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Review article

Cognitive Behavior Therapy for Children with Anxiety: Considerations for a Low Resource Setting like India

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Abstract

Childhood anxiety disorders are common, chronic and cause impairment if left untreated. Early identification and treatment are, therefore, essential. Cognitive Behaviour Therapy (CBT) for children with anxiety has increasingly received attention from researchers worldwide. It is now accepted that CBT should be the first line of treatment for children with anxiety. The fact that it is based on skills training for the child and also incorporates parents as co- therapists make it important to establish a strong foundation for problem-solving, anxiety management and coping skills which will be useful for all future encounters with anxiety provoking situations. It is necessary to modify the CBT techniques based on the population that is being catered to, and it is also important to incorporate cultural, social and language factors into the modules that are created for specific populations. In India, common presentations of anxiety could be in the form of somatic symptoms or academic underachievement.

The primary focus of this paper is to highlight the utility of this approach in low resource settings such as India with suggestions for its modifications for use in the clinical setting. Existing low-cost models are described. Unique issues in implementing CBT in India are discussed.

Keywords: CBT, Children, Anxiety, Low resource settings, India

Introduction

Anxiety spectrum disorders are not only one of the most common disorders in children but also the most underdiagnosed and undertreated due to the nature of the complaints – mostly internalizing and not really troublesome to others. It is a well-known fact that prevalence rates of all mental disorders, including anxiety disorders, are much higher in lower- and middle-income countries (LMICs) [1]. There are, however, challenges including difficulty with delivery of services, dissemination of information, utilization of psychosocial treatment services that is also due to lack of policy and legislation, insufficient financial resources, insufficient evidence for cultural sensitivity of such interventions and lack of trained personnel [2]. Recently, Evidence-Based Programs (EBP) have been disseminated in LMIC by adapting them according to local needs [3].

The prevalence of anxiety disorders in India has ranged from 1.3 to 4.2% [4-6]. Another study found that children present to the clinic with a variety of anxiety symptoms and disorders, the most common (in children who are 12 years and above) being obsessive compulsive disorder, followed by phobias, generalized anxiety disorder, social anxiety disorder, separation anxiety disorder and panic disorder in that order [7].

There have been attempts to provide formal training programs in some centers, and they also provide supervision. However, these are still few.

In this paper, an attempt will be made to provide a rationale for the need to modify the current Western models of CBT for young children with anxiety, provide cost-effective strategies for use in low resource settings like India, delineate the modifications necessary and discuss considerations for routine use in resource limited settings.

Clinical presentation of anxiety in India

Young people with anxiety disorders (this paper focuses on children below 14 years) are unlikely to present for help independently, with parents commonly raising concerns to either the Paediatrician or the mental health professional. The challenge is to distinguish pathology from 'normal' developmentally appropriate fears and worries. Very often, in India, children are brought with somatic problems, academic problems, school refusal, elective mutism, dissociative symptoms, peer-related problems, sibling issues and even irritability and aggression, all of which may be the result of an underlying anxiety disorder [8]. It is important, therefore, to evaluate carefully when a child is brought to the clinic with any of the above concerns.

Role of CBT in the management of childhood anxiety:

Many clinicians in India use CBT, either alone or as part of an eclectic therapeutic plan. However, there have been no published attempts at adapting this therapy to the Indian context. It is possible that each practitioner has her/ his own adaptation for use with their specific populations, but there has not been much dissemination of this for fellow clinicians. CBT is the most commonly favored and used form of treatment for most adult conditions too. Its use in children, especially younger children, has only been in vogue over the last two decades and much of the research has been carried out in the last ten years. Needless to say, almost all of these have been published in the West.

The core differences in the use of CBT in the West compared to India are with regard to three main areas – 1. Practical considerations of time, cost and physical distance from the therapy centre, 2. Actual therapeutic process related issues such as difficulties with recognition of cognitive errors, using cognitive strategies, doing homework assignments and language-related issues and 3. Socio-

cultural factors such as family involvement, recognition of the primary caretaker, role of religion, knowledge and beliefs.

