Enhanced Cognitive-Behavioural Treatment for Parent–Child Dyads with Anxiety Disorders

Therapist Manual for Parent Sessions

Samantha Galea and Katherine A. Lawrence

Monash University

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This manual encompasses the parent treatment component of a concurrent CBT Treatment for Anxiety Disorders in Parent-Child Dyads. It has been adapted from: Norton, P. J. (2012). *Group cognitive-behavioral therapy of anxiety: A transdiagnostic treatment manual*. New York, NY: Guilford and Norton, P. J. and Hope, D. A. (2001), *Anxiety Treatment Program – Therapist Manual*, with permission from the authors.

Explanatory Note:

This parent treatment manual has been developed to accompany the equivalent child treatment manual. Together, the two manuals comprise the enhanced cognitive-behavioural treatment for parent–child dyads with anxiety disorders. Research indicates that bidirectional transmission and maintenance of anxiety within parent–child dyads may be better targeted when parents and children receive equivalent and concurrent CBT. Accordingly, the current intervention was designed to simultaneously treat parent and child anxiety disorders, as well as to provide opportunities for anxiogenic dyadic factors to be specifically targeted via additional treatment components.

This enhanced CBT intervention has been trialled in a pilot feasibility and acceptability study, however, the efficacy of the intervention remains to be evaluated in a randomised controlled trial. It is therefore at the discretion of clinicians or researchers to utilise this treatment manual based on their professional judgement about its suitability for the intended recipients in clinical or research contexts. Further information about the literature supporting the intervention development, along with an overview of the content and structure, is detailed in the open access pilot study protocol of the concurrent enhanced CBT intervention:

Galea*, S., Salvaris*, C. A., Yap, M. B. H., Norton, P. J., & Lawrence, K. A. (2021). Feasibility and acceptability of an enhanced cognitive behavioural therapy programme for parent-child dyads with anxiety disorders: A mixed-methods pilot trial protocol. *Pilot and Feasibility Studies*, 7(1), 109. doi:10.1186/s40814-021-00846-8; * Joint first authors.

Further enquiries about the manual can be directed to: Katherine.Lawrence@monash.edu

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Table of Contents

Pre-Treatment Feedback Session

Topics	**Materials**
1) Socialisation to Treatment	Forms:
2) Expectations of Treatment	Feedback Form 1 – SUDS Scale Anchors
3) SUDS Ratings	Feedback Form 2 – Trigger and Response Listing
4) Developing a Trigger and Response Hierarchy	Feedback Form 3 – Trigger ➔Response Hierarchy
	Pens and/or marker for white board

Overview

The pre-treatment feedback session is held in two parts. During part one, the parent and child, along with both therapists are present, while in part two the parent and child are separated into two sessions along with the corresponding therapist. The purpose of the feedback session is fourfold: (1) to socialize the parent and child to the treatment, and to the requirements and expectations of treatment, (2) Provide feedback based on the diagnostic assessment (3) to describe and illustrate SUDS and Coping Behaviour ratings, and (4) to develop a Trigger➔Response Hierarchy.

Part One:

Socialisation to Treatment

Clients should be provided a brief overview of what the treatment will entail so they may make informed decisions regarding their treatment options. Both the parent and child will participate in separate but concurrent treatment sessions. The treatment will involve 10 weekly sessions that will each last approximately 1 to 1.5 hours. The treatment consists of three primary components. First, clients will learn more about anxiety, what triggers their anxiety, and how they individually experience anxiety. The second component addresses the thoughts and perceptions that underlie the anxiety difficulties. The final component of treatment focuses on helping the clients gradually face their fears. This final exposure component is broken up into two parts, where clients initially learn how to apply the skill during individual exposure sessions, before moving to a joint phase. In the shared exposure phase, parents and children will act as silent observers during each-others exposure sessions. The purpose of this is twofold: (1) where

parents can observe their child coping with anxiety, whereby helping parents challenge perceptions related to their child's inability to cope and (2) children can observe their parents face fears through modelling positive anxiety coping behaviour, assisting the child to challenge cognitions about threats in the environment as well as their ability to cope with threat.

Requirements and Expectations for Treatment

The key rules for participation in the treatment are attendance and being on time, completion of assignments, and participation. Each session, the client will progress through the specific steps that build on the previous session's work. When clients miss a session, it may interrupt the scaffolding of treatment, and also delay the treatment ending. Therefore, it is very important that both parent and child clients attend every session. As treatment is designed to run in parallel, both the parent and their child will need to be present at each appointment. Explain that if something comes up and an absence is unavoidable for one or both members of the dyad, the client should call the clinic as soon as possible to reschedule the appointments. Each session only has a limited amount of time, so being on time helps ensure that the client completes everything that is planned. Strongly encourage clients to be on time for each session.

Discuss that each client will be given tasks or exercises to complete out of session. These exercises are designed to reinforce what was covered in session, and extend the treatment gains from the therapy room to the real world. It is critical that clients try to complete all assigned work. Further, parents will be involved in the setting of homework for their child, to ensure they understand their child's homework tasks should they be required to provide assistance for their child in-between sessions.

Finally, and perhaps most importantly, is to encourage participation in the sessions and in between session work. Treatment is an active process, so clients must participate in the process to see positive gains. Before moving on, clients should have expressed some commitment to following these general requirements. These requirements will be reviewed again during the first session.

Discuss Child Assessment Feedback

The therapist who conducted the child assessment should briefly discuss the results of the assessment report to the parent and child, in language the child can understand. A copy of the assessment report should also be provided to the parent. The child and parents should also be provided the opportunity to ask any questions about the assessment feedback and report, and the therapist should attempt to answer simply and clearly. Once complete, the child and therapist who conducted the child assessment should leave the room to complete the appropriate Child Manual hierarchy and SUDs ratings forms.

Part 2:

Discuss Parent Assessment Feedback

The therapist who conducted the parent assessment should now briefly discuss the results of the assessment report with the parent, with a copy of the assessment report provided. Give the parent an opportunity to ask any questions about their assessment feedback and report. Once complete, continue on to complete the in-session forms detailed below.

SUDS Ratings

Throughout treatment clients will be regularly asked to rate their level of anxiety. This rating is known as the Subjective Units of Distress Scale or SUDS. SUDS are made on a 0 to 100 scale with higher numbers representing greater anxiety. A SUDS of zero indicates no anxiety while a SUDS of 100 indicates the worst anxiety experienced or the worst imaginable anxiety. Read the SUDS value and the associated descriptor from the *Feedback Form 1: SUDS Anchor Form*, and have the client briefly describe a situation, event, or object that would cause him or her that much anxiety.

Developing a Trigger ➔ Response Hierarchy

Begin the process of developing hierarchies with the client. Discuss that the hierarchy will serve two general purposes. First, the hierarchy will provide a roadmap to guide the graded

exposures. Second, the hierarchy will provide a baseline from which change can be later measured. The steps in developing a Trigger ➔ Response hierarchy include:

(1) Developing a list of about 10 triggers that provoke anxiety/fear
(2) Rank ordering the list of triggers
(3) Identifying the typical behavioural response
(4) Assigning SUDS ratings

Using *Feedback Form 2: Trigger and Response Listing*, facilitate a discussion where a list of the client's triggers can be generated. The therapist should prompt the client with the triggers already identified during the pre-treatment assessment, to ensure the client does not feel they are rehashing previously discussed content. Also, the therapist should attempt to ensure that the client includes both examples from the range of their principal fears, as well as variations of the principal fears (e.g., large and small dogs, public speeches and informal conversations, etc.). For each trigger, have the client briefly describe what they might do to reduce their fear or anxiety (e.g., escape, avoidance, negative coping behaviours).

Once the list has been generated, have the client rank order the triggers according to how much anxiety or fear the trigger would cause them, with 1 being the most anxiety-provoking and 10 being the least anxiety-provoking. When the rank-ordered hierarchy is complete, transcribe the hierarchy to the *Feedback Form 3: Trigger ➔ Response Hierarchy*. Each item on the *Feedback Form 3: Trigger ➔ Response Hierarchy* should be read back, and the client should rate how anxious the situation or stimulus would make them (SUDS). After the hierarchy has been completed, quickly review it to make sure there are no problems.

End of Pre-Treatment Feedback Session

Discuss any remaining questions or concerns that the client might have, and then remind the clients of the date and time of the first session. Thank the parent and child for coming in and express optimism about the upcoming treatment.

Session 1: "Introduction to the Anxiety Treatment Program"

Topics	**Materials**
1) Introductions	Forms:
2) Review of Treatment Rules	1.1 – Interaction of Anxiety Components
3) Discussion of Anxiety and Anxiety Disorders	1.2 – The Development & Treatment of Anxiety
4) Psychoeducation: Parental Modelling	1.3 – Monitoring the Components of Anxiety
5) Discussion of the Three Components of Anxiety	Session 1 Summary Form
6) Homework	
7) Preview of Treatment Components	Pens and/or marker for white board

Introductions

Therapist begins by thanking the client for beginning and committing to treatment. Prepare the client for the general format of the first session by giving the client an overview of the session. Explain that this session will feel somewhat like a class, and the emphasis will be on learning things about anxiety and fear that will help set the stage for later parts of treatment. Although there is a large amount of content to get through, the therapist should ensure that they are checking in throughout for the clients understanding, as well as prompting clients to generate personal examples. Allow the client an opportunity to ask any questions they might have prior to beginning the session content.

Say: *Thank you for coming today. [Name of Child Therapist] and myself are excited to be working with you and [child's name] over the next 10 weeks to help you both tackle anxiety. Today we have a fair amount of content to get through. I'll be doing much of the talking, which is a little different to how our other sessions will run. I'll be checking in with you throughout to make sure you understand, but please feel free to ask any questions or have me clarify any information that doesn't make sense. Also, I'll be asking you at different points to have a think about some examples of how anxiety has impacted on your life.*

Say: *In session we'll be covering what anxiety is and some of the ways anxiety can develop, we'll talk about the different components of anxiety, and we'll discuss the upcoming*

components of treatment in more detail so that you know what to expect. Before we get started do you have any questions or comments?

Review of Treatment Rules

The therapist should then briefly discuss the basic requirements for treatment to be successful.

Say: I know you would likely have discussed these points before, but they are important enough that we should briefly cover them again. At the FEAR Clinic, we have a strong policy for maintaining confidentiality. In fact, in most cases we are legally and ethically bound not to give out any information about any client. [Discuss legal limits to confidentiality]. The other things that are important are attendance and being on time. If something comes up and an absence is unavoidable, please call the clinic as soon as you can. As well as making sure you come to each session, it is also important that you be on time for each session. We only have a limited amount of time for each session, so being on time helps ensure that we can complete everything that we need to cover.

Say: Another important part of the treatment will be activities that I'll ask you to do at home between sessions. These tasks are designed to help transfer what you learned or worked on during session into the real world. Whenever between session work is assigned, we will discuss and negotiate the tasks. I want these exercises to be something that you feel comfortable and capable of doing. If it seems like I'm assigning too much or too difficult tasks, please let me know and we will work to make it less time consuming or less difficult. However, it is important that you do your best to complete these negotiated exercises before the next session.

Say: Finally, it's important to point out that you are participating in this program not only as an individual, but also as a parent along with your child. That means that the work in these sessions will focus on your anxiety, while at the same time your child will be focusing on their experience of anxiety. The sessions and content that you complete will

mirror what your child is completing, that way you'll both be tackling anxiety at the same pace. It also means you'll be able to support your child with their learning in-between sessions too.

Discussion of the Nature of Anxiety

The session should continue with a discussion of the nature of anxiety. Fear and anxiety should be conceptualized as systems in humans that are designed to protect the person from current or future threats to their safety or security. Although fear and anxiety are different constructs, the distinctions between them are not important in the context of the treatment. Therefore, the terms will be used interchangeably throughout the manual.

Say: Let's start now by discussing what anxiety is. Anxiety is an emotional state experienced when a person anticipates threat or is threatened in some way. Put simply, it is fear about what might happen. The 'what might happen' or 'threat' can vary from situation to situation, and from person to person. It is a normal part of everyone's life. Here are some examples:

1. *When walking alone at night past a dark alley, most people would experience some anxiety and would probably not take a shortcut through the alley (or, at least, do so quickly and carefully).*
2. *When dropping of your child at kindergarten for the first time, most people would probably experience some anxiety about leaving their child in someone else's care or about how their child might adjust without them.*
3. *When meeting the future in-laws, most people would experience some anxiety and would probably do something to prepare so that they will make a good first impression.*

Say: Anxiety is experienced by nearly everybody when they feel there is some type of threat. Typically, this anxiety is unpleasant but not unmanageable, and quickly decreases once the fear is faced. In fact, when there is some type of threat, anxiety is very useful. It motivates

people to prevent the threat or protect themselves from being physically or emotionally harmed.

Say: In situations where someone becomes anxious because of a threat, the anxiety motivates the individual to either protect him or herself, escape from the threat, or avoid the threat altogether. As you can see, anxiety itself is usually a very helpful thing and everybody experiences anxiety. It's not something that you either have or don't have. Instead, anxiety is a continuum from very little to very severe. Different people may experience more or less anxiety than others, and the amount of anxiety a person experiences at any given time can vary a lot as well.

When Anxiety Becomes a Problem

Discuss the differences between helpful and/or "normal" anxiety and anxiety that is a problem, presenting anxiety as existing on a continuum. Highlight both the misperception and over-exaggeration of threat, as well as how that anxiety negatively impacts some facets of a person's life.

Say: As I mentioned, everybody experiences some amount of anxiety. Some people, however, don't experience problems in life due to their anxiety while others do. So, then what is the difference between "normal" or appropriate anxiety and anxiety that is a problem or inappropriate? Anxiety that is a problem differs from typical anxiety in a few important ways. First, when someone has a problem with anxiety they often experience intense fear or anxiety about things that do not cause any anxiety, or at least very little anxiety, in others. Here's an example. Before I begin, however, I should tell you that all of the stories we will share with you are either made up, or have been changed enough that the individual we describe cannot be identified.

Say: Frank has an anxiety problem – a fear of heights. He will only go up in tall buildings if he absolutely must, but he always stays toward the middle of the building, never near the

windows. He will not stand on a balcony because he fears that he will fall, or the balcony will collapse. Frank's family once went to the Grand Canyon, but Frank refuse to leave the hotel room when the family went to tour the ridge of the canyon.

