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Coaching Approach Behavior and Leading by Modeling: Rationale, Principles, and a Session-by-Session Description of the CALM Program for Early Childhood Anxiety

Anthony C. Puliafico, *Columbia University, New York State Psychiatric Institute*
Jonathan S. Comer, *Boston University, Center for Anxiety and Related Disorders*
Anne Marie Albano, *Columbia University, New York State Psychiatric Institute*

*Whereas the cognitive-behavioral treatment of childhood anxiety has been well-researched and empirically supported over the last 20 years, interventions for anxiety in young children (ages 7 and below) have garnered little attention. Because young children generally lack the required developmental skills to effectively engage in cognitive-behavioral treatment, a simple downward extension of treatments used for older children is inappropriate. The CALM program (**C**oaching **A**pproach behavior and **L**eading by **M**odeling) was developed as a developmentally compatible intervention to treat anxiety disorders in young children ages 3 to 7. The CALM program is an adaptation of Parent-Child Interaction Therapy (PCIT), and an extension of Pincus, Eyberg, and Choate's (2000) adaptation of PCIT for young children with separation anxiety disorder. It is a parent-focused treatment that teaches parents skills to effectively reinforce their children's brave behavior and coaches the use of these skills during in-session parent-child interactions. The treatment emphasizes live, bug-in-the-ear coaching of parents during in vivo exposure sessions. This article describes the CALM program in detail.*

Childhood anxiety disorders constitute a serious public health concern, affecting up to 10% of children and adolescents (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Merikangas et al., 2010). Children suffering from anxiety disorders frequently experience significant impairment in academic, social, and family functioning (Grills & Ollendick, 2002; Hughes, Lourea-Waddell, & Kendall, 2008). Moreover, when left untreated, childhood anxiety disorders often persist and are associated with depression and substance abuse in adolescence (e.g., Buckner et al., 2008; Kaplow, Curran, Angold, & Costello, 2001; Kendall, Safford, Flannery-Schroeder, & Webb, 2004; Lewinsohn, Holm-Denoma, Small, Seeley, & Joiner, 2008), as well as occupational impairments and reduced quality of life in adulthood (Comer et al., 2011; Merikangas et al., 2007).

Over the last 20 years, cognitive-behavioral treatment (CBT) has garnered strong empirical support in the treatment of childhood anxiety in children ages 7 and above (see Kendall, Furr, & Podell, 2010; Silverman, Pina, & Viswesvaran, 2008). Whereas specific treatment programs for child anxiety vary, well-supported protocols share a number of core components, including (a) psychoeducation about anxiety; (b) instruction in and practice of anxiety management skills such as relaxation training or cognitive restructuring; and (c) gradual exposure to feared situations. These strategies allow a child to reframe the internal experience of anxiety and to re-estimate threat in the environment. But what if an anxious child lacks key developmental skills required to productively engage in well-supported treatments? How best to treat anxious children below the age of 7, who typically have a limited ability to accurately report on his or her thoughts, to think about alternative ways to perceive anxiety-provoking situations, to consider how anxious he or she may be in an imagined scenario, or to delay the reward of anxiety relief in an exposure situation?

The treatments that have been empirically supported for youth with anxiety disorders require a set of developmental abilities that younger children typically do not fully possess. Treated children are expected to describe their internal thoughts and feeling states in treatment. They are further required to sustain attention toward goal-directed behaviors and to hold previously learned concepts in mind within and across treatment sessions. Exposure-based interventions require a child to suppress dominant attentional and behavioral responses, and to plan and

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delay rewards. The aforementioned metacognitive (Flavell, Miller, & Miller, 2001, Schneider, 2008) and executive functioning (Garon, Bryson, & Smith, 2008) skills are generally limited in young children and continue to develop throughout childhood. Consequently, the optimal course of treatment for anxiety in young children is considerably less clear.

This dilemma becomes most concerning when considering that as many as 9% of preschoolers suffer from an anxiety disorder (Egger & Angold, 2006), and the median age of anxiety disorder onset is 6 years (Merikangas et al., 2010). The presence of anxiety at a young age predicts anxiety presence later in childhood and even in adulthood, and earlier onset is associated with more intractable course of illness (Kessler et al., 2005). Clearly, the identification of developmentally appropriate treatment options for young children constitutes a vital public health agenda. If anxiety can be effectively treated in young children, then the development of additional disorders through adolescence and young adulthood may be delayed or prevented.

