Stress and Anxiety Disorders in Young Children

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STARNET Workshop
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DISCLOSURE STATEMENT

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No conflict of interest to disclose

Off-label use of: SSRIs, TCA's, Clomipramine, Venlafaxine, Benzodiazepines, Buspirone, Guanfacine, Clonidine, Buproprion

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WHY DO THIS WORKSHOP?

Childhood anxiety disorders are common, under-recognized, and quite impairing

Effective screening, assessment and treatment tools for childhood anxiety disorders already exist

Through this workshop hope to increase early recognition and effective treatment

Encourage further training and use of CBT

Learning Objectives:
Outline for Workshop

Screening and monitoring treatment for anxiety disorders and comorbid disorders

Treatment planning

Modifications of CBT for anxiety disorders

Medication treatment for anxiety disorders and comorbid disorders

A team approach: Working with parents and schools

Case examples and challenges in treating children with anxiety disorders
9:00 am – 11:45 am
Overview
Normal Worries, Stress and Risk Factors
Indicators of Anxiety and Stress Disorders
Screening & Assessment Tools
Treatment Planning/Interventions
Lunch: 1 hour break 11:45 to 12:45
12:45 pm – 4:00 pm
Interventions Continued
Adaptations for Young Children
Involving School and Family
Case discussion
4:00 pm Evaluation

Normal Worries & Stressors

- Normal Fears and Worries
- Stressors and Transitions

Normal Fears and Worries

Infants:
- Fear of loud noises, being dropped or startled, loss of support, separation from mother
- Fear of strangers (child learns difference between others and primary caregiver)

Toddlers:
- Fear of imaginary creatures (monsters), small animals
- Fear of darkness
- Separation anxiety

Elementary school-age:
- Fear of physical injury
- Fear of natural events (storms)
- Fears about school

Teenagers:
- Fears of social evaluation and school performance

Fears are adaptive and develop in response to perceived dangers, but become problematic if they do not subside with normal development and if they impair the child’s functioning

Common Stressors and Transitions in Young Children

- Birth of new sibling
- Divorce
- Family move
- Close relative or friend moves away
- Loss of pet
- Death of relative
- Transition to daycare or pre-school
- Starting KG
- Riding school bus

Tips to Reduce Stress & Anxiety: Everyday Life Situations

- Schedule in down-time for yourself and child
- Take time to listen and talk with your child
- Help your child identify strengths and provide opportunities to develop these
- Focus on only a few extracurricular activities at a time and allow child to have fun and develop competence
- Take walks, exercise together as a family
- Make time to eat meals together or create other family rituals
### Traumas That May Cause Significant Stress and Anxiety
- Car accidents
- Fires
- Tornadoes or other Natural disasters
- Repeated medical procedures
- Robberies or Break-ins
- Violent Injury or Witness to Violence
- Domestic Violence or Verbal Abuse
- Physical Abuse, Sexual Abuse, Neglect
- War
- Media exposure to frightening images/trauma (violence, disasters, war, horror movies)

### Tips to Reduce Stress & Anxiety: Traumatic Events
- Establish safety/prevent further trauma
- Parents need to model healthy coping and seek support/help if needed
- Encourage child to talk about fears and worries and take time to listen
- Provide reassurance and keep up regular family routines
- Help child to develop healthy coping strategies or seek help if needed

### Symptoms of Significant Stress and Anxiety in Children
- Recurrent fears and worries
- Difficulty falling asleep or nightmares
- Hard to relax
- Extreme difficulty separating from parents
- Scared about going to school
- Frequent irritability, crying, tantrums
- Uncomfortable in social situations at school, eating with others, at parties
- Unable to recover after stressor or trauma or remains chronically irritable or withdrawn

### Anxiety Disorders in Children and Adolescents
- Very common: 8-10% of youth have at least one anxiety disorder
- Runs in families (Genetics and modeling)
- Co-occur with ADHD in children, and depression and substance abuse in teens
- Can persist into adulthood
- Treatments are available and effective: Cognitive-behavioral therapy and medication
- Early identification and treatment can reduce severity and impairment in social and academic functioning

### Risk and Protective Factors
#### Biological and environmental risk factors
- **Biological**: genetics, parental anxiety disorders, and temperament (shy, BI)
- **Environmental**: parent-child interactions (parenting styles, reinforcement and expectations, attachment), parental anxiety disorders, modeling, stressors and trauma

#### Protective factors
- Active, problem-focused coping skills, distraction strategies (vs avoidant coping)
- Social supports
- Family supports, family coping style

### Risk Factors in Children with Anxiety Disorders
- Genetic factors associated with propensity toward fearfulness
- Greater autonomic reactivity in response to stress & different patterns of cortisol regulation in children with anxiety disorders
- Environmental factors may determine presence of specific fears and specific anxiety disorder.
Common Co-Occurring Disorders
- ADHD (30%): Inattention, restlessness (also with PTSD)
- Depression (28% to 69% increases with age)
  - Poor concentration, sleep problems, somatic complaints
- Substance Abuse in young children in utero exposure when parents have anxiety disorders and substance abuse
- PDD social awkwardness, social communication deficits, repetitive behaviors, adherence to routines
- Reactive Attachment Disorder
- Learning Disorders
  - Worry about school performance, Dyslexia
- Language Disorders: Social communication, avoidance
- Oppositional Defiant Disorder:
  - Distinguish from avoidance behaviors
- Bipolar: Inattention, restlessness, irritability, poor concentration, trouble sleeping

Tools for Screening and Measuring Progress

Screening for Anxiety Disorders
- Childhood anxiety disorders are common and often co-occur (8-10%)
- Routinely include screening for anxiety symptoms as part of any child and adolescent evaluation
- Obtain information from multiple informants (child, parent, school)

Tools for Screening and Measuring Progress: Anxiety Disorders
- BASC and CBCL are good broad band measures that can be completed by child, parent, and teacher and assess externalizing and internalizing symptoms
- MASC (March et al., 1997) and SCARED (Birmaher et al., 1999) are good self-report anxiety measures for 8 years and older
- These screening measures sensitive to change & treatment progress

Tools for Screening and Measuring Progress: Comorbid Disorders
- CDI is a good self-report for depression
- Conner’s is a good parent and teacher report for ADHD
- Both of these are sensitive to change & treatment progress
- Screen for substance abuse
- Consider LD, language disorders

T-Scores And What They Mean
- Mean T-score = 50
- Standard deviation (sd) = 10
- T-scores from 40-60: Average range
- 65-70: Borderline significant (top 5%)
- 70 or higher: Clinically significant (top 2%)
- T-scores 39 and below: Low
- Train clinical team to score and interpret these screening measures: CBCL or BASC (broad-band), MASC (anxiety), CDI (dep), Conner’s (ADHD)
Screening Measures for Young Children
- ITSEA
- CBCL version 1-1/2 to 5 years
- BASC-2
- Preschool Anxiety Scale
- Conners’ Rating Scale (ages 3-5)

Infant Toddler Social-Emotional Assessment (ITSEA)
- Au: Carter & Briggs-Gowan, 2000
- Also has shorter version: Brief ITSEA or BITSEA
- 12-48 months old
- assesses social-emotional/behavioral problems and competencies

Child Behavior Checklist (Achenbach, 2004)
- Ages 1 1/2 - 5 years
- Parent version & Caregiver version
- Includes cross-informant syndromes
- Includes a Language Development Survey
- Includes DSM profiles
  - Affective, Anxiety, Pervasive Developmental, ADHD, ODD