Say: *Susan, on the other hand, doesn't have anxiety problems about heights. Tall buildings and balconies don't make her anxious. When she went with her family to the Grand Canyon, she felt a little cautious when peering over the edge of the canyon, but she otherwise felt fine.*

Encourage clients to speak and briefly discuss the specific fears they experience that brought them to treatment. Encourage clients to discuss worry related to their child if relevant. Therapist should gently guide clients who are having difficulty sharing their problems.

Say: *Tell me, which of your worries would you say results in or triggers severe anxiety for you? What sort of things or situations cause anxiety for you but not for other people you know?*

Have the client briefly discuss some of the important ways that their anxiety interferes with their daily life, work/school, social life, or other parts of their life such as their relationship with their child. Record major points on paper or the board.

Say: *Another important difference between the normal experience of anxiety and problematic anxiety is the extent to which the anxiety interferes with a person's life. If your anxiety is interfering with your daily life, work, or your social life, it is likely a problem for you. Can you describe any of the ways that your anxiety interferes with different areas of your life? How does anxiety interfere with your life as a parent?*

Why Do Some People Experience Anxiety Problems?

Provide a brief discussion of the origins of problematic anxiety, highlighting the influence of genetic, early learning, and important life experiences. Express these influences as predisposing toward the development of an anxiety problem, but show that the interaction of some or all of these influences is typically necessary for excessive anxiety to develop. In essence, try to discourage the client from assuming a single determining factor, (e.g., my children will be anxious because of my anxiety genes, my anxiety is my caregivers' fault, everyone who experiences a trauma will have an anxiety disorder). The goal of this discussion is to help the client view their anxiety difficulties more objectively and scientifically rather than subjectively and emotionally. The goal is also to introduce the concept of an anxious style that will be the focus of the final aspect of treatment.

Say: *A commonly asked question is "Why do some people develop anxiety problems?" Although there are no certain answers, the latest research suggests that anxiety problems are more common in families, and develop from the combination of two things – from your genetics and from what you learned about the world when you were a young child. While we know that Anxiety Disorders are more common in families, it doesn't automatically mean that this commonality is genetic. Research tells us that genetic factors alone explain approximately 30-50% of the transmission of anxiety disorders. That means that a large proportion of the explanation comes from our own experiences, and what we learn from others.*

Say: *In fact, there seem to be three main types of experiences that can contribute to the development of anxiety disorders: experiencing something negative or threatening, witnessing something negative or scary, or learning that something is dangerous or negative. An example of experiencing something negative could be stumbling on a word during a presentation and having an audience member laugh. A person might then avoid all public speaking due to fears of embarrassment. An example of witnessing something negative could be having a loved one die suddenly from a heart attack. That person might*

become excessively concerned about their health and fear unusual body sensations. An example of learning that something dangerous could be a person who is always told that germs are dangerous and that you should always wash your hands to avoid getting sick. As a result, that person may fear contamination and continually wash their hands to get rid of germs.

Say: It is also useful to understand how our genetics and environment can impact on our experience of anxiety. I like to use a cup of water as a metaphor to understand this [Form 1.2]. Each person's genetics determine the amount of water already in the cup. People with a greater genetic vulnerability will have more water already in the cup while people may have less water in the cup. When negative or scary things are learned, witnessed or experienced water is added to the cup. If these things are more intense or powerful, more water is added to the cup. A specific fear of something develops when the cup overflows.

Provide parents with an opportunity to reflect on the genetic and environmental factors discussed above. Allow them to explore and wonder about how past experiences may have impacted on their current experience of anxiety.

Say: What about for you, can you think of anything threatening that you may have experienced, witnessed, or learned that might have contributed to your anxiety? What about any genetic or early life influences?

Anxiety about Parenting

Here it is important to normalize the significant milestone of becoming a parent, and having worries about their child and their child's future. This section is an opportunity to build rapport through acknowledging the difficulty of becoming a parent, it also helps scaffold the parent social modelling psychoeducation. Further, this section should highlight the bidirectionality of anxiety in a parent child dyad: the parent may contribute to their child's anxiety, but an anxious child will likely contribute to their parent's anxiety.

Say: *There is no doubt that becoming a parent is one of the most significant milestones in life. Becoming a parent could be described as a new life chapter, but it might have felt like a whole new re-write of the book! It's an exciting time of love and connection, but can also be a period of stress, worry, and pressure from your own and others' expectations. This is because parenting is a time of great change, and these changes and challenges can occur for parents during different times in their child's development.*

Say: *Does this sound similar to your own experience? Did you find any stage of adjusting to parenting particularly easy or difficult? And how might have this impacted on your experience of anxiety?*

Say: *Interestingly, much of the focus and worry about parenting is usually related to how a parent could be impacting their child. While this is important, another important and often forgotten aspect is how a child can impact on their parents. When talking specifically about anxiety, children with anxiety can often trigger significant worry and anxiety in their parents. For example, a child who has difficulty separating from a parent during the school drop off might trigger feelings of guilt and worry in the parent related to how their child will cope alone. Do experience any feelings or worries triggered by your child's experience of anxiety?*

Psychoeducation: Parental Modelling

This section is for the exploration of ways the client might inadvertently model anxious behaviours and thoughts to their child. The purpose is for the parent to develop insight into how their cognitions and behaviours can potentially impact on their child's cognitions and behaviours. Additionally, the exercise helps clients to develop a greater understanding on the unique influences of anxiety in parent-child dyads.

Say: Since the focus of treatment relates to your anxiety, but also your child's anxiety, I want to spend some time talking about a special type of learning about threat, called modelling. Children frequently copy their parents; just think of the little boy or girl who pretends to shave to be just like dad. It's reasonable then to expect that children may learn ways to behave or cope through watching and imitating their parents. Let's go through an example:

Say: Joe has a 9-year-old daughter named Maddy. When Joe was 7, he was playing outside with his siblings and a stray dog bit him on the arm. His siblings and dad managed to scare the dog off, but Joe's arm required 4 stitches. Since then, Joe has had an intense fear of dogs. He is extremely wary when it comes to dogs, especially around his daughter Maddy. He doesn't let her play in the front yard for fear of a stray dog wandering in. He also doesn't let Maddy pet the neighbour's dog, taking every opportunity to explain to Maddy that dogs are very dangerous. When Joe and Maddy are walking down the street and they see a dog, Joe immediately stiffens up, grabs Maddy by the hand and squeezes tightly, telling her that she is safe with dad, and that the 'bad dog' can't get her. Now, every time Maddy sees a dog, she immediately tenses and runs up to her dad and squeezes onto his leg in fear.

Generate a discussion of how Joe's experience of a dog bite, has influenced the way he responds to dogs. Importantly these behaviours are consistently 'modelled' to Maddy who learns that dogs are dangerous, and imitates the same behaviours of her father around dogs. Allow the client some time to reflect on ways they potentially may model anxious behaviours to their child. Finally, make it clear that the discussion of modelling is not to blame parents for anxiety in their child, but it is for them to understand the influences of their own and their child's anxiety.

Say: What are some of the things that Joe does that might communicate to Maddy that she should be afraid of dogs? What about Maddy's behaviours around dogs?

Say: Now thinking about your own relationship with your child, are there any ways in which your own experience of anxiety might impact on your child's anxious behaviours? Do you notice your child behaving similarly in situations that cause you anxiety?

Say: I really want to stress that this exercise is not one of self-blame. I find that many parents want to know at least a bit about the potential causes of anxiety in children. What's important to remember here is that it doesn't matter where the anxiety came from, what matters is that we become aware of the patterns so we can do something about it. The fact that children are like little sponges that absorb the information around them means we can use the power of modelling to our advantage. It means that parents can model courageous behaviour to show their child helpful ways to manage tough situations. Throughout treatment you and your child will learn these helpful ways of managing tough situations, and you'll have the opportunity to model courageous behaviours in a supportive environment.

The Three Components of Anxiety

Briefly review a hypothetical example of someone experiencing anxiety disorder. Be sure the example describes cognitive, physiological, and behavioural symptoms.

Say: You may have noticed that I talk about a number of things happening when someone is anxious or fearful. These things fall into what psychologists call the Three Components of Anxiety. These three components are the Physiological Component, the Thought Component, and the Behavioural Component. I would like to discuss what typically occurs with each of the three components of anxiety, and then discuss why these things happen when you are anxious. Finally, I'll talk about how the three components of anxiety can work against people with anxiety disorders, and actually strengthen the anxiety disorder. By understand what these components are, we understand what we are targeting and that means we can make changes.

Physiological Component

Say: *The physiological component of anxiety includes the bodily feelings and sensations people experience when anxious. Some of the common physiological sensations are: racing or pounding heart (also called heart palpitations), shakiness, tingling in the fingers or toes, and dizziness, to name a few. What are some other physiological sensations you experience when anxious?*

List all the symptoms on paper/white board, filling in important omissions and expanding others to their physiological roots. For example, dizziness and stomach distress can be elaborated by discussing changes in blood flow.

Thought Component

Say: *The second component of anxiety is the Thought Component. The thought component is what people think about and pay attention to when anxious. Addressing thoughts is particularly important in treating anxiety disorders, because what we tell ourselves has a great impact on how we react and feel. We will spend a lot of time later in treatment looking at the types of thoughts you have when you are anxious. In the meantime, what are some of the thoughts that you have when you become anxious?*

List the cognitions on the board/paper below the physiological symptoms.

Behavioural Component

Say: *The final component, the Behavioural Component, consists of what you do when you are anxious. There are typically three general types of anxiety behaviours. First, there are the so-called nervous behaviours that people do when they are anxious. This type of behaviour is common, and includes behaviours like tapping your feet, checking your watch, avoiding eye-contact.*

Say: Next are called Escape/Avoidance Behaviours. These involve either escaping from or avoiding places or things that may make you anxious. Escape/Avoidance behaviours are interesting because they are so effective in reducing anxiety in the short-term. If a person becomes anxious about possibly having a panic attack while in crowded store, leaving the store at the first sign of anxiety is a very effective way of making sure it won't happen.

Say: While escape/avoidance behaviours are effective in controlling anxiety in the short-term, they have many negative long-term effects. First, and most obviously, escaping or avoiding things prevents people from doing what they want to do or need to do. They interfere with your ability to live your life as you want. Second, after having to escape or avoid things because of their fears, people often feel badly about themselves or depressed.

Say: The final negative long-term effect of escape/avoidance behaviours is that escape/avoidance behaviours become stronger every time you do these behaviours, making it harder and harder to stop these behaviours. As we mentioned earlier, escape/avoidance behaviours are very effective in the short-term reduction of anxiety. Your mind and body treat this as a reward: "I feel anxious → I leave → I feel better." A simple rule of psychology is: If a behaviour leads to reward, the behaviour is more likely to occur again.

Say: The final type of anxiety behaviours are what we call Coping Behaviours. Often, people cannot avoid or escape the things they fear, so they learn to do things to try and minimize their anxiety. Often, but certainly not always, coping behaviours have a direct link to the anxiety or feared situation. For example, someone who frequently worries that something awful may have happened to their child might call school to check up on their child several times a day. Sometimes, however, coping behaviours may seem completely unrelated to the fears.

Say: Coping behaviours, like escape/avoidance behaviours, are effective in the short-term reduction of anxiety, but counterproductive in the long-term. If the coping behaviour leads to a reduction in anxiety, it is much more likely that the person will continue to use the coping behaviours. In fact, this seems to be why some people have coping behaviours that do not seem to be related to their fears at all. If a person's anxiety happens to go down when they do something, the person will often continue to do that behaviour when they get anxious.

Say: One type of coping behaviour that is particularly unhelpful is the excessive use of alcohol or drugs. Alcohol and many types of drugs can counteract the effects of anxiety, but this can lead to dependence. Moreover, while using alcohol and drugs might appear to reduce the effects of anxiety in the short term, in the long term they create more problems and often lead to greater anxiety. Please let me know if you are concerned that you may be drinking or using drugs as a coping behaviour.

Downward Spiral of the Three Components

Discuss how the three components interact with each other, and can create a downward spiral of anxiety. *Form 1.1* is a figure representing this spiral. Showing this figure or redrawing it on the board often helps clients understand the interaction.

Say: The strength of the three components of anxiety seems to vary quite a bit from person to person, and even from situation to situation. Some people, for example, will report a number of thoughts and behaviours, but not a lot of physiological symptoms. Other say that they cannot identify many thoughts, but that they have a lot of physiological symptoms and escape/avoidance behaviours. While the strength of each seems to vary among people, it is almost always the case that all three components are happening to some extent when a person becomes anxious.

Say: More importantly, the three components of anxiety affect each other, and can cause the episode of anxiety to become more and more intense. [Use Form 1.1] For example, here is a description of Bob, who has trouble speaking with authority figures because he fears that he will look inferior to them. More specifically, Bob become anxious that he will look guilty of something when speaking to authority figures. A police officer comes to his door while canvassing Bob's neighborhood. [Walk through spiral].

Say: See how the physiological component (sweating), the cognitive component (thoughts of looking guilty, thoughts of going to jail), and the behavioural component (fidgeting, no eye-contact, rushing the conversation and closing the door) of Bob anxiety affected each other making him more and more nervous.

Say: Here is another example of the three components of anxiety. Here we have Jan who has lots of worries about her child Ruby's safety. When Ruby is about to cook a batch of pancakes, Jan becomes anxious that Ruby will seriously hurt herself.
[Walk through spiral].

Say: Can you see how the thought component ('Ruby can't do it alone because she'll hurt herself') impacted on the physiological component (heart beating faster), impacted on the behavioural component (hovering and taking over), affecting each other and contributing to Jan becoming more and more anxious.

Say: I have used these examples, but the same type of process happens with any type of fears. How about for you? Looking at the components you listed, how do they affect the other components?

Have a brief discussion of some clients' experience of the three components interacting. Ask the client to recall a recent anxiety episode and record the components that they recall

experiencing during that episode on *Form 1.3*. Ask the client to briefly describe the episode, and list the thoughts, physical sensations, and behaviours in the appropriate columns.

Homework

Assign the homework about monitoring the three anxiety components during at least two anxiety provoking situations that occur over the next week.

Say: Now I'd like to talk to you about this week's in-between session work. This week's you will monitor two anxiety episodes even more closely. This will help you learn to identify what anxiety feels like for you. Use this form [Hand out Form 1.3] to break down the specific components of the anxiety you experience during these episodes. We've already completed an example for you to reference during the week. If no anxiety-provoking situations come up this week, try to think of recent anxiety-provoking situations to use when filling out the form.

