

# **COGNITIVE BEHAVIOR THERAPY IN THE TREATMENT OF ANXIETY DISORDERS IN CHILDREN**

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## **Abstract**

*People with anxiety disorders often have maladaptive thinking patterns or perceptions; Cognitive Behavior Therapy teaches patients to use a variety of desensitization techniques and to replace the destructive patterns and perceptions with positive, more realistic expectations of self. This paper will discuss how patients with anxiety disorders, receiving Cognitive Behavior Therapy, are taught how to modify cognitive structures, problem solve, challenge irrational thoughts, and productively self-talk. This paper will also discuss the use of exposure therapy, relaxation techniques, and creating a mind-body connection.*

## **Introduction**

People who suffer from anxiety disorders, whether diagnosed or not, may not realize that this condition, given the appropriate therapy, is very treatable. With a caring and genuine therapist that implements the use of Cognitive Behavior Therapy (CBT), clients are likely to find not only relief from nervous suffering, but are able to lead productive lives as well.

## **Treatment**

Cognitive Behavior Therapy is a combination of behavior therapy and cognitive therapy. Key factors in using CBT involve having the client reframe cognitive structures and challenge negative perceptions. According to Kendall and Suveg (2006), “The overall goal of the treatment program is to teach children to recognize signs of anxious arousal and to let these signs serve as cues for the use of anxiety management strategies” (p. 258). Empirical studies are now suggesting that CBT may be the most effective treatment for people with anxiety. (R. Walrath, class lecture, October 20, 2009)

## **Modify Existing Cognitive Structure(s)**

According to Southam-Gerow and Kendall (2000):

A central treatment goal of CBT is to help children build a *coping template* with the hope that children will develop a new—or modify existing—cognitive structure(s) for processing information about the world. An important part of this process is accomplished by having the child practice this new way of thinking (e.g. schema) in the presence of the therapist, permitting the therapist to aid the child in further refining his/her attributions about prior behavior and expectations about future behavior. (p. 334)

## Self-Talk

Within this coping template, the therapist teaches the child that his or her internal dialogue must be restructured to contain positive, self-affirming thoughts rather than defeatist, negative messages. Southam-Gerow and Kendall (2000) further suggested:

The process of changing ‘faulty’ cognitive functioning to thinking which is more adaptive is sometimes called cognitive restructuring. The first step involves helping the child identify his/her *self-talk*, whereby the child may be asked to think of thoughts running through his/her head as ‘thought bubbles’, similar to those seen in comic strips. (p. 345)

It is vital that the therapist discuss with the child what types of statements he or she is telling oneself. Generally, when a person is suffering from anxiety, the internal dialogue is focused on negative thoughts. This means that perhaps hundreds of times in one day, the child is engaging in an internal rehearsal of destructive thoughts. The cycle continues as the child feels more anxious or depressed, and self-esteem continues to plummet. In CBT, the child is taught to recognize these negative self-thoughts as counterproductive, and the therapist teaches the child how to formulate positive self-talk, using only and affirmative, self-esteem building statements. The client must practice this new self-talk until it becomes a habit; they must also learn to actively change negative statements into positive statements. The eventual desired outcome is that the client internalizes the positive statements cognitively, and a positive one replaces the once negative perception of self. According to Kendall and Suveg (2006):

The goal of building a new template for thinking is not so that the perceptions of stress will disappear forever, but so that the formerly distressing misperceptions and arousal, when seen through a cognitive coping structure, will serve as reminders for the use of coping strategies. (p. 262)

## Homework

The practice of using this self-talk is also an example of a homework application that may be implemented in CBT. According to Westra, Dozios, and Marcus (2007), “In CBT, homework completion is posited to play a key role in outcomes, and early homework compliance appears to have a significant impact on treatment outcome, suggesting the importance of assessing homework adherence early in treatment” (p. 363). One additional benefit to self-talk is that it can be practiced anywhere, anytime and does not call undue attention to the sensitized client.

