion about the intervening days with respect to the child's anxiety—how he's improving in terms of coping and managing it and how he's rewarding himself for his progress. Discuss the two situations recorded in his Coping cat workbook, focusing particularly on the child's experiences with recalling and using the FEAR plan. Address any difficulties with the four steps. Be encouraging: with practice, the four steps will be almost automatic and not require as much concentration as they do in the beginning.
- Ask the child to describe his experiences when explaining the 4-step plan to a parent. Reward the child for his cooperation with points, as appropriate. If any part of the STIC was not completed, do it with the child at the start of the session.

3. Review the idea of progressing from learning to practicing new skills

- Remind the child that in today's session he will begin to practice his newly acquired skills in real situations and describe the change in the type of activities that are forthcoming. Instead of learning about the child's thoughts and feelings and learning how to develop coping strategies, the focus will shift to practicing the skills and coping strategies, sometimes in the session/office and sometimes out of the office in the real situation. Add that parents will often be joining sessions now so that they and the therapist can work as a "team" to fight the child's anxiety. The therapist explains that all team

members will have different roles to help the child practice brave behavior.

4. Practice using imaginal and/or in-vivo exposure in low anxiety-provoking situations

For each imaginal exposure task practiced:

- **Preparation**
Describe the chosen practice situation and discuss/develop a FEAR plan with the child for coping with anxiety (the plan can be entered on p. 44 in the workbook). To make the imaginal situation as real as possible, the therapist uses actual items that would be part of the situation as props and asks the child to rate the situation on the 0-8 SUDS scale, or Feelings Thermometer, introduced in Session 2.
- **Practice**
The therapist pretends she is the child and models thinking through the situation out loud while using the FEAR plan to help herself recall the steps to cope. Be a coping model—it doesn't have to be perfect, just a useful illustration. Then the therapist asks the child to think through a slightly different, but similar, scenario using the same props. The therapist may prompt the use of the FEAR plan as needed.

During the imaginal exposure the child provides a SUDS rating before and after the exposure task as well as every minute (or so) during the exposure. The therapist records the child's SUDS rating and rates how anxious she feels the child is, at pre-, during (every minute or so), and post-exposure.

For each in-vivo exposure task practiced:

- **Preparation**
In preparation for the in-vivo exposure task, the therapist and child develop a FEAR plan for coping with the upcoming anxious situation and enter it in the Coping cat workbook. The therapist and child negotiate a reward to be given for completing the in-vivo task.
- **Practice**
Using props as appropriate, the therapist asks the child to use his new skills in an actual situation that had been practiced through the imaginal procedure, with the therapist accompanying the child as he carries out the exercise. As this is the first attempt to practice in real life, the therapist asks the child to have available his FEAR card and to check it if he begins to experience difficulty. If the child is not able to proceed at any point in the practice, the therapist encourages self-reward for the partial success he did achieve. She then joins him in the exercise, providing prompts as needed. When the child is successful with the therapist's participation, he is asked to use the steps independently in a similar situation.

Throughout the in-vivo exposure, the child provides a SUDS rating before and after the exposure task as well as every minute during the exposure.

The therapist records the child's SUDS rating and also rates how anxious she feels the child is, using the same scale at pre-, during (every minute), and post-exposure (see Kendall et al., 2005a and Session 10's "Tips from the Trenches" for a description of SUDS and the potential uses of SUDS). The child is rewarded for effort and completing the in-vivo.

During the exposure, the therapist monitors the parents as well as the child. If necessary, the therapist coaches the parents to employ their own skills, and reminds them of the guidelines for being a supportive parent during an exposure. Unnecessary reassurance and other forms of accommodation are noted and, to the extent that it is possible, reduced in the moment.

5. Plan exposure task(s) for Session 11

- Using the situations cards/fear ladder in the Coping cat workbook (pp. 74-77), the therapist and child decide on the situation that the child will practice in Session 11. The situation is one that is associated with low levels of anxiety.