Preview of Treatment Components

Briefly discuss the components of treatment: Education/Self-Monitoring, Cognitive Restructuring, and Graded Exposure. Further, emphasize that each component of treatment will require work both in-session and at home. Stress the importance of completing assigned homework exercises, as they will help the clients apply the skills they learn in the session to the real world.

Say: Now that you have a better understanding of what anxiety is and how it affects you, I'd like to finish today's session by briefly discussing what you can expect from this anxiety treatment, and how the different parts of it will work to break the negative spiral of anxiety. Remember the cup metaphor [Form 1.2], which represented our anxious style and that the cup filled with water when we learn, witness or experience negative or scary things? Well what is really important about this treatment, is it will teach you different strategies to manage fears and anxieties – effectively these strategies will help to drain some water from the cup to ensure the cup doesn't continue to overflow.

Education

Say: *Today we spoke about anxiety and anxiety disorders. [Form 1.2: Draw an X to symbolise piercing the cup, and write Education]. This educational part of the treatment is important for several reasons. First, it helps make sure that we are all "speaking the same language" during the rest of the treatment. Second, many people find that learning more about their anxiety difficulties actually helps reduce their anxiety. The various feelings, thoughts, and urges to do things don't seem as mysterious or unusual when you understand what they are and why you experience them. Finally, knowing about anxiety disorders sets the stage for the next components of the treatment.*

Specific Cognitive Restructuring

Present Cognitive Restructuring as a set of skills designed to help identify and reevaluate the ways of thinking and interpreting situations that are contributing to the fears. Cognitive Restructuring emphasizes cognitions relating to the specific presenting fears.

Say: *The second part of the treatment is what we call cognitive restructuring. Cognitive restructuring is designed to help break the downward spiral by working against the cognitive or thought component of anxiety [Form 1.2: Draw an X to symbolise piercing the cup, and write Cognitive Restructuring]. We'll start looking at this next week, but you will learn to carefully analyze your own thoughts as they relate to your specific fears.*

Graduated Exposure

Provide a brief discussion of exposure exercises. It is important to highlight that the exposures will be done in a graduated manner and that the clients will already have some skills in place to help them work through the exposure exercise.

Say: Once you have the cognitive restructuring skills in place, we will then move to the third part of the treatment, Graduated Exposure [Form 1.2: Draw an X to symbolise piercing the cup, and write Graduated Exposure].

Say: Exposure means that you will be facing the things that you fear. We won't have you facing your toughest fears right away. Instead, you will start with some easier things, and by gradually building on your successes, you will slowly but surely move up to face your tougher fears. We will begin by doing these exercises during therapy, and also have you gradually confront your fears in the real world.

Say: Also, for part of this treatment you will participate as a silent observer of your child completing exposures, and your child will do the same for you. We think this is a really unique and powerful component of this treatment, because it will allow you both to see each other successfully facing fears.

End of Session 1 and Preview of Next Session

Thank the client for coming to session, and congratulate them for beginning the journey toward overcoming their anxiety. Provide the client with the *Session 1 Summary Form*. Also, before finalizing the session, accompany the parent to the child's session, where they will be present for the child's homework task explanation. Inform the parent that this will occur at the conclusion of each session, to ensure they are able to assist the child with any homework difficulties during the week.

Session 2: "More on Anxiety and Challenging Our Anxious Thoughts"

Topics	Materials
1. Agenda & Homework Review 2. Adaptive Basis of Anxiety 3. Psychoeducation: Parental Over-involvement 4. Cognitive Restructuring Rationale 5. Identifying Automatic Thoughts 6. Homework	Forms: 2.1 – Thought Record Form Session 2 Summary Form Pens and/or marker for white board

Setting the Agenda

At the beginning of each session, ground clients back into therapy by 1) asking what content they remember from last week, and 2) setting the agenda for today's session. By reviewing what the client remembers from the previous session, the therapist obtains an idea of the clients understanding, what was important or new learning, and also gives the therapist and opportunity to correct any misinterpretations. Setting the agenda also lets the client know what they can expect from the session, and allows them to add items they feel are important to discuss, engaging them in the therapy process.

Evolutionary/Protective Basis of Anxiety & Homework Review

Reframe the physiological, cognitive, and behavioural components of anxiety from an adaptive perspective. Explain that anxiety, when properly elicited in response to a threat, serves a very important protective function. The concept of "fight-or-flight" seems to be easy for clients to understand, and is often a good starting point for this discussion. The primary purpose of this discussion is to reinforce the notion that anxiety is a normal and useful reaction to threat.

Say: *Today we'll spend some time reviewing last week's homework, before continuing with some education and then move onto some cognitive restructuring. Specifically, we'll spend a little time revisiting what anxiety is and how it affects you. One of the things you may remember from last session is that we said that fear and anxiety are systems that our body uses to try to protect us from current or future dangers. Anxiety and fear are almost like an alarm system. When the system detects a danger, a fire for example, it sets of the*

alarm and automatically works to protect you from the danger, by turning on sprinklers and opening emergency exits so you can escape the danger.

Say: The body's anxiety and fear systems work in much the same way. In fact, most if not all, of the things we experience when anxious play a role in either warning us or protecting us from a current or future danger. One of the interesting things about this anxiety alarm system is that it is a simple system, it does not do things differently when there are different kinds of threats. Rather, our body's alarm system reacts the same whether or not the threat is to our lives such as a wild tiger or a serious illness, to our self-esteem or status, to our loved ones, or some other type of threat.

Ask the client to pull out their homework from Session 1 *"Monitoring the Components of Anxiety".* If the client has not completed the homework task, complete it now in session.

Say: Now let's take a closer look at some of the physiological symptoms that you experienced during this past week. What were some of them? Can you think how these may be useful in protecting us if we were in danger?

Review the clients physiological symptoms and assist them with generating a list of others if they found this difficult. Briefly discuss ways in which those symptoms may be adaptive in a dangerous situation. Examples include:

- Changes in heart rate to increase blood flow and fuel supply to muscles that may be needed to fight or flee a threat
- Changes in respiration to increase levels oxygen in the blood to fuel muscles
- Increased muscular tension to prepare muscles

Say: How about the cognitive component of anxiety? Why do you think our attention immediately jumps to the threat and we start having thoughts and worries about how bad a situation could be?

Again, review the clients listed cognitions. Briefly explain that when anxious or afraid, our minds are designed to stop thinking about other things, and pay attention to the threat and potential consequences.

Say: Finally, how about the behavioural component of anxiety? What do you think are the advantages of the strong motivation to escape and avoid? What about coping behaviours? How could they be useful in protecting us from threats or dangers?

Review the clients listed behaviours, and then discuss the advantages. The adaptive value of escape and avoidance behaviours are fairly self-explanatory. The value of coping behaviours, such as compulsive rituals, may be less apparent. Explain that if something seems to have gotten rid of the threat in the past, we will usually keep doing it, even if it doesn't automatically make sense. As an example, a dangerous wild animal suddenly turns and runs away from me after I make an unusual noise. I have no idea why the animal ran away (the noise could have scared it, the noise could have hurt its eardrums, the noise could have had no effect and the animal just walked away). But, if I see that kind of animal again, I will make the noise again.

Say: Basically, anxiety and fear are normally good things although they can be quite unpleasant. They are systems that help to keep us alive. They are systems which are there to protect us from dangers. But, as we said before, anxiety has become a problem for you because the alarm is going off when it perhaps shouldn't.

Psychoeducation: Parental Overcontrol

Facilitate a discussion about parent overcontrol and its impact on child anxiety. To help parents better understand the behaviours, parent over-protection is used within scripted text as it is more intuitively understood. Discuss the special relationship between a parent and their child, and validate the parent's experience through acknowledging that child anxiety is likely to affect parent anxiety by increasing their worries about their child, particularly about their child's

ability to cope independently or their parenting ability. Link how this increased worry may also increase the parents own anxious overcontrolling or overprotective behaviours, like watching child closely, permitting/encouraging avoidance, or rescuing/doing things for the child. Talk briefly about the benefits and then the consequences of overcontrol for themselves and their child.

Say: I want to have a think about the behavioural component some more, but this time with you and your child in mind. Being a parent isn't always easy, and this can be even more challenging when your child experiences anxiety. We spoke last week about how parent modelling can contribute to anxiety in children, but in turn a child's own anxious behaviours can contribute to anxiety in the parent. This can cause an increase in worry about your anxious child, but can also change a parent's behaviours in relation to their anxious child. Parents might start to become overprotective, by doing things like watching the child closely, permitting or even encouraging they avoid certain tasks, even taking over a situation, directing your child on what to do, how to behave, or even take over completely and do something on behalf of your child.

Generate a discussion with the client about the pulls and benefits of engaging in overcontrolling behaviours toward their anxious child. Elicit a discussion about why the parent might behave that way, and normalize the behaviours. Consider reasons of overcontrol for the child's benefit: child is distressed or there is the potential for threat, watching closely over the child means they can act quickly or protect them, avoiding tasks or taking over means their child's distress decreases quickly. Consider reasons for overcontrol for the parent's benefit: parents might be busy, and it reduces the child's distress quickly in the short term, it makes the parent feel good to be useful to their child, stepping in can also quickly reduce the parents distress and anxiety. Further, overcontrolling/protective behaviours may stem from the client's belief that it is what a parent *should* do!

Say: Have you ever found yourself doing this? Why do you think you act that way? What are some of the advantages of this behaviour?

Next, explore the consequences to the behaviour. Assure parents that they engage in these behaviours not because they are naturally mean or pushy, but that they are trying to help the situation. In the short term, these behaviours help reduce anxiety for the parent and their child. The immediate reduction in anxiety means parents are more likely to be overcontrolling in the future. The child learns they cannot handle feared situations themselves, and can only do it with their parent's help. This increases child anxiety next time they encounter the situation, re-enforcing the parent's overcontrolling behaviours. Over time, this reduces the parent's confidence in their own and/or their child's ability, sending a message that the child cannot cope alone. This can exacerbate the parent's worry/anxious cognitions and maintain the overcontrolling behaviours.

Say: What do you think might be some of the consequences of this behaviour? Why might this re-enforce a pattern of anxiety for you and your child?

Importance of Thoughts

In this section, we begin to introduce the idea that it isn't the thing, event, or situation that causes anxiety, but rather our *interpretation* of the thing, event, or situation. Describe a hypothetical person who has fears that are different from any of the clients fears. Show how their interpretation of the feared stimulus, not the feared stimulus itself, evokes the anxiety.

Say: The first step is noticing and acknowledging why at times parents might become overprotective of their child, but now I want to start exploring strategies to help break the cycle. You might have noticed in our discussions that overprotective behaviours usually happen because of an anxious thought, usually that something bad might happen if you don't step in. So, it appears our thoughts about a situation are really important because they can influence how we feel and act. Let's explore this with an example.

Say: Jacob has a fear of health problems. He had always been somewhat anxious all of his life, but when he was a teenager, his father suddenly collapsed from a stroke and died later in the hospital. While Jacob was at the hospital with his father, he also saw lots of other stroke patients. Some of them couldn't speak well, others were partially paralysed. Ever since then, Jacob has been terrified of having a stroke or some other sudden major health problem. Specifically, whenever Jacob experiences a sharp headache, he automatically fears that he is having a stroke or an aneurysm. Terrified that he will die, Jacob will immediately rush to the Emergency Room. Each time, the doctors run some tests and assure him that he isn't dying, and he feels lucky… like he cheated death. He worries that the next time, though, he might really have a stroke.

Say: Let's look at Jacob's story for a moment. What was it that triggered his anxiety in the story? [Headache]. What could be some reasons that someone could have a headache? Jacob thought it could be a stroke. What are some other reasons why people have headaches? [Develop a list of 5 or 6 neutral causes of headaches]. How do you think someone would react if they had a headache and assumed it was because of [Reason #1]? How about [Reason #2]?

Say: So, it looks like how you interpret different things makes a difference in how you react to those things. If you believe that something is dangerous, you'll react fearfully. In Jacob's case, although the headache could have been the result of any number of things that are not dangerous, Jacob's interpretation of the headache as a sign of a stroke is what made him anxious.

Next, use the example of Jacob to explore the influence of anxiety in a parent-child dyad. Here a similar but different situation might trigger a similar interpretation and response from a parent. Again, highlight how important the interpretation of the event is, rather than the event

itself. Finally, tie it together by demonstrating how cognitions impact upon behaviour, potentially re-enforcing anxiety for the parent and their child.

Say: Now let's use the same example, but this time with an added piece of information, Jacob is a dad of a 10-year-old son Daniel. Everything else you know about Jacob's is still the same, his father died of a stroke, and ever since that experience Jacob has been terrified that he will have a stroke. One day, Jacob's son Daniel comes to him saying, 'Dad, I've got a headache'. Again, Jacob feels terrified that his son might be having a stroke, and that he could die. He immediately rushes his son to the Emergency Room.

Say: Let's look at Jacob's story again. What was it that triggered his anxiety in the story? [his son Daniel's headache]. What could be some reasons that Daniel could have a headache? What are some other reasons why people have headaches? [Develop a list of 5 or 6 neutral causes of headaches]. How do you think someone would react if their child had a headache and they assumed it was because of [Reason #1]? How about [Reason #2]?

Say: You see, although the situations were different, the same anxious thoughts were triggered for Jacob. That is because in both situations Jacobs interpretation of the events were catastrophic and very dangerous, and therefore his reactions were driven by this fear. Again, Jacob's interpretation of his son's headache as a stroke is what caused him to feel anxious, and this led him to him overreacting or becoming overprotective.

Say: How do you think this might affect Daniel the next time he has a headache? What do you think Daniel's interpretation of a headache might be in the future?

Cognitive Restructuring

Say: As we discussed last week, one of the components of treatment will involve looking at your thoughts and learning ways to analyze your own thoughts. This process is called Cognitive Restructuring. Cognitive Restructuring involves identifying negative, irrational,

or incorrect thoughts, and logically challenging the negative or incorrect assumptions in these thoughts. On the other hand, Cognitive Restructuring is NOT simply replacing negative thoughts with positive thoughts, nor is it changing thoughts of danger into thoughts of safety. The goal is to help you learn to see the things that you fear in an unbiased way.

Automatic Thoughts

Say: Automatic thoughts are thoughts that automatically pop into our heads in response to things happening around us. When people with anxiety disorders encounter something that they fear, they have Automatic Thoughts that something is dangerous or threatening, or that something dangerous or threatening will happen. People with anxiety disorders have thoughts of threat even when there is no threat, or a threat is very unlikely.