Although the treatment of child anxiety disorders presenting in children below 7 years has historically been neglected by research, a handful of research groups working with anxious preschoolers have recently begun to show support for the use of developmentally sensitive downward extensions of child anxiety treatments (Cartwright-Hatton et al., 2011; Freeman et al., 2008; Hirshfeld-Becker et al., 2010; Kennedy, Rapee, & Edwards, 2009; Waters, Ford, Wharton, & Cobham, 2009). Kennedy et al. (2009) developed an 8-session parent-based intervention for children ages 3 to 4 exhibiting high behavioral inhibition and who had at least one parent with a diagnosed anxiety disorder. This intervention was associated with greater reduction in anxiety symptoms and in behavioral inhibition compared to a waitlist control at 6-month follow-up.

Hirshfeld-Becker et al. (2010) adapted Kendall's Coping Cat treatment for children ages 4 to 7. Their treatment, known as the Being Brave program, consisted of 20 weekly sessions; Sessions 1 to 6 and 20 were conducted with parents, and Sessions 7 to 19 were conducted with both parent and child. In a randomized trial, the Being Brave program was associated with a 69% response rate on the Clinical Global Impression Scale for Anxiety compared to a 32% response rate for waitlist control participants. Compared to controls, participants receiving the Being Brave treatment also exhibited greater reduction in anxiety symptoms and increased parent coping at posttreatment. Results were maintained at 1-year follow-up.

Waters et al. (2009) compared a group cognitive-behavioral treatment for child anxiety—the Take Action Program—conducted with parents and children to a version of the treatment conducted with parents only. Sixty participants ages 4 to 8 were randomized to the parent and child group, the parent-only group, or a waitlist control. Both treatment programs lasted for 10 sessions and involved psychoeducation, training in relaxation, cognitive restructuring, social skills, and graded exposure. Both active treatments outperformed the waitlist control, with 55.3% of children in the parent-only group and 54.8% in the parent-and-child group no longer meeting diagnosis for an anxiety disorder. Results were maintained at 1-year follow up.

Cartwright-Hatton et al. (2011) completed a randomized clinical trial comparing a group-based treatment, the Timid to Tiger program, for parents of 74 anxious children up to age 9 to waitlist control. All children either met criteria for an anxiety disorder or exceeded the cutoff scale for internalizing problems on either the Child Behavior Checklist or the Preschool Behavior Checklist. Group treatment consisted of ten 2-hour sessions and provided psychoeduction about anxiety while teaching parents to use positive attending, active ignoring, reward systems, limit setting, and time-out procedures to reinforce exposure to feared situations and extinguish avoidance behavior. Fifty-seven percent of children whose parents participated in the Timid to Tiger program no longer met criteria at posttreatment, compared to 15% of children of waitlist-control parents, and these results were maintained at 12-month follow-up.

The programs outlined by Kennedy et al. (2009), Hirshfeld-Becker et al. (2010), Waters et al. (2009), and Cartwright-Hatton et al. (2011) include important developmental adaptations, with the most salient adaptation being a greater emphasis on parental involvement. Increasing the role of parents in the treatment of anxiety in young children makes good clinical sense given that certain parenting behaviors, such as overprotection, high control, and accommodation of children's anxiety-related avoidance, have been associated with heightened childhood anxiety (Hudson, Comer, & Kendall, 2008; McLeod, Wood, & Weisz, 2007; Moore, Whaley, & Sigman, 2004; Rapee, 1997; Siqueland, Kendall, & Steinberg, 1996; Wood et al., 2003). Given relationships between parenting behaviors and childhood anxiety, as well as noted limitations that established child anxiety treatments may hold for young children, interventions focusing primarily on *parents* instead of *children*, and modifying parenting behavior, may be most particularly well-suited in the successful treatment of early childhood anxiety. One particularly promising model for parent-based treatment of early childhood psychopathology, generally used in the treatment of children with disruptive behavior disorders, is Parent-Child Interaction Therapy (PCIT; McNeil & Hembree-Kigin, 2010).

PCIT was originally developed to treat young children with disruptive behavior problems (McNeil & Hembree-Kigin, 2010). It is a directive, short-term treatment that entails (a) teaching parents skills to more effectively manage their child's problematic behavior, and (b) live coaching of these skills while the parent and child interact