Behavior Assessment System for Children, 2nd Edition (BASC-2)
- Available through American Guidance
- Ages 2-0 through 21-11 years
- Parent & Teacher versions for younger ages
- Admin. Time: 10-20 min
- Yields standard scores

Preschool Anxiety Scale (Spence, 2001) - Screening measure
- Parent-report for 3-5 year olds
- Means and SDs (not norms yet)
- Provides overall measure of anxiety plus
  - Separation anxiety
  - Physical injury fears
  - Social phobia
  - Obsessive compulsive
  - Generalized anxiety disorder

Selective Mutism Questionnaire (R. L. Bergman Ph.D.)
- Parent report and teacher report
- Items relate to situations in school, with family, in social situations outside school, and “other” situations
- Parents rate how often child interacts with others
- Behavior and interference ratings
- Research measure under development
Assessment of Anxiety Disorders

- ADIS-C
- Differential Diagnosis
- Severity and Impairment

ADIS-DSM-IV-Child Version

- ADIS-DSM-IV-Child Version (Silverman & Albano, 1996) for youth 6-17 years old to supplement clinical interview
- Considered Gold Standard
- Feelings Thermometer to assess severity, functional impairment (interference), and monitor progress
- Developmentally appropriate language and situations that apply to youth
- Assessment of commonly comorbid disorders (ADHD, depression, dysthymia)

Differentiating Anxiety Disorders

- SAD
- GAD
- Social Phobia
- Selective Mutism
- Specific Phobia
- Panic Disorder
- OCD
- PTSD

Differentiating from Physical Conditions

- Physical conditions with anxiety-like symptoms: hyperthyroidism, caffeinism (soda), migraine, seizure disorders, lead intoxication, pheochromocytoma, cardiac, etc.
- Medication side effects: prescription (antiasthmatics, steroids, sympathomimetics) and non-prescription drugs (cold medicines, antihistamines)
- Somatic symptoms commonly associated (stomachaches, headaches), consider MHA early in medical evaluation

Differential Dx: Psychiatric

Psychiatric conditions (similar symptoms):
- ADHD (restlessness, inattention)
- Psychotic disorders (restlessness, social withdrawal)
- PDD (social awkwardness, social communication deficits, repetitive behaviors, adherence to routines)
- LD (worries about school performance)
- Bipolar disorder (restlessness, irritability, insomnia)
- Depression (poor concentration, sleep problems, somatic complaints)
**Tools to Assess and Monitor Severity and Impairment**

- **Feelings Thermometer** to assess severity, functional impairment (interference), and monitor progress.
- **Feelings Barometer** can include faces rather than numbers, or link the two.
- Choose developmentally appropriate tool; young children may use 1-2-3 faces scale.

**Example: Screening 3 year old boy**

- Unable to speak at settings outside home despite good language development at home.
- Can be very stubborn and has tantrums if things are not the way he wants.
- Family history of anxiety.
- CBCL parent 1-1/2 – 5 years.
- CBCL teacher 1-1/2 – 5 years.
- SMQ parents and school.

**Example: 3 year-old boy continued**

- **Diagnoses:**
  - Selective Mutism
  - Social Phobia, with OCD features

**Developmental Considerations**

**Preschool children**

- Clear subtypes of anxiety may be less differentiated than school-age and older.
- Clinical impact of symptoms may be significant despite not meeting full criteria.

**Separation Anxiety Disorder**

- Excessive fear and distress when separated from parents/primary caregivers or home.
- Worry about parents’ health and safety.
- Difficulty sleeping without parents.
- Difficulty alone in another part of the house.
- Complain of stomachaches and headaches.
- May refuse to go to school or playdates.

**Generalized Anxiety Disorder**

- Excessive, chronic worry related to school, making friends, health and safety of self and family, future events, local and world events.
- Also has at least one of these symptoms: motor/muscle tension, fatigue, difficulty sleeping, irritability, poor concentration.
- Often perfectionists.
- Anxiety may be significant, but not apparent to others.
- Physical complaints are common.
GAD: Additional features

- Excessive self-consciousness, frequent reassurance-seeking, worry about negative consequences
- Perfectionistic, excessively critical of themselves, persistent worries
- Common somatic complaints: GI distress, headaches, frequent urination, sweating, tremor

Social Phobia (Social Anxiety Disorder)

- Excessive fear or discomfort in social or performance situations
- Extreme fear of negative evaluation by others
- Worry about doing something embarrassing in settings such as classrooms, restaurants, sports, musical or speech performance
- Difficulty participating in class, working in groups, attending gym, using public rest rooms, eating in front of others, starting conversations, making new friends, talking on the phone, having picture taken

Social Phobia

- Commonly feared social situations:
  - Public performances (reading aloud in front of class, music/athletic performances),
  - Ordinary social situations (starting or joining conversations, speaking to adults)
  - Ordering food at restaurants, attending dances and parties, taking tests, working or playing with other children, asking teacher for help (Beidel et al. 1999)
- Diminished social skills, longer speech latencies, fewer or no friends, limited activities, school refusal (Beidel et al. 1999)

Selective Mutism

- Unable to speak in certain situations (school) despite able to speak in other settings (home)
- Difficulty speaking, laughing, reading aloud, singing aloud in front of people outside the family or their “safe zone”
- Speech/language development normal, but may have some speech/language difficulties
- Parents or siblings often speak for the child
- Often have symptoms of social phobia as well

Selective Mutism

- Transient mutism during transitional periods: first month of school or move to a new home
- Relationship between SM and Social Phobia
- Associated features: excessive shyness, fear of social embarrassment, social isolation, clinging, compulsive traits, negativism, temper tantrums, controlling or oppositional behavior, particularly at home

Specific Phobia

- Excessive fear of a particular object or situation
- May avoid the feared object or situation
- If a fear is severe enough to impair a child’s functioning, then it is a phobia
- Common phobias: animals/insects, heights, storms, water, darkness, blood, shots, traveling by car/bus/plane, elevators, loud noises, costumed characters, doctor or dentists, vomiting, choking, catching a disease
### Specific Phobia
- Anxiety may be expressed through crying, tantrums, freezing, clinging
- Three factors:
  - Animal phobias: tachycardia (sympathetic activation)
  - Blood-injection-injury phobias: bradycardia (parasympathetic activation)
  - Environmental or situational phobias: cognitive symptoms such as fear of going crazy or misinterpretation of body symptoms

### Panic Disorder
- Recurrent panic attacks or intense fear:
  - Racing heart, sweating, shaking, difficulty breathing, nausea, dizziness, chills/flushes, numbness/tingling, fear of dying/going crazy
- Eventually child feels frightened “out of the blue” or for no reason at all
- Can lead to avoidance of situations due to fears of having a panic attack

### Panic Disorder
- Full panic disorder best documented in adolescents
- Panic attacks in younger children are usually cued or triggered by specific event of stressor, with out-of-blue attacks rare

### Differentiating the Specific Childhood Anxiety Disorders
- GAD and Social phobia
  - Worries of GAD is pervasive, and not limited to specific object (Specific phobia) or social situations (Social phobia)
  - GAD anxiety is persistent, Social phobia anxiety dissipates upon avoidance or escape of social situation
  - Worries about quality of relationship with GAD versus embarrassment and social evaluation fears with Social phobia