Say: Let's look at the example of Jacob again. Although headaches almost never signify a catastrophic health condition, Jacob immediately assumed it was. In this situation, Jacob's Automatic Thoughts might have been 'I am having a stroke', 'I am having an aneurysm', or 'I'm going to die'. Similarly, Jacob may have had the same thoughts about his son Daniel.

In-Session Exercise: Identifying Automatic Thoughts

When the client appears to understand and accept the concept of Automatic Thoughts, begin the in-session exercise. Ask the client to describe a memorable situation where they became particularly anxious or fearful. The situation may or may not involve their child, and the automatic thoughts may be related to themselves, may be related to thoughts about their child, or could be related to both. When the client is describing the situation, probe for AT's and record these on the board/notepad. Probes such as "what did you worry might happen if…," "what might have happened…," or "what is the worst that could have happened" may be necessary to elicit AT's until the client become comfortable with the process of identifying AT's. At this point all thoughts should be reinforced as good thoughts, although the therapists should attempt to rephrase thoughts into an active voice to most closely reflect the actual AT.

Homework

Assign homework *Form 2.1: Thought Monitoring* and ask each client to pick at least one time this week when they become anxious monitor and record their AT's. Again, the situation may or may not involve their child, and the automatic thoughts might relate to themselves, to their child, or both.

Say: *What we have just finished doing, identifying Automatic Thoughts, was very important. It is the first step in learning to evaluate and challenge the negative thoughts that are driving your fears. But to be able to challenge and restructure your thoughts and perceptions, you need to know what these thoughts and perceptions are. Over the next week, I would like you to practice monitoring and identifying your Automatic Thoughts. At least once this week when you become anxious, I want you to pay close attention to your automatic thoughts and record them on this form. The situation may or may not involve your child, and your thoughts might relate only to you, to your child or both. Feel free to record your Automatic Thoughts during more than one episode of anxiety. If you have an anxiety-free week and don't have any experiences that are very anxiety provoking, go ahead and fill out the form using the memory of a recent experience where your anxiety or fears were a problem.*

End of Session 2 and Preview of Next Session

Thank the clients for coming to session again. Provide the client with the *Session 2 Summary Form* and discuss briefly that during the next session, they will begin the process of challenging and disputing their automatic thoughts. Finally accompany the parent to the child's session, where they will be present for the child's homework task explanation.

Session 3: "Cognitive Restructuring: Challenging Anxious Thoughts"

Topics	Materials
1. Agenda & Homework Review 2. Thinking Errors 3. Disputing Questions 4. Rational Responses 5. Full Cognitive Restructuring Practice 6. Homework 7. Preview of Graded Exposure Sessions	Forms: 3.1 – Disputing Questions 3.2 – Cognitive Restructuring Practice Session 3 Summary Form Pens and/or marker for white board

Setting the Agenda & Review Homework

Before reviewing homework, ground clients back into therapy by 1) asking what content they remember from last week, and 2) setting the agenda for today's session. Then spend 5 to 10 minutes reviewing the client's homework from the past session. Discuss the AT's the client identified having during an incident over the past week. Ask the client to briefly describe the situation (i.e., what was happening, what triggered their anxiety/fear, etc.) and the list the thoughts that they identified.

Thinking Errors

If the client appears comfortable with the concept of AT's, spend several minutes reviewing the notion that AT's tend not to be accurate reflections of reality. Remind them that in the example of Jacob, he over-exaggerated the likelihood of danger — his thoughts were not accurate. He assumed his/Daniel's headache meant he was having a stroke or aneurysm even though it is extremely unlikely that any given headache is the result of a potentially fatal condition.
When the client appears willing to consider that their AT's may not be completely accurate, introduce Overestimation and Catastrophizing thinking errors.

Say: When we look closely at Automatic Thoughts, you can start to see that the thoughts have some critical errors in logic, or Thinking Errors. Generally, these Thinking Errors fall into two categories: (a) overestimating the likelihood of a negative outcome [Write OVERESTIMATION on board/notepad], (b) and catastrophizing about how terrible or negative something will be [Write CATASTROPHIZING on board/notepad],

Say: When overestimating, a person takes a less likely negative outcome and assumes that it is likely or guaranteed to happen. For example, the thought "If I get on a plane it will crash", or "if I let Timmy leave the house in mismatched clothes, he will be ridiculed and bullied by all of his classmates." is an example of Overestimating. This person is Overestimating the probability of something bad happening.

Say: Catastrophizing is when someone assumes the worst possible worst possible meaning is true. Some examples of Catastrophizing might be "if I make a mistake, then I must be a failure" or "If I faint, people will think I'm weak and that would be unbearable", or "If I let Timmy leave the house in mismatched clothes, people will know I'm a terrible mother".

Say: Let's take a look at some of the thoughts you recorded last week to see if there are any thinking errors in those thoughts.

Using the AT's listed on last session's *Form 2.1: Thought Monitoring* homework form, clients should begin to identify evidence of Thinking Errors in their AT's. In turn, have the client select a powerful AT from their homework and identify any TE's in that thought. If the client appears to be having trouble identifying TE's, ideas or suggestions should be generated with the therapists help.

Challenging Automatic Thoughts

Briefly review the rationale for cognitive restructuring, emphasizing that the second part of it is to challenge these erroneous thoughts. Discuss that the client will learn to question the accuracy of their thoughts and develop a set of more accurate or neutral interpretations of an anxiety provoking situations. Lastly, briefly discuss that this process may help in two ways. First, the client can plan for upcoming events or situations that are expected to be anxiety-provoking. Second, with practice, logically analyzing challenging thoughts may become as automatic as the automatic thoughts.

Say: Remember, Cognitive Restructuring is not just replacing negative thoughts with positive ones. Instead, it is a way to challenge the errors you have been finding in your Automatic Thoughts. You will learn to question the accuracy and probability of your automatic thoughts using "Disputing Questions."

Disputing Questions

Say: Once you identify thinking errors in an automatic thought, the next step is to question the accuracy, truthfulness, or usefulness of the thoughts. Over the years, psychologists have developed a list of general questions that are very useful for challenging automatic thoughts. The questions on this list [Form 3.1] are called Disputing Questions.

Say: The key to using Disputing Questions effectively is to both ASK and FULLY ANSWER the Disputing Question. The answer to the disputing question may seem obvious, but it is still important to actually say the answer to yourself.

Say: In some cases, a Disputing Question may not 'work' for a given thought. That is, the answer to the Disputing Question may not successfully counter the original Automatic Thought. Other times, answering a Disputing Question may just raise more questions or negative thoughts. These situations are both fine. If either happens, go ahead and ask/answer another Disputing Question. Do it a third and fourth time if necessary. The goal is to arrive at a conclusion that successfully challenges your AT and, as a consequence, reduces your anxiety. Having to ask and answer more Disputing Questions does not mean that your anxiety or your thoughts are more severe or more resistant to change. It just means that you need to find the questions that will work best for you in that situation.

Say: We have found this set of Disputing Questions to be very helpful for a wide range of automatic thoughts and thinking errors. But these thoughts are certainly not the only

questions can be useful. Any question that helps you challenge the correctness of your automatic thoughts, and helps you come up with alternative possibilities, is a helpful Disputing Question.

In-Session Exercise: Asking and Answering Disputing Questions

Begin the exercise of using Disputing Questions by selecting an AT from a previous example, such as Jacob who feared that a headache signaled an impending stroke.

Say: Remember the example of Jacob who we discussed last week? Jacob was the man who feared when he had a headache, he might be having a stroke. As we discussed, Jacob had the Automatic Thought, "I am having a stroke" when he had a headache. [Write "I am having a headache" on board/notepad]. During treatment, Jacob identified this Automatic Thought as having an Over-Estimation Thinking Error; while it is extremely unlikely that his headache meant he was having a stroke, he felt convinced that it was so. If Jacob we to begin using the Disputing Questions, what do you think would be a good Disputing Question he could ask of himself? [Write response on board/notepad]. What do you think Jacob's response to that question would be? [Write response on board/notepad]. What Disputing Question would be a good follow-up to that answer?

Say: What about Jacob's the Automatic Thought's when his son Daniel had a headache. His automatic thought about Daniel might have been the same "Daniel is having a stroke" when he had a headache. [Write "Daniel has a headache" on board/notepad]. What type of Automatic Thought might this be? That's right, it is the same as in the example before, where Jacob is Over-Estimating; while it is extremely unlikely that Daniel's headache meant he as having a stroke, he felt convinced that it was so.

Say: If Jacob were to begin using the Disputing Questions, what do you think would be a good Disputing Question he could ask of himself? [Write response on board/notepad]. What do you think Jacob's response to that question would be? [Write response on board/notepad]. What Disputing Question would be a good follow-up to that answer?

Continue working through the example of Jacob, offering question or answer suggestions as necessary, until an effective challenge has been developed. If appropriate, discuss with the client that in the second example, the disputing questions might end up being exactly the same as in the first example. This is not completely unexpected because Jacob's interpretation is both examples is the same, regardless of the difference in situations.

Rational Responses

After the client has had the opportunity to use Disputing Questions to challenge an AT, introduce the concept of Rational Responses.

Say: One of the most valuable aspects of Cognitive Restructuring is that you can take what you have learned and use it in the future if you find yourself having the same thoughts. For example, the next time Jacob had a headache, he could remind himself of what he learned when he did the cognitive restructuring. To make this easier, we use something called a Rational Response, and it is the last step in Cognitive Restructuring.

Say: In essence, a Rational Response summarizes the main ideas developed while asking and answering the Disputing Questions and boils them down into a single short statement. There isn't any special trick to developing a good Rational Response. It should be short, so you can quickly say it yourself, positively phrased, and it should be something that will remind you of the important answers to your Disputing Questions.

Return to the Disputing Questions and answers developed for Jacob. Briefly review the questions and answers generated, and ask the client to try to identify what they think is the point that would be most important for Jacob to remember. Shape the "main point" with the client until it resembles a brief and positively phrased statement.

Full Cognitive Restructuring Practice

Once all steps have been discussed and demonstrated, ask the client to walk through the entire Cognitive Restructuring process with the help of the therapist. The client should select a powerful AT from the previous homework, identify the TE(s) associated with that thought, ask and answer Disputing Questions, and develop a Rational Response.

Homework

Assign the weeks homework but providing *Form 3.2: Cognitive Restructuring Practice*. Explain that clients should continue monitoring Automatic Thoughts as with the previous session, but should now also incorporate Asking/Answering Disputing Questions, and the development of a Rational Response.

Preview of Next Session

Next session will be the beginning of graduated exposure. Remind the client that they will not be facing their toughest fears right away, instead they will start with easier fears and slowly move up from there. They won't be pushed farther than the therapist thinks they can go. Discuss that it is common to want to skip the first exposure session or use some negative coping strategies, such as alcohol, medications, etc.

Say: Next week will be the beginning of the exposure tasks. You might remember from our past discussions that exposure means that you will be gradually facing the things that you fear. You won't have you face your toughest fears right away. Instead, you will start with some easier things, and by gradually building on your successes, you will slowly but surely move up to face your tougher fears. We will begin by doing some of these exercises during therapy, but you will also gradually confront your fears in the real world.

Say: Exposure is a powerful technique because it works on all three of the components of anxiety. It helps you work against the behavioural component by either having you do things you avoid or escape from, or stop doing coping behaviours. Second, it helps

challenge the cognitive component because you will get to test whether or not your fears would come true.

Preview of Joint Exposure Sessions

Re-introduce the joint exposures to clients, and provide a rationale for the sessions. It is likely that parent will have some reservations or worries about having their child observe their exposures. Answer any questions and concerns parents may have, and encourage the importance of these observed exposures as a way to break maintenance cycles unique to the parent and child relationship. Help answer any questions the parent might have, and encourage them to utilize the learned cognitive restructuring skill to challenge worries that may arise about the observed exposure sessions.

Say: As you know, you are not participating in this treatment alone. In the first three exposures you will participate as a silent observer of your child's exposure tasks, and your child will do the same for your exposure tasks. We think this is a really unique and powerful component of this treatment, because it will allow you both to see each other facing fears. This is an incredible opportunity to help break some of the modelling and overprotective cycles we've spoken about in the past few sessions.

Say: You will have the opportunity to observe your child use adaptive skills to face challenging and anxiety provoking situations. This might be difficult for you to watch at times, because as a parent you want to protect them from situations that make your child anxious. You might even want to step in and remove them from the situation, or take over in the task. Therefore, having to silently observe will be really great practice to help sit with worries and urges to over-protect. It might also be a good opportunity to start challenging some of the automatic thoughts that come up which might trigger overprotective behaviours. On the other hand, you might not have any worries or urges to interrupt, and that's ok too, you might learn something new and unexpected about yourself or your child's ability to cope.

Say: *What do you anticipate will happen when you act as a silent observer to your child? Do you think you'll have an urge to over-protect, or do you think the opposite is true?*

Say: *Also, your child will get an opportunity to watch you complete your exposures too. This will be really important for your child as they will get to watch you model adaptive and courageous coping behaviours. Ultimately, this is important to help break the cycle of modelling anxious behaviours. This is because by observing you, it will likely motivate your child to adopt courageous coping strategies when they are anxious, as they are reassured by your (the parents) ability to do the same.*

Say: *Do you have and worries about having your child observe your exposure session? If so, would it be useful to utilize this newly learnt cognitive restructuring skill to take a closer look at those thoughts?*

If necessary, provide an additional copy of *Form 3.2: Cognitive Restructuring Practice* to challenge thoughts related to the joint exposure sessions.

End of Session 3

Thank the client for their participation in the session. Provide the parent with the *Session 3 Summary Form*. Finally accompany the parent to the child's session, where they will be present for the child's homework task explanation.

Preparation for Sessions 4–9

Graded Exposure

Exposure is an important part of the treatment for anxiety disorders. Exposures are broken into two sections: Session 4-6 “Facing Your Fears Together” and Session 7-9 “Facing Your Fears”. Generally, exposure therapy is useful to gradually expose clients to feared stimuli, with the aim to reduce the persons fearful reaction to the stimulus and decrease avoidance.

Rationale for Observed Exposure – Sessions 4-6 “Facing Our Fears Together”.

