



Contains Video <sup>1</sup>

## Flexible Applications of the Coping Cat Program for Anxious Youth

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*The current article offers suggestions for ways to adapt empirically supported treatments (ESTs). A specific manualized EST (Coping Cat; Kendall & Hedtke, 2006a) is used to illustrate the concept of “flexibility within fidelity” (Kendall & Beidas, 2007; Kendall, Gosch, Furr, & Sood, 2008). Flexibility within fidelity stresses the importance of using ESTs while considering and taking into account individual client presentations. In this discussion, recommendations are offered for the use of the Coping Cat with younger youth, adolescents, and youth with secondary comorbidities (i.e., social skills deficits, inattentive symptoms, and depressive symptoms).*

THE American Psychological Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP) recommend the utilization of evidence-based practice (EBP; AACAP, 2006; APA, 2005) in the provision of mental health treatment. EBP as defined by APA (2005) is “the integration of the best available research with clinical expertise.” The definition offered by APA suggests that to effectively practice EBP, clinicians apply empirically supported principles in treatment. This definition leaves room for clinical expertise and knowledge to synthesize scientific findings while taking into account individual client characteristics, situations, and needs. For a treatment to be deemed an empirically supported treatment (EST), it is necessary for the treatment to demonstrate efficacy across several randomized clinical trials (RCT) by multiple research investigators (Chambless & Hollon, 1998). One criticism of EBP and ESTs is the reliance on treatment manuals to ensure standardization and fidelity to the treatment protocol. Critics have suggested that using a manual stifles creativity, creates technicians rather than skilled clinicians and is not feasible in treating clients with comorbid treatment presentation (e.g., Bohart, O’Hara, & Leitner, 1998; Duncan & Miller, 2006; Lambert, 1998; Westen, Novotny, & Thompson-Brenner, 2004). A study reporting usage of manuals and ESTs found that 47% of clinicians reported never using a manual in their clinical practice (Addis & Krasnow, 2000), suggesting that almost 50% of mental health professionals may be resistant to or not interested in the use of treatment manuals and ESTs.

We proffer the idea of *flexibility within fidelity* (Kendall & Beidas, 2007; Kendall, Gosch, Furr, & Sood, 2008). We believe that treatment manuals may be used as frameworks for treatment delivery but that clinical skill is essential in their moment-to-moment implementation (see also Abramowitz, 2006). An emphasis on the therapeutic alliance and collaboration between the client and therapist is important in the implementation of manualized treatments (Creed & Kendall, 2005), and manuals are best when implemented while taking into account individualized client needs and concerns (as recommended by APA). We offer the analogy of a cookbook when thinking about how to implement a manualized treatment flexibly. All chefs receive the same list of ingredients and steps to follow. However, each chef is free to infuse their recipe with their own special touches and style—while not veering too far from the recipe to ensure they reach the desired outcome. Attending to individual circumstances (e.g., altitude, ingredient availability) is paramount. Additionally, if the cake catches fire, the chef is required to attend to that prior to adding the next ingredient!

To illustrate the concept of flexibility within fidelity, we will discuss flexible applications of cognitive behavioral therapy (CBT) for anxious youth. CBT is classified as an EST for youth anxiety (e.g., Silverman, Armando, Pina, & Viswesvaran, 2008). Results from numerous RCTs suggest that anxious youth who receive CBT experience significantly more improvement when compared to anxious youth who are assigned to a waitlist condition (Barrett, Dadds, & Rapee, 1996; Kendall, 1994; Kendall et al., 1997). Approximately 60% of youth no longer meet criteria for their principal anxiety disorder following 12 to 16 sessions of CBT (Kendall, 1994; Kendall et al., 1997; Walkup et al., 2008), and these treatment effects are

<sup>1</sup> Video patients/clients are portrayed by actors.

maintained at long-term follow-up (Barrett et al., 2001; Garcia-Lopez et al., 2006; Kendall & Southam-Gerow, 1996; Kendall et al., 2004). The effects of CBT appear to be augmented by the addition of a selective serotonin reuptake inhibitor (SSRI), with 81% of youth responding to treatment following 14 sessions of CBT + SSRI (Walkup et al., 2008).

To bring the concept of flexibility within fidelity to life, we draw examples from the Coping Cat program. The Coping Cat program is one example of CBT for youth anxiety: it consists of 16 sessions, follows a therapist manual (Kendall & Hedtke, 2006a) and uses a client workbook (Kendall & Hedtke, 2006b). The manual guides the treatment, whereas the workbook contains client tasks, which correspond sequentially with the treatment.<sup>2</sup>

The program is a 16-session manualized treatment for children, aged 7 to 13, who meet criteria for generalized anxiety disorder (GAD), social phobia (SP) and/or separation anxiety disorder (SAD). The first 8 sessions of the treatment are dedicated to psychoeducation, where the youth learns how to identify cues for anxiety and skills to help him/her cope with anxiety. The second 8 sessions of the treatment are more behavioral in nature: the youth faces his/her fears in a graded hierarchy. To make it easier for youth to remember learned skills, the Coping Cat program uses a mnemonic (the FEAR plan). The “F” (Feeling Frightened?) step focuses on somatic reactions to anxiety, the “E” (Expecting Bad Things to Happen?) step helps youth identify anxious cognitions, the “A” (Attitudes and Actions that Can Help) step provides coping skills for the youth to implement (e.g., coping thoughts, problem-solving, relaxation, belly breathing), and the “R” (Results and Rewards) step allows youth to rate their performance and effort and be rewarded for facing their fears. For a more complete discussion of the FEAR plan and basic implementation of the Coping Cat program, please see the companion article (Podell, Mychailysyn, Edmunds, Puleo, & Kendall, 2010; this issue) in this issue of *Cognitive and Behavioral Practice*. The *Coping Cat* manual (Kendall & Hedtke, 2006a) exemplifies the concepts of flexibility within fidelity by offering suggestions within the manual of places where the therapist can be flexible (i.e., “flex” call outs).