### Differentiating Anxiety Disorders: Clinical Points
- Cued panic attacks can occur with any of the anxiety disorders in youth, and common among adolescents
- Irritability and angry outbursts may be misunderstood as oppositionality or disobedience
- Tantrums, crying, stomachaches, headaches common in children with anxiety
- Children (versus adults) may not see fear as unreasonable

### Post-Traumatic Stress Disorder
- Clinical Symptoms
- Developmental Considerations
- Impact of trauma early in life
Post-Traumatic Stress Disorder

- Exposure to a traumatic event that involved possible death or injury to self or others (may be victim, witness, hear about)
- Re-experiencing of traumatic event (intrusive thoughts, nightmares, distress with reminders)
- Avoidance of stimuli associated with trauma and numbing of general responsiveness (foreshortened future, lack of interest, lack of facial expressiveness)
- Persistent increased arousal (difficulty sleeping, irritability/outbursts of anger, poor concentration, hypervigilant, easily startled)

Proposed criteria for PTSD in preschool children (Scheeringa et al., 2003)

- Less dependent on verbalizations and more clearly focused on behavioral manifestations
- More developmentally relevant
- Includes new cluster of symptoms and requires at least one of the following:
  - 1) New separation anxiety
  - 2) New onset of aggression
  - 3) New fears without obvious links to trauma, such as fear of going to the bathroom alone or fear of the dark

PTSD Symptoms in Children (Lenore Terr, 1991)

- Repeated memories of the event: visualization or “re-seeing” aspects of the trauma (esp. when quiet, nighttime)
- Behavioral enactments and repetitive play
- Trauma-specific fears
- Pessimistic attitudes about people, life, & future: hopelessness and difficulty forming close relationships

PTSD Symptoms at Different Ages and Developmental Stages

- No child is too young to develop PTSD
- Infants: Irritable; sleep problems; diarrhea; & frequent physical illness
- Preschoolers: Increased dependency; separation anxiety; irritability; traumatic drawings, stories, & play; sleep problems (fear of dark, nightmares, frequent awakening); may blame self

PTSD Symptoms at Different Ages: Children

- Elementary school age:
  - More typical PTSD symptoms
  - May show less somatic symptoms
  - Vacillate between withdrawn, friendly, and aggressive.
  - Guilt may be present

PTSD at Different Ages: Adolescence

- Overly compliant or withdrawn
- Aggressive, substance abuse, & sexual acting-out
- At risk for depression, suicide, overdose
- Chronic traumas at risk for dissociation and self-injury
- Guilt may be prominent (harder to treat, increased anxiety)
- Separation anxiety may be present
Developmental Effects of Early and Severe Trauma

- Elevated levels of stress hormones
- Impaired brain growth (smaller volume)
- Impaired memory processing
- Impacts all functions of the brain: emotional, cognitive, behavior, physiological
- Increase psychiatric and physical illness
- Disorganized attachment and dissociation when parental disorganization from unresolved grief

Effects of Early and Severe Trauma in Young Children (NCTSN)

- Impaired affect regulation
- Parent and child may serve as traumatic reminders
- New negative attributions based on trauma experience (traumatic expectations)
- Disturbances in quality of attachments
- Impaired readiness to learn
  (Alicia F. Lieberman Ph.D., AACAP 2005)

Factors that Influence Development of PTSD

- Child’s subjective experience of event
- Nature of the trauma (violent or not)
- Proximity, Severity and Duration
- Age when occurred
  - Child’s prior inner resources and coping style
  - Family psych history
  - Family support following trauma
  - School support

Impact of Domestic Violence in Infants and Young Children

- Expectation of protection from attachment figure is shattered
- Protector becomes the source of danger
- "Unresolvable fear": Nowhere to turn for help
- Contradictory feelings toward the parent
- Fear of mother, fear of losing mother
- Protectiveness of mother, anger at mother
  (Alicia F. Lieberman Ph.D., AACAP 2005)

Impact of Exposure to Domestic Violence in Young Children

- RELATIONSHIP WITH FATHER
  - Longing for absent father
  - Idealization of absent father
  - Fear of father
  - Identification with the aggressor
    (Lieberman & Van Horn, 1998, AACAP 2005)

Obsessive Compulsive Disorder

- Obsessions: Scary, bad, unwanted or upsetting thoughts, impulses, or pictures that keep coming back over and over
- Examples of obsessions: Aggressive obsessions, contamination, doubting, nonsensical thoughts, hoarding/saving, religious, symmetry/exactness, violent thoughts/images, thoughts about sex, thoughts of death/dying
- Child tries to ignore or suppress the thoughts, impulses, or images
Obsessive Compulsive Disorder

- **Compulsions**: repetitive behaviors or mental acts (praying, counting, repeating words/numbers silently) that the child feels compelled to do in order to stop discomfort/anxiety of obsessions
- Examples: Cleaning/washing, checking, counting, hoarding/collection, repeating words/numbers silently, ordering/arranging, praying, seek reassurance, touching/tapping, “tell on yourself”, “just right”
- Persistent obsessions, compulsions, or both that occupy more than 1 hour each day
- Repetitive and difficult to control

OCD: Essentials of Criteria

- **Obsessions**
  - recurrent and persistent ideas, thoughts, impulses or images
  - Experienced as intrusive & inappropriate
  - Cause marked anxiety or distress

OCD: Essentials of Criteria

- **Compulsions**
  - Repetitive and intentional behaviors (or mental acts)
  - Performed in response to obsessions
  - Or according to certain rules that must be applied rigidly
  - Meant to neutralize, reduce discomfort, or prevent a dreaded event or situation
  - Obsessions create anxiety which is relieved by compulsive rituals

OCD: Some Clinical Points

- Doubting, need to be on time, look just right can be part of other anxiety disorders too
- Children with PTSD may also have rituals that resemble OCD to organize their world and give them some sense of control of events
- Children with OCD may have tantrums and meltdowns when it is hard to “shift gears”
- **Also need to rule out autism/PDD (not same fear of something bad happening)**
- Consider if triggered by Strep infection and if associated with tics/Tourette’s/ADHD

OCD: Neuroanatomy

- Frontal Cortex
- Basal Ganglia
- Motor Cortex
- Thalamus

Postulated Infectious/Autoimmune Etiology

- Pediatric Autoimmune Neuropsychiatric Disorders Associated with Strep. = **PANDAS**
- Pediatric Infection-Triggered Autoimmune Neuropsychiatric Disorders = **PITANDs**
PANDAS Pathophysiology

Infection (group A beta-hemolytic strep.)

\[\text{Immune Response (antibodies produced)}\]

\[\text{Reversible (?) Lesion of Basal Ganglia}\]

\[\text{OCD and/or tics}\]

Treatment Planning for Childhood Anxiety Disorders

**Age, severity, impairment, and comorbidity**

- **Mild severity**: Consider CBT first
- **Mod-severe**: Medications considered for acute relief of anxiety, partial response from other treatment, comorbid disorders that may benefit from meds and multimodal approach
- **Severe**: Combination intensive treatments with CBT and medications may be necessary
- **Older youth, depression, and social withdrawal** often need intensive treatment
- Involve child and family in treatment planning

**Treatment Planning Continued**

*If Parental Anxiety Disorders Present:*

- Teach parents anxiety reduction skills
- Consider if independent treatment of parental anxiety disorders needed (meds, therapy)
- Consider additional parental involvement with younger child
- Older youth - depression, social withdrawal, substance abuse often need intensive focus

