Fear Not, Child

Children with anxiety disorders can wallop their worries—and get back their life—by being encouraged to do just what they fear most. One doctor details how he helps his young patients

By Jerry Bubrick

ILLUSTRATIONS BY PJ LOUGHRAN

EDITORS' NOTE: All patient names in this article are pseudonyms.

When I first met Julia, she was the most anxious, depressed child I had ever seen. Twelve years old, she had stopped going to school and seldom left her apartment. Her eyes were big with fright. When she spoke, it was in a very soft, crackly whisper, and she would stammer, as if struggling to find words.

Julia was terrified that anyone who might see her would know instantly that something was wrong with her. When she did build up the courage to venture out, she would open the door and peek out; if she saw a neighbor in the hallway, she would close the door and wait until the coast was clear. She was not able to see friends or go anywhere comfortably, and her confinement made her feel hopeless.

Julia suffered from social anxiety, a fear that stems from being evaluated, judged and found wanting by others—and by oneself. About 1.8 million children in the U.S. suffer from clinically serious anxiety, according to the Centers for Disease Control and Prevention, with the type of anxiety tied to a child’s developmental level. Separation anxiety is the most prevalent in preschool or early grade school, for example, when children typically learn to separate from attachment figures. Social anxiety tends to show up around puberty, when children become more tuned-in to others around them.

Talk therapy, even with an experienced, dynamic clinician, was not working for Julia. She and her therapist had discussed how hard life was for her, but she was not learning why or how to make it better. In fact, talk therapy can be counterproductive for children such as Julia. Her therapist had told her to stay out of school until they could get to the bottom of her anxiety, but the longer a child is out of
her social world, the harder it is for her to go back.

The best path for Julia, as I saw it, diverged dramatically from the one her previous therapist had taken. Rather than exploring the anxiety's roots, I discuss its effects. Instead of letting fears guide behavior, I change the behavior to get rid of the fear. I practice what is called cognitive-behavior therapy (CBT) with children, and the data show that it works. In an intensive version of the therapy, I use two-hour sessions daily, or almost daily, until a patient is stable. I told Julia's parents that if they stuck with the program I was confident we could show their daughter how to regain control of her life.

Unlearning Anxiety

Traditional psychotherapists view anxiety disorders as a function of unresolved issues in childhood, such as unsuccessful toilet training or disturbing sexual urges. Therapy is a process of trying to identify and resolve those past problems, which are often buried in the subconscious. Cognitive-behavior therapists, on the other hand, believe that anxiety is caused partly by genes and partly by learned patterns of thought and behavior.

CBT is geared toward unlearning those negative habits. It is based on the hypothesis that how we think and act both affect how we feel. By changing thinking that is distorted or dysfunctional, we can positively affect our emotional state. Moreover, if we recognize that some behaviors generate and reinforce feelings that harm us, we can lessen those emotions by changing those behaviors.

The cognitive component of CBT dates back to the 1950s, when a clinical psychologist named Albert Ellis, frustrated by the ineffectiveness of psychoanalysis, developed something he called rational emotive behavior therapy: active, goal-oriented treatment in which the therapist engages patients in identifying, challenging and replacing self-defeating thoughts and beliefs, which he called “crooked thinking.” In the 1960s psychiatrist Aaron Beck of the University of Pennsylvania had also become disillusioned by psychoanalysis. Focusing on his patients' negative views, he developed what he called cognitive therapy as a way of helping them reframe such notions. The roots of the behavior-modification part of CBT emerged in the early decades of the 1900s and beyond, when pioneers in behaviorism such as Ivan Pavlov, John Watson and B. F. Skinner experimented with conditioning—linking actions to environmental stimuli—and using positive and negative reinforcement to alter behavior. The cognitive and behavioral approaches were merged in the late 1970s.