## Building Self-Esteem

Children’s self esteem will suffer when anxiety symptoms become unmanageable, and their participation in daily activities is dramatically reduced or arrested. This is why it is imperative to help the child develop a new schema to facilitate changing perceptions, thus, greatly reducing the presenting symptoms. If parents are unable to help the child build self-esteem or reframe the schemas, then finding a therapist that uses is CBT is warranted. Often times it is the child with a perfectionist personality that tends to have more anxiety; working with the child to reduce unrealistic expectations is imperative to implement with self-talk and cognitive schemas. Kendall and Suveg (2006) suggested:

Cognitive modeling, rehearsal, social reinforcement, and role play are all used to help the child build a coping template that helps in interpreting future interactions with feared situations in a new light. The therapist works with the child to (1) remove characteristic misinterpretations of environmental events and (2) gradually and systematically build a frame of reference that includes strategies for coping. (p. 262)

### **Modeling and Role Play**

The therapist should model in therapy alternative ways of perceiving or dealing with anxiety provoking situations. For the client, this may include role-playing, discussion of feelings, visualization and incorporating stress reduction techniques. It is the modeling and practicing with the client that aide in the desensitization process, and the cognitive reshaping (Kendall and Suveg, 2006). Because it is done in the safety of the therapeutic setting, the child is able to rehearse anxious scenarios in an effort to cope more effectively when faced with them in real life situations. As with any type of new skill, it is in the practicing that makes the client more proficient, thus, paving the way for a lowered anxiety level.

### **Realistic Problem-Solving Strategies**

Further supporting these techniques, Kavan, Elsasser, and Barone (2009) reported:

Patients are taught to challenge unrealistic or unwarranted worrying and to replace these thoughts with more realistic problem-solving strategies. They also may be instructed in the use of self-calming techniques, such as deep breathing, relaxation, and exercise, to reduce physiologic arousal and to enhance their sense of control over their symptoms. Patients are then encouraged to use these techniques outside of the clinical setting. (p.787)

Teaching problem solving strategies is a mainstay of CBT. During this multi-step process, the client is taught how to challenge his or her existing thoughts and behaviors. This must be done sequentially and empathetically not only because it challenges the client's existing schemas and behaviors, but the therapist must be careful not to add the element of shame since the client had previously not functioned in the way the therapist will be teaching. In problem solving, discussion of current schemas and brainstorming of more productive thoughts will be executed, and if the client is engaging in avoidance behavior, ideas will be generated to facilitate the client's return to desired activities rather than avoid them (Kendall and Suveg, 2006). This cognitive and behavior reshaping may cause the client greater anxiety initially as he or she is learning how to deal effectively with anxiety without avoiding it; however, in conjunction with this, anxiety reducing activities must be taught as well.

### **Mind-Body Connection**

One of the techniques used in CBT to overcoming anxiety is to create a mind-body connection. Kendall and Suveg (2006) reported the following:

Many youth with anxiety experience physical symptoms that they may attribute to an illness, as opposed to anxiety. Youth are taught to help discriminate when their somatic symptom (e.g. stomachache) may be due to anxiety or an illness by examining the context in which the symptoms occurs (e.g. only before school). (p.260)

This is a skill that must be learned and is easier for some to learn than others, depending on factors such as intellectual ability, ability to adapt to change, and motivation to change. One of the strategies utilized in CBT is helping the child to develop this awareness. The physical symptoms are more of a discomfort rather than a danger to the child; however, when the child does not recognize the symptoms as stress related, then second fearing, or fear of the fear, develops. By teaching children to understand that anxiety will manifest physical symptoms such as: heart palpitations, blurry vision, low energy levels, lack of desire to participate in activities that once brought pleasure, shallow breathing, depletion, over-whelming sadness, avoidance behaviors, and phobias, this new cognitive foundation allows the client to recognize the symptoms as those of anxiety, and not of a life-threatening illness. Further, the education of this mind-body connection teaches the client to deal effectively with the symptoms by utilizing sequential steps of desensitization taught in CBT.

### **Progressive and Cue-Controlled Relaxation Techniques**

Once the mind-body connection is understood, the therapist may introduce anxiety-reducing behaviors; progressive and cue-controlled relaxation techniques are two such examples (Southam-Gerow & Kendall, 2000). Progressive relaxation is a gradual relaxation technique in which each body part is isolated, tensed and then released. The client may practice this with a narrated relaxation tape, with the therapist, the parents, and/or until he or she has learned the technique well enough to do it alone. It is highly effective for children with anxiety disorders because it is a strategy that can be done anywhere either before feeling the symptoms or in the moment while symptoms are presenting. It is difficult to feel overwhelming anxiety when breathing is being regulated and the body is entering into a deeper level of relaxation.