In this discussion, we present common challenges to treating anxious youth that are consistent with a flexible implementation of the Coping Cat. Specifically, we focus on flexibility when taking into account developmental considerations and secondary comorbidities (i.e., social skills deficits, inattentive symptoms, and depressive symptoms). Vignettes of re-enacted treatment sessions

(with all identifying information removed) demonstrating the flexible application of these concepts are included to augment our written explanations. For other samples of specific treatment sessions, please see the training DVD (CBT4CBT; Kendall & Khanna, 2008); for further suggestions regarding the flexible implementation of the Coping Cat program, see Kendall, Gosch, et al. (2008). Note that we have not focused on gender or ethnicity/race as factors to consider given that CBT for anxious youth produces similar results regardless of gender or ethnicity/race. For example, although there are differences in attrition (Sood & Kendall, 2006), there are no differences in outcomes associated with child gender or ethnicity (Treadwell, Flannery-Schroeder, & Kendall, 1995). However, we encourage all therapists to be aware of and sensitive to cultural practices when evaluating anxiety in children and implementing the Coping Cat. Western practices (e.g., sleeping in separate beds at an early age) may not be held by all cultures; thus, it is important to discuss the cultural values of the family and/or of active members in the child's home with parents and youth. Understanding cultural differences is essential when conceptualizing a case in order to develop appropriate treatment goals for each individual child; however, cultural difference may not be easily anticipated or apparent, unless the therapist takes the initiative to invite discussion on the topic and display his/her investment in culturally sensitive treatment.

### Developmental Considerations

Taking into account chronological age, IQ, and other facets of development is crucial to successful implementation of the Coping Cat program. Remember that age is merely a proxy for developmental level, so it remains important (even when age is known) to assess the youth's developmental level before deciding which version of the Coping Cat program to use. As a rough guideline, the Coping Cat program is recommended for youth ages 7 to 13. For older youth (13 to 17 years) we suggest the C.A.T. project (Kendall, Choudhury, Hudson, & Webb, 2002). With regard to IQ, we recommend that youth have an IQ of at least 80 so that they may adequately understand the cognitive portion of the treatment. However, the treatment can be applied in a more behavioral fashion with youth whose IQ is below 80 (see Suveg and colleagues, 2006, for an example of the flexible application of the Coping Cat for a cognitively impaired youth).

### Adapting the Coping Cat for Younger Children

Both cognitive (e.g., cognitive restructuring) and behavioral (e.g., graded exposure) principles are important in the implementation of the Coping Cat program. However, younger children may have difficulty with certain components of the program depending upon

<sup>2</sup>All “clients” are clinic staff and have consented to the recording and distribution of these videos.

their developmental level. We have worked with 7-year-olds who have no problem identifying their anxious cognitions and 10-year-olds who are unable to apply the cognitive principles, thus making it important to assess the youth's understanding of the concepts presented in treatment. We offer suggestions to flexibly implement the Coping Cat for younger children or children with less advanced cognitive abilities.

#### *Using Play*

The program places an emphasis on the use of activities to help youth learn the cognitive-behavioral model. As opposed to teaching the youth about feelings, thoughts, and behaviors didactically, the therapist and youth *discover* these concepts through play. Many "flex" activities are suggested throughout the manual as ways for the therapist to pick and choose which activities might appeal to the youth that they are working with, allowing for high collaboration. All of the activities are suggested, with an emphasis on having fun in session to build rapport and increase the child's engagement. For example, in the first session, to build rapport the therapist and child can play a "personal facts" game to see how many personal facts each can remember about the other, and a small prize could go to the winner. When learning about feelings, a youth and the therapist could play feelings charades (i.e., act out different feelings and try to guess what the other is doing), make a feelings dictionary/collage (i.e., look through magazines and cut out pictures of different feelings), or act as a feelings spy/detective (i.e., go through the waiting room and try to guess how people are feeling based on their bodily and facial expressions). In regard to learning about somatic cues to anxiety, the child can draw a life-size picture of themselves on a large piece of paper and identify and draw their own personal somatic cues. Each of these activities, more or less appropriate for youth of varying abilities, help the child learn about the cognitive-behavioral model in a fun and experiential way.

#### *Relaxation*

Relaxation is an important component of CBT and is a direct complement to learning about somatic cues for anxiety. After we present the "F" step to youth (i.e., identifying somatic triggers for anxiety), we subsequently teach youth how to relax their bodies. To bring these ideas to life, we use examples that resonate for youth. For example, when exploring how muscles tense up when we are anxious, we might use the example of "walking like a robot" or "uncooked spaghetti." When discussing how our muscles feel when we are relaxed, we might compare them to "limp or overcooked spaghetti." Speaking about muscle tension in this way allows youth to grasp the concepts in a fun and understandable way. When discussing deep abdominal breathing, it can be useful to provide an

analogy of "blowing up a balloon" to help youth learn how to fill their stomach with air, smelling roses and blowing out birthday candles, or breathing in the smell of hot pizza and blowing out to cool it down.

One way that we make relaxation more fun for youth is to use a script that teaches progressive muscle relaxation by providing analogies for the different muscle groups (adapted from Koeppen, 1974). For example, instead of saying "tense up your fist," a youth is told to "squeeze lemons to make lemonade." By providing these useful analogies, youth are more apt to remember what to do when they begin feeling somatic cues of anxiety, and it makes it more fun for them. Additionally, we create an individualized CD or MP3 for each youth with their therapist's voice guiding them through the exercises to take home to practice. For younger children with shorter attention spans, we recommend shorter exercises targeting just a few muscle groups (Kendall, Gosch, et al., 2008).