At age 12, Julia rarely left her apartment. When she did muster the courage to go out, she first peeked out from behind the door to make sure the coast was clear.
Research over more than 20 years has shown definitively that CBT is the most effective treatment for reducing symptoms of severe anxiety. In a meta-analysis (statistical review) of 48 controlled studies of CBT for anxiety in children published in 2012, clinical psychologist Shirley Reynolds of the University of East Anglia in England and her colleagues determined that this form of therapy works for anxiety in kids, too, particularly if it is tailored to the type of fear the child experienced. Other researchers have shown how CBT affects the brain. In 1996 psychiatrist Jeffrey M. Schwartz of the University of California, Los Angeles, and his colleagues reported that a course of eight to 12 weeks of CBT, delivered about two hours a week, was associated with specific metabolic changes within a brain circuit thought to be involved in anxiety disorders, suggesting that the therapy is resolving symptoms by altering the function of this circuit.

Unfortunately, many of the children who could benefit from CBT do not receive it. This problem stems in part from a lack of experienced clinicians. In addition, many pediatricians, school psychologists and others are unaware of the benefits of the therapy and so fail to refer children. Meanwhile some doctors and therapists mistakenly believe that the therapy is too tough on children when, in fact, the treatment is very gentle. We work at a child's pace, supply emotional support, and ask youngsters to do only what they are ready to do.

Hierarchy of Fears

For children with anxiety disorders, the process begins by helping them, and their parents, distance themselves from the anxiety by having them conceptualize it as a bully in the brain. We encourage children to give the bully a name and talk back to it. Kids have called their nemesis the Witch, Mr. Bossy, Chucky, the Joker and, in the case of teenagers, names I cannot repeat. We explain that we are going to teach skills to handle the bully, giving children the idea that they can control their anxiety rather than letting it control them.

Another part of the process involves mapping out how the anxiety is affecting a child's life. In Julia's case, her anxiety, and desire to avoid it, was cutting her off from everything she enjoyed in her life, making her depressed. I drew a flowchart that looked something like this:

Anxiety > Anticipatory Anxiety > Avoidance > Depression

As a sixth grader, Julia had hung out with friends, gone to restaurants, played the violin and walked in the park. Now she did none of those things. A year ago she counted seven kids as her good friends; now she was down to one she saw very rarely. She was not sleeping. Julia's depression was a result of her anticipatory anxiety, a free-floating form of anxiety that someone feels when anticipating going into a situation she thinks will cause debilitating fear. If she went out in public, someone might see her, and she might be so overcome with anxiety that she would have a full-blown panic attack, in which people experience physical symptoms they misinterpret as a heart attack and worry they may be dying. (The actual symptoms are not dangerous, however.) So she avoided going out. And the avoidance only heightened and reinforced her social anxiety. Once I sketched out that chain of events, Julia got it, and I had her buying in, a little bit, to the idea that this therapy was going to be different. Her buy-in was important because the next step—facing down her fears—would depend on her trusting me.

The core behavioral technique in the treatment of anxiety is exposure and response prevention. Adopting poet Robert Frost's claim that "the only way around is through," this method slowly and systematically helps a child face her fears, so she can habituate to them rather than avoiding or escaping them by continually seeking reassurance or engaging in ritualistic behaviors such as hand washing.

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The first step is to identify triggers. We design a "hierarchy of fears," a series of incremental challenges, each of which is tolerable, that together build to significant progress. Instead of thinking in black-and-white terms—I can't touch a dog, or I can't cross a bridge—kids are coaxed to consider degrees of difficulty. We might ask a child with contamination fears, for example, "On a scale of 1 to 10, how difficult would it be to touch the door handle with one finger? To touch and open the door?" For a child with a fear of vomiting, we might ask: "How difficult would it be to write the word 'vomit'?" If that challenge is a 3, to say "I will vomit today" might be a 5. To see a cartoon of someone vomiting might rate a 7. To watch a real video of someone vomiting might be considered a 9. At the top of the hierarchy most likely would be eating something the child thinks will make him vomit. By rating these different fears, kids come to see that some are less extreme than they had thought.