6. Assign STIC task

- Ask the child to review and practice using the FEAR steps in at least one anxious situation, similar to those practiced during the session and to record his experiences in his workbook. Negotiate a reward for the out of session in-vivo practice.
- Discuss with parent what their role will be in assisting the child to complete the exposure at home, including any existing accommodations that need to be reduced or eliminated.
 -
- Take a few minutes to play a game or engage in a fun activity at the end of the session as a reward for the child's participation in his first practice session.

STIC

- **Child and Parent:** Child exposure

Session 11: Second Exposure

Conducted with: Parent and Child

Purpose: Continue practicing and applying the skills for coping with anxiety in situations that produce low levels of anxiety for the child. Guide parent to reduce related accommodations.

Goals:

1. Meet with parents and be open to further discussion of exposure tasks and their role.
2. Review STIC task from Session 10 with parent and child
3. Continue practicing using exposure in low anxiety-provoking situations
4. Plan an exposure task(s) for Session 12
5. Assign STIC task

Tasks

1. Meet with parents to discuss exposure tasks and their role

- The therapist begins the session by checking in with the parents. Discuss success of week's exposure homework, for the child as well as the parent. Explore barriers to success and any difficulty reducing accommodation. For parents who have had difficulty running exposures at home, role-plays may be conducted with the therapist and parent.
- The day's exposure task is discussed as well as parents' reaction. Parents' role in the exposure is clearly discussed. For early exposures, parents are typically invited to simply watch, while employing their own skills to minimize their distress. Parents are also asked to monitor and minimize any accommodations, including excessive reassurance.

2. Review STIC task from Session 10

- Ask the child to share his picture or cartoon (sci-fi) character drawing who can help him cope with his anxiety
- Discuss with the child his anxious experience--the experience he practiced during the week. Reward the child's cooperation with points/stickers as appropriate. If any part of the STIC was not completed, do it with the child at the start of the session or practice the anxious experience planned for the STIC during today's session if possible.

3. Continue to Practice using imaginal and/or in-vivo exposure in low anxiety-provoking situations

For each exposure task practiced:

- Preparation
Describe the chosen practice situation and discuss/develop a FEAR plan with the child for coping with anxiety (the plan can be entered in the workbook). To make the imaginal situation as real as possible, the therapist uses actual items that would be part of the situation as props and asks the child to rate the situation on the 0-8 SUDS scale, or Feelings Thermometer, introduced in Session 2. The therapist and child negotiate a reward to be given for completing the task.

- Practice
Using props as appropriate, the therapist asks the child to use his new skills in an imagined or actual. The therapist may accompany the child as he carries out the exercise or, if appropriate, encourage him to practice independently.
- Throughout the in-vivo exposure, the child provides a SUDS rating before and after the exposure task as well as every minute during the exposure. The therapist records the child's SUDS rating and also rates how anxious she feels the child is, using the same scale at pre-, during (every minute), and post-exposure. The child is rewarded for effort and completing the exposure.
- During the exposure, the therapist monitors the parents as well as the child. If necessary, the therapist coaches the parents to employ their own skills, and reminds them of the guidelines for being a supportive parent during an exposure. Unnecessary reassurance and other forms of accommodation are noted and, to the extent that it is possible, reduced in the moment.

4. Plan exposure task(s) for Session 12

- Using the situations cards/fear ladder in the Coping cat workbook (pp. 74-77), the therapist and child decide on the situation that the child will practice in Session 12. The situation is one that is associated with moderate levels of anxiety. Mention that next week the child will be practicing his coping skills using the FEAR plan in more challenging situations and maintain a positive, adventurous outlook.
- .

6. Assign STIC task

- Ask the child to review and practice using the FEAR steps in two anxious situations that provoke mild anxiety and to record his experiences in his workbook. Collaborate on a reward for the STIC tasks.
- Discuss with parent what their role will be in assisting the child to complete the exposure at home, including any existing accommodations that need to be reduced or eliminated.
 -
- If necessary, complete a role-play in session with child and parent, rehearsing expectations and roles for the exposure that has been assigned as a STIC task

STIC

- **Child and Parent:** Child exposure

Session 12: Third Exposure Session

Conducted with: Parent and Child

Purpose: Practice applying the skills for coping with anxiety in imaginal and in-vivo situations that produce moderate levels of anxiety in the child.