#### *Coping Thoughts*

One of the main components of the psychoeducation portion of treatment is to teach youth how to challenge their anxious cognitions (as part of the "A" step). One way for youth to do this is to generate coping thoughts to help them face their fears. An emphasis is placed on identifying anxious and coping self-talk and how this might influence behavior. For some youth, the generation of coping thoughts can be very difficult, particularly for the younger or less cognitively advanced participant. As a result, instead of generating one coping thought for each different situation, it can be helpful to come up with one coping thought that the child can always turn to. For example, "Be brave," or "I can do it." This coping thought can be put on a coping keychain, or even written on the bottom of a shoe for easy access in anxiety-provoking situations. Another option would be for the youth to identify a role-model (e.g., sports player, singer, actress) and to create a poster with their role-model stating their coping thought as a visual reminder. This could hang above their bed or in a frequently accessed location in their bedroom. Identifying songs that are empowering for the youth can also be motivating. One youth in our clinic who loved Hannah Montana would sing the song "Nobody's Perfect" to herself when worrying about not making mistakes.

#### *Exposure Tasks*

An important behavioral component of the treatment consists of exposure challenges. One way to remind youth of their successes with exposure challenges includes the use of a digital camera. This allows therapists to take pictures of the youth engaging in his/her exposure tasks and then make a collage of all of his/her different accomplishments. This can be a powerful visual reminder

for youth who have difficulty remembering how to utilize cognitive restructuring strategies and can also be a nice way to share the experiences with family members. Remember that positive reinforcement is a potent motivator for youth to engage in exposure challenges, so be sure to brainstorm rewards that are motivating for the youth. Examples include collectable cards (e.g., Pokémon cards), stickers, and small prizes that can be purchased in bulk. One youth at our clinic received one baseball card for every 5 people he spoke to during a social phobia exposure task, and that was a strong motivator for him to face his fear. His success during the social interactions also served as a natural reinforcer.

### **Adapting the Coping Cat for Adolescents: The C.A.T. Project**

We suggest the C.A.T. project for youth ages 13 to 17. However, we offer suggestions on how to adapt either treatment (i.e., Coping Cat and C.A.T. project) for adolescents.

Our experience is that it can often be difficult for anxious adolescents to present for treatment at a "child" clinic. Often, their parents are bringing them in for treatment and they may not believe that they need services. They may also feel that the content of the workbook is "babish" and they may feel worried that they are too old to benefit from such a treatment. We suggest that it is important to acknowledge and validate these concerns and to allow the youth the space to have doubts about the treatment. One way to present this is to ask the youth for a few trial sessions before they "sign on" or "hire you." This allows them the room to decide if they want to engage in treatment and transfers some autonomy to the youth. Another alternative for youth who seem less than excited is to provide the youth with a notebook or journal in which to engage in and record the exercises. Journaling can be a powerful tool for adolescents to begin to be able to share their thoughts, feelings, and behavior with their therapists. It can also engage the teenager in thinking about what *their* goals for treatment are (i.e., treatment deliverables) so that they feel they are working towards an end that they value.

Issues of confidentiality are always important in therapy but this is particularly true with adolescent clients. Making a point to meet with both the parents and adolescent together and making clear what types of information will be shared with the parents is paramount and is a place for clinical judgment and flexibility. For example, if the adolescent shares that they experimented with alcohol, this may not be information that the therapist is required to share with the parents. However, if the teen shares that they drove a car while intoxicated, this may be a safety concern that should be shared with the parents. Ideally, the therapist and adolescent would

make an agreement about his/her sharing the information with his/her parents together in therapy rather than the therapist "telling on" the youth. Addressing issues of confidentiality up front helps create a safe space for the adolescent to feel comfortable speaking with the therapist regarding his/her experiences and concerns.

Although the use of play is encouraged in the Coping Cat program, clinical judgment is necessary when working with adolescents. As opposed to playing the personal facts game, the therapist might have a discussion with adolescents about their likes and dislikes. However, if an adolescent is socially phobic and is having trouble generating questions, the personal facts game may provide helpful prompts for discussion. Adolescents may be less amenable to making a life-size drawing of themselves and labeling their somatic symptoms or playing feeling charades, and may be more interested in discussing these feelings and the effect on their lives. Stickers and other small rewards are likely to be less motivating for adolescents, and it is important to identify rewards that are potent reinforcers (e.g., small gift cards). Adapting the exercises to each adolescent's developmental level contributes to his/her feeling that treatment is a good match and that their therapist "gets them."

Exposure tasks are implemented with teen clients, although often the feared situations and themes are different from what a younger youth might bring to treatment. Although a 7-year-old socially phobic youth might be concerned with attending a birthday party, an older socially phobic youth might worry about dating. As noted previously, it is important to solicit the teen's goals for treatment and make the exposure tasks pertinent to the teen's life both in and out of session. Video 1 illustrates these central tenets when a socially phobic teen completes an exposure of calling a florist to arrange for a corsage for his prom date.<sup>2</sup>

### **Social Skills Deficits**

The social maturity and abilities of anxious children also vary widely and can be addressed flexibly within the context of a manual. Research suggests that same-aged children display a range of social abilities that are distributed in the population (Constantino & Todd, 2003). A range of social abilities are thus also evident in anxious children presenting for treatment. The identification of social skill differences may be particularly relevant to the treatment of children with SP (e.g., Beidel, Turner, & Morris, 2000). Though children with SP do not necessarily display social deficits, these deficits can accompany the disorder and warrant a more tailored treatment (Beidel, Turner, & Morris, 1999; Spence, Donovan, & Brechman-Toussaint, 1999).

We present examples from our clinic to illustrate how social deficits can both complicate and be flexibly



**Video 1.** Exposure with a socially phobic adolescent.

addressed within the context of a manual-based treatment. This section will not discuss treatment of anxious children with comorbid autism spectrum disorders. The modifications necessary for children on the autism spectrum are not necessarily similar to those appropriate for a child with milder and more generalized social deficits (e.g., while family involvement may be particularly helpful for a child on the spectrum it may hinder the progress of a socially immature and socially phobic adolescent). The occurrence of anxiety disorders in children with autism spectrum disorders, however, has prompted the development of several manualized treatments for this population that can be consulted as needed (Reaven et al., 2009; Sofronoff, Attwood, & Hinton, 2005; Wood et al., 2009).