Available models for CBT with young children with anxiety in the West:

1. **'Being Brave' Module**

This is a manualized, cognitive-behavioural, parent-child treatment - designed for children 4-7 years of age - that was developed by Hirschfield – Becker and colleagues [9] that is offered in up to 20 weekly, 50-minute sessions. A parent workbook accompanies it. This protocol begins with six parent-only sessions–three sessions on general principles of anxiety management and three on strategies to coach their child to face feared situations. The rest of the sessions are with the child and one or both parents. The program concludes with a parent- only session with a focus on maintaining gains and preventing relapse. The child sessions of the intervention were loosely adapted from Kendall's "Coping Cat" program [10,11].

2. **'Cool Little Kids' Program**

The Cool Little Kids program is a program that aims at preventing emotional disorders [12]. The program was basically developed to identify and manage anxious behaviours as well as risk factors in pre-school children aged 3-6 years. The program includes six parent sessions which are generally in group format (90-minute each). The program includes psychoeducation and parent management training with a particular focus on parental overprotection. It also includes graded exposure and cognitive restructuring for parental anxious thoughts.

3. **'Coping Cat' Program**

This program consists of 16 sessions, follows a therapist manual [10] and uses a client workbook [11] The manual guides the treatment, whereas the workbook contains client tasks, which

correspond sequentially with the treatment. The program is a 16-session manualized treatment for children, aged 7 to 13, who meet criteria for anxiety. The first eight sessions are focused on psychoeducation, where the child learns how to identify cues for anxiety and skills to help him/her cope with anxiety. The next eight sessions of the treatment are more behavioural in nature: the child faces his/her fears in a graded hierarchy. The program uses the mnemonic 'FEAR' to remember learned skills better. The "F" (Feeling Frightened?) step focuses on somatic reactions to anxiety, the "E" (Expecting Bad Things to Happen?) step helps children identify anxious cognitions, the "A" (Attitudes and Actions that Can Help) step provides coping skills for the children to implement (e.g., coping thoughts, problem-solving, relaxation, belly breathing), and the "R" (Results and Rewards) step allows children to rate their performance and effort and be rewarded for facing their fears. The 'Coping Cat' program has been adapted for use in Canada (Coping Bear) [13] and in Australia (Coping Koala) [14]

4. **FRIENDS Program**

The FRIENDS program [15] has been inspired by Kendall's Coping Cat and has replaced the 'FEAR' acronym with 'FRIENDS'. It also encourages children to (a) *think of their body as their friend* because it tells them when they are feeling worried or nervous by giving them clues; (b*) be their own friend* and reward themselves when they try hard; (c) *make friends*, so that they can build their social support networks; and finally (d) *talk to their friends* when they are in difficult or worrying situations. Although retaining the core components of CBT for childhood anxiety (exposure, relaxation, cognitive strategies, and contingency management), the FRIENDS program has several unique features. It has two parallel forms: one for children (ages 6 to 11 years) and the other for youth (ages 12 to 16 years). Second, it incorporates a family-skills component, which

includes cognitive restructuring for parents and partner-support training and encourages families to build supportive social networks.

The above models have all been used in various contexts and found to lead to definite improvements in symptoms. However, the detailed nature of the sessions, the level of expertise required from the therapist, the reliance on technical jargon, the need for regular homework exercises, the degree of involvement of parents, all make these difficult to use in their prescribed format in India. It is essential, therefore, to adapt the strategies used to suit local needs in order to ensure its utility for children and families in our setting.

A recent meta-analysis [16] looked at the question 'What is the best psychotherapeutic approach for anxiety disorders in children and adolescents in terms of efficacy and acceptability? The meta-analysis included 101 unique trials with 6625 participants who received 11 different psychotherapies and four control conditions. They found that only group CBT was significantly effective in reducing anxiety symptoms post-treatment and at short term follow up.