Goals:

1. Meet with parents to discuss exposure tasks and their role.
2. Review STIC task from Session 11 with parent and child
3. Practicing using exposure in medium anxiety-provoking situations
4. Plan an exposure task(s) for Session 13
5. Assign STIC task

Tasks

1. Meet with parents to discuss exposure tasks and their role

- The therapist begins session by checking in with the parents. Discuss success of week's exposure homework, for the child as well as the parent. Explore barriers to success and any difficulty reducing accommodation.
- The day's exposure task is discussed as well as parents' reaction. Parents' role in the exposure is clearly discussed. If in-session exposures have been going well, parents may be asked to lead a short exposure later in session, following an exposure led by the therapist as in previous sessions. As usual, parents are also asked to monitor and minimize any accommodations, including excessive reassurance.

2. Review STIC task from Session 11

- Discuss with the child his anxious experience--the experience he practiced during the Review and discuss the two anxious experiences the child experienced (exposed himself to) during the week. Have him describe how he coped with the anxiety and how he rewarded himself. Reward the child's cooperation with points/stickers as appropriate. If the STIC was not completed, practice the anxious experiences planned for the STIC during today's session if possible.

3. Continue to Practice using imaginal and/or in-vivo exposure in moderate anxiety-provoking situations

For each exposure task practiced:

- Preparation
Describe the chosen practice situation and discuss/develop a FEAR plan with the child for coping with anxiety (the plan can be entered in the workbook). To make the imaginal situation as real as possible, the therapist uses actual items that would be part of the situation as props and asks the child to rate the situation on the 0-8 SUDS scale, or Feelings Thermometer, introduced in Session 2. The therapist and child negotiate a reward to be given for completing the task.

- Practice
Using props as appropriate, the therapist asks the child to use his new skills in an imagined or actual. The therapist may accompany the child as he carries out the exercise or, if appropriate, encourage him to practice independently.
- Throughout the in-vivo exposure, the child provides a SUDS rating before and after the exposure task as well as every minute during the exposure. The therapist records the child's SUDS rating and also rates how anxious she feels the child is, using the same scale at pre-, during (every minute), and post-exposure. The child is rewarded for effort and completing the exposure.
- During the exposure, the therapist monitors the parents as well as the child. If necessary, the therapist coaches the parents to employ their own skills, and reminds them of the guidelines for being a supportive parent during an exposure. Unnecessary reassurance and other forms of accommodation are noted and, to the extent that it is possible, reduced in the moment.
- If appropriate, have a parent conduct a similar exposure. This can be done in situations where the parent has already demonstrated aptitude with the concept of exposures, or in situations in which the therapists believes the parent may experiencing difficulty conducting exposures at home. Involvement of the parent may vary depending on the child's age and developmental level (e.g. merely prompting a teenager to complete an exposure may be sufficient, while a younger child may require more monitoring). The therapist intervenes as necessary to coach parents through leading exposure.

4. Plan exposure task(s) for Session 13

- Using the situations cards/fear ladder in the Coping cat workbook (pp. 74-77), the therapist and child decide on the situation that the child will practice in Session 13. The situation is one that is associated with moderate levels of anxiety.

5. Assign STIC task

- Ask the child to review and practice using the FEAR steps in two anxious situations that provoke moderate anxiety and to record his experiences in his workbook. Collaborate on a reward for the STIC tasks.
 - Remind family there are 4 more sessions!
 - Discuss with parent what their role will be in assisting the child to complete the exposure at home, including any existing accommodations that need to be reduced or eliminated.
-

STIC

- **Child and Parent:** Child exposure

Session 13: Fourth Exposure Session

Conducted with: Parent and Child

Purpose: Practice applying the skills for coping with anxiety in imaginal and in-vivo situations that produce moderate levels of anxiety in the child.

Goals:

1. Meet with parents to discuss exposure tasks and their role.
2. Review STIC task from Session 12 with parent and child
3. Practicing using exposure in medium anxiety-provoking situations
4. Plan an exposure task(s) for Session 14
5. Assign STIC task

Tasks

1. Meet with parents to discuss exposure tasks and their role

- The therapist begins session by checking in with the parents. Discuss success of week's exposure homework, for the child as well as the parent. Explore barriers to success and any difficulty reducing accommodation
- The day's exposure task is discussed as well as parents' reaction. Parents' role in the exposure is clearly discussed. For later exposures, parents take a more active role coaching the child through the exposure, while also employing their own skills to minimize their distress. Parents are also asked to monitor and minimize any accommodations, including excessive reassurance.