**Child-Adolescent Anxiety Multimodal Study (CAMS)**


- 488 children (7-17y): SAD, GAD, Social Phobia
- 14 sessions of CBT, sertraline to 200mg/day, combination CBT and sert, or 12 weeks of placebo.
- Very much or much improved on CGI-Improvement scale: 81% combination, 60% CBT, 55% sertraline, 24% placebo
- Both CBT and sertraline reduced severity of anxiety in children with anxiety disorders, combination had superior response rate

**Treatment Planning**

- **Psychoeducation** - with the child and parents about the illness and principles of CBT
- **Parent training** - To establish daily structure, expectations, positive reinforcement, monitoring of symptoms and progress at home
- **Case management that includes contact with the school**
CAMS Study
- No increased frequency of physical, psychiatric, or harm-related adverse events in sertraline vs. placebo groups
- Suicidal or homicidal ideation was uncommon, no child attempted suicide
- Youth with ADHD were included. Youth with depression or PDD were excluded
- Combination therapy offers best chance for positive outcome: consider family preference, cost, treatment availability.
- Placebo for sertraline only group, not for sertraline plus CBT group.

Treatment planning: 3 year old boy
- CBT strategies adapted for young child: behavioral focus and using play
- Positive reinforcement chart at home and school
- Parent guidance
- Team effort with parents, child, school and therapist
- SSRI medicine trial due to severity of anxiety symptoms, mutism
- Assertiveness skills and social skills training

Review of Exposure-Based CBT for Childhood Anxiety Disorders
- Overview of CBT
- Modify for each anxiety disorder

CBT Principles for Anxiety (Albano & Kendall)
- Psychoeducation (about anxiety and CBT)
- Somatic management skills training (self-monitor anxiety and learn muscle relaxation, diaphragmatic breathing, imagery)
- Cognitive restructuring (challenge negative thoughts and expectations; positive self-talk;)
- Practice Problem Solving Skills
- Exposure methods (imaginal and live exposures with gradual desensitization)
- Relapse prevention and booster sessions

Modular Approach to CBT (Chorpita 2001)
- Toolbox of skills, coping strategies
- Tools tailored to fit child or family
- Learning process to gather “clues” to understand and conquer child’s anxiety
- Exposure is main ingredient

PSYCHOEDUCATION
- Involve child and parents
- Understanding anxiety disorders
- Discuss how CBT works
Psychoeducation:

Alarms and False Alarms
- Alarms (anxiety) can protect us from danger
- Anxiety disorder: Alarm a little too sensitive
- False alarms: Alarm goes off too much

Goals of treatment:
- Teach skills to identify when danger is not real: anxiety is not needed
- Identify accurately when situations are safe
- Shrink or eliminate tension, worry, fear, panic
- Encourage hope and confidence "I can do it!"
- Reduce avoidance, increase opportunities for corrective experiences.

Identifying and Monitoring Anxiety Symptoms

- Establish target symptoms
- Fear Hierarchy
- Monitor intensity and frequency

Establish Target Symptoms

- Learn to monitor feelings of anxiety
- Establish level of distress
- Develop Fear Ladder of feared stimuli (situations, objects, cues, sensations) within primary diagnosis
- Child rates each on the Fear Thermometer
- May also rate with parents

Monitor Intensity & Frequency

- Child: Regular self-monitoring of anxiety
- Also monitor: mood, related behavior and avoidance
- Parents: Establish baseline and monitor progress in intensity and frequency
- Learning to record date, situation, anxiety symptoms in a treatment notebook
- Fear Ladder and Feelings Thermometer

Somatic Management Skills Training

- Diaphragmatic breathing
- Muscle relaxation
- Imagery

Identify Feelings of Anxiety

- Identify somatic symptoms of anxiety: Stomachaches, headaches, muscle tension (anticipatory anxiety)
- Identify body's physical response to perceived danger or fear:
  Heart racing, breathing fast, sweating, frequent urination
- Make a list of child's anxiety "body feelings": Use picture of body to pinpoint how symptoms develop (see handout).
**Diaphragmatic Breathing**
- Therapist demonstrates “belly breathing”
- Place hands on abdomen during inhale/exhale to assist with learning
- Inhale through nose, exhale through mouth
- Accept any deep breathing initially
- Blowing bubbles with young children

**Muscle Relaxation**
- Stiff and tense muscles versus relaxed
- Practice tightening and relaxing to appreciate the difference: squeezing lemons, turtleshell, putting on the brakes (Coping Cat, Kendall)
- Progressive muscle relaxation, scripts, tapes,
- May use imagery to identify tense areas and assist with relaxing muscles

**Relaxing Imagery**
- Relaxing colors
- Relaxing “place” in child’s mind (detailed image under child’s guidance)
- Make a relaxing tape together
- Relaxing images, posters in bedroom
- Tape relaxing images to notebook (e.g., pet)
- Relaxing color swatches in desk or cubby

**Cognitive Restructuring**
- Challenge Negative Thoughts
- Challenge Negative Expectations
- Positive Self-Talk

**Cognitive Distortions**
- Youth with anxiety disorders:
  - Assume bad things will happen
  - Biased attention to threatening words and criticism
  - Interpret ambiguous situations as threatening
  - More negative self-talk
  - Underestimate their strengths
  - Assume they cannot handle stressful situations
  - Catastrophic thinking: Assume the worst

**Cognitive Restructuring: Goals**
- Identify negative thoughts that predict bad things will happen- thinking traps
- Evaluate negative thoughts to determine if they make sense
- Use realistic positive self-talk to argue with negative thoughts and boss them back.
- Replace thinking traps with coping thoughts
Cognitive Restructuring: Probability Overestimation

- Estimate probability of good and bad things happening (events) from 0 to 100
- Thoughts are predictions/guesses about the future: sometimes they are right, sometimes wrong
- Always predicting things will go badly versus evaluating evidence for the predictions
- Set of questions:
  - What is your thought/prediction?
  - How likely does it feel? (0-100)
  - What are alternative thoughts?
  - What is the proof?
  - How likely is it really? (0-100)

Cognitive Restructuring: Catastrophic Thinking

- Catastrophic thoughts are a type of thought where child fears that something terrible will happen and will not be able to cope with it.
- Usually worse than would really happen, and child really can cope with it.
- If the worst thing really happened:
  - How terrible would it be? What is terrible for you about that?
  - Would you be able to cope? Have you cope with something similar? Evidence you can?
- These questions can be applied regularly to catastrophic thoughts

STIC Tasks

- Show That I Can (STIC) tasks are homework
- Recognizing feelings in self and others
- Checking out how body reacts to anxiety
- Learning to be comfortable and relaxed
- Recognizing negative/bad thoughts & other thoughts
- Learning strategies to target bad thoughts
- Attitudes (self-talk) that can help child cope with thoughts
- Actions (relaxation) that can help child cope with feelings

CHAT Plan

- Check out how my body is feeling
- Having Bad Thoughts
- Attitudes and Actions that can help
- Time for a Reward

CHAT PLAN: Check Out How My Body Is Feeling

- Recognizing feelings (distinguishing between fear, sadness, anger)
- Body cues that indicate anxiety or muscle tension (physical symptoms of anxiety)
- Choose members of “helping team” that can assist child to reduce anxiety
- Learning to be comfortable and relaxed
- Deep breathing, muscle relaxation, imagery
- Physical reactions as cues to begin relaxation