Next, we expose the child to the stressor in its mildest possible form and support him or her until the anxiety subsides. Fear, as with any sensation, diminishes over time, and children gain a sense of mastery as they feel the anxiety wane. In Julia’s case, we invited a colleague she had not met to my office to have a conversation. Julia was to ask my colleague a set series of questions. Afterward, Julia and I asked our visitor how she had done. "Did she make eye contact? Did she seem anxious to you?" Hearing, and handling, this feedback was the second part of the exposure because the feedback touched the core of her anxiety, which related to how others perceived her. Once she was comfortable interviewing a stranger in a controlled environment, we asked her to go into the hallway and approach someone and have a conversation. Again, she asked specific questions—"I'm taking a poll. What's your favorite restaurant?"—and we asked for feedback from those she polled.

To more powerfully trigger her fear of embarrassment, we asked her to be deliberately annoying by asking someone the same question repeatedly. Then, to purposely draw negative attention in a different way, we introduced a ridiculous wig. First I wore the wig, while Julia, with me, asked questions of others around the halls. Then she wore the wig and even brought some more silly wigs from home. Eventually we took coffee orders around the office and went to Starbucks, wearing the wigs.

"Blah, Blah, I'm Not Listening"

Social anxiety does not always manifest as shyness or social inhibition. It is also behind a lot of disruptive behavior that is often misinterpreted as will-
ful aggregation. One patient of mine, a 10-year-old boy named James, found himself in the emergency room after an incident that started when another boy asked him an embarrassing question. The boy said he had heard that James wanted to see a picture of one of their classmates in a bikini. James denied it, got agitated and shoved the boy. An altercation ensued; James turned into a Tasmanian devil, destroying papers and throwing things. He ended up in the vice principal’s office, where he kicked the vice principal to try to get away. School officials called 911, so James could get a psychiatric evaluation.

It was not the first time James had snapped. Everyone saw him as a bully—angry, aggressive and out of control. He was banned from the cafeteria, so his parents had to take him home for lunch every day. His parents had tried therapist after therapist. Nothing was working.

We found that James was off the charts for social anxiety. He could not accept any—even constructive—criticism. He avoided even the possibility of negative feedback, which he found humiliating. When his parents asked him how his day was, he literally covered his ears and said, “Blah, blah, I’m not listening.” So when the boy came to him and said, “Hey, I heard you want to see so and so in a bikini,” even if the claim was true, James was so embarrassed that he freaked out.

For a child such as James or Julia, whose functioning was severely impaired, the treatment should at first involve multiple hours every day for a week or several weeks and only later consist of the typical weekly sessions. Such intensive treatment jump-starts positive change and builds a child’s confidence that things can get better, motivating him or her to work hard. In addition, evidence suggests that the most change occurs between sessions, when patients apply the skills they have learned. When sessions are close together, kids complete the homework more consistently, resulting in faster acquisition of skills. In-

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tensive outpatient treatment also enables families who do not have ready access to a qualified clinician to travel to one.

We treated James daily for two weeks until he was much more functional, and then he returned weekly 10 times. In addition to wearing wigs, James walked a pet banana on a leash on the sidewalk. At one point we went to Grand Central Station and assigned him to ask strangers, “Where is Grand Central Station?” or “Is this the place to get trains?” Since his treatment, he has not missed a day of school or earned a detention. He is back to eating lunch in the cafeteria, too.

Multiple studies during the past six years back
up our experience that daily CBT for several weeks can reduce anxiety by at least as much as having months of weekly sessions. In a study published in 2007 psychologist Eric Storch of the University of South Florida and his colleagues found that three quarters of 20 children and adolescents shed symptoms of obsessive-compulsive disorder (OCD)—in which individuals attempt to control fears or unwanted thoughts with compulsive or ritualized actions—after 14 sessions of family-based intensive (daily) CBT. In contrast, just half of 20 youths who had received the same number of weekly treatments went into remission. In a second trial published in 2010 Storch and his colleagues found that 14 sessions of intensive CBT led to a significant reduction in OCD symptoms as well as associated depression and behavioral problems in 24 of 30 youths for whom medication had not worked well. Sixteen of the kids went into remission.

"Is There Something Wrong with Your Legs?"