2. Review STIC task from Session 12

- Discuss with the child his anxious experience--the experience he practiced during the Review and discuss the two anxious experiences the child experienced (exposed himself to) during the week. Have him describe how he coped with the anxiety and how he rewarded himself. Reward the child's cooperation with points/stickers as appropriate. If the STIC was not completed, practice the anxious experiences planned for the STIC during today's session if possible.

3. Continue to Practice using imaginal and/or in-vivo exposure in moderate anxiety-provoking situations

For each exposure task practiced:

- Preparation
Describe the chosen practice situation and discuss/develop a FEAR plan with the child for coping with anxiety (the plan can be entered in the workbook). To make the imaginal situation as real as possible, the therapist uses actual items that would be part of the situation as props and asks the child to rate the situation on the 0-8 SUDS scale, or Feelings Thermometer, introduced in Session 2. The therapist and child negotiate a reward to be given for completing the task.

- Practice
Using props as appropriate, the therapist asks the child to use his new skills in an imagined or actual. The therapist may accompany the child as he carries out the exercise or, if appropriate, encourage him to practice independently.
- Throughout the in-vivo exposure, the child provides a SUDS rating before and after the exposure task as well as every minute during the exposure. The therapist records the child's SUDS rating and also rates how anxious she feels the child is, using the same scale at pre-, during (every minute), and post-exposure. The child is rewarded for effort and completing the exposure.
- During the exposure, the therapist monitors the parents as well as the child. If necessary, the therapist coaches the parents to employ their own skills, and reminds them of the guidelines for being a supportive parent during an exposure. Unnecessary reassurance and other forms of accommodation are noted and, to the extent that it is possible, reduced in the moment. If appropriate, have a parent conduct a similar exposure, with therapist intervening as necessary to coach parents.

4. Plan exposure task(s) for Session 13

- Using the situations cards/fear ladder in the Coping cat workbook (pp. 74-77), the therapist and child decide on the situation that the child will practice in Session 13. The situation is one that is associated with high levels of anxiety.

5. Assign STIC task

- Ask the child to review and practice using the FEAR steps in two anxious situations that provoke moderate anxiety and to record his experiences in his workbook. Collaborate on a reward for the STIC tasks.
 - Discuss with parent what their role will be in assisting the child to complete the exposure at home, including any existing accommodations that need to be reduced or eliminated.
-

STIC

- **Child and Parent:** Child exposure

Session 14: Fifth Exposure Session

Conducted with: Parent and Child

Purpose: Practice applying the skills for coping with anxiety in imaginal and in-vivo situations that produce high levels of anxiety in the child.

Goals:

- Meet with parents to discuss exposure tasks and their role.
- Review STIC task from Session 13 with parent and child
- Practicing using exposure in high anxiety-provoking situations
- Plan an exposure task(s) for Session 15
- Assign STIC task

Tasks

1. Meet with parents to discuss exposure tasks and their role

- The therapist begins session by checking in with the parents. Discuss success of week's exposure homework, for the child as well as the parent. Explore barriers to success and any difficulty reducing accommodation
- The day's exposure task is discussed as well as parents' reaction. Parents' role in the exposure is clearly discussed, including who will lead the exposure and what skills the parent may need to employ to avoid accommodations.

2. Review STIC task from Session 13

- Discuss with the child his anxious experience--the experience he practiced during the Review and discuss the two anxious experiences the child experienced (exposed himself to) during the week. Have him describe how he coped with the anxiety and how he rewarded himself. Reward the child's cooperation with points/stickers as appropriate. If the STIC was not completed, practice the anxious experiences planned for the STIC during today's session if possible.