CHAT PLAN: Having Bad Thoughts

- What am I thinking? Saying to myself in anxious situations (self-talk)
- Recognizing thoughts that make child feel more anxious or worried
- Thoughts are not always accurate
- Alternative thoughts/ Different thoughts
- Different thoughts can lead to different feelings and actions
- Challenging negative thoughts and expectations
CHAT PLAN: Attitudes and Actions That Can Help

- Problem solving
- What to do when you feel anxious or scared

- **Attitudes** are good thoughts (self-talk) that will help stop bad thoughts

- **Actions** are things child can do to help feel better or have better thoughts

CHAT PLAN: Time For A Reward

- Self-evaluation and Reward
- Learning to evaluate self fairly
- Self-evaluation based on effort, not results
- Feeling competent and able to tackle challenging situations

Example STIC Task

- **Situation:** Getting allergy shots each week
- **My body's reaction:** tense, sweaty, SOB, hi HR
- **Anxious thoughts:** I will have a bad reaction to the shot. I will get very sick and might die. **Other thoughts:** I might not die. I might get through it.
- **Actions that can help:** use relaxation strategies, distraction by playing with brother, listening to music in car and waiting room to decrease anxiety build-up
- **Attitudes that can help:** Doctor is there and can assist if reaction does occur (very low probability). Shots help to reduce reactions. I have never had a reaction and get shots every week. I can handle this! I will not let my worry take control!
- **Rewards:** hot chocolate, ice cream treat or buy a book at Bordens

Coping Bag or Coping Kit

- Calming photos or relaxing images
- Squooshy balls or things to keep hands busy
- Notecard with positive “self-talk” statements
- Relaxing songs (Ipod etc)
- A favorite book to read
- Coloring or sketching supplies
- Relaxation script

Modifications for Younger Child

- Scripting positive self-talk and role-play with puppets, toy characters in session and at home with parents until comfortable trying independently
- “Cheerleading” to practice positive self-talk
- Giving negative thoughts or anxiety a “name”
- Use super hero strengths to boss-back or fight worry or negative thoughts
- Positive reinforcement plan with tangible reward critical: Consistent and often

EXPOSURES

- Graded Exposures
- Imaginal and In-Vivo Exposures
- Integrating CBT Strategies
## Anxiety and Avoidance
- Exposures allow children to practice what they are afraid of and see that bad things they fear do not usually come true.
- Avoidance does not allow for this experience.
- Avoidance increases anticipatory anxiety.
- The therapist role is to teach coping strategies, then support and guide the child to try exposures.
- Eventually things that are seen as threatening can be seen as safe.

## Exposures
- Graded so child can experience success and build confidence (not flooding).
- Explain that discomfort is part of exposure.
- Begin with relaxation exercise to start with anxiety at low level.
- Review coping strategies.
- Establish reward system.
- Move from easiest to most challenging items on Fear Ladder.
- Therapist should avoid too much reassurance during exposure.

## Graded Imaginal Exposure
- Child imagines item or situation from Fear Ladder/Hierarchy in detail.
- Begin with easy items to more challenging.
- Child notes intensity on Fear Thermometer.
- Bring anxiety to 2 or below before next item.
- Ask: Did anything terrible happen?
- Praise often. Reward for efforts & successes.
- Incorporate relaxation and self-talk learned to reduce anxiety.
- Adjust frequency, intensity of sessions based on success.

## Graded In Vivo or Live Exposure
- Can begin with imaginal or live exposure, depending on what child can tolerate without feeling overwhelmed.
- Exposures: imaginal, models, films, pictures.
- Promote success by asking child to check fear thermometer often.
- Proceed with graded exposure and use coping strategies to reduce anxiety.
- Praise and reward.
- Adapt coping strategies to meet needs.
- Give homework to practice exposures.

## Exposure/Fear Ladder
- Goal is to gradually expose child to anxiety-provoking stimuli (situations, objects, cues, sensations). Venturing outside “talking zone”.
- **Target behavior** to work towards that is challenging but realistic.
- **Little step activities** to help get more comfortable up to target behavior.
- **Rate each little step** from least to most anxiety-provoking (fear hierarchy).
- Involve child, parent, school team.
- Separate Fear Ladder for different diagnosis.

## Develop a Reward System
- Reward system will be different for each child.
- Rewards need to be motivating for child.
- Work with child on reward for each little step.
- Can earn points for little steps and cash in at various points for rewards of different values.
- Coordinate positive reinforcement plan or sticker chart with parent and school team.
- Important to reward frequently and experience success often.
- The younger the child the more frequent rewards are needed.
Implement Exposure Ladder

- Start off slowly and let child practice each little step until comfortable
- Master one little step before moving to next
- Allow child to go at his/her own rate
- Make changes in ladder as needed so child experiences SUCCESS
- Include child to determine realistic little steps
- Develop new exposure ladders as target behavior is mastered

Appreciating Accomplishments: Rewarding Self

- Children with anxiety tend to underestimate their capabilities and accomplishments
- Part of CBT is learning to reward self (initially may need rewards from others and structured plan to monitor self-rewards)
- CBT programs reward child with frequent praise and concrete rewards
- Fun activity, certificate of accomplishment, or videotape to share with others

Booster Sessions and Relapse Prevention

- Review progression from anxiety to coping (drawing or videotape)
- Review what has gotten better, what remains
- Discuss strategies to address what remains
- Emphasize progress as related to child and family efforts, not therapist
- Praise child for practicing and family for coaching
- Addressing Lapses and preventing Relapses
- Check ups and booster sessions

Beyond Standard CBT

- Social skills training
- Assertiveness skills
- Self-esteem
- Working with parents and schools

Social Skills: Meeting and Greeting New People

- Having a conversation: taking turns asking, telling, saying something and listening
- Role-play situations with child or teenager
- Practice with a friend and new children
- Coordinate with school staff (lunch group)
- Involve parents in sessions in younger child

Social Skills: Nonverbal Communication

- Importance of nonverbal communication and improving conversation skills
- Personal space
- Eye contact
- Speaking voice (volume)
- Involve parents in sessions for younger child
Assertiveness Training

- Many anxious children work hard to always please others and avoid conflicts
- May fear something bad will happen if they upset others or just discomfort
- More likely to be bullied
- Child works on identifying own needs and negotiating these with children and adults
- Review assertiveness strategies, role-play in session, then carry out exposures
- Can use toys, puppets with young children to practice. Involve parents in sessions.
- Use relaxation, coping strategies and fear ratings during role-play

Assertiveness Training: Example

- 6 y.o. girl with GAD, SAD, Turner’s & small stature. Often picked up by other children and girls fight over her not allowing her to play with other peers. Sometimes children hold her down. Led to school phobia. She fears other children will be punished if she tells.
- Practiced using loud voice, mean face and posture in session. Role-play with peers who are pushy and demand her to listen.
- Practiced turning on “drama” when child annoying her and will not accept no to get teacher’s attention
- Coordinated plan with school regarding practicing assertiveness and monitoring of bullying by teacher in classroom and especially at recess.
- Patient has benefited greatly from CBT, low dose SSRI.