#### **Psychoeducation**

Many aspects of the psychoeducational portion of the Coping Cat treatment are social in nature and thus inherently challenging to a child with social deficits. The “F” step, for instance, asks children to identify numerous nonverbal and psychosocial cues of discomfort, such as facial expressions, gestures, body posture, and social responsiveness, to alert themselves to their feelings of anxiety. The games typically employed to highlight this process (i.e., feeling charades, making a feelings dictionary, being a feelings spy) may be confusing and overwhelming for children with social deficits, who are

likely to need more time and more activities to learn these skills. A flexible use of the Coping Cat in this case might be to play multiple, rather than one, feeling identification game focused on basic, rather than more complex, emotions. Ultimately, the purpose of the games is to enable the child to identify their anxious feelings—thus, fear or worry may be emphasized over other emotions if the child is struggling to understand the material. To help the child better understand and succeed at these games, the therapist might use a pregenerated list of simple emotion words (i.e., *sad, afraid, happy, surprised, worried, angry*) from which the child can choose rather than asking the child to generate these emotions (Reaven, Hepburn, Nichols, Blakely-Smith, & Dasari, 2005). Additionally, rather than asking the child to generate a list of somatic reactions to fear or anxiety, the child and therapist might first do some investigative work asking a variety of people around the clinic what their bodies do when they are feeling scared. Such a survey may provide the child with a list of somatic responses to choose from to describe his/her own feelings, as well as offer him/her further insight into the feelings and experiences of others. These skills may be taught over multiple sessions rather than just one session if a social skills deficit is observed.

Children's variable social abilities are also applicable when considering cognitive restructuring exercises. As part of the Coping Cat program, therapists typically encourage children to challenge worries brought up in

the “E” step with coping thoughts and actions, the “A” step. Such coping thoughts often question how realistic a child’s worry may be. For children with social phobia and social deficits, at least some of the worries generated in the “E” step may be legitimate concerns (e.g., a child with social skills deficits may be more likely to be rejected socially). To address this difference flexibly, the therapist helps the child distinguish between her realistic and unrealistic fears and generate different sets of coping strategies accordingly (Reaven et al., 2005). For example, a child with social deficits might worry both that she will be teased at school, and that she will freeze while playing in the school band. It may be a realistic worry that a child with social deficits will be teased at school. As such, a strategy is to teach the child skills to cope with teasing rather than encourage the child to challenge this worry. By comparison, if the child is a talented musician, the therapist might help the child remember that he/she has played successfully in front of many audiences before.

### Exposure Tasks

A realistic assessment of the child’s social abilities, strengths and weaknesses is similarly crucial when designing exposure tasks, especially those for youth with SP. For a socially phobic child with social deficits, exposures may serve both to habituate the child to her fears and give her an opportunity to practice and improve her social skills. As such, the child’s exposure tasks should

be graded both in terms of fear level and social complexity. For example, if the issue is fear of speaking to an adult, the child might first practice ordering an item from a clerk and build up to initiating and sustaining a conversation, a task that is considerably more interpersonally complex. Social skills can be taught prior to the exposure and practiced during in-session role-plays with the therapist, other clinic staff, and eventually same-aged peers (Wood et al., 2009). The video component included in this section illustrates how a therapist might help a youth prepare for a social exposure with a focus on social skills (e.g., eye contact). The therapist utilizes a social anxiety exposure task (i.e., the child surveying clinic staff about movie interests) as an opportunity to also teach about and practice social skills. The therapist and child collaborate about what social skills the child will practice during the exposure, discuss why these skills are important, and develop ways to help the child remember to do each of them (Video 2). In addition to discussing the child’s anxiety, social skills coaching may be done both before and after the exposure task, to emphasize the dual nature of the interaction.

Finally, though it may be distressing for both the child and therapist, giving the child the opportunity to experience and cope with a negative interpersonal outcome in session may be particularly useful in helping her respond to potentially unsuccessful social attempts outside the clinic. For example, the therapist can set up an



**Video 2.** Exposure with an emphasis on social skills for anxious youth with comorbid social skills deficits.

exposure scenario with a colleague in which the youth asks the staff member to play a game with her and then experiences an unanticipated negative response. The staff member may tell the youth they are not interested in playing with her, state that there is someone else they would rather play with and precede to initiate play with someone else in the clinic, or alternatively, agree to play the game but then appear disinterested or bored by the youth's conversation. This allows the youth to experience social rejection with the support of their therapist while also implementing the coping skills learned during the treatment. We have found that such exposures may better approximate and prepare a child with social deficits for their typical social interactions. It is our experience that social interactions become more challenging and demanding as children age; thus, potential social deficits are also more likely to become apparent as the child develops. Helping the child learn to cope with negative outcomes allows them to shape rather than be limited by negative social experiences. Such exposures may also encourage a more realistic and resilient cognitive style to help the child prepare for, rather than fear, the social challenges ahead.

#### *An added note*

Despite the therapist's best efforts, some children with social skill deficits may continue to struggle with the psychosocial aspects of treatment. All is not lost. There is some suggestion that exposures can reduce anxiety symptoms independent of cognitive restructuring techniques (Bryant, Sackville, Dang, Moulds, & Guthrie, 1999). Through participation in the exposure tasks, the therapist may guide children to alternative behavioral reactions, reinforced by participation in the exposure itself. Such learning may be beneficial even to a child with a lesser grasp of the cognitive and social components of therapy.