3. Practice using exposure in high anxiety-provoking situations

For each exposure task practiced:

- Preparation
Describe the chosen practice situation and discuss/develop a FEAR plan with the child for coping with anxiety (the plan can be entered in the workbook). To make the imaginal situation as real as possible, the therapist uses actual items that would be part of the situation as props and asks the child to rate the situation on the 0-8 SUDS scale, or Feelings Thermometer, introduced in Session 2. The therapist and child negotiate a reward to be given for completing the task.
- Transfer of control should be considered. Depending on progress and developmental level, it may be appropriate to have the child take the lead in preparing for the exposure, or to have the parent coach the child through preparation.

- Practice

Using props as appropriate, the therapist asks the child to use his new skills in an imagined or actual. Either the therapist or the parent may lead the exposure. The therapist may accompany the child as he carries out the exercise or, if appropriate, encourage him to practice independently.
- Throughout the in-vivo exposure, the child provides a SUDS rating before and after the exposure task as well as every minute during the exposure. The therapist records the child's SUDS rating and also rates how anxious she feels the child is, using the same scale at pre-, during (every minute), and post-exposure. The child is rewarded for effort and completing the exposure.
- During the exposure, the therapist monitors the parents as well as the child. If necessary, the therapist coaches the parents to employ their own skills, and reminds them of the guidelines for being a supportive parent during an exposure. Unnecessary reassurance and other forms of accommodation are noted and, to the extent that it is possible, reduced in the moment.

4. Plan exposure task(s) for Session 15

- Using the situations cards/fear ladder in the Coping cat workbook (pp. 74-77), the therapist and child decide on the situation that the child will practice in Session 15. The situation is one that is associated with high levels of anxiety.

5. Assign STIC task

- Ask the child to review and practice using the FEAR steps in two anxious situations that provoke high anxiety and to record his experiences in his workbook. Collaborate on a reward for the STIC tasks.
 - Introduced as a fun opportunity, the child is asked to start thinking about a “commercial” that he can produce in the final session (Session 16). For example, he can show other people how to cope with a scary situation. If the child prefers, he can feature his cartoon character. The commercial can be designed for radio, TV, or newspapers, or can be a poem, song, brochure, booklet, skit, or anything else that the child would like to do. Encourage creativity
 - Remind the family that there are only two more sessions!
 - Discuss with parent what their role will be in assisting the child to complete the exposure at home, including any existing accommodations that need to be reduced or eliminated.
-

STIC

- **Child and Parent:** Child exposure

Session 15: Sixth Exposure Session

Conducted with: Parent and Child

Purpose: Practice applying the skills for coping with anxiety in imaginal and in-vivo situations that produce high levels of anxiety in the child.

Goals:

1. Meet with parents to discuss exposure tasks and their role.
2. Review STIC task from Session 14 with parent and child
3. Practicing using exposure in high anxiety-provoking situations
4. Plan an exposure task(s) for Session 16
5. Discuss briefly the end of treatment
6. Assign STIC task

Tasks

1. Meet with parents to discuss exposure tasks and their role

- The therapist begins session by checking in with the parents. Discuss success of week's exposure homework, for the child as well as the parent. Explore barriers to success and any difficulty reducing accommodation
- The day's exposure task is discussed as well as parents' reaction. Parents' role in the exposure is clearly discussed. For later exposures, parents may take a more active role coaching the child through the exposure, while also employing their own skills to minimize their distress. Parents are also asked to monitor and minimize any accommodations, including excessive reassurance.

2. Review STIC task from Session 14

- Discuss with the child his anxious experience--the experience he practiced during the Review and discuss the two anxious experiences the child experienced (exposed himself to) during the week. Have him describe how he coped with the anxiety and how he rewarded himself. Reward the child's cooperation with points/stickers as appropriate. If the STIC was not completed, practice the anxious experiences planned for the STIC during today's session if possible.
- Have the child share his ideas for the commercial. If there was little preparation, do the brainstorming and planning in the session. Talk with him about the characters and any props or scenery that will be needed for the commercial and make specific plans for filming the commercial. Provide the child with the option of filming the commercial at home (versus in session). Making the tape with the therapist is preferred, but if the child decides to film the commercial at home, be sure the child brings in the videotape so that it can be viewed during the last session. Reward the child as appropriate.