Building Self-Esteem

- Gradually gaining sense of competence in various situations
- Identifying and considering one’s own thoughts and feelings versus relying on guidance/perspective of others
- Learning to accept compliments

Working with Parents and Schools

- Active Ignoring
- Rewards
- Involving Parents in CBT with child
- Working with Schools
- Family treatment

Working with Parents and Teachers: Active Ignoring

- Active reinforcement of positive behaviors
- Active ignoring of unwanted behavior to extinguish (complaining, reassurance-seeking, crying, whining, somatic complaints)
- Role-play with parents, discuss with teachers
- Temporary increase in problem behavior, does not mean they should give in
- Reduces children depending on adults rather than trying new coping skills

Working with Parents and Teachers: Rewards

- Child chooses meaningful rewards
- Small, inexpensive, or preferred activity
- Reinforcement after desired behavior
- Short list of desired behaviors (fear ladder)
- Substitute new behaviors as mastered
- Timely, consistent rewarding
- Coordinate reward system between home & school
- Post in visible location at home; teacher keeps in desk at school
- Child learns self-praise over time
Involving Parents in Treatment

- Parents with anxiety disorders can benefit from anxiety management skills/treatment and can improve effectiveness of CBT in child
- Parents may be overprotective, controlling, or facilitate avoidant responses
- Parents included in child’s treatment as “coaches” to assist child in coping with current and future anxiety issues

Parent Involvement

- Learn how to handle child’s anxiety
- Learn graduated exposure and how to use it
- Modify view of child as vulnerable and in need of protection or control
- See child as resilient and capable of coping
- Help parent to feel knowledgeable and skilled enough to help the child cope with future challenges
- Involve all relevant caregivers to increase consistency of response to anxiety

Parent (Teacher) Involvement

- Parents (teachers) can model calmness and problem-solving approaches
- Find middle ground: encourage the child to approach feared situations and give child control over pace that is tolerable
- Give prompts, but resist need to “rescue”
- Focus on small, positive steps, build courage, competence, and autonomy for child

School Interventions for Anxiety

- School personnel who child can meet with regularly and be available to help child calm
- Discourage leaving school (fever or vomiting)
- Encourage self-monitoring with Feelings Thermometer
- Coping bag available if needed
- Reinforce attempts to use relaxation/coping skills as well as successful coping
- Desensitization program with graded exposure
- Regular contact & coordination with parents

School Interventions for Students with Anxiety

- Modified assignments
- Comprehension checks
- Identify adult at school outside classroom who can meet with child and engage in problem-solving or anxiety management strategies
- School staff prompt child to use coping strategies prior to school triggers (tests, recess, starting assignment)
- Testing in private, quiet place to reduce anxiety
- Educate teacher about child’s anxiety and suggest strategies to facilitate child’s coping (reframe)
- Children with anxiety disorders might qualify for a Section 504 plan or special education if significant impact on school functioning (handout)

Family Interventions

- Family structure and process, vs individual
- Clarifying roles, boundaries, power in the family
- Parental emotional overinvolvement
- Parental criticism and control
- Family communication
- Impact of child anxiety on parent behavior
- Integrative models (Dadds & Roth, 2001)
- Interaction between attachment and parent-child learning process, behavioral and temperamental characteristics of child and parent
- Consider impact on siblings
Family Interventions Can…

- Address risk factors such as parental anxiety, insecure attachment, parenting styles.
- Improve parent-child relationships
- Strengthen family problem solving
- Strengthen family communication skills
- Foster parenting skills that encourage healthy coping and autonomy in anxious child

Thought, Feelings, Actions

Applying CBT Principles to the:
- Presentation of anxiety disorders
- Exposure/Fear Ladder
- Treatment of anxiety disorders

CBT Model of Anxiety: Anxiety’s Three Components (S. Francis, 2004)

- Cognitive: think
- Physiological: feel
- Behavioral: do

Evidence-Based Treatment Approaches

Cognitive therapy
- Relaxation
- Exposure and practice
- 10 - 16 weeks
- manual-based

Exposure/Fear Ladder

- Goal is to gradually expose child to anxiety-provoking stimuli (situations, objects, cues, sensations).
- Target behavior to work towards that is challenging but realistic
- Little step activities to help get more comfortable up to target behavior
- Rate each little step from least to most anxiety-provoking (fear hierarchy)
- Involve child, parent, school team
- Separate Fear Ladder for different diagnosis

Separation Anxiety Disorder

Fear of harm to self or parents during separation
- Somatic complaints (stomachaches, headaches)
- Avoidance and distress (clinging, shadowing, tantrums, crying, sleeping with parents, going to school office, chronic absence)
Interventions for SAD
- Cognitive restructuring to look at fears of bad things happening when away from parents
- Exposure to feared situations away from caregivers
- Parents and school often take an active role to avoid school refusal
- Parent training to increase child’s independent functioning and sense of self-competence

SAD Fear/Exposure Ladder
- 8 y.o. boy with SAD
- Joins soccer practice with mother in car next to field
- Attend laser tag party (gets lost in the dark)
- Mother or sitter leave him alone at soccer practice (he is kidnapped)
- Mother late to pick him up at school (she forgets him and he will never go home)
- Sleep alone in his room (men who robbed family on vacation will come to hurt or kill him and his family and no one will be able to help him)

Generalized Anxiety Disorder
- **think** Excessive worry about future events, past actions, competence
- **feel** Somatic complaints (stomachaches, headaches, muscle tension)
- **do** Perfectionism, over-preparation for tests and projects, excessive slowness, reassurance seeking, tears, avoidance

Interventions for GAD
- Relaxation skills and distraction strategies emphasized for young children
- Can use positive self-talk and fight back worried thoughts (cheerleader, trick worries)
- Cognitive restructuring in older children
- Imaginal exposures common for GAD
- If perfectionistic, graded exposure can help
- Involve parents to reduce response to reassurance-seeking
- Eager to please, struggle with conflicts, physical symptoms, sleep difficulty

GAD Fear/Exposure Ladder
- **think** Feared consequence of worry, not worry itself
- **feel** Being late for school or an activity
- **do** Someone in the family gets physical illness
- **think** Making a mistake on a homework assignment
- **do** Getting less than perfect grades
- **think** Doing poorly on test as result of worry
- **feel** Saying something that upsets a sibling
- **do** Saying something that upsets a friend
- **think** Saying the wrong thing

Social Phobia
- **think** Feared consequence of attention
- **feel** and embarrassing self
- **do** Increased heart rate, shaking, sweating, hyperventilation, dizziness
- **do** Avoidance of feared social situations, pseudomaturity, school refusal
Treatment for Social Phobia

- Children with social phobia have poorer social skills and functional limitations such as few friends, low participation in activities, and avoidant coping
- CBT and additional social skills training needed to build confidence and promote positive learning experiences
- Increased social opportunities for practice

Social Phobia Fear/Exp Ladder

- Attending gymnastics class (least anxiety)
- Ordering at a restaurant
- Calling a friend to initiate an outing, playdate
- Initiating a conversation with a friend
- Initiating a conversation with a new student or unfamiliar relative
- Reading to teacher without other students there
- Reading aloud in front of the class (most)

Specific Phobia

- Excessive fear of a particular object or situation
- Increased heart rate, shaking, sweating, stomachaches
- Avoidance of the feared object or situations; running away

Treatment of Specific Phobia

- Start by improving coping skills during exposure: relaxation & cognitive modification of unrealistic fears
- Treatment focused on graded exposure
- Flooding is not recommended in children
- Modeling: observing good coping skills through films, videotapes (symbolic models) or in real life (live models).
- Participant modeling in which child assisted to directly approach feared object or situation by parent, teacher, therapist, another child