Cost-effective models:

Attempts have been made - in many settings - to develop cost effective models to ensure that more children with anxiety and their families can access therapy. Listed below are some of the favored models:

1. **Brief CBT model [17]:** BCBT is based on, and includes, basic elements of the Coping Cat. The BCBT is divided into two main parts, the first part focusing on psychoeducation (e.g., cognitive restructuring, problem-solving), and the second part is focused on the practice of these newly learned skills. It is delivered over eight sessions, of 1 hour duration each, with the exception of Sessions 1 and 4, which include an extra 30 minutes for consultation with parents. BCBT takes 40% less treatment time when compared to the original treatment.

The sessions are planned as follows: 1) Building rapport, treatment orientation, parent meeting, 2) Identifying anxious feelings, self-talk and learning to challenge thoughts, 3) Problem solving, self-evaluation and self-reward, 4) Review skills, practicing in low anxiety-provoking situations, 5-7) Practice with increasingly anxiety-provoking situations and 8) Practicing in high anxiety situations and celebrating success.

2. **eCBT:** Internet-delivered CBT (ICBT) is a newer method of making evidence-based treatments available to children and families who do not have physical access to these interventions. Research on ICBT for children has increased in recent years with there being several meta-analyses showing that ICBT is also an effective treatment for young people [18-20]. ICBT for children with anxiety has been shown to reduce symptoms as well as increase functioning [21-23]. A study done in Norway [24] showed statistically significant changes from pre- to post-treatment. They also found that therapeutic gains were maintained for up to three months from the post-treatment assessment. At follow-up, 68% were no longer in need of treatment. This study suggests the feasibility of implementing ICBT in regular health care, and this would probably increase accessibility for treatment in children with anxiety disorders who live far away from specialist clinics.
3. **Bibliotherapy:** Bibliotherapy is a treatment using written materials for mental health problems. The main advantages are ease of use, low cost, low demand for professional input, and greater privacy. There are a few meta-analyses have focused on the effect of bibliotherapy on depression and anxiety disorders in children and adolescents. One study [25] was a meta-analysis of randomized clinical studies of bibliotherapy as part of CBT in children and adolescents with anxiety. They found that bibliotherapy was more effective with adolescents, and there were less robust effects for younger children with anxiety. In

an earlier study, Rapee et al. [26] compared bibliotherapy with standard treatment and wait-list controls, and found a definite benefit of bibliotherapy over wait-list, though not as effective as standard treatment involving face to face interaction with children and parents.

4. **Parent Training Alone:** Since research implicates family accommodation in the maintenance and course of childhood anxiety, parental involvement is essential – either jointly with therapy for the child or even on its own [27]. Parent training usually consists of psychoeducation, reducing parental anxiety, contingency management, cognitive restructuring, improving the parent-child relationship and relapse prevention [28]. There is evidence that parental involvement is more impactful in CBT with younger children with anxiety especially when one parent is also anxious. However, the conditions under which parental involvement in child focused CBT improves outcome is currently unclear. A study conducted recently [29] showed that the SPACE (Supportive Parenting for Anxious Childhood Emotions) program was as effective as CBT for children with anxiety disorders in children. By and large, most studies have shown that parental involvement is an essential component, especially with younger children. A practical step by step approach is available as well [30]. The PCIT-CALM program (***P***arent ***C***hild ***I***nteraction ***T***herapy with ***C***oaching ***A***pproach behaviour and ***L***eading by ***M***odeling) has also been found to be effective [31].

Modifications of CBT in different cultures and low resource settings:

Although much of the research on CBT in children with anxiety have been published from the West, some attempts have been made to adapt these models for use in other contexts too. Hinton and Patel [32] have suggested some ways to make CBT more appropriate for ethnic minority, refugee and global groups:

1. **Create positive expectancy and treatment credibility**– Frame the treatment as addressing issues of concern to the patient, which may include culturally emphasized symptoms. The goal is to present the CBT treatment in terms of local practices and ideas of efficacy.
2. **Address locally salient catastrophic cognitions about symptoms and address key dimensions of psychopathology**– In different cultures, anxious cognitions are viewed differently. Some use bodily symptoms more than psychological symptoms to signify anxiety.
3. **Use culturally specific metaphors, proverbs, stories and analogies**– CBT principles are best presented in a culturally sensitive way by using proverbs and expressions from the culture. Similarly, salient metaphors may be used.
4. **Present CBT information and techniques in terms of local psychology, physiology and spiritual tradition**– Each culture will have certain ideas about how and why symptoms occur, which may be rooted in local religious traditions.
5. **Include CBT- consistent therapeutic techniques from the local traditions**– It is important to remember that each culture will have specific methods to relieve distress. It would, therefore, be helpful to frame CBT techniques in terms of local religious traditions.
6. **Adaptation of key CBT techniques to promote tolerability and cultural appropriateness**– It would be necessary to plan exposure exercises based on somatic sensations the child experiences.
7. **Reduce stigma**– It is essential to explain to children and their parents that psychological problems are treatable and can also address local ideas of mental illness.

Research from low resource settings worldwide:

CBT has been used in low resource settings for children with anxiety. A study was conducted in Pakistan using the 'Coping Cat'(CC) program for children aged 8-13 years [33]. The program was translated and adapted to their cultural setting and was named 'Bahadur Billi'. The authors found that the program significantly reduced children's self-reported anxiety sensitivity and anxiety symptoms in an orphanage-based school setting at post-assessment, and six months follow up as compared to a waitlist control group. They also report that the CC program is rated as useful, comprehensive and helpful by the children.

Another study was conducted in Brazil to evaluate the effectiveness of CBT in the community [34]. The study was conducted on 20 children with anxiety. A total of 14 sessions of group CBT and two concurrent sessions of parent training based on the Coping Cat program was conducted. All scales showed an improvement in anxiety. The authors concluded that group CBT was effective in treating anxiety disorders in children. They also state that CBT protocols which are adapted and developed for use in low- and middle-income countries will prove useful.

Trauma-focused CBT (TF-CBT) was evaluated in Zambia in children, including psychoeducation, parenting skills, relaxation, affective modulation, cognitive coping and restructuring [35]. They found that flexibility in using this approach is necessary to increase relevance in different cultures. Interestingly, the authors discuss some practical issues that may be of relevance in our country as well - particularly the difficulty in keeping appointments and arriving late and requesting that longer sessions and less frequent sessions are held due to the practical issue of travelling to a health care center. Flexibility to offer shorter sessions if they are late and longer sessions if they travel long distances are also factors that are of relevance to us in the Indian context.

Another study from Pakistan evaluated psychologists' experience of CBT [36] (though not restricted to children), and the authors conclude that, for CBT to be acceptable, accessible and effective in Non-Western cultures, numerous adjustments need to be made, taking into consideration factors related to service structure and delivery, patient's knowledge and beliefs about health and the therapy itself. They also suggest that interviews with psychologists in these countries can provide insights which can guide the development of therapy and manuals to support its delivery.

Research on CBT with children and adolescents in the Indian Context:

There are some considerations while planning CBT with children in India (and this is also common to other therapies with children) – co-operation of parents, psychological sophistication of the child and parents, educational level of parents, language issues, the decision to engage for a longer duration, the ability to do homework assignments which are an integral part of the CBT process and the ability to monitor thoughts, feelings and behaviour in a sensitive manner.

In a paper that examined the child's perspective in dealing with anxiety using a qualitative methodology, Kandasamy et al. [37] found that, in children with anxiety aged 6–16 years, the narratives highlighted the importance of cognitive interventions. The authors suggest workbook based Cognitive Behavior Therapy (CBT) interventions, considering the lack of trained professionals to administer cognitive behavioural interventions in India.

Attempts have been made to evaluate CBT with children and adolescents in the Indian context too. In one review and viewpoint, Halder and Mahato [38] enumerated the challenges and gaps in the practice of CBT in the Indian context (not specific to anxiety, though). They explained the role of culture, parenting issues, issues with acceptance and stigma, difficulties with structuring sessions and planning treatment, financial issues, dealing with comorbidities and ways to facilitate

behavioural and cognitive change. The authors concluded that CBT could be used as an effective treatment for many of the childhood and adolescent mental health conditions as the first line of treatment, provided the familial, cultural and compatibility perspectives are appropriately considered.

