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Stepping Toward Making Less More for Concerning Anxiety in Children and Adolescents

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Kendall et al.'s (2016) article, 'What Steps to Take? How to Approach Concerning Anxiety in Youth," is another important and admirable step that Philip Kendall and collaborators have taken to illuminate critical issues facing the science and practice of clinical psychology. The article contains thoughtful and clinically astute suggestions about using specific components of cognitive behavioral treatment (CBT) in stepped care models for concerning anxiety in children and adolescents including pragmatic examples of separating CBT "into steps of differing intensities" (p. x). The authors also highlight glaring knowledge and research gaps in this emergent area. These gaps suggest a myriad of theoretical, empirical, and clinical steps that are worth taking.

We elaborate on some of the gaps and outline steps we are taking with children and adolescents with concerning anxiety to close these knowledge gaps. We organize our commentary by clinical science theory, clinical research, and clinical practice for presentation ease. Admittedly, theory, research, and practice are inter-related and inform one another. Theory informs empirical research and can maximize treatment effects by ensuring that critical components of evidence based treatments are transported to and implemented in clinical practice. The knowledge acquired through empirical research and clinical practice, in turn, continually informs and advances clinical science theory (Silverman & Kurtines, 1997).

Clinical Science Theory

A portion of our title, "…Making Less More" is derived from a commentary by Gerald Davison (2000), "Stepped Care: Doing More with Less," in response to articles contained in a Special Section on this topic in *Journal of Consulting and Clinical Psychology*. In reading through the excellent articles we wondered – did the field get stuck in an elevator over these 16 years rather than take the stairs? We raise the question because it appeared that the steps taken since the Special Section can be characterized as "baby."

Most of the gaps discussed across the articles still exist and are highly relevant, including when and how to step up. Kendall et al. (2016) emphasize that when and how to step up remains unknown, and factors such as parent psychopathology, youth age, family interaction patterns, and comorbidity patterns are likely to play an important role in determining these issues.

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We found the following lines from Davison (2002) succinctly (and brilliantly) encapsulate this key clinical science theory gap, “Sometimes one can do more with less…. Sometimes we do less with more. Sometimes we end up doing much less with less. And sometimes having less time to work with patients ends up costing more in the long run.” (Davison, 2000; p. 580). When the “sometimes” is “this time” and “with whom” remains unresolved and is still one of the major challenges of stepped care with anxious youth.

This gap raised by Davison (2000) and Kendall et al. (2016) harken back to similar, nagging issues raised in the broader evidence based treatment literature regarding the importance of developing evidence based explanations about not just whether treatments work, but how (mediational processes) and for whom (moderation processes) (e.g., Silverman & Kurtines, 1997). Davison's “sometimes” scenarios highlight the theoretical idea that different types and intensity of interventions (e.g., print and internet self help resources) will be needed (sometimes) for different anxious children and adolescents depending on baseline characteristics. The lack of advancement in this realm is alarming given one scenario is harm to an anxious child (i.e., “doing much less with less”).

Theory construction and evaluation in stepped care strike us as posing even more exceptional conundrums and challenges than traditional treatment intervention work. This is because stepped care requires moving from least restrictive efforts to increasingly more intensive efforts. The types of corrective actions to step up such efforts necessitates principles and frameworks that consider the assortment of complex processes/mechanisms (i.e., mediators) that are involved in applying a specific therapeutic step across various subgroups of anxious children and adolescents (i.e., moderators). Further, different processes/mechanisms and varying combinations of processes/mechanisms are likely to be implicated in each therapeutic step of a stepped care model. The interactive nature of the processes/mechanisms that are contained in each step care model and their effects will also likely vary by the particular sequences or permutations in which the steps are delivered and the baseline characteristics of the youths.

Given these complexities, we are not surprised that clinical science theory construction and evaluation got stuck in the elevator in the stepped care edifice. As interest in stepped care approaches grows, we look forward to studies grounded in guided principles and frameworks that lend themselves to model testing that will serve to build and link clinical science theory and clinical research and practice within a given stepped care approach.

Clinical Research

Kendall et al. (2016) highlight a number of critical clinical research and practice gaps that would be useful to close to advance stepped care models for concerning anxiety in children and adolescents. One of the steps they emphasize relates to the need to take corrective actions when required. They note:

> “A hallmark of stepped-care is its ability to ‘self-correct’ when a client is not making sufficient treatment gains. Though tools exist to guide providers in making decisions, little research has directly examined precisely when a youth should be ‘stepped up’ to a higher level of care” (p.x).