### **Diaphragmatic Breathing or Alternate Nostril Breathing**

This gradual relaxation method is often paired with diaphragmatic breathing or alternate nostril breathing (Kendall and Suveg, 2006). Not only are these highly effective techniques used in CBT, but the more they are practiced, the quicker and easier it is for the client to maintain or return to a lower level of anxiety. With a lowered self-esteem, or the idea of imaginary audience, a great attribute of this strategy is that it may be practiced discretely, much the same as with gradual relaxation. Consequently, if the child is feeling anxious in the middle of math class, he or she may begin practicing diaphragmatic breathing, reduce the anxiety, and no one will ever know!

### **Exposure Therapy**

Kashdan and Herbert (2001) detail the necessity of facing fears through exposure therapy as a strategy used in CBT for desensitization: “Exposure is a cornerstone of all behavioral and cognitive-behavioral interventions for anxiety disorders” (p.49). Gradual desensitization is a step-by-step strategy in which the client is gradually exposed to the situation that triggers an anxiety episode. For example, if a child experiences this, the parent may take the child to the school parking lot and never enter the school building. This may occur over the course of several days; all the while, the child would practice breathing techniques or other relaxation exercises to deal effectively or reduce the anxious symptoms. The progression would be on-going, where gradual exposure to the school parking lot will advance to entering the building, staying in the building for a given amount of time, until the goal of staying throughout the school day is reached. In order to facilitate progress towards desensitization of whatever

is causing the client anxiety, the client needs to implement the use of any relaxation techniques on a daily basis.

Edelman (2007) concurs by stating, “to plan exposure exercises, the situations and behaviors that the patient most fears and or avoids need to be identified and subsequently ordered from the least to the most anxiety provoking” (p. 219). These skills or tools work extremely well with anxiety for children and adults as well.

It is imperative that the therapist teaches the client to focus on the positive aspects of recovery. Kavan, Elsasser, and Barone (2009) suggested:

Patients may be asked to monitor their symptoms of anxiety along with situational factors and thoughts leading up to episodes of increased anxiety. This information is used to help them recognize triggers of anxiety and patterns of maladaptive thinking. Patients are taught to challenge unrealistic or unwarranted worrying and to replace these thoughts with more realistic problem-solving strategies. (p.787)

### Monitor Progress

To monitor progress, the therapist may establish the use of a daily/weekly chart, or suggest the client keep a journal. It is imperative that the client understands that, actively practicing CBT strategies, is to be perceived as a successful venture. Clients need encouragement to recognize and to reward themselves for being an active participant in their recovery. The client may create a chart where one side details unrealistic worry or expectations, and the other lists more productive thoughts or realistic expectations, as a method of monitoring as well. For some clients, the use of visual aids are essential for the understanding of self monitoring or other aspects of CBT; it is important that the therapist introduce the procedure and individualize it towards the client’s needs. Steinfeld, Coffman, and Keyes (2009) confer: “CBT rests on a foundation of tailoring treatment to client needs and goals, and therapists work collaboratively with a client to address these issues in the manner most helpful to the client” (p. 411). It is important with children to involve the primary care givers in this therapeutic process. They will serve as catalyst for reinforcing prosocial behaviors, aid in creating visual aides, helping to formulate and maintain new schemas, and even being part of the reward. Kendall and Suveg (2006) suggested making a list of possible rewards to further aide in progress (p. 270).

### Relapse Prevention

Once the client’s stress level is manageable, Velting, Setzer and Albano (2004) state that “all CBT programs involve a *relapse prevention* component geared toward consolidating the child’s anxiety management skills and promoting generalization and maintenance of treatment gains” (p. 50). This further reiterates the concept of practice and homework to maintain a low, manageable stress level, but more importantly to have the child feel confident in dealing effectively when a stressful situation arises.

Cognitive Behavior Therapy is an active therapy that requires the client to take ownership in the recovery process. Freedom from unnecessary suffering is attainable for those incorporate the components of CBT into daily living; with the practice of newly acquired skills, CBT is a highly effective treatment for those with anxiety disorders.

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