### **Inattentive and Hyperactive Symptoms**

Many anxious youth exhibit symptoms of inattention and hyperactivity (e.g., Verduin & Kendall, 2003). In a recent RCT (Kendall, Hudson, Gosch, Flannery-Schroeder, & Suveg, 2008), 32% of anxious youth also met diagnostic criteria for attention-deficit/hyperactivity disorder (ADHD). Examination of treatment outcome identified comparable response rates between anxious youth with versus without comorbid ADHD (Flannery-Schroeder, Suveg, Safford, Kendall, & Webb, 2004; Hughes, Brown, & Kendall, 2009; Kendall, Brady, & Verduin, 2001; Rapee, 2000), and one study found that higher rates of externalizing symptoms observed during early treatment sessions predicted greater improvement in anxiety at posttreatment (Edmunds & Kendall, 2009). Of note, all participants in these studies had a primary anxiety disorder and secondary ADHD, and many of these youth were receiving stable dosages of stimulant medication for their ADHD. If a client

presents with anxiety as well as significant inattentive or hyperactive symptoms, it is important to first determine which problem is principal (Kendall, Gosch, et al., 2008). If disruptive behavior is deemed primary, it would be best to deliver a treatment explicitly targeting behavior problems. If anxiety is the primary diagnosis, it would be appropriate for the therapist to administer the Coping Cat program as well as consider consultation with a physician to discuss whether stimulant medication would benefit the child. Even when anxiety is determined to be the primary problem, inattention and hyperactivity pose extra challenges for therapists working with anxious youth. This section offers suggestions for flexible adaptation of the *Coping Cat* program in an effort to overcome these challenges.

### **Structure**

When flexibly adapting a manual-based treatment, therapists must consider the many different aspects of treatment, including content, delivery, and structure. When considering youth with co-occurring inattentive and hyperactive symptoms, we believe that it may be beneficial for therapists to alter the structure and delivery rather than the content of therapy (Grover, Hughes, Bergman, & Kingery, 2006). It may be unreasonable to expect some inattentive youth to sustain attention for a full 50 minutes. For these clients, therapists can consider delivering treatment content in shorter intervals interspersed with brief breaks. During breaks, therapists can play a game with the youth which serves the dual purpose of addressing inattention and building rapport. For example, every 15 minutes the therapist and youth could play a short game in the clinic, do 20 jumping jacks, or a similar child-chosen activity. Once the therapist and youth establish an appropriate break schedule, it can be displayed on a whiteboard or sheet of paper that is visible to the youth. In Video 3, the therapist utilizes behavior management techniques (e.g., setting an agenda, points system) to help an inattentive youth stay on task during a psychoeducation session.

In our clinic, therapists find it useful to alter the length of the relaxation exercises when working with inattentive youth. Rather than presenting the entire 15-minute exercise all at once, therapists introduce relaxation in segments. For example, the therapist may spend a few minutes introducing deep breathing exercises. After a short break, the therapist then leads a muscle tension exercise focused on one muscle group. The child's take-home assignment (Show-That-I-Can [STIC] task) is to practice each of these exercises spread over time in order to discover which specific exercises are most helpful.

### **Delivery**

Therapists can make an extra effort to deliver treatment content in a highly interactive fashion. The



**Video 3.** Session management strategies for anxious youth with comorbid disruptive behaviors.

goal is to make each session as fun and engaging as possible. For example, when introducing the “F” step, which teaches youth to recognize when they are feeling anxious, the therapist can choose to play a feelings charade game (i.e., the therapist and youth take turns acting out different emotions) rather than creating a feelings collage (i.e., cutting faces from magazines and identifying the displayed emotion). The charades game involves more interaction and physical activity than the collage-making and thus may be more appealing to active or inattentive youth. Therapists can also consider incorporating other engaging motor activities throughout the psychoeducation portion of treatment. For example, while the therapist and child are discussing content, they can throw a ball back and forth or they can take turns shooting a basketball. Additionally, this can be turned into a game. For example, during the feelings session, each time the therapist or child misses a shot, they might have to name or describe a different emotion. We recommend that therapy rooms have soft balls (e.g., Nerf balls) in them for these purposes, and basketball hoops on the backs of the door to facilitate these activities.

#### Setting

To foster an environment conducive to learning, therapists may need to pay special attention to objects in the therapy room that may distract inattentive youth

(Grover et al., 2006). Consider distraction-free zones that only include objects pertinent to that session's content. The games used during break times should be out of view during delivery of the treatment. If space permits, therapists can designate “work” zones and “play” zones in order to make clear to the child that it is time to either focus on the program or take a break. The therapist and child can come up with their own names for these physical areas and segments of time. It is important to use consistent language and demarcate consistent areas throughout treatment.

#### Rewards

Rewards are an important component of the Coping Cat program. Each week, youth receive points for completing their STIC tasks. Rewards are also part of the FEAR plan. The “R” step of the FEAR plan explicitly teaches youth to recognize the effort and progress they are making and to reward themselves for their work (as in the exposure tasks). Rewards serve as incentives to participate in exposures as well as a means of acknowledging and celebrating the youth facing his/her fears. When working with inattentive or hyperactive youth, therapists may find it advantageous to expand the reward system. Research suggests the usefulness of contingency management in shaping appropriate behavior in youth with ADHD (Hinshaw, Klein, & Abikoff, 2007). In addition to

rewarding anxious youth for efforts to be courageous, therapists can use rewards to promote on-task behavior (e.g., behavioral chart or daily report card). Throughout the session, the therapist can keep track of each minute the youth engages in on-task behavior and place a check mark on the chart. The youth can then exchange these points for a small reward. In addition to tangible rewards, such as stickers and toys, the therapist can consider social rewards, such as playing a favorite game or drawing.

### Depressive Symptoms

Research from community and clinical samples suggests that depressive symptoms and disorders are highly comorbid in anxious youth (e.g., Beidel et al., 1999; Chavira, Stein, Bailey, & Stein, 2004). Youth with a principal diagnosis of SP or GAD may be especially likely to present with comorbid depressive symptoms (Crawley, Beidas, Benjamin, Martin, & Kendall, 2008; Verduin & Kendall, 2003). Anxiety-disordered youth with comorbid depressive symptoms tend to have more severe symptomatology than anxiety-disordered youth without depression (e.g., Franco, Saavedra, & Silverman, 2007; Masi, Favilla, Mucci, & Millepeidi, 2000), increased functional impairment (e.g., Manassis & Menna, 1999; Masi et al., 2000), lower levels of involvement in extracurricular activities (Franco et al., 2007), and less favorable response to anxiety-focused CBT (O'Neil & Kendall, 2009). Youth with comorbid anxiety and depression are also typically older than youth presenting with only anxiety (Brady & Kendall, 1992; Strauss, Last, Hersen, & Kazdin, 1988).