A key intervention included in this treatment manual are the three observational exposure sessions, where the parent and child act as silent observers to each other’s exposure exercises. The benefits to the observational exposures for the parents include:

- By observing their child complete exposure sessions, the parent is able to gather new evidence and challenge beliefs related to their child’s ability to independently confront, cope, and utilise strategies to manage anxiety.
- The parent is encouraged to utilise cognitive restructuring strategies to help them manage anxious cognitions prior to observing the exposure. As parents are silent observers of their child’s exposure, the parent is also able to practice regulating their own emotional experience and possible behavioural responses such as the desire to over-protect or accommodate the child’s anxiety.
- Parents are then asked to reflect on the experience following the exposure, which provides parents an opportunity to consider new learning about themselves and their child through the process of participating as an observer.
- Overall, the new evidence generated through the observational exposure tasks are hoped to reduce anxiety maintenance factors within the dyad, subsequently reducing anxiety for the parent client.

Rationale for Individual Exposure - Session 7-9 “Facing Your Fears”

After completing the initial observed exposure sessions, the parent and child dyad will participate in an additional three individual exposure sessions. The rationale for this ordering of

exposure sessions was to ensure parent clients received the full benefit of exposure sessions, that is to explore situations on their hierarchy that elicited greater anxiety without the need to modify the content or selectively choose exposures based on child appropriateness.

Observational Exposures

The first three exposures comprise the joint observational exposures. The co-therapists (that is the parent therapist and child therapist) should spend some time prior to Session 4 examining both the parent and child's Trigger ➔ Response Hierarchies, and begin planning how best to conduct the observed exposure sessions. Consider ways that appropriate items on the hierarchy can be created *in vivo*, simulated, or imagined, during the exposure sessions. Consideration of the child's developmental stage and parent's privacy should be given when determining the appropriateness of the observed exposures. Exposures deemed inappropriate for the child to observe should not be discarded, but instead considered for the parent's individual exposures or for in-between session homework.

Further, planning about the logistics and time considerations of the observed exposures should be completed. Specific attention should be placed on planning exposure activities that may require an excursion, or the involvement of confederates. If appropriate, it may be useful to plan complimentary exposures that may maximize resources.

Conducting Exposure Sessions

The general framework for the client's first exposure is that the therapist designs the exposure. This is based on selecting a moderately (approx. SUDS = 50) difficult item from the client's hierarchy. As well, behavioural goals should be set by the therapists for the first exposure. Having the therapists select the first exposure and set the behavioural goals is threefold. First, it demonstrates to the client the process of creating and conducting an appropriate exposure. In addition, the clients will also develop an understanding of an appropriate, but not excessive, level of difficulty needed for therapeutic exposure. Second, it minimizes the likelihood that a client has a negative first experience by beginning with an exposure that is too difficult or too

easy. Finally, clients who are anxious about their first exposure sometimes delay it by spending undue amounts of time selecting and designing an appropriate exposure.

Subsequent exposures should reflect an increase in difficulty from the last successful exposure. As treatment progresses, the responsibility for designing the exposure should gradually shift to the client. The goal, however, is for clients to be facing their most difficult trigger by the end of treatment.

Variations of Graduated Exposure

In Vivo Exposure: Probably the most potent form of exposure is *in vivo*, or "in real-life", exposure. The advantage of *in vivo* exposure is that it is not contrived, made-up, or simulated. The clients are facing their fears directly. This can be important, because during other exposures that are not conducted *in vivo*, clients can distance themselves emotionally from the task by thinking that "it is not real". Despite the advantages of *in* vivo exposure, it tends to be difficult, impossible, or unethical to conduct in the therapy space for most clients' fears. In most cases, therefore, other forms of exposure are conducted during the sessions, and the client then conducts *in vivo* exposures as homework.

Simulated Exposure: The most common form of exposure used during session is Simulated Exposure. In Simulated Exposures, the feared object or situation is recreated in session. One primary difference between Simulated and *In Vivo* exposure is that the client is aware that the object or situation is not real which, as noted above, provides a way for clients to emotionally distance themselves from the exposure. Our experience suggests that most clients are capable of, and do, immerse themselves in the exposure when encouraged to do so. Although the range of simulations is virtually unlimited, there are two types of commonly used simulated exposures that deserve special attention.

Interoceptive Exposure: Interoceptive exposures are frequently used with clients whose fears relate to somatic sensations. Although interoceptive exposure produces the actual feared

sensations, and could thus be considered *in* vivo, the actual cause of the symptoms is artificial and could result in emotional distancing. For example, clients with a fear of panic attacks may not become unduly anxious during an interoceptive exposure exercise because they know that the symptoms they are experiencing are not the result of a panic attack, but rather the interoceptive technique.

Role-play exposure: Another variation of simulated exposure is role-played exposure. In role-played exposure, a therapist or another client engages with the client in a mock-up of a feared situation. Role-played exposures are commonly employed with clients who have socio-evaluative fears. For example, if a client had anxiety about asking someone for a date, a simulated exposure could have the client simulate asking a coworker out for coffee after work. Another client or a therapist could play the role of the coworker in the role-play.

Every effort should be made to keep the client and all other participants "in character" during exposures, particularly role-played exposures. Breaking character frequently signifies that a client is engaging in emotional avoidance of the exposure. Examples of breaking character include asking questions about the exposure (e.g., "Should I just pretend that…") or making comments outside of the role (e.g., "Boy, this is tough"). Therapists and others involved in an exposure should ignore the character break and continue with the exposure. After the exposure is completed, the importance of staying in role should be briefly reviewed. If the client continually breaks character, consider:

Say: Remember, we want the exposures to be as realistic as possible so that if you _____ outside of session, you will feel like you have already successfully faced it. Doing other things during exposures in session, such as _____, it makes the exposure less realistic and therefore less helpful when you _____ outside of session.

Imaginal Exposure: This form of exposure has the client imagine the feared object or situation as clearly as possible. A therapist typically will narrate a script for the client to imagine. To aid in

practicing the exposure as homework, imaginal exposure scripts are frequently recorded on audiotape and provided to the client. Imaginal exposures are frequently used when the situation or object would be impossible/extremely difficult or unethical to simulate.

Homework

The number of times an exposure should be conducted during a given week depends in large part on the two factors: (a) the frequency with which the feared stimulus typically arises, and (b) the amount of time and effort necessary to stage the exposure.

Stimulus Frequency: Homework exposures addressing more frequently arising stimuli should be conducted more often while homework exposures addressing less frequently arising stimuli may not require as many repetitions. For example, a client who is having intrusive thoughts and engaging in coping behaviours several times per day or a client who is experiencing several panic attacks per day should probably conduct homework exposure once or twice each day. Conversely, a client who encounters a feared stimulus less frequently, such as an individual with a fear of speaking to authority figures who must give weekly or monthly presentations at work to management, should only need to conduct an exposure once or twice per week.

Time and Effort Requirements: The time and effort required to stage a homework exposure is an additional factor that must be considered when scheduling the number of exposures that should be conducted. Exposures with more intensive requirements such as those designed for fears of long-distance driving, fears of flying, or fears of public speaking, may be reasonably conducted only once or twice per week. Exposures with less intensive requirements, such as spinning in a chair to evoke interoceptive stimuli or listening to an audio cassette of combat sounds, may be conducted several times without much difficulty.

Sessions 4-6: "Graded Exposure: Facing Our Fears Together"

Topics	**Materials**
1. Agenda 2. Conducting Observational Exposures 3. Observational Exposure Activities 4. Homework	Forms: 4.1 – In-Session Exposure Form 4.2 – Post-Exposure Form 4.3 – Homework Exposure Form 4.4 – Observational Exposure Form 4.5 – Post-Observational Exposure Form Sessions 4-9 Summary Form Pens and/or marker for white board

Set the Agenda

To begin, ground clients back into therapy by sending a few minutes 1) asking what content they remember from last week, and 2) setting the agenda.

Conducting Joint-Observational Exposures

The general format for conducting the joint-observational exposures, along with the recommended session timeline, is detailed in Table 1 below. Given the amount of in session activities, the therapist should flag the tight agenda with the client, and inform them that they may redirect the client back to the agenda if session content is deviating. Alternatively, you may decide to allocate an additional 15 mins to the observed exposure sessions to allow for smoother transitions.

Table 1

Joint-Observational Exposure Task Recommended Format and Timeline.

Parent Session – Therapist 1	**Child Session – Therapist 2**
Review Homework (5mins)	Review Homework (5mins)
Pre-Exposure Cognitive Restructuring – Form 4.1 (10mins)	Exposure Process Discussion (10mins)
Conduct Exposure Task (10-15 mins)	Observation of Parent Exposure Task (10-15mins)
Post-Exposure Review – Form 4.2 (5mins)	Post-Observed Exposure Review (5mins).

Pre-Child Exposure Cognitive Restructuring - Form 4.4 (10mins)	Pre-Exposure Cognitive Restructuring (10mins)
Observation of Child Exposure Task (10-15mins)	Child Exposure Task (10-15mins)
Post-Observed Exposure Review - Form 4.5 (5mins)	Post-Exposure Review (5mins)
Homework – Form 4.3 (incl. Child Homework) (5mins)	Homework (5mins)

Joint-Observational Exposure Activities

Review Homework: Briefly review Cognitive Restructuring homework to ensure that the client appears to understand, and is able to use, Cognitive Restructuring. Have the client briefly summarize the anxiety-provoking situation, the AT they questioned, and the Rational Response they generated. Discussion of the Thinking Errors, the Disputing Questions used, or the answers to the Disputing Questions, is not necessary, as it will take time away from the exposure exercises. From Session 4, the client will be engaging in homework exposures. Discuss successes and, if any, difficulties encountered during the homework exposures. Ensure that the client is engaging in the entire homework exposure process, including the pre-exposure cognitive restructuring.

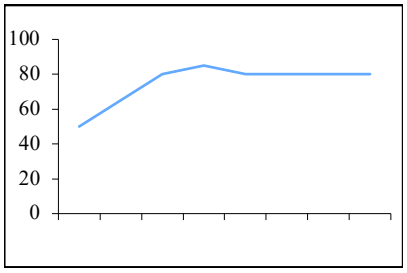
Pre-Exposure Cognitive Restructuring: Prior to each exposure, the client should be instructed to use cognitive restructuring skills to prepare for the exposure, and record the relevant information on Form 4.1. Clients should spend a few minutes visualizing the trigger and identify several Automatic Thoughts they will likely have during the exposure. The Automatic Thoughts should be briefly reviewed, and the most potent thought should be selected. Thinking Errors in that Automatic Thought should be identified, and the Automatic Thought should be then subjected to Disputing Questions. Finally, the answers to the Disputing Questions should be transformed into a brief and positive Rational Response. A behavioural goal should be set, and the client should be reminded that the therapist will be periodically asking for a SUDS rating.

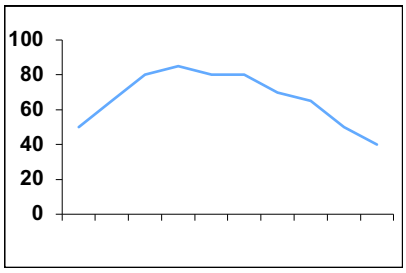
Conducting the Exposure: Periodically throughout the exposure, the therapist will ask the client for a SUDS rating. The frequency and timing of SUDS ratings depends on several factors: Obtain more frequent ratings during exposures that will likely be brief, while ratings can be sought less frequently during longer exposures. SUDS ratings should be sought immediately before the exposure; before, during, and/or after particularly difficult or anxiety provoking parts of an exposure; and at points where the therapist can observe or anticipate increases or decreases in anxiety or fear.

The client and therapist should also negotiate one or more behavioural goals for the client to attempt during the exposure. Effective behavioural goals should be attainable but somewhat challenging; goals that a client can easily achieve are not therapeutic, while goals that a client cannot currently achieve are counterproductive. The behavioural goals should be observable and measurable by both the client and the therapist, and should about doing something rather than *not* doing something. Finally, the success of the behavioural goal should be completely under the control of the client e.g., *getting change from a stranger* is not completely within a person's control; the stranger may not have change or could refuse. However, *ask a stranger for change* removes the aspect of the goal that is out of one's control.

Lastly, the client should be informed that the therapist will be periodically asking for a SUDS rating. Remind the clients that the SUDS ratings are the 0 to 100 ratings of anxiety or fear, with higher numbers reflecting greater anxiety or fear. Inform the client that when the therapist says "SUDS", they should (a) provide a general rating (precision is not necessary), (b) repeat their Rational Response to themselves, and (c) re-immerse themselves back into the exposure.

The exposure should continue as long as is necessary for the SUDS ratings to climax and begin declining. This is valuable in later





demonstrating that, by facing fears and not escaping or avoiding, the fear or anxiety will decrease. In some instances, very long periods may pass without evidence that the SUDS will decline. In such cases, the exposure should be continued long enough for the SUDS ratings to plateau. This pattern can then be used to demonstrate that, despite continuing to approach the feared object or situation, their fear did not continue to increase uncontrollably. Indeed, these clients should be assured that with repeated future exposures, their SUDS ratings will start to decline throughout the exposure.

Post-Exposure Review: Following each exposure, reinforce the clients for their effort and successes. Complete *Form 4.2* with the client, to discuss the experience of their exposure. Ask the client to describe his or her experience, particularly discuss their pattern of anxiety or fear over the course of the exposure. The SUDS ratings can be charted by the therapist on the board/paper to demonstrate or facilitate discussion of the pattern during the exposure. Briefly discuss whether or not the client experienced any expected or unexpected Automatic Thoughts, as well as how helpful they found the Rational Response. Also, review the behavioural goal and whether or not it was achieved.

Be aware of signs that the client may be disqualifying the positive, such as 'I could never have done that on my own', 'I was only able to do that because the confederate was so nice'. This process is important to help the clients slowly gather evidence throughout the exposures that they can cope and utilise adaptive skills during anxiety provoking situations. Even in unsuccessful exposures, clients should be strongly reinforced for the attempt. As a rule of thumb, all clients should leave an exposure session feeling positive about the experience.

Pre-Observed Exposure Cognitive Restructuring: During the observed exposure, it is possible that the parent may be experiencing anxiety about observing their child in an anxiety provoking situation. They may also anticipate or experience and urge to respond when watching their child in distress. If this is the case, the client should be directed to use cognitive restructuring skills to prepare for the observation of the child's exposure. The relevant information should be

recorded on *Form 4.4*. The same format for the form should be followed as per the client's own exposure cognitive restructuring practice.