Specific Phobia of Dogs: Fear/Exposure Ladder

- Feeding a dog from child’s hand (highest fear)
- Letting a dog lick hand of parent, then child
- Parent petting dog, then assisting child to pet dog
- Visiting friend with a dog, watching friend handle dog
- Standing next to a dog while owner pets dog
- Walking on other side of street with dog
- Seeing a dog at the store
- Watching a movie about a dog (Lassie, Air Bud)
- Seeing a dog on TV

Panic Disorder

- Fears physical symptoms of anxiety (heart attack, suffocation)
- Increased heart rate, shaking, sweating, numbness, hyperventilation, dizziness
- Avoidance of places where attacks may occur (e.g., school, stores)
Panic Disorder

- Less common in young children
- Sensation of anxiety (rapid HR) lead to feeling of panic attack might begin, increased anxiety, until feeling of panic out of control
- Treatment focused on reducing fear of “triggering” sensations of panic
- Treatment of fear of physical sensations
- Exercises to simulate sensations/triggers for panic attacks

Treatment for Panic Disorder

- Psychoeducation regarding physical symptoms
- Cognitive modification of misinterpretation of physical symptoms
- Relaxation training
- Interoceptive exposure: inducing physical symptoms in sessions (dizziness, SOB, sweating), and overcoming sense of panic/doom.
- Decrease avoidance & increase control.
- Move from office to natural environment if possible to address avoidance directly.

Panic Disorder Fear/ Exp Ladder

- Induce physical feelings and expose to feared situations:
  - Holding breath and imagine going to the mall
  - Holding breath and going to the mall
  - Driving with parents, friend, by self after panic attacks frequent during driving
  - Run in place and endure panic symptoms

School Refusal

- Can be variety of fears (separation, social anxiety, test anxiety)
- Worry, tension, increased heart rate, shaking, sweating
- Frequent absence, tardiness, tears, tantrums, somatic complaints, visits to school nurse

School Refusal/School Phobia

- This is a behavior cluster, not a diagnosis
- Need to consider anxiety disorders and depression
- Consider SAD, GAD, Social phobia
- Need to rule out learning disability that can lead to frustrations, poor performance, low self-esteem. Increased risk for anxiety and depression. Dyslexia in young children.
- More common during transitions to a new school (pre-school, KG, middle school, high school)
- Assist parents to reduce secondary gains

Interventions for School Refusal

- Rule out LD and language impairments
- If depression and anxiety present, CBT and meds often needed
- Assist parents and school staff to maintain patient in school. Avoid home-bound school
- Use library or other area to calm or complete work part of day, build up in class time
- Graded exposures to school situations
- Active ignoring of unreasonable somatic complaints and reward regular attendance
- Use relaxation and coping strategies to reduce anxiety at school. Coaches at school too.
School Refusal: Fear/Exp Ladder

- Be careful not to start exposures close to vacations or holidays
- Initially work on preparing for going to school (depending on severity of fears) with live and imaginal exposures (driving past school, walking on school grounds, entering school)
- Increasing time at school, not necessarily in classroom
- Start with most comfortable setting/activity in classroom
- Work up to part of day and eventually full day
- Set up rewards for each step

Selective Mutism

**Think**

Fear of speaking in unfamiliar situations and in the presence of non-family members

**Feel**

Increased heart rate, shaking, sweating, hyperventilation, dizziness

**Do**

Unable to speak in certain situations (school) despite able to speak in other settings (home); Difficulty speaking, laughing, reading aloud, singing aloud in front of people outside the family or their “safe zone”

Treatment of Selective Mutism

Parents and school working together

Treatment for Selective Mutism

- Most children with SM have Social phobia
- Often need CBT and social skills training
- Severity often warrants medication (SSRIs)
- Management team with parents and teacher monitoring child’s communication
- Positive reinforcement for attempts on graded exposure ladder
- Steps to speaking outside “comfort zone”: Relaxed nonverbal communication, mouthing, speaking to parent, whispering to peers
- Discourage others from speaking for the child
- Videotaped modeling

CBT for Selective Mutism

- **Exposure based approach** for social anxiety
- Expanding the “safety zone” or “talking zone”
- **Social skills** and assertiveness training
- **Contingency management plan** for home and school to enhance exposures and expectancy that child will speak in public situations
- **Beyond standard anxiety CBT treatment**
- **Meeky Mouse Therapy Program** CBT program for children with SM D. Fung, A. Kenny and S. Mendlowitz Hospital for Sick Children, Toronto Canada
- **QUIET Plan** (parents) and **CHAT Plan** (child)

Selective Mutism: Fear Ladder

- Target behavior: Child reads in front of class
- Child reads to teacher & 3 peers in classroom
- Child reads to group of peers at recess
- Child speaks to teacher at recess
- Child reads with known peer outside class
- Child speaks to known peer on playground
- Child whispers to known peer on playground
- Nonverbal communication with known peer
Fear Ladder Example: Child

**TARGET BEHAVIOR:**
Child reading to teacher in the classroom

- Little step 8: Child reads to father while teacher sits at her desk grading papers
- Little step 5: Child reads to father in the classroom (no one else present in class)
- Little step 3: Child reads to father outside classroom in school (e.g., library)
- Little step 2: Child reads to father in the car (parking lot at school)
- Little step 1: Child reads to father in the car (driveway at home)

CBT Modifications for SM

- Team approach with school involved regularly
- Conversational visits
- Verbal intermediary (parent, friend, doll, toy puppet, recording device) that makes more comfortable in trying to speak/communicate. Does not speak for child.
- Positive reinforcement frequently
- Reinforce for nonverbal as well as verbal responses
- SM child can enlist strong negative response in adults (labeled as "refusing to talk")
- Parents and siblings need to resist desire to speak for child

Modifications for Young Child

- Set up opportunities for frequent rewards with stickers, ability to earn small things (pencils)
- Use child’s interests and talents: drawing, puppet play, physical activities, games to engage and create “comfort zone”
- May start with one setting: therapist, S/L room, SW or psychologist
- Can pull in some familiar friends at school for group play, exposure opportunities
- Shift gears from exposures that increase anxiety to fun activities to decrease avoidance and shut down

QUIET Plan for Parents & School

- Quest for knowledge about SM
- Using ratings to monitor mutism and communication
- Involve school as part of the team
- Exposure ladder and reward program
- Taking stock of progress

Learn about Selective Mutism

- Parents, siblings, peers speaking for SM child should be discouraged/not be allowed
- Encourage social contacts and opportunities for communication in family, friends, school
- Multimodal approach to treatment often involves CBT, meds, speech and language evaluation/treatment, social skills training
- Reinforcement for speaking with absence of reinforcement for mute behaviors
- Self modeling with audio or videotapes of self speaking

Rating Degree of Mutism

- Rate on a scale of 1 (complete mutism at school) to 13 (normal speaking) the degree of mutism
- Establish baseline
- Monitor over time
- Discuss goal of expanding the “safety zone”
13 Stages in the Emergence of Speech at School

- C. Cunningham’s work; adapted by Kenny, Fung, Mendlowitz
- Helps to establish intermediary goals in tx
- Have parents, teachers rate at what stage child is at different points in treatment
- Way to monitor progress