Given the high comorbidity of anxiety and depression, it is likely that those working with youth presenting for anxiety treatment will encounter depressive symptoms. A number of adaptations can be made to the Coping Cat program to address comorbid depressive symptomatology. These include spending increased time building rapport, addressing common depressive “thinking traps” during cognitive restructuring, and incorporating behavioral activation into exposure tasks (Crawley et al., 2008).

### Rapport Building

Anxious youth, particularly those with SP, are likely to present as quiet and reserved. A withdrawn presentation may be especially common in youth with comorbid depressive symptoms. The Coping Cat program dedicates most of the first treatment session to rapport building, but additional time spent may be required for many youth presenting with comorbid depressive symptoms. One way therapists in our clinic have done this is to spend the first portion of every session (e.g., 10 minutes) engaging in a fun activity (e.g., playing a game) until sufficient rapport has been established. This serves the dual purpose of providing an opportunity to begin the session in a pleasurable manner as well as to allow for informal

“getting to know you” conversation between the therapist and child in a relaxed and nonthreatening context. This level of adaptation is typically sufficient to build rapport with withdrawn clients, however, if the child is having an especially high level of difficulty connecting with the therapist, it may be necessary to dedicate additional time to rapport-building. For some clients who have had particular difficulty building rapport with us, we have even left the clinic to engage in a fun activity, such as kicking a ball around outside, going to buy a treat, or visiting a nearby arcade to play a short game. Although some therapists may feel they are doing clients a disservice by not moving quickly into the “active” components of treatment, the importance of developing a positive relationship should not be ignored. In our experience, clients who have good rapport established with their therapist are more likely to willingly engage in the critical and challenging exposure tasks, and to work to try to implement coping strategies outside of session.

### Cognitive Restructuring

Youth with comorbid depressive symptoms are likely to make self-critical attributions and engage in negative “thinking traps” commonly seen in depressed individuals (e.g., black-and-white thinking, imagining the worst outcome). When discussing the youth's anxious cognitions during the “E” step of the FEAR plan, therapists can also be on the lookout for or directly query about negative cognitions regarding themes of failure, personal loss, or negative foreshadowing about the future (e.g., “I'm worthless,” “I'm a loser and I always will be a loser”; Grover et al., 2006). These depression-related thoughts can be addressed while coaching the child client to identify and challenge his/her anxious cognitions. We have found that for many anxious youth with depressive symptoms it can be helpful for the child client to learn to label and distinguish between their anxious self-talk and depressive self-talk. We encourage children to label these cognitions however they find helpful (e.g., “my worry voice” and “my hopeless voice”). While the goal is ultimately to challenge unhelpful cognitions, this strategy also may have the added benefit of increasing self-monitoring and awareness of anxiety- and mood-related symptoms to help the child learn to distinguish between these negative affect states. Additional sessions can be added to allow additional time to challenge depressive thoughts, and this can be practiced and reinforced across exposure sessions as well.

### Behavioral Activation

Behavioral activation and pleasant activity scheduling can be incorporated into treatment for anxious youth who have withdrawn from previously enjoyed activities or who report decreased interest and/or enjoyment in pleasurable

activities (Grover et al., 2006). Increasing the child's activity level and involvement in activities may not only improve depressive symptomology but may also facilitate the child's use of anxiety management skills (e.g., they may have more energy to engage in active coping strategies). Behavioral activation is easily incorporated into the Coping Cat program during the exposure tasks. Exposure tasks can be designed to not only expose youth to anxiety-provoking situations but to also expose them to pleasurable experiences. For example, a 9-year-old youth who is anxious about asking peers to play can be challenged to invite a friend over to play their favorite sport or game. Additionally, as part of the child's reward (the "R" step) for engaging in an exposure task, a parent can be encouraged to plan a fun, physical activity such as a trip to the park.

#### Final Note

In any therapeutic context it is important to assess symptomology to guide treatment and monitor progress. We have found this to be especially important when working with anxious youth with comorbid depressive symptoms. Youth can be taught to monitor their moods using a mood tracking worksheet as part of their weekly STIC task and therapists can routinely assess mood and risk of harm to self with youth and their parents. If depressive symptoms are initially more severe or impairing than anxiety symptoms or if this becomes the case during treatment, therapists are encouraged to strongly consider suspending anxiety treatment to focus on mood stabilization. This can be done by shifting from the Coping Cat to a depression treatment protocol and/or augmenting treatment with medication. This monitoring is important not only from a risk-management perspective but also because anxiety treatment is less likely to be effective when depressive symptoms are at a level at which they are interfering with treatment.

#### Conclusions

We hope that we have provided useful instances of when and how the Coping Cat manual-based treatment can be applied flexibly. Of course, this is not an exhaustive list of all of the possible variations, but these are some of the common experiences that therapists might have. The main point we wish to convey is that manual-based treatments *can* and *should* be adapted flexibly to match the individual client presentation as recommended by the APA (2005).

A related question can arise: When does flexibility become nonadherence to a treatment? This question is difficult to answer and is beyond the scope of this paper, but a valuable one. One suggestion is as follows: Are the treatment principles still being followed? This necessitates that the therapist be familiar with the foundational principles of CBT (see Beidas & Kendall, *in press*). For example, exposure tasks are fundamental to CBT. It does

not matter that a specific exposure task take place, or how the exposure task is conveyed, as long as the underlying principle is not ignored. However, if a therapist finds him- or herself veering from the underlying principle (e.g., the therapist doesn't do exposures because they are too difficult), then this becomes nonadherence.

Well-constructed treatment manuals can enhance clinician skill rather than detract from it, by providing a wealth of activities and knowledge for a clinician to use and adopt. Flexible implementation of ESTs allows for clinicians to implement the treatment while also accounting for individual differences in client presentation.