Observation of Child Exposure: Similar to when the client was completing their own exposure, periodically ask the client for a SUDS rating. The frequency and timing of SUDS ratings depends on several factors: Obtain more frequent ratings during exposures that will likely be brief, while ratings can be sought less frequently during longer exposures. SUDS ratings should be sought immediately before the observed exposure; before, during, and/or after particularly difficult or anxiety provoking parts of an exposure; and at points where the therapist can observe or anticipate increases or decreases in anxiety or fear.

Post-Observed Exposure Review: Following the observed exposure, complete *Form 4.5* with the parent, to discuss the experience of observing their child's exposure. Stay curious with the parent to explore what they observed their child doing (e.g., facing fears), and what that means (e.g., that their child can cope adaptively). Again, be aware of signs that the parent may be disqualifying the positive, such as 'my child could only do that because the therapist was there'. Help parents slowly gather evidence over the observational exposure sessions related to their child's coping ability during anxiety provoking situations. Encouragement of their effort to promote autonomy should also be given, as the parent may have wanted to get involved in the exposures but were able to manage these emotions and behaviours.

Homework

Assign a homework exposure to be conducted before the next session. Clients should use Form 4.3, to guide and record their pre-exposure cognitive restructuring, behavioural goals, and their SUDS ratings.

End of Session & Preview of Next Session

After Sessions 4 & 5: Briefly mention that next session will involve continuing the graduated exposure exercises with the observation component, while slowly moving up their hierarchy. As

well, briefly remind the clients that while the exposures may be sometimes uncomfortable, exposure is one of the most powerful techniques for overcoming fears. The therapist may need to remind the client of the importance of the observed components to disrupt modelling and overcontrolling anxiety maintenance cycles. At the end of session 4, provide the parent with the *Sessions 4-9 Summary Form.* As per usual, at the end of the session accompany the parent to the child's appointment, where they will be present for the child's homework task explanation.

After Session 6: Remind clients that exposure work will continue for the next three sessions. However, the observational exposures are complete, and the focus will be on individual work continuing to move up the exposure hierarchy. Finally accompany the parent to the child's session, where they will be present for the child's homework task explanation.

Sessions 7-9: "Graded Exposure: Facing Your Fears"

Topics	**Materials**
1. Agenda 2. Conducting Individual Exposures 3. Individual Exposure Activities 4. Homework	Forms: 4.1 – In-Session Exposure Form 4.2 – Post-Exposure Form 4.3 – Homework Exposure Form Pens and/or marker for white board

Setting the Agenda

To begin, ground clients back into therapy by spending a few minutes 1) reviewing the content they can recall/was pertinent from the previous week, and 2) setting the agenda for today's session.

Conducting Individual Exposures

The general format for conducting the individual exposures, along with recommended session timeline, is detailed in Table 2.

Table 2 - Individual Exposure Recommended Format and Timeline.

Parent Session – Therapist 1
Review Homework (5mins)
Pre-Exposure Cognitive Restructuring – Form 4.1 (10-15mins)
Conduct exposure (10-15 mins)
Post-Exposure Review – Form 4.2 (5mins)
Homework – Form 4.3 (incl. Child Homework) (10mins)

Individual Exposure Activities

Review Homework: Briefly review Cognitive Restructuring homework to ensure that the client appears to understand, and is able to use, Cognitive Restructuring. Have the client briefly summarize the anxiety-provoking situation, the AT they questioned, and the Rational Response they generated. Discussion of the Thinking Errors, the Disputing Questions used, or the answers

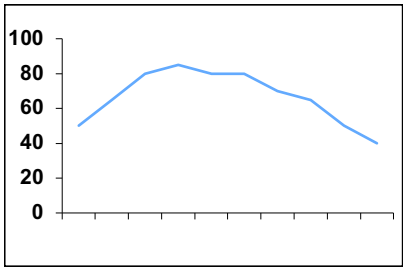
to the Disputing Questions, is not necessary, as it will take time away from the exposure exercises. Discuss successes and, if any, difficulties encountered during the homework exposures. Ensure that the client is engaging in the entire homework exposure process, including the pre-exposure cognitive restructuring.

Pre-Exposure Cognitive Restructuring: Prior to the exposure, instruct the client to use cognitive restructuring skills to prepare for the exposure, and record the relevant information on Form 4.1. Clients should spend a few minutes visualizing the trigger and identify several Automatic Thoughts they will likely have during the exposure. Briefly review the Automatic Thoughts and select the most potent thought to restructure. Thinking Errors in that Automatic Thought should be identified, and the Automatic Thought should be then subjected to Disputing Questions. Finally, transform the answers to the Disputing Questions into a brief and positive Rational Response. A behavioural goal should be set, and the client should be reminded that the therapist will be periodically asking for a SUDS rating during the exposure.

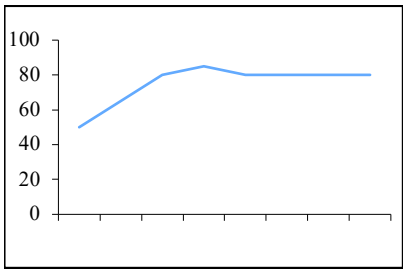
Conducting the Exposure: Periodically throughout the exposure, the therapist will ask the client for a SUDS rating. Remind the clients that the SUDS ratings are the 0 to 100 ratings of anxiety or fear, with higher numbers reflecting greater anxiety or fear. Inform the client that when the therapist says “SUDS”, they should (a) provide a general rating (precision is not necessary), (b) repeat their Rational Response to themselves, and (c) re-immerse themselves back into the exposure.

The frequency and timing of SUDS ratings depends on several factors: Obtain more frequent ratings during exposures that will likely be brief, while ratings can be sought less frequently during longer exposures. SUDS ratings should be sought immediately before the exposure; before, during, and/or after particularly difficult or anxiety provoking parts of an exposure; and at points where the therapist can observe or anticipate increases or decreases in anxiety or fear.

The client and therapist should also negotiate one or more behavioural goals for the client to attempt during the exposure. Effective behavioural goals should be attainable but somewhat challenging; goals that a client can easily achieve are not therapeutic, while goals that a client cannot currently achieve are counterproductive. The behavioural goals should be observable and measurable by both the client and the therapist, and should be about *doing* something rather than *not doing* something. Finally, the success of the behavioural goal should be completely under the control of the client e.g., *getting change from a stranger* is not completely within a person's control; the stranger may not have change or could refuse. However, *ask a stranger for change* removes the aspect of the goal that is out of one's control.



The exposure should continue as long as is necessary for the SUDS ratings to climax and begin declining. This is valuable in later demonstrating that, by facing fears and not escaping or avoiding, the fear or anxiety will decrease. In some instances, very long periods may pass without evidence that the SUDS will decline. In such cases, the exposure should be continued long enough for the SUDS ratings to plateau. This pattern can then be used to demonstrate that, despite continuing to approach the feared object or situation, their fear did not continue to increase uncontrollably. Indeed, these clients should be assured that with repeated future exposures, their SUDS ratings will start to decline throughout the exposure.



Post-Exposure Review: Following each exposure, reinforce the client's effort and success. Using Form 4.2 with the client, ask them to describe their experience of anxiety over the course of the exposure. Chart the SUDS ratings on the board/paper to demonstrate or facilitate discussion of the pattern of anxiety during the exposure. Briefly discuss whether or not the client experienced any expected or unexpected Automatic Thoughts, as well as how helpful they

found the Rational Response. Also, review the behavioural goal and whether or not it was achieved.

Be aware of signs that the client may be disqualifying the positive, such as 'I could never have done that on my own', 'I was only able to do that because the confederate was so nice'. This process is important to help the clients slowly gather evidence throughout the exposures that they can cope and utilise adaptive skills during anxiety provoking situations. Even in unsuccessful exposures, clients should be strongly reinforced for the attempt. As a rule of thumb, all clients should leave an exposure session feeling positive about the experience.

Homework

Assign the homework exposure to be conducted before the next session. Clients should use Form 4.3 to guide and record their pre-exposure cognitive restructuring, behavioural goals, and their SUDS ratings.

End of Session & Preview of Next Session

After Session 7 & 8: Briefly mention that next session will involve continuing the graduated exposure exercises, slowly moving up their hierarchy. As well, briefly remind the clients that while the exposures may be sometimes uncomfortable, exposure is one of the most powerful techniques for overcoming fears. Finally accompany the parent to the child's session, where they will be present for the child's homework task explanation.

After Session 9: Remind clients that next week is the last week of treatment. The focus will be on ending treatment and relapse prevention, specifically focusing on maintaining gains and continuing progress toward a less anxious lifestyle. Finally accompany the parent to the child's session, where they will be present for the child's homework task explanation.

Session 10: "Finishing Treatment: Where to From Here?"

Topics	Materials
1. Agenda & Homework Review 2. Approaching Anxiety and Rear 3. Dealing with Stressors, Lapses, and Bad Experiences 4. Congratulations and Celebration	Forms: 5.1 – Maintaining Gains & Continuing Progress 5.2 - Lapse & Relapse Session 10 Summary Form Refreshments and/or snacks Pens and/or marker for white board

Preparation for the Final Session

Final treatment sessions can be emotional moments for clients. They have made significant changes in their lives, and because of this, we encourage that the final session has a lighter, celebratory feel to it. The session should be split into two parts, the first is to finalise treatment with the completion of relapse prevention material, and the second is to provide a space for the parent and their child can congratulate each other on their work and achievements. Consider providing refreshments and snacks to add to the celebratory feel of the final session. Also, this may be a suitable time to provide the client with a bound copy of all forms in case the client wants to continue using them after treatment.

Setting the Agenda & Homework Review

Before reviewing homework, ground clients back into therapy by sending a few minutes 1) asking what content they remember from last week, and 2) setting the agenda for today's session.

Then, spend a moderate amount of time reviewing exposure homework. Although homework exposure exercises will not continue to be assigned, clients should be strongly encouraged to adopt an exposure lifestyle once treatment has ended. If clients feel themselves becoming excessively anxious about something, it should be seen as an opportunity to employ cognitive restructuring skills and do an exposure exercise.

Maintaining Gains and Continuing Progress

Say: It can sometimes be easy to slip back into old habits after treatment when you don't have to worry about me looking over your homework. It can also be easy to give yourself a break from all of the Exposure and Cognitive Restructuring work. I want to strongly encourage you NOT to do these things. Now is an important time for you. It is your opportunity to not let fear stop you from doing what you want to do, being who you want to be, living how you want to live.

Say: Here are some general tips to help you maintain your gains and continue to manage your fears and worries into the future. [Hand out Form 5.1]. First, approach anxiety. Treat every episode of anxiety as an opportunity to learn by practicing the skill's you have learnt: cognitive restructuring and exposure exercises. This can help you take back some control over anxiety, and not let it stop you from doing the things you want to do. I know you can do it.

Say: Second, regularly practice and use these skills when confronted by fears. As we keep stressing, change takes practice and patience. Practice until rational and balanced thoughts become your Automatic Thoughts.

Say: Third, reward yourself. You have worked very hard and made some difficult changes in your life. You deserve a reward or celebration. It doesn't have to be anything big or expensive, just enjoyable and memorable. Go out for dinner and a movie. Cook a nice dinner and rent a movie. Go dancing. Send your kids over to their grandparents' house for the night. Just do something to reward yourself for all of your hard work. It might also be a nice idea to organize a separate reward for you and your child in recognition of all the hard work you have been doing together over the past 10 weeks.

Continue to brainstorm reward ideas with the client. Particularly encourage ideas that a client wouldn't have done previous because of fears (e.g., a client with a fear of flying now taking a

trip by air somewhere, a client with agoraphobic fears going to a concert they have wanted to see).

Dealing with Stressors, Lapses, and Bad Experiences

Discuss that lapses can happen, particularly in periods of stress. Emphasize that the clients have the skills to recover from a lapse and regain control.

Say: The most important thing to remember is that a lapse doesn't equal a relapse. A lapse is avoiding something you should be doing, repeatedly checking something when you should trust yourself, and so on. Lapses can also occur after an unusual bad experience, such as a person who used to fear flying having a bumpy flight. A relapse, on the other hand, is when the anxiety takes control over some part of your life again. If you catch yourself lapsing, use the skills you now have. Do some Cognitive Restructuring of your Automatic Thoughts and perform your own Exposures. You CAN stop a lapse from leading to a relapse.

Say: Sometimes, things might become a little more difficult or you might find it hard to regain control over a lapse. In these types of situations, it is smart to give us a call so we can schedule a session or two to help you get back on track. What are some things that might be signs that you should call us?

Hand out *Form 5.2: Lapse & Relapse* and have the client record some signs that might indicate that they should call for a booster session.

Congratulations and Celebration

Before concluding the formal part of the session ask the client what gains they are most proud of, what they found most enjoyable during treatment, what they found most helpful, and so forth. Provide the client with the *Session 10 Summary Form*, and a blank bound copy of all in-session and homework forms. Inform the client that the session is officially over, but that they

can stay and celebrate for a while longer with their child and the child therapist. Congratulate the parent-child dyad for completing the treatment.