To guide such decision making requires empirically informed knowledge about when to step up treatment versus maintain treatment versus terminate treatment. Garnering this knowledge requires clinical scientists' continuous monitoring or tracking of their treatments and to then use these tracking data to adjust, or step up, the treatment based on the anxious youth's progress or lack thereof. We recently showcased this type of approach by empirically identifying tailoring variables (i.e., variables that provide prospective information about final treatment response) amongst children and adolescents who were treated with CBTs for whom we then generated decision rules about treatment next steps (Pettit, Silverman, Rey, Marin, & Jaccard, in press).

We identified a class of youth Nonresponders who could be hypothesized as likely to benefit from a CBT step up and/or augmentation because CBT alone was ineffective at mid-treatment and mid status predicted post status. We also identified a class of youth Early Responders who could be hypothesized as likely to be good candidates for either a CBT abbreviation or some other form of short term CBT intervention (Step 3 in Kendall et al., 2016), because CBT alone was found to be effective at mid-treatment and mid-treatment status predicted post-treatment status. Between these classes was a third class of youth who partially responded at mid-treatment and showed a mixed pattern of responding at the end of CBT.

As clinical scientists develop and evaluate stepped care protocols for concerning anxiety in children and adolescents, we encourage researchers to consider designing treatment studies that include a focus on discovering tailoring variables. Potential tailoring variables would be selected a priori on the basis of theory and/or research and would be assessed continuously throughout treatment with an eye toward determining the optimal timing or session number to move to the next step. Once a tailoring variable is empirically shown to predict final treatment response, clinical researchers can then use it to generate decision rules about when to step up.

Clinical Practice

Kendall et al. (2016) present a thoughtful sequence of useful cognitive behavioral intervention options at graded levels of intensity and we applaud them all. We briefly present two other options for consideration. We are rigorously pursuing both because we believe they offer considerable potential in advancing stepped cared models in clinical practice for concerning anxiety in children and adolescents. Both may prove applicable for “Step 2: Initial Therapeutic Involvement” (Kendall et al., 2016, p. xx) and “Step 3: Short-term Therapist Intervention” (p. xx). One is a computer based approach, Attention Bias Modification Training, and the other is a parent based program, Supportive Parenting for Anxious Childhood Emotions Program.

Attention Bias Modification Training

Behavioral and neuroscience research findings consistently show that individuals with anxiety disorders, including children and adolescents, exhibit heightened attention to threatening stimuli such as angry faces. The translational treatment implication of these

findings, Attention Bias Modification Training (ABMT) is that attention can be shaped and modified through repetitive, computer based training, which further shows promise for reducing concerning anxiety in children and adolescents.

ABMT is ideally suited as a low intensity intervention in a stepped care sequence. It is brief; the modal treatment course spans four weeks with one to three 15-minute sessions per week. It also is inexpensive; the computer based program does not require skilled clinicians. Finally, it is portable; existing ABMT protocols have been administered in clinics or using combinations of clinic- and home-based administrations.

We have two ongoing projects relevant to using ABMT in clinical practice as a low intensity intervention in a stepped care sequence. One is using ABMT for subthreshold or subclinical impairing levels of anxiety (i.e., below diagnostic criteria) in children and adolescents. Our efforts to address subthreshold anxiety with ABMT seems a plausible way to proceed initially rather than with a high intensity interventions such as therapist delivered CBT. If we find promising anxiety reduction, a logical next step is to use ABMT for mild to moderate levels of anxiety in children and adolescents within a stepped care sequence.

It is this sequence that we are currently using in our second project. Specifically, in the initial step, children and adolescents complete 4 weeks of ABMT followed by a post-ABMT assessment. At the post-ABMT assessment, children and adolescents who display successful anxiety reduction end treatment and enter a monitoring phase. Children and adolescents who display minimal anxiety reduction are stepped up to a 12 to 14 week CBT protocol followed by a post-CBT assessment.