3. Continue to practice using exposure in high anxiety-provoking situations

For each exposure task practiced:

- Preparation
Describe the chosen practice situation and discuss/develop a FEAR plan with the child for coping with anxiety (the plan can be entered in the

workbook). To make the imaginal situation as real as possible, the therapist uses actual items that would be part of the situation as props and asks the child to rate the situation on the 0-8 SUDS scale, or Feelings Thermometer, introduced in Session 2. The therapist and child negotiate a reward to be given for completing the task.

- Transfer of control should be considered. Depending on progress and developmental level, it may be appropriate to have the child take the lead in preparing for the exposure, or to have the parent coach the child through preparation.
- Practice
Using props as appropriate, the therapist asks the child to use his new skills in an imagined or actual. Either the therapist or the parent may lead the exposure.

The therapist may accompany the child as he carries out the exercise or, if appropriate, encourage him to practice independently.

- Throughout the in-vivo exposure, the child provides a SUDS rating before and after the exposure task as well as every minute during the exposure. The therapist records the child's SUDS rating and also rates how anxious she feels the child is, using the same scale at pre-, during (every minute), and post-exposure. The child is rewarded for effort and completing the exposure.
- During the exposure, the therapist monitors the parents as well as the child. If necessary, the therapist coaches the parents to employ their own skills, and reminds them of the guidelines for being a supportive parent during an exposure. Unnecessary reassurance and other forms of accommodation are noted and, to the extent that it is possible, reduced in the moment.

4. Plan exposure task(s) for Session 16

- The next session will be the last session for practicing the FEAR plan in anxious situations. Using the situations cards/fear ladder (pp. 74-77 of the Coping cat workbook), collaborate with the child to select a challenging (and probably successful) situation for Session 16. The situation is associated with high levels of anxiety, but also keep in mind that ending on a positive experience is preferred.

6. Discuss briefly the end of treatment.

- Remind the child that the next session is the last one. Briefly recap what the child has accomplished and learned, emphasizing his progress during the previous weeks. Convey confidence in the child's ability to maintain his treatment gains with continued practice at home. Encourage the child to share his feedback about the treatment process and ask him to share any questions or concerns that he may have about terminating treatment.

6. Assign STIC task

- Ask the child to use the FEAR steps in two anxious situations and to record what happened for brief discussion during the last session. Negotiate a reward for each out of session in-vivo practice.
- The next session is the last session and will involve videotaping of the brief (a few minutes) commercial. Prepare any materials that will be needed to complete the task. As you prepare for the last session and the commercial, keep in mind that it should be fun—

it's a chance for the child to "show off" and celebrate his successes. If the child anticipates doing the commercial at home, think it through with him and remind him to bring in the videotape so that it can be viewed during the session and the proper enthusiasm can be engendered. After the session, if parents have been cooperative, encourage them to help the child prepare the commercial and make arrangements to attend the next session.

- Discuss with parent what their role will be in assisting the child to complete the exposure at home, including any existing accommodations that need to be reduced or eliminated.

STIC

- **Child and Parent:** Child exposure

Session 16: Final Exposure Session and Terminating Treatment

Conducted with: Parent and Child

Purpose: Provide a final practice task applying the skills in an in-vivo exposure that produces high levels of anxiety in the child. Produce the “commercial.” Review and summarize the training program. Make plans with the parents to help the child maintain and generalize newly acquired skills. Bring closure to the therapeutic relationship.

Goals:

- Meet with parents to discuss exposure and termination.
- Review STIC task from Session 15 with parent and child
- Conduct a final exposure in high anxiety-provoking situation
- Discuss briefly the end of treatment