Mehta [39] discussed new advances in CBT (though again, not restricted to anxiety disorders) and indicated that, for children and adolescents, CBT had demonstrated its effectiveness in a wide range of psychological problems.

Single case studies have been published on child and adolescent population with anxiety and depression with creditable results [40,41]. In addition, some work on early detection of anxiety disorders in children and adolescents has been conducted [42]. This editorial commentary on the need for early detection stated that there is evidence that childhood anxiety disorders are the beginning of a 'cascade of psychopathology' and therefore, there is a need for early detection and treatment. It causes impairment in functioning as well as hampering general health, resulting in financial, interpersonal and educational difficulties.

Some practical approaches to CBT in this group have been published that indicates that this is a favored model for children and adolescents in India [43].

Another recent study [44] has shown a favorable outcome in children and adolescents with anxiety spectrum disorders receiving treatment-as-usual in a tertiary care setting. The authors indicate a need for interventional research with a specific focus on universal preventive programs for anxiety spectrum disorders that are feasible for delivery in low and middle-income countries.

Some unpublished doctoral theses have also used CBT with children and adolescents (including versions of the Coping Cat program) and found these to be useful, at least in the short term, as long term outcome has not been attempted.

In an article that provides clinical practice guidelines for India, Bhide and Chakraborty [45] describe issues specific to psychotherapeutic interventions for children and adolescents. In this, CBT is also described for children as a treatment of choice, and the authors suggest developmental considerations while choosing this form of therapy. They discuss the need to consider factors such as age, verbal felicity, cognitive flexibility as well as duration, intensity and frequency of the symptoms. Family-related factors and the need for parent/ family involvement in therapy were emphasized.

Practical considerations for CBT with young children in the Indian Context:

Although there is substantial research on CBT from the West, treatment guidelines using CBT for young children with anxiety disorders are not available. Some practical considerations need to be taken into account while formulating guidelines for the use of CBT in the Indian Context.

In the author's clinical experience, the following are the factors that need to be considered. These may need corroboration from therapists in other settings in the country in order to be generalizable.

1. **Parents:** Parents do not consider anxiety as a clinical problem (except if it leads to school avoidance or severe separation anxiety) and the general impression is that children grow out of it. It is also important to remember here that anxiety runs in families and parents may, therefore, 'understand' the child's anxiety and may not seek clinical attention for it. It is also a consideration that children may not be able to give consent for the therapy.
2. **Diary:** Keeping a diary to write down behaviours, thoughts, and feelings is not a familiar practice in the Indian culture. Generally, parents do not follow these instructions and tend to prefer giving their input live in the session then come with completed homework assignments. On the other hand, some parents keep copious notes and dutifully do the homework assignments, and this usually indicates that the parent/s are also anxious making

the job slightly more difficult. Here, parenting styles are likely to reflect over involvement and accommodation. It would be important to emphasize the utility of the diary and how it helps to monitor progress.

3. **Use of reinforcements:** The other major issues, not restricted to children with anxiety, but generally in behavioural therapy for any child psychiatric condition, is that parents do not positively favor the use of reinforcements. They are considered 'bribes' and parents do not like to use them, even in the short term. Differences between 'bribes' and reinforcement will, therefore, need to be discussed early on in the treatment program.
4. **Use of stories:** There are some culturally acceptable alternatives to CBT using folk tales. They also provide moral stories that teach coping skills using animals as main characters. There are also other stories of valor and bravery that can be used as role models. Each therapist can have their list of books that provide examples of courage, use of positive self-talk and also ways to work with negative thoughts.
5. **Role of the extended family:** The extended family plays an essential role in parenting a child in India and can have its advantages and disadvantages. The positives are obvious– there is sharing of responsibilities, there is physical and psychological support available, cultural practices are handed down more easily, emotional bonds get stronger, children learn to value the presence of the elders in the family, and this helps them deal with people outside better. On the other hand, disciplining can be a significant challenge when there are too many opinions. It would be essential to get all members of the family who are involved with the child to be part of the training program.
6. **Use of play:** Children may take some time to warm up to the CBT protocol, and it would not be amiss to use play as an initial ice breaker. This is especially so when one considers

the fact that one may be dealing with very young children who may find direct CBT a little hard to both understand and implement. The first session with the child could be dedicated to using play as a method of building rapport.