This clinical approach appears highly promising in reducing concerning anxiety and thereby speaks to ABMT's potential in stepped care. We also will examine the moderator questions we raised earlier (i.e., baseline characteristics of children and adolescents who respond well to ABMT versus those who need higher intensity treatment). These characteristics may be used as tailoring variables to generate decision rules for initiating treatment with ABMT as a low intensity short-term therapist intervention (Kendall et al.'s Step 3) or skipping directly to CBT as a higher intensity therapeutic intervention (Kendall et al.'s Step 4).

Supportive Parenting for Anxious Childhood Emotions

Research linking childhood anxiety to parenting characteristics, and research supporting links between anxiety and its disorders in children and in parents, have led to repeated efforts to enhance outcomes for childhood anxiety by involving parents in the treatment process. In light of evidence suggesting that the majority of these efforts have not yielded the sought-after gains, relative to treating the child without involving parents, we have shifted our efforts to focus on parent-specific mechanisms of change, that are not targeted in child treatment. Reducing family accommodation, or the changes that parents make to their own behavior to help a child avoid or alleviate distress related to the anxiety, is one such parent-specific mechanism of change (Lebowitz et al., 2013). Family accommodation is helpful in alleviating the child's distress in the short term, but over time is associated with more severe

anxiety symptoms and greater impairment, and theoretically is contrary to the goals of independent coping and reducing avoidance.

The treatment protocol that has placed the strongest emphasis on reduction of family accommodation is the Supportive Parenting for Anxious Childhood Emotions Program (SPACE). SPACE is a parent-based intervention for childhood anxiety and OCD that does not require child participation, and can be delivered as a stand-alone treatment or in conjunction with child treatment. The primary focus in SPACE is on parent change rather than on direct child change, allowing the treatment to be implemented even in cases where the child is reluctant or completely opposed to engaging in therapy directly

In SPACE, parents are first educated on the differences between protective behavior, which reduces child anxiety in the short term but does not emphasize coping or promote self-regulation, and supportive behavior which conveys to the child an acceptance and validation of their distress, along with a confidence in the child's ability to cope and tolerate discomfort. SPACE emphasizes systematic monitoring and reduction of family accommodation and provides parents with tools to do so in a supportive manner. SPACE also includes a set of tools for coping with common difficult responses from children such as increased distress in the short term or disruptive behaviors, as well as other challenges such as facilitating productive cooperation between two parents. We have shown the feasibility and acceptability of SPACE and preliminary positive evidence in open trials with children with obsessive compulsive disorder and another with anxiety disorders, with a larger randomized controlled trial currently underway.

Reducing family accommodation fits into a stepped care model and offers potential for varying levels of intensity of treatment, as well as flexible integration before, alongside, or after direct child treatment. In one example of a stepped care model involving reduction of family accommodation, parents whose children had not yet begun individual therapy were invited to participate in a brief parent group, lasting 5 weekly sessions. During the sessions, parents e received information relating to the family impact of childhood anxiety disorders, and were encouraged to monitor their own accommodation of their child's symptoms. The rationale for reducing family accommodation as a means of encouraging increased independent coping in the child, and reducing the reliance on the parent for regulation of internal distress was presented and an emphasis was placed on replacing protective parental behavior with supportive behavior, defined as the integration of empathy and validation for the child, with confidence in the child's ability to cope and to tolerate distress. Following the group, children who continued to require individual treatment were enrolled in therapy.

A benefit of SPACE within the context of stepped care is the ability to work with parents even when children are not motivated for direct child therapy. Clinically we have found that such low motivation is often accompanied by high levels of family accommodation. For example, a child with separation anxiety may be less motivated to work at overcoming her concerning anxiety if her parents accommodate highly by not leaving her alone, sleeping near her, etc. A stepped model of care may include an initial “go” with SPACE, as efforts to engage the child directly can often be nonproductive (and even counterproductive; or do much less!), and this “go” can then be stepped up with child therapy when the family

accommodation has been reduced, if symptoms remain. In other scenarios, the sequence of stepped care could be reversed. Parents of a child who has not responded sufficiently to individual therapy are offered SPACE as a next step in the treatment process. And in yet other cases combining both treatments simultaneously makes the most clinical sense.

Closing Comments

We believe Kendall et al.'s (2016) article, with its many excellent astute clinical suggestions, will play an important role in stepping toward making less more, and doing more with less. We hope this commentary, which highlighted additional steps, will also help move the field toward this goal, including interfacing theory, research, and practice and closing key knowledge gaps relevant to each.

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