Tasks

1. Meet with parents to discuss exposure and termination

- The therapist begins session by checking in with the parents. Discuss success of week’s exposure homework, for the child as well as the parent. Explore barriers to success and any difficulty reducing accommodation
- The day’s exposure task is discussed as well as parents’ reaction. At this point in treatment, parents are ideally more comfortable with exposures and their own role supporting their child’s brave behavior rather than accommodating. Parents may still wish to employ their own skills. Ongoing difficulties are discussed.
- Parents reaction to termination is discussed. Encourage the parents to share their feedback about their child’s progress and ask any questions or share any concerns that they may have about concluding treatment. Describe for the parents that there may be times that are difficult in terms of coping with anxiety--this is normal. But, with continued practice there comes continued improvement.
- Discuss parents own progress in handling their child’s anxiety and employing new skills. Review which skill have been most helpful, and additional goals parents may wish to continue working on for themselves. As with their child, parents are reminded that there will be times that managing their child’s anxiety is difficult, but that continuing to practice their skills will lead to ongoing improvement.
- Parents are invited to call if they have any further questions/concerns. They are also told to call to inform the therapist as to how the child is progressing. In short, the therapist invites further contact around future successes. If necessary, offer referrals for additional services (e.g., an obese child may want to try to lose weight).

2. Review STIC task from Session 15

- Review the anxious experiences the child was exposed to during the week, focusing on his autonomous efforts, his progress to date, and any special ways he has been able to become less anxious. As he describes how he coped with the anxiety and how he rewarded himself it can be helpful to applaud the improvements and share pride in the gains. At this juncture, the child is likely doing things that he could not do at the start of treatment. Reward the child appropriately. If the STIC was not completed during the past

week, practice the anxious experiences planned for the STIC during today's session if possible.

3. Conduct a final exposure in high anxiety-provoking situation

- Preparation
Discuss the anxious situation selected in Session 15 to practice in today's session. Create a FEAR plan for coping with the anxious situation and enter it on p. 70 of the workbook. Keep in mind that we want this to be a successful experience for the child.

- Practice
As appropriate, the therapist and child leave the office and go to a location in which the child can practice the situation just discussed using the FEAR plan, in real life. Transportation, if necessary, is arranged prior to the session. Because this is the final session, the exposure task is conducted at a nearby location so as to reserve time for the production of the commercial, a discussion of treatment termination, and some fun.

As in past exposure tasks, the therapist can remark on aspects of the situation that might be generating anxiety in the child. However, it is good to have the child do this for himself. The child can describe his own feelings, somatic reactions, and anxious self-talk, as well as how to make it more adaptive. If the child wants to just "do it" and is moving forward (approaching) into the situation without distress, this can be supported. Importantly, the child is transitioned to take more of the lead in the use of the steps of the FEAR plan.

As in the past exposure tasks, gather SUDS ratings. Following the final exposure task, think through and talk about the child's performance—note the progress since the start of treatment. Help the child note success on any or all parts of the FEAR plan.

4. Have fun producing the "commercial."

- Prior to the session, the therapist prepares the room where the taping will take place. If additional people are needed, make necessary arrangements. A blank tape/CD and videotaping equipment are prepared, and some materials to decoratively label the video are available.
- Review, with some guidance but without grand expectations, the final arrangements for filming. Integrate the materials that the child has prepared for the filming to those already set up. Have fun with a practice run (or dress rehearsal).
- Videotape the brief commercial and view it. It is often that parents are invited to view the tape, and sometimes parents are included in making the tape. The content and quality of the video is less important than the celebratory context of the event: the child has come along way and there is a recognition and reward for this progress. Parents may need to be guided to see the advances and not to harp on imperfections. Make a copy of the tape so that both the child and the therapist have one.

5. Summarize the treatment program and bring to closure the relationship

- Recap with the parents and child what has been accomplished over the course of treatment. Review with the parents the "FEAR" acronym, ceding the expert role to the

child. Note that there have been gains but that there are areas still in need of improvement—this is always the case. Spend some time celebrating child’s accomplishments. Share some of the highlights of the therapy experience and ask the child to do the same. Begin to create the “history” of the treatment by talking about what has transpired. Encourage the child to continue to use what has worked for him and convey confidence in his ability to do so successfully. At the same time, point out that it is reasonable for there to be new situations and future times that may seem challenging.

- Inform the family that you will call to “check-in” and see how the child is doing. If appropriate, schedule a meeting for a posttreatment assessment and ask the parents to bring their current contact information for follow-up.
- Ask parents to leave for a few minutes so that you can share a “good-bye” with the child. When the parents have left the office, express your satisfaction with and encouragement for the child’s efforts and present the child with a certificate (last page of the Coping cat workbook) to commemorate completion of the treatment program. Have the certificate cosigned by an official (give the certificate added meaning, and provide an opportunity for another person to congratulate the child).