Parents also play an important role in exposure therapy. Not only do they urge their children to do their homework but they also must learn to stop doing things that enable the anxiety to grow. With the best of intentions, parents often let children avoid what they fear, sometimes even banishing words, sounds or objects that trigger a child's anxiety. Instead of making such accommodations, I advise parents to encourage a child to face her fears. For example, if Julia said, “I can't go get the mail,” instead of saying, “That's okay, I'll get it,” her parents were taught to challenge her. "Is there something wrong with your legs?" they might jokingly ask. If Julia really could not get the mail, her mom and dad learned to find something she could do, such as just opening the door or going part of the way.

In the case of Michael, an 11-year-old with severe OCD and a fear of contamination, his mother opened doors for him so he would not have to touch the doorknob. She put his laundry in the hamper so he could avoid touching dirty clothes. Among the things he saw as contaminated were his brother and sister. So if Michael's mom was carrying food to him and his sister walked in front of her, she threw away the food. Michael had not eaten at the table with his family for 15 months.

We explained to Michael's mother that going to such great lengths to protect Michael from his anxiety was actually reinforcing it. "Before I knew what accommodation was, I thought I was helping," she told me. "I was devastated to know I was feeding the OCD instead." Once I identified the accommodations Michael's mom was making, I worked with her to gradually remove them as soon as I felt Michael was ready. So instead of trying to help Michael feel safe when he was, say, anxious about touching the doorknob, she encouraged him to sit with the anxiety, knowing it would pass, and he would be able to open the door himself.

Some evidence supports the importance of parents in the process. In one study published in 2006 child psychologist Jeffrey J. Wood of U.C.L.A. and his colleagues assigned youth with anxiety disorders who were six to 13 years old to either family-focused CBT, in which parents were taught more effective
communication strategies in conjunction with children’s treatment, or CBT with minimal involvement from parents. The children who received the family therapy showed a 79 percent reduction in anxiety symptoms compared with a 53 percent improvement in those who had been in the therapy without parent participation.

Many anxious children can also benefit from medication, especially antidepressants, either alone or in combination with CBT. Unless a child is too impaired for CBT or the family is unwilling to do the work involved, we recommend therapy alone for the first few months to better evaluate its efficacy and then add medication when necessary. The combination of CBT and medicine has been shown to be the most effective approach for moderate to severe cases of anxiety.

On Top of the World
For the first three weeks, I saw Julia three to five times a week for two hours each time. I wanted to boost her confidence and get her back out into the world. Once she was feeling more energized and the depression was fading, I gave her homework. I assigned her to go for a 10-minute walk in the park; she did not have to talk to anyone, just be outside. Then I told her to go to a restaurant to pick up a menu. One restaurant became three—later, five. Next, she had to go to Macy’s and buy something. Eventually we worked on seeing friends. At first, friends visited her apartment. Later, I assigned her to go out with friends to restaurants and movies as a reintroduction to being social in the city. Our approach was the exact opposite of the one espoused by her previous therapist: stay inside until they unearthed the roots of her anxiety.

After six weeks of intensive therapy, Julia was feeling—and acting—close to her old self again, and we switched to weekly sessions. She had not returned to school, however, because she felt the environment was too demanding and critical. Julia’s parents found a new school for her.

During the summer, Julia went on a family trip to Europe, armed with an action plan for her anxiety and a lifeline to us. “You can always text or call me,” I told her. But I did not hear from her. When she came back, she was much happier and more confident than she had been before she left. By fall, Julia was ready for her new school. Within a few weeks there, she had started to make friends—and soon she had many. She joined the track team and got into the musical a cappella group.

One day she returned to her old school to see her friends perform in a talent show. The lead singer of one of her friends’ groups was sick, and the other members asked Julia, on the spur of the moment, to sing in her place. In front of the entire school, Julia sang an Adele song. She came out of that performance on top of the world, and the experience crystallized for her how much better her life has become after shedding her ever present apprehension. “Time goes by so much faster,” she says, “when you’re not constantly dreading things.”

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FURTHER READING
■ To learn about CBT for anxiety disorders, visit the Anxiety and Depression Association of America’s Web site: www.adaa.org/resources-professionals/teaching-slides
From Our Archives
■ Obsessions Revisited. Melinda Wenner Moyer; May/June 2011.