7. **Homework assignments:** Attempts should be made from the beginning when the therapy plan is being made that the homework assignments are essential and will, in fact, determine the outcome to a large extent. Some of the reasons that assigning homework tasks to young children can be difficult are - limited executive functioning, restricted attention, and poor organizational skills. All of these are vital components of effective treatments for internalizing symptoms in older children [46]. Importance of homework assignments and how they provide the base to work further during the sessions need to be emphasized.
8. **Practical issues:** In India, one of the concerns is to conform to scheduled appointments. Long distances, other family commitments, missing school, parents losing a workday, charges – all make it difficult to attend regular therapy sessions. Even if a contract is made with the family to commit to a particular number of sessions, it seldom actually works. Coming late for appointments, not being able to wait to be seen, long duration of the sessions have all been, at some point or the other, been practical impediments to therapy. Many families, in fact, would like the therapist to do whatever is necessary to work with the child than do any homework assignments. The author has found it helpful to state, in the beginning, the plan for the therapy–targets for change, sessions, duration, the role of parents, skills that will be addressed for the child, cost and the possible outcome. It would help to use a mix of face to face sessions, eCBT and bibliotherapy given the practical considerations.

In addition, Kumar [47] discusses the issues specific to CBT with Indian children. The following are suggested as guidelines that can inform clinical practice:

1. Inclusion of the family
2. Address somatic complaints and academic issues which may be the presenting symptom.
3. Highlight areas of strength.
4. Be aware of language used. Although children may be English speaking, the connotation of words may be different.
5. Make child aware of need to label emotions.
6. Using well- researched 'child- friendly' techniques work well including 'bag of feelings', use of metaphors, creative play materials, behavioral experiments and stories.

From the review of available literature, it can be summarized that, in the Indian context, too many sessions, increased frequency of sessions and longer duration of sessions are difficult. It is necessary, therefore, to use cost- effective methods that can be used and this includes use of bibliotherapy, parent training, use of peers and siblings, using developmentally appropriate toys and play materials, e- resources and behavioral strategies like rewards and praise. Group intervention can also be planned to be able to target more children in need of help. Treating parental anxiety, if dysfunctional, can also be part of the module. The module that can be used should use data from available local literature and include social and practical aspects to make it more relevant to the Indian context. Parental involvement would need to be ensured as has been recommended all over the world [48]. In fact, as evidenced in several studies, parental training can be used as a proxy for child treatment as well [49]. In addition, it is suggested to include peers and siblings in exposure exercises. It is important to conceptualize that most children with anxiety may not have

access to a trained professional therapist. It is necessary, therefore, to simplify strategies that have been found effective in other low resource settings.

Future Research Recommendations:

CBT for children with anxiety in the Indian context is worth exploring as there have been very few studies. Therapists need to consider the practical aspects of planning, implementation and follow up of these children to maximize gains. In India, some further modifications need to be made in terms of more realistic goals, more practical session plans and use of cultural and practical modifications, as necessary. Conducting randomized controlled studies would be a necessary future pre-requisite to actually delineate unique factors that are involved in immediate, short- term and long- term favorable outcomes.

Training personnel to provide CBT for young children and their parents could be a future goal. Research into process and outcome issues also need to be planned. There is a need to work towards developing modules that are easily replicable in settings across the country and amenable to be provided by different cadres of mental health professionals considering the severe shortage of adequately trained personnel and the large numbers of children and families who will need the service. A combination of good psychoeducation, parental training using CBT principles, live sessions with the child using a combination of CBT and play, providing e-resources and bibliotherapy may be the model to follow. Monitoring progress and planning long term follow up of these children and their families may provide crucial information on framing future modules of treatment for our population. Children with anxiety need to be identified early and plans for early intervention need to be made in order to reduce dysfunction, improve quality of life and, overall, improve outcome.

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