Additional Materials

LEMUR

Skills to help yourself help your child

Label your child's anxious feelings. Label your child's emotions and encourage them to use his/her new skills.

Express empathy and compassion for your child. Express empathy for your child's anxiety, without rushing to accommodate or minimize your child's distress

Model calm, non-anxious behavior. Monitor your own distress or frustration, and model the behavior you wish your child to practice

Use your skills. Employ relaxation and coping thoughts to handle your own distress or frustration.

Reward brave behavior. Provide praise and rewards for your child's desired behavior.

~ ~ ~

Tracking Your Child's Anxiety I

Please track times this week your child was anxious, with special attention to your response to your child.

Situation	My Child's Response	My Reaction to my Child (including thoughts and actions!)

Tracking Your Child's Anxiety II

Please track times this week your child was anxious, with special attention to time that you accommodated your child's anxiety.

Situation	My Child's Response	My Reaction to my Child (Special attention to accommodation)

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Tracking Your Child's Anxiety III

Please track times this week your child was anxious, with special attention to time that you tried to limit accommodation.

Situation	My Child's Response	My Reaction to my Child (Special attention to accommodation)	LEMUR Skill I Practiced

Pointers for Experienced Coping Cat Therapists

This therapist treatment manual is an augmentation of the *Coping cat therapist manual* (Kendall & Hedtke, 2008), with adjustments made to address parental accommodation. For those therapists already familiar with the traditional Coping Cat manual, here is a brief session by session-by-session outline highlighting differences and similarities.

Session 1

- This session combines the traditional first and second session of Coping Cat. It includes introducing the program and rapport building from session 1 as well as identifying feelings and normalizing anxiety from session 2. To allow sufficient time, constructing a hierarchy, traditionally done in session 2, is optional.
- In the brief end-of session check in with parents, they are given a log to track their child's anxiety.

Session 2

- This session combines the traditional third and fifth session of Coping Cat. It includes identifying the child's somatic reaction to anxiety from session 3 as well as the relaxation exercises from session 5. Both activities are slightly truncated to allow sufficient time.
- In the end-of session check in with parents, the anxiety log is reviewed.

Session 3

- This session is a parent session, similar to the traditional fourth session of Coping Cat. In addition to learning about the child's anxiety and educating the parents about the program, this session also introduces the concept of accommodation. Parents are asked to track their accommodation in the following week.

Session 4

- This session covers material from the traditional sixth session of Coping Cat, including identifying and challenging anxious self-talk.
- In brief end-of session check in with parents, the accommodation log is reviewed.

Session 5

- This is the second parent session, which focused on identifying and understanding accommodation. The role of accommodation in maintaining anxiety is reviewed, specific ways a parent accommodates are identified, and alternatives to accommodation are discussed. Parents are asked to track their accommodation and begin considering other ways to respond to their child's anxiety

Session 6

- This session covers material from the traditional seventh session of Coping Cat, including problem solving and the "A" step.
- In the end-of session check in with parents, the accommodation log is reviewed.

Session 7

- This is the third parent session, which focuses on difficulties parents may have in reducing accommodation. Parents are taught skills to handle their own anxiety, frustration or distress, and techniques for handling their child's behavioral or emotional outbursts are introduced. Parents are asked to begin practicing other responses to their child's anxiety besides accommodation.

Session 8

- This session covers material from the traditional 8th session of Coping Cat, including the "R" step and a review of the FEAR plan. When appropriate, a hierarchy may be constructed with the child if not completed in session 1.
- In the end-of-session check in with parents, their efforts to begin reducing accommodation are reviewed.

Session 9

- This is the last parent session, similar to the traditional ninth session of Coping Cat. In addition to educating parents about exposures, this session also reviews how parents can utilize skills to reduce accommodation in exposures and at home. Parents are asked to continue reducing accommodation. Parents are asked to continue reducing accommodation in the following week.

Exposure Sessions

- Exposure sessions are conducted similarly to traditional Coping Cat exposures. Parents are included in exposures, and meet individually before the exposure to review their role in avoiding accommodation.