#### Appendix A. Supplementary Data

Supplementary data associated with this article can be found, in the online version, at [doi:10.1016/j.cbpra.2009.11.002](https://doi.org/10.1016/j.cbpra.2009.11.002).

#### References

- Abramowitz, J. (2006). Towards a functional analytic approach to psychologically complex patients: A comment on Ruscio and Holahan. *Clinical Psychology: Science and Practice*, 13, 163–166.
- Addis, M., & Krasnow, A. (2000). A national survey of practicing psychologists' attitudes toward psychotherapy treatment manuals. *Journal of Consulting and Clinical Psychology*, 68, 331–339.
- American Psychological Association. (2005, August). *American psychological association policy statement on evidence-based practice in psychology*. Retrieved March 6, 2006, from <http://www.apa.org/practice/ebpreport.pdf>.
- Barrett, P., Dadds, M., & Rapee, R. (1996). Family treatment of child anxiety: A controlled trial. *Journal of Consulting and Clinical Psychology*, 64, 333–342.
- Barrett, P., Duffy, A., Dadds, M., et al. (2001). Cognitive-behavioral treatment of anxiety disorders in children: long-term (6-year) follow-up. *Journal of Consulting and Clinical Psychology*, 69, 135–141.
- Beidas, R.S., & Kendall, P.C. (in press). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science & Practice*.
- Beidel, D. C., Turner, S. M., & Morris, T. L. (1999). Psychopathology of childhood social phobia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38, 643–650.
- Beidel, D. C., Turner, S. M., & Morris, T. L. (2000). Behavioral treatment of childhood social phobia. *Journal of Consulting and Clinical Psychology*, 68, 1072–1080.
- Bohart, A., O'Hara, M., & Leitner, L. (1998). Empirically violated treatments: Disenfranchisement of humanistic and other psychotherapies. *Psychotherapy Research*, 8, 141–157.
- Brady, E. U., & Kendall, P. C. (1992). Comorbidity of anxiety and depression in children and adolescents. *Psychological Bulletin*, 111, 244–255.
- Bryant, R. A., Sackville, T., Dang, S. T., Moulds, M., & Guthrie, R. (1999). Treating acute stress disorder: An evaluation of cognitive behavioral therapy and supporting counseling techniques. *American Journal of Psychiatry*, 156, 1780–1786.
- Chambless, D., & Hollon, S. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7–18.
- Chavira, D. A., Stein, M. B., Bailey, K., & Stein, M. T. (2004). Comorbidity of generalized social anxiety disorder and depression in a pediatric primary care sample. *Journal of Affective Disorders*, 80, 163–171.
- Constantino, J. N., & Todd, R. (2003). Autistic traits in the general population: A twin study. *Archives of Genetic Psychiatry*, 60, 524–530.

Crawley, S., Beidas, R., Benjamin, C., Martin, E., & Kendall, P. C. (2008). Treating socially phobic youth with CBT: Differential outcomes and treatment considerations. *Behavioural and Cognitive Psychotherapy*, 36, 379–389.

Creed, T., & Kendall, P. (2005). Therapist alliance-building behavior within a cognitive-behavioral treatment for anxiety in youth. *Journal of Consulting and Clinical Psychology*, 73, 498–505.

Duncan, B., & Miller, S. (2006). Treatment manuals do not improve outcomes. In J. C. Norcross, L. E. Butler, & R. F. Levant (Eds.), *Evidence-based practices in mental health* Washington, DC: American Psychological Association.

Edmunds, J. M., & Kendall, P. C. (2009). *Externalizing comorbidity, in-session externalizing behavior, and outcome in youth treated for anxiety disorders*. Manuscript submitted for publication.

Flannery-Schroeder, E., Suveg, C., Safford, S., Kendall, P. C., & Webb, A. (2004). Comorbid externalizing disorders and child anxiety treatment outcomes. *Behaviour Change*, 21, 14–25.

Franco, X., Saavedra, L. M., & Silverman, W. K. (2007). External validation of comorbid patterns of anxiety disorders in children and adolescents. *Journal of Anxiety Disorders*, 21, 717–729.

Garcia-Lopez, L., Olivares, J., Beidel, D., Albano, A., Turner, S., & Rosa, A. (2006). Efficacy of three treatment protocols for adolescents with social anxiety disorder: a 5-year-follow-up assessment. *Journal of Anxiety Disorders*, 20, 175–191.

Grover, R. L., Hughes, A. A., Bergman, R. L., & Kingery, J. N. (2006). Treatment modifications based on childhood anxiety diagnosis: Demonstrating the flexibility in manualized treatment. *Journal of Cognitive Psychotherapy: An International Quarterly*, 20, 275–286.

Hinshaw, S. P., Klein, R. G., & Abikoff, H. B. (2007). Childhood attention-deficit/hyperactivity disorder: Nonpharmacological treatments and their combination with medication. In P. E. Nathan, & J. M. Gorman (Eds.), *A guide to treatments that work* (pp. 3–27), 3<sup>rd</sup> ed. New York: Oxford University Press.

Hughes, A. A., Brown, R. T., & Kendall, P. C. (2009). *Treatment outcomes for children with anxiety disorders and comorbid attention-deficit hyperactivity disorder*. Manuscript submitted for publication.

Kendall, P. C. (1994). Treating anxiety disorders in children: Results of a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 62, 100–110.

Kendall, P. C., & Beidas, R. S. (2007). Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity. *Professional Psychology: Research and Practice*, 38, 13–19.

Kendall, P. C., Brady, E. U., & Verduin, T. L. (2001). Comorbidity in childhood anxiety disorders and treatment outcome. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 787–794.

Kendall, P., Choudhury, M., Hudson, J., & Webb, A. (2002). *The C.A.T. project manual*. Ardmore, PA: Workbook Publishing.

Kendall, P. C., Flannery-Schroeder, E. C., Panichelli-Mindel, S., Southam-Gerow, M., Hennin, A., Warman, M., et al. (1997). Therapy for youths with anxiety disorders: A second randomized clinical trial. *Journal of Consulting and Clinical Psychology*, 65, 366–380.