Feedback Form 1: Subjective Units of Distress Scale Anchors

0 25 50 75 100
|----------|
No fear/anxiety Extreme fear/anxiety

Describe a situation or event that would probably cause the following level of anxiety:

25 Experiencing mild anxiety.

50 Anxiety become uncomfortable

75 Anxiety very uncomfortable.

100 Highest anxiety ever experienced, or worst imaginable anxiety

Feedback Form 2: Trigger and Response Listing

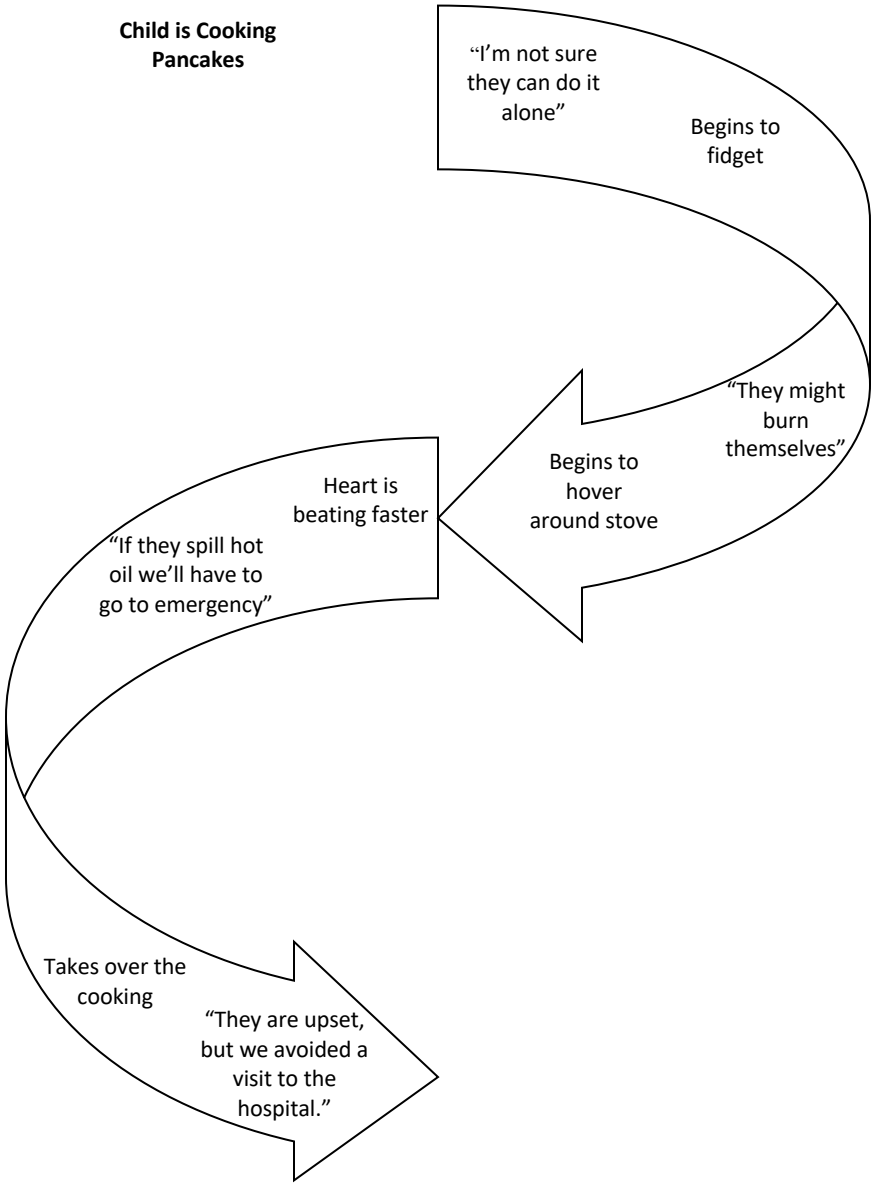
Rank	Trigger	Response

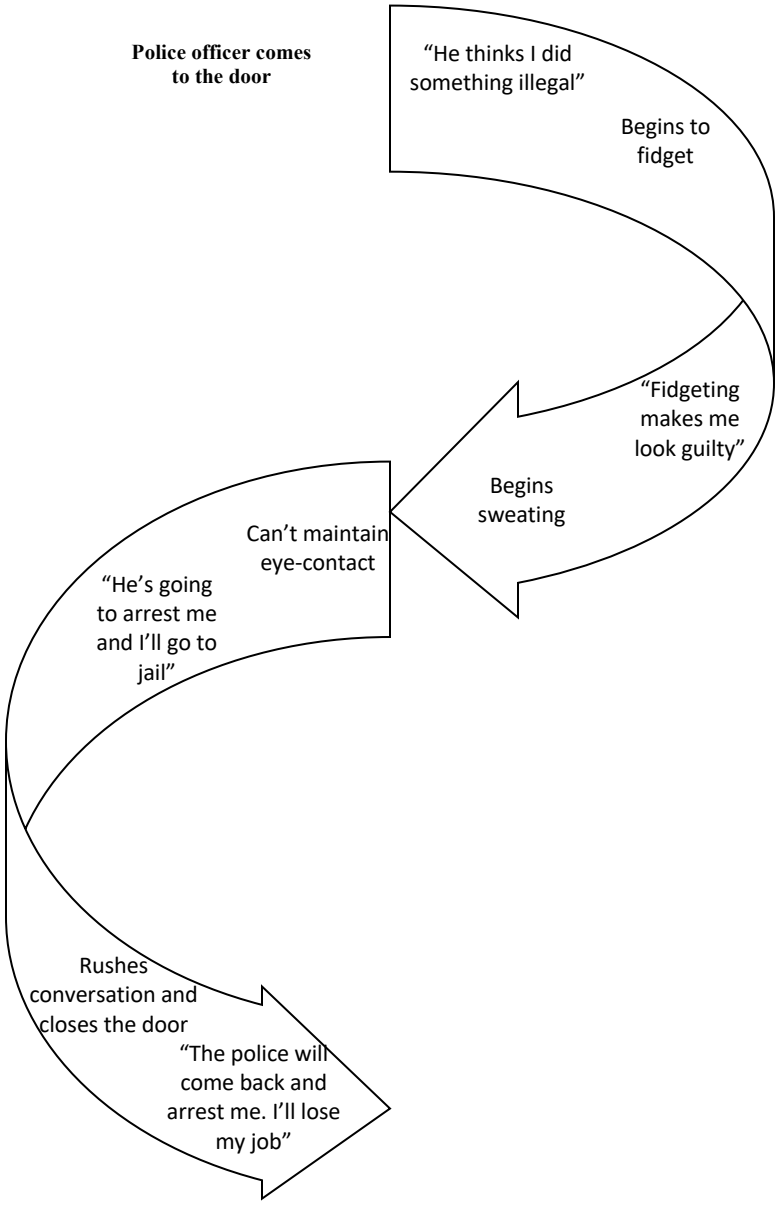
Feedback Form 3: Trigger ➔ Response Hierarchy

0 25 50 75 100
SUDS |----------|
No fear/anxiety Extreme fear/anxiety

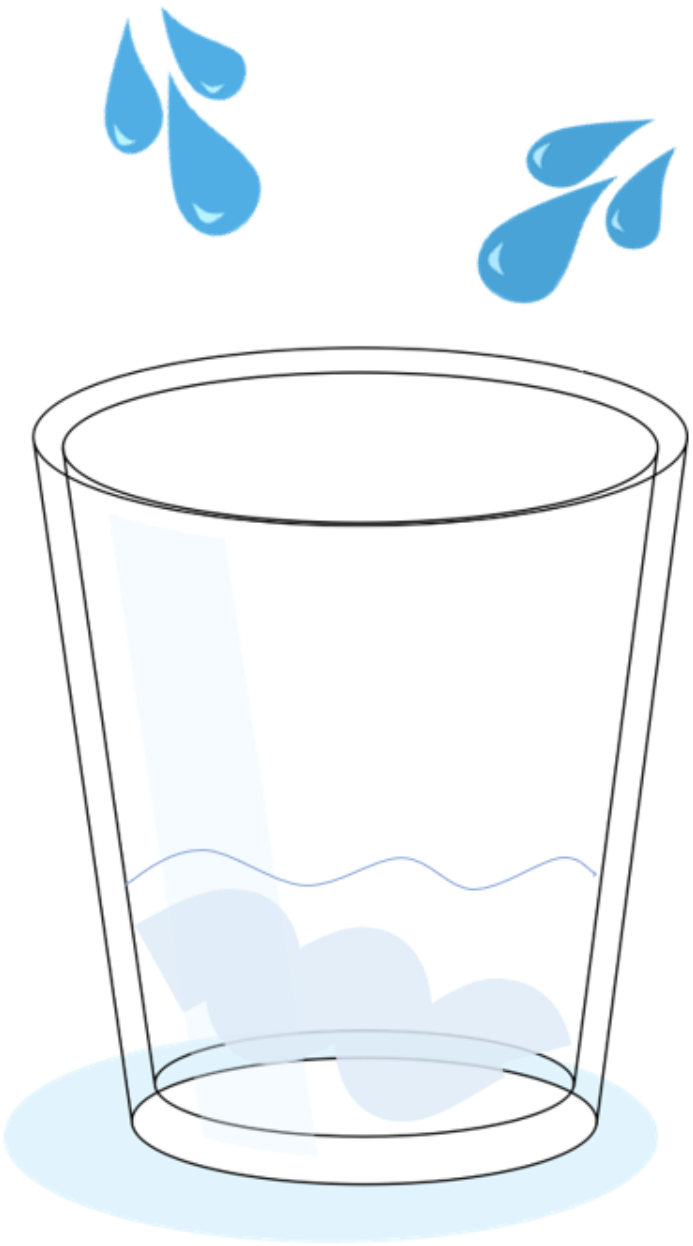
	Trigger	SUDS	Response
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Form 1.1: Interaction of Anxiety Components





Form 1.2: Development & Treatment of Anxiety



Form 1.3: Monitoring the Three Components of Anxiety Date: _____

Briefly describe each anxiety-provoking situation:

1. _____

2. _____

3. _____

Physiological Component What I *felt* was…	**Cognitive Component** What I *thought* was…	**Behavioural Component** What I *did* was…
1.		
2.		
3.		

Form 2.1: Thought Monitoring Form Date: _____

Describe a situation that made you anxious or fearful (remember this situation may or may not involve your child): _____

_____

_____

List the Automatic Thoughts you recall having: (They might be related to you, your child, or both).

Form 3.1: Disputing Questions

1. Do I know for certain that _____?

For example: Do I know for certain that I am/my child is having a heart attack?

2. Am I 100% sure that _____?

For example: Am I 100% sure that the elevator will run out of air?

3. Does _____ really mean _____?

For example: Does feeling anxious really mean looking incompetent?

4. What evidence do I have that

   _____?

For example: What evidence do I have that my children are hurt?

5. Is there another explanation for _____ besides

   _____?

For example: Is there another explanation for the bumpiness besides "the plane is crashing"?

6. What are the chances that _____ will actually happen/actually happened?

For example: What are the chances that my child will slip and hurt themselves on that water I spilled?

7. If I did _____, what is the worst that would really happen?

For example: If I did start shaking, what is the worst that would really happen?

8. If _____ did happen, how bad would it be?

For example: If people did disagree with me, how bad would it be?

Form 3.2: Cognitive Restructuring Practice Date: _____

Describe the trigger that made you anxious or fearful: _____

_____

_____

List the major Automatic Thoughts you experienced:

1._____

2. _____

3. _____

4. _____

5. _____

Pick one of these Automatic Thoughts and identify the Thinking Errors in that thought:

Thinking Error	**Explain**

[Next Page]

[Practice Using Disputing Questions – Continued]

Use Disputing Questions to challenge the Automatic Thought:

Disputing Question: _____

_____

Answer: _____

_____

Q: _____

_____

A: _____

_____

Q: _____

_____

A: _____

_____

Q: _____

_____

A: _____

_____

Develop a Rational Response: Remember, the Rational Response should be brief and positive, and it should remind you of the major points from the answers to the Disputing Questions.

_____

_____

Form 4.1: In-Session Exposure Form Date:_____

Describe the Exposure: (please be brief but provide the important details)

_____

_____

List the major Automatic Thoughts you will probably have in this exposure:

1._____

2. _____

3. _____

Pick one Automatic Thought and identify evidence of overestimation or catastrophizing:

Use Disputing Questions to challenge the Automatic Thought:

Q: _____

A: _____

Q: _____

A: _____

Q: _____

A: _____

Q: _____

A: _____

Develop a Rational Response: (brief, positive, and summarizes Disputing Question answers)

_____

_____

Behavioural Goal(s):

_____

_____

SUDS 0----------50----------100

None Moderate Extreme

Time 0 _____

Time 1 _____

Time 2 _____

Time 3 _____

Time 4 _____

Time 5 _____

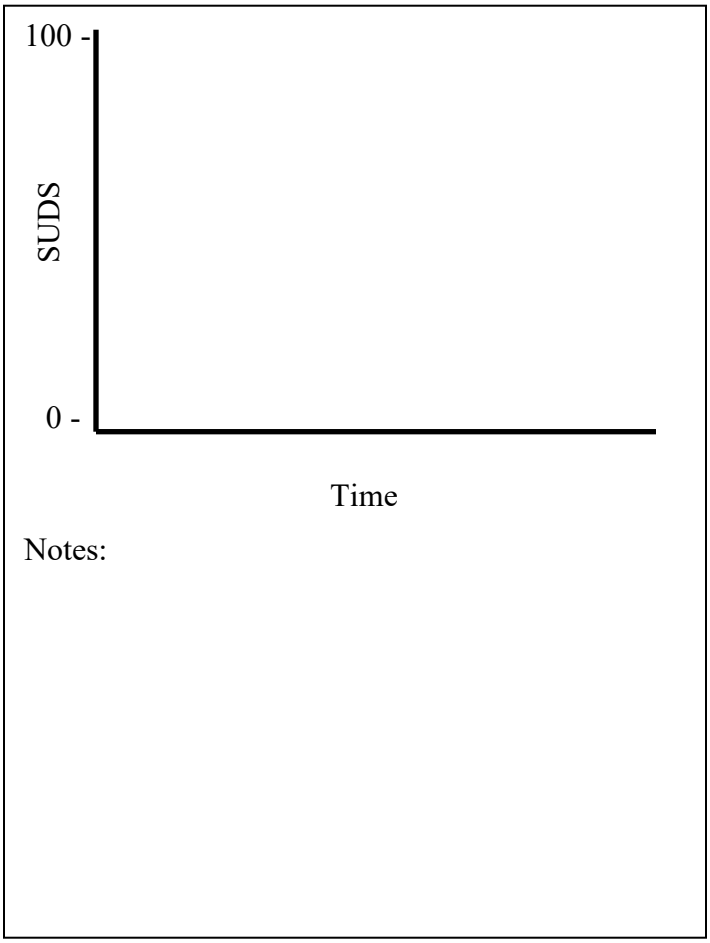
Time 6 _____

Time 7 _____

Time 8 _____

Time 9 _____

End _____



Form 4.2: Post-Exposure Form Date: _____

Describe the Exposure: (please be brief but provide the important details)

_____

_____

Describe the outcome of your exposure - Were there changes in SUDs ratings, did you meet your behavioural goals?:

_____

_____

_____

_____

What new evidence do you have about your experience of anxiety following the exposure?:

_____

_____

_____

What new evidence do you have about your ability following the exposure?:

_____

_____

_____

Notes:

_____

_____

_____

_____

Form 4.3: Homework Exposure Form Date: _____

Describe the Exposure: (please be brief but provide the important details)

_____

_____

List the major Automatic Thoughts you will probably have in this exposure:

1._____

2. _____

3. _____

Pick one Automatic Thought and identify evidence of overestimation or catastrophizing:

Use Disputing Questions to challenge the Automatic Thought:

Q: _____

A: _____

Q: _____

A: _____

Q: _____

A: _____

Q: _____

A: _____

Develop a Rational Response: (brief, positive, and summarizes Disputing Question answers)

_____

_____

Behavioural Goal(s):

_____

_____

SUDS 0----------50----------100

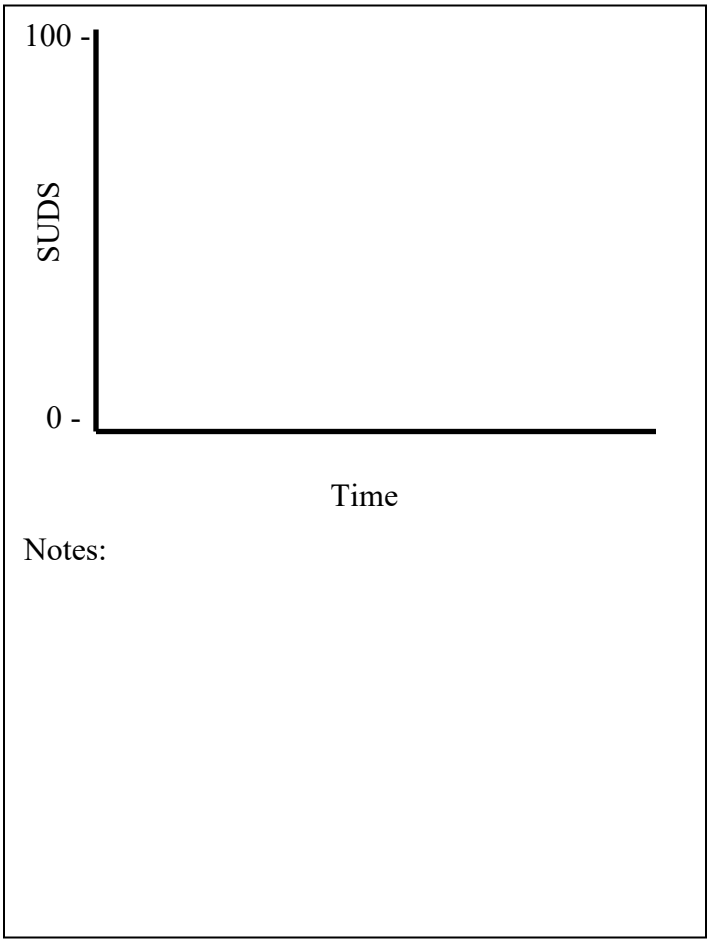
None **Moderate** **Extreme**

Just Before Exposure _____

Highest During _____

Lowest During _____

Just After Exposure _____



Notes:

Form 4.4: Observational Exposure Form Date: _____

Describe your child's Exposure: (please be brief but provide the important details)

_____

_____

List the major Automatic Thoughts you have about observing your child's exposure:

1._____

2. _____

3. _____

Pick one Automatic Thought and identify evidence of overestimation or catastrophizing:

Use Disputing Questions to challenge the Automatic Thought:

Q: _____

A: _____

Q: _____

A: _____

Q: _____

A: _____

Q: _____

A: _____

Develop a Rational Response: (brief, positive, and summarizes Disputing Question answers)

_____

_____

Behavioural Goal(s):

_____

_____

SUDS 0----------50----------100

None Moderate Extreme

Time 0 _____

Time 1 _____

Time 2 _____

Time 3 _____

Time 4 _____

Time 5 _____

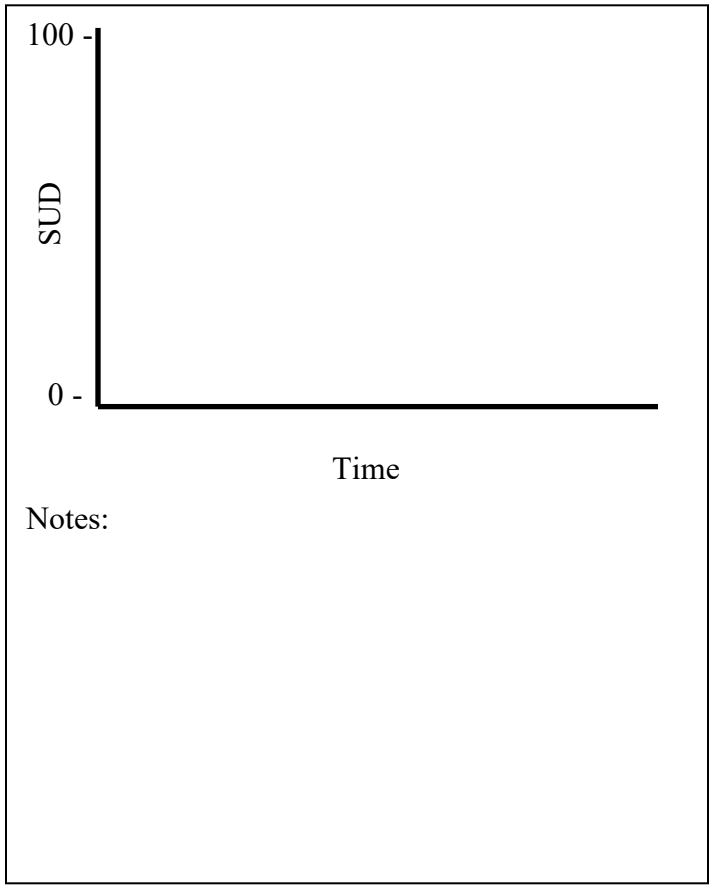
Time 6 _____

Time 7 _____

Time 8 _____

Time 9 _____

End _____



Form 4.5: Post-Observational Exposure Form Date: _____

Describe your child's exposure: (please be brief but provide the important details):

_____

_____

_____

Describe the outcome of your child's exposure:

_____

_____

_____

What new evidence do you have about your child following the exposure?:

_____

_____

_____

What new evidence do you have about yourself following your child's exposure?:

_____

_____

_____

Notes

_____

_____

_____

_____

FORM 5.1: Maintaining Gains & Continuing Progress.

1) Approach Anxiety

Treat every episode of anxiety as an opportunity to learn and practice the skills you know: Cognitive Restructuring & Exposure.

2) Practice

Regularly practice and use your Cognitive Restructuring skills with your fears.

Practice not only makes perfect, but practice makes habit.

3) Reward Yourself

You have worked very hard and made some difficult changes in your lives. You deserve a reward or celebration. Find an enjoyable and memorable way to give yourself the pat on the back you deserve.

…And don't just do this once, make it a regular part of your new commitment of approaching anxiety.

Form 5.2: Lapse & Relapse

Every once in a while, something may happen where you might want or need some help to overcome a lapse and get back on track. We want to be there to help. If you experience any of the warning signs below and cannot regain control yourself using the cognitive restructuring and graded exposure skills you have learned, call _____ on (___) _____.

Session 1 Summary Form

What is Anxiety?

- Anxiety is a normal emotional state experienced when we anticipate or are confronted with a threat. Adults and children may need to learn ways of managing anxiety to make sure it does not get in the way of them living their life.
- Anxiety generally develops due to the combination of our genetics, and our experiences such as experiencing, witnessing and/or learning something as negative or dangerous.

Anxiety in Parents and Children.

- Children experiencing anxiety can trigger similar worry and anxiety in their parents, just as parents with anxiety can model anxious worries and behaviours to their child.
- Parents play a big role in helping their children learn to be confident and less anxious. This program helps you and your child learn ways of managing anxiety in tough situations.

Three Components of Anxiety

- When feeling anxious there are changes in our bodies, how we think, and how we behave. These three components can affect each other, and can increase the intensity of the anxiety experience.

Treatment of Anxiety.

- Just as anxiety can be learned through our experiences, we can learn new strategies to help us to manage anxiety. The main components of this program are:
    - Education: understanding anxiety and anxiety disorders.
    - Cognitive Restructuring: Learning to challenge the negative thoughts and assumptions people have when feeling anxious.
    - Graded Exposure: Gradually facing fears to test out the new strategies and create new experiences.

Session 2 Summary Form

Taking a Closer Look at the Three Components of Anxiety

- Anxiety is like our body's fire alarm system in that it detects danger and sets of a cascade of changes in our bodies when danger is detected:
    - Physiological symptoms allow our body to prepare to fight, flight, or freeze. For example, our heart beats faster to pump more blood to our major muscle groups to ensure we're able to use them should we need to fight the threat or run away.
    - Thoughts about the threat allow us to redirect our attention to the potential consequences and influence how we respond in attempt to keep safe.
    - Behaviours are what we do to keep safe when faced with a threat. The escape/avoidance of threat are the most common, where the escape from threat to reduce anxiety, or avoid the threat/anxiety all together.

The Behavioural Component in More Detail: Overprotective Parenting

- A child's anxiety can cause increased worry for their parent, and this can influence the parent's behaviours in response to their anxious child.
- Parents try their best to protect their children from threat and distress, but sometimes they may become overprotective and controlling.
- Supporting children to explore and experience new situations helps them to develop a sense of mastery and belief that they can cope in different situations.

Automatic Thoughts

- In feared situations, automatic thoughts pop into our heads to tell us that something is dangerous or threatening, or that something dangerous or threatening might occur.
- People with anxiety disorders have thoughts of threat even when there is no threat, or a threat is very unlikely.
- Identifying automatic thoughts is the important first step to the cognitive restructuring skill.

Session 3 Summary Form

Thinking Errors

- The first step of cognitive restructuring is to identify thinking errors of overestimating or catastrophising in your automatic thoughts:
    - Overestimating the likelihood of a negative outcome.
    - Catastrophising about how terrible or negative something will be.

Challenging Automatic Thoughts (Cognitive Restructuring)

- Cognitive restructuring is a way to challenge the errors you have found in your automatic thoughts. It is a process of challenging the accuracy and probability of your automatic thoughts using "Disputing Questions".

Using Disputing Questions

- The goal of asking disputing questions is to help you arrive at a conclusion that successfully challenges your automatic thought and, as a consequence, reduces your anxiety.
- The key to using Disputing Questions effectively is to both ASK and FULLY ANSWER the Disputing Question, even when the answer may seem obvious.
- In some cases, a disputing question may not 'work' well for a given thought. If this happens, go ahead and ask/answer another disputing question.

Developing a Rational Response

- The final step of the cognitive restructuring process is developing a rational response.
- A rational response is a summary of the main ideas developed while asking and answering the disputing questions and boils them down into a single short statement.

Sessions 4-9 Summary Form

What is Graded Exposure?

- Exposure means a gradual facing of the things that you fear. Starting with some situations that make you moderately anxious before gradually moving up to face tougher fears.
- Exposure is a powerful technique because it works on all three of the components of anxiety:
    - Behavioural component: you get to try out a different way of coping that is different from avoiding/escaping from, or use coping behaviours to manage.
    - Cognitive component: you get the opportunity to test whether or not your fears would come true.
    - Physiological component: you learn that the uncomfortable physical symptoms are tolerable, will pass, and not catastrophic.

Why are Observational Exposures Important: *Facing Your Fears Together?*

- Opportunity to help break some of the anxiety modelling and overprotective cycles:
    - By observing your child face fears, you learn to sit with anxiety and apply strategies to help manage it. You might also learn that your child can cope, and can use their own strategies to manage anxiety too.
    - By having your child observe you, your child gets to watch you model helpful strategies to manage anxiety, and they might then feel more confident to approach anxiety provoking situations and use the same strategies too.

How to Conduct Graded Exposure

1. Develop an exposure hierarchy:
    - Make a list of situations that provoke anxiety, and rate how anxiety provoking each situation is but allocating a subjective units of distress rating (SUDS: 0-100 rating scale, where 0 = no anxiety, and 100 = worst anxiety).

- Start with the situation that causes the least amount of anxiety, and slowly build up to the situation that causes the most amount of anxiety.

2. Plan your exposure:
    - Plan your exposure by thinking through the different ways you could experience being in the anxiety provoking situation: Consider what you would do, where you might conduct it, how long you will practice it for, and if you need assistance from anyone else to conduct the exposure.
3. Use the Cognitive Restructuring Strategies & Conduct Your Exposure:
    - Identify automatic thoughts, identify any thinking errors of overestimating or catastrophising, ask and fully answer disputing questions, and arrive at a rational response.
    - Plan a behavioural goal for the exposure. Examples could be “Ask a person for change”, “Stay on the train for 6 stops”, “Proof-read the e-mail once and send”.
4. Conduct the Exposure:
    - Remember to rate your SUDS before, during (several times), and after the exposure. Each time you rate your SUDS, quickly remind yourself of the rational response.
    - At the end of the exposure, write some notes about your experience. Consider: how your anxiety levels might have changed throughout the exposure? Did anything unexpected occur and/or was it in line with your original fears? Did you learn anything new from doing the exposure?
5. Practice:
    - Finally, like learning any new skill, exposure takes practice.
    - Practicing exposures provides you with multiple opportunities to challenge automatic thoughts, adjust to physiological symptoms, and generate new evidence and alternatives to the original fear.

Session 10 Summary Form

Maintaining Gains and Continuing Progress

- Congratulations on completing the program! Here are some tips to help you maintain the incredible gains you have made, and continue the progress:
    - Approach anxiety: Treat every episode of anxiety as an opportunity to learn by practicing the skill of cognitive restructuring and exposure.
    - Regularly practice and use these skills when confronted by fears. Change takes practice and patience.
- Reward yourself for all your hard work. It doesn't have to be anything big or expensive, just enjoyable and memorable.
- It might also be a nice idea to organize a separate reward for you and your child in recognition of all the hard work you have both achieved over the past 10 weeks!

Lapse VS Relapse

- The most important thing to remember is that a lapse doesn't equal a relapse.
- A lapse is a bump in the road such as avoiding something you should be doing, permitting your child to avoid, or even taking over when they feel anxious.
- A relapse, on the other hand, is when the anxiety takes control over some part of your life again.
- If you catch yourself lapsing, use the skills you now have. Do some cognitive restructuring of your automatic thoughts and perform your own exposures.
- You CAN stop a lapse from leading to a relapse.
- Sometimes, things might become a little more difficult or you might find it hard to regain control over a lapse. This is not a failure! It is a sign that things might be particularly challenging for you at the moment.
- Keep on practising! Now is an important time because it is your opportunity to **not** let fear and anxiety stop you from doing what you want to do, being who you want to be, and living how you want to live.