Kendall, P., Gosch, E., Furr, J., & Sood, E. (2008). Flexibility within fidelity. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47, 987–993.

Kendall, P. C., Hudson, J. L., Gosch, E., Flannery-Schroeder, E., & Suveg, C. (2008). Cognitive-behavioral therapy for anxiety disordered youth: A randomized clinical trial evaluating child and family modalities. *Journal of Consulting and Clinical Psychology*, 76, 282–297.

Kendall, P. C., & Hektke, K. (2006a). *Cognitive-behavioral therapy for anxious children: Therapist manual*, 3rd ed. Ardmore, PA: Workbook Publishing.

Kendall, P. C., & Hektke, K. (2006b). *The coping cat workbook*, 2<sup>nd</sup> ed. Ardmore, PA: Workbook Publishing.

Kendall, P. C., & Khanna, M. (2008). *CBT4CBT: Computer-Based Training to be a Cognitive-Behavioral Therapist (for anxiety in youth)*. Ardmore, PA: Workbook Publishing.

Kendall, P. C., Safford, S., Flannery-Schroeder, E., & Webb, A. (2004). Child anxiety treatment: Outcomes in adolescence and impact on substance use and depression at 7.4-year follow-up. *Journal of Consulting and Clinical Psychology*, 72, 276–287.

Kendall, P. C., & Southam-Gerow, M. (1996). Long-term follow-up of treatment for anxiety disordered youth. *Journal of Consulting and Clinical Psychology*, 64, 724–730.

Koepen, A. (1974). Relaxation training for children. *Elementary School Guidance Counselor*, 4, 14–21.

Lambert, M. (1998). Manual-based treatment and clinical practice: Hangman of life or promising development? *Clinical Psychology: Science and Practice*, 5, 391–395.

Manassis, K., & Menna, R. (1999). Depression in anxious children: Possible factors in comorbidity. *Depression and Anxiety*, 10, 18–24.

Masi, G., Favilla, L., Mucci, M., & Millepiedi, S. (2000). Depressive comorbidity in children and adolescents with generalized anxiety disorder. *Child Psychiatry and Human Development*, 30, 205–215.

O'Neil, K. A., & Kendall, P. C. (2009). *Role of comorbid depression and co-occurring depressive symptoms in outcomes for anxiety-disordered youth treated with cognitive-behavioral therapy*. Manuscript submitted for publication.

Podell, J., Mychailyszyn, M., Edmunds, J., Puleo, C., & Kendall, P. (2010). The Coping Cat Program for anxious youth: The FEAR plan comes to life. *Cognitive Behavioral Practice*, 17. doi:10.1016/j.cbpra.2009.11.001.

Rapee, R. M. (2000). Group treatment of children with anxiety disorders: Outcome and predictors of treatment response. *Australian Journal of Psychology*, 52, 125–130.

Reaven, J., Blakeley-Smith, A., Nichols, S., Dasari, M., Flanigan, E., & Hepburn, S. (2009). Cognitive behavioral group treatment for anxiety symptoms in children with high-functioning autism spectrum disorders: a pilot study. *Focus on Autism and Other Developmental Disabilities*, 24, 27–37.

Reaven, J., Hepburn, S., Nichols, S., Blakeley-Smith, A., & Dasari, M. (2005). *Coping group: Fighting worry and facing fears: an unpublished treatment manual for children with ASD and anxiety disorder*. Unpublished manuscript, University of Colorado at Denver and Health Sciences Center.

Silverman, W. K., Pina, Armando A., & Viswesvaran, C. (2008). Evidence based psychological treatment for phobic and anxiety disorders in children and adolescents. *Journal of Clinical Child and Adolescent Psychology*, 37, 105–130.

Sofronoff, K., Attwood, T., & Hinton, S. (2005). A randomized controlled trial of a CBT intervention for anxiety in children with Aspergers syndrome. *Journal of Child Psychology and Psychiatry*, 46, 1152–1160.

Sood, E. D., & Kendall, P. C. (2006). *Ethnicity in relation to treatment utilization, referral source, diagnostic status and outcomes at a child anxiety clinic*. Presented at the annual meeting of the Association for Behavioral and Cognitive Therapies, Chicago, IL.

Spence, S., Donovan, C., & Brechman-Toussaint, M. (1999). Social skills, social outcomes, and cognitive features of childhood social phobia. *Journal of Abnormal Psychology*, 108, 211–221.

Strauss, C. C., Last, C. G., Hersen, M., & Kazdin, A. E. (1988). Association between anxiety and depression in children and adolescents with anxiety disorders. *Journal of Abnormal Child Psychology*, 16, 57–68.

Suveg, C., Comer, J., Furr, J., & Kendall, P. (2006). Adapting manualized CBT for a cognitively-delayed child with multiple anxiety disorders. *Clinical Case Studies*, 5, 488–510.

Treadwell, K., Flannery-Schroeder, E., & Kendall, P. (1995). Ethnicity and gender in relation to adaptive functioning, diagnostic status, and treatment outcome in children from an anxiety clinic. *Journal of Anxiety Disorders*, 9, 373–384.

Verduin, T. L., & Kendall, P. C. (2003). Differential occurrence of comorbidity with childhood anxiety disorders. *Journal of Clinical Child and Adolescent Psychology*, 32, 290–295.

Walkup, J., Albano, A. M., Piacentini, J., Birmaher, B., Compton, S., Sherrill, J., Ginsburg, G., Rynn, M., McCracken, J., Waslick, B., Iyengar, S., March, J., & Kendall, P. C. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *New England Journal of Medicine*, 359, 2753–2766.

Westen, D., Novotny, C., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin, 130*, 631–663.

Wood, J. J., Drahota, A., Sze, K., Har, K., Chiu, A., & Langer, D. A. (2009). Cognitive behavioral therapy for anxiety in children with autism spectrum disorders: a randomized, controlled trial. *Child Psychology and Psychiatry, 50*, 224–234.

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