13 Stages in Speech Emergence in School (least to most)

1: Complete mutism at school
2: Participates nonverbally
3: Speaks to parent at school (usually when teachers or students are absent)
4: Peers see child speaking (but don’t hear)
5: Peers overhear child speaking
6: Speaks to Peer through Parent or Sib
7: Speaks softly or whispers to one peer

13 Stages in Speech Emergence in School (cont’d)

8: Speaks to one peer w/ normal volume
9: Speaks softly or whispers to several peers
10: Speaks in normal voice to several peers
11: Speaks softly or whispers to teacher
12: Speaks in normal voice to teacher
13: NORMAL SPEECH IN SCHOOL

Monitoring Communication

- List people with whom child speaks or whispers (people in talking/safety zone)
- Rate degree of distress speaking to each individual
- List situations where child speaks or whispers (places in talking/safety zone)
- Develop a chart to monitor these over time

School Management Team

- Develop school management team with parents
- Teacher, school psychologist, speech-language pathologist, principal
- Determine whether conversational visits are needed at school
- Invite person with whom child speaks to school and engage child in activity, communication

Conversational Visits

- People to visit (family, neighbor, friend)
- Times of day to visit (before school, recess, lunch, after school, evening)
- Places to visit (private setting to classroom)
- Types of activities to stimulate speech (games from home, computer, art, reading)
- Make a table of above and rate the amount of comfortable speaking encouraged by each activity
Treatment of Youth with OCD

- Modifying CBT with ERP
- Multimodal Approach

Multimodal Treatment of Youth with OCD

- Cognitive behavioral therapy (CBT) in conjunction with medications (SSRI's)
- Exposure and Response Prevention (ERP)
  Develop fear hierarchy, expose to phobic stimuli and repress rituals or avoidance
- Family therapy can help decrease the parents’ involvement in the child’s rituals and reinforcing behavior-based interventions
- Selective serotonin reuptake inhibitors (SSRI's) and Clomipramine (TCA and SSRI) are effective

Boy with OCD

- 6 year old boy with OCD
- Intrusive thoughts/fears of hurting his brother.
- Doubting: Reassurance seeking “Is this right? Am I OK?” Fears of upsetting and harming others.
- Underwear and pants have to fit “just right”. Mother has to take in all waists. Nothing can be loose fitting
- Perfectionism: Erasing, rewriting drawings, work to make it “right”. Takes lots of time. Cannot be rushed to complete things.
- Fears of upsetting God and others:
  apologizing, “I’m sorry”, Sign of the cross

How I Ran OCD Off My Land (J. March MD, MPH: March Manual)

- Psychoeducation with OCD as medical illness and engage child and family in treatment
- Define OCD as the problem: nasty nickname with plans to “boss back” OCD with therapist
- Story about OCD in child’s life: over time authors OCD out of his/her life
- Map child’s OCD: obsessions, compulsions, triggers, avoidance behaviors, consequences
- Anxiety management training
- Exposure and response prevention (E/RP) using transition zone where some success in resisting OCD (diagram)

CBT for OCD: Adaptations for Young Child

- OCD Storybook (with farm animals and OC Flea)
- Positive reinforcement program
- Readjust hierarchy to achieve success with little steps in exposures if needed.
- For young children can do imaginal exposures using puppets, toys, cartoons to practicing “bossing back” OCD
- Can adopt characteristics from superheroes that help child to defeat OCD
- Watch OCD shrink in size, make this concrete for young children in various ways
- OCD monster and worry monster are similar
OCD Exposure/Fear Ladder

- Holding doorknob (exposure) and not washing hands (response prevention)
- Moving items around in room (E) and not reorganizing before leaving the house (RP)
- Complete homework assignment without rechecking several times
- Wear socks to school that are not perfectly matching
- Arrive late to school or event and still participate
- Imaginal exposures for obsessions not associated with compulsions

Treatment of PTSD

Multimodal Treatment
Child-Parent Psychotherapy
Trauma-Focused CBT

Posttraumatic Stress Disorder or Acute Stress Disorder

- Unwanted or intrusive thoughts of a previously experienced or witnessed traumatic event (e.g., nightmares)
- Hypervigilance, distractibility, irritability
- Avoidance of situations that may provoke memories, regression to earlier stage of development

Child-Parent Psychotherapy for Trauma in Young Children

Multimodal Treatment for PTSD
Prevent further trauma, establish safety

Psychoeducation and support for parents so they can support the child.

Direct exploration of trauma/Trauma narrative:
CBT strategies such as relaxation, positive imagery, thought stopping so child can discuss trauma without fear and establish sense of competence/control.

Challenge negative assumptions: Use CBT to change attitudes such as “it’s was my fault” and “nothing is safe anymore”. Address survivor’s guilt and omen.

Medications: SSRI’s, Clonidine/Guanfacine

Child-Parent Psychotherapy Trauma-Related Goals

- Increased capacity to respond realistically to threat (battered mother may not recognize danger until too late)
- Differentiation between reliving and remembering
- Normalization of the traumatic response
- Placing the traumatic experience in perspective (encourage other activities versus focus on trauma, otherwise may let go of other aspects of life)

A. Lieberman, AACAP 2005 (NCTSN)
Balancing Trauma Treatment with Other Goals for Child-Parent Psychotx

- Trauma lens: Identify reminders, expectations and affects based on trauma experiences
- Other lenses: Focus on strengths and vulnerabilities
- Prioritize treatment goals based on the experiences and needs of child and caregiver

Specific Elements of Protocols for Trauma-Focused CBT (TF-CBT)

- Psychoeducation about child abuse and safety
- Parent management skills
- Gaining skills in expressing feelings (affect modulation)
- Training in coping skills (relaxation)
- Recognizing the relationships between thoughts, feelings, and behaviors (cognitive processing)
- Trauma narrative Gradual exposure
- In vivo mastery of traumatic reminders (desensitization)
- Cognitive processing of the abuse experience(s)
- Joint child-parent sessions

Psychoeducation

- Introduce CBT model
- Provide information regarding PTSD physical and psychological reactions to trauma and loss
- Explain the critical role of parents/families support and instill hope for recovery
- Normalize the child’s and parent’s reactions to severe stress
- Educate family about benefits and need for early treatment
  (J Cohen, A. Mannarino, AACAP 2005)

Parenting Skills

- TF-CBT sees parents as central agent of change
- Goal is to establish parent as person child turns to for help in times of trouble
- Explain parent strongest source of healing
- Focus on areas parent feels most important
- Explain transient behavioral problems
- Emphasize need to return to/maintain routines
- Strengthen/reinforce positive parenting practices (praise, selective attention)
- Enhance enjoyable child-parent interactions
- Give parent permission to discipline children despite “what the child has gone through”

Common Parental Issues in Child Traumatization

- Inappropriate self-blame and guilt
- Inappropriate child blame
- Over-protectiveness
- Over-permissiveness
- PTSD symptoms in parents may get activated
- Research indicates that treating parents, parental support, and parent’s emotional response to trauma were related to child’s Recovery (Deblinger et al., 1996; Cohen & Mannarino, 1996; 1997)
Relaxation

- Individualized relaxation strategies for stress management for parent and child
- Developmentally, culturally sensitive and appropriate
- Flexible, imaginative, creative use of relaxation
- Practice at home together in ways that enhance child-parent bonding and positive interactions, and child’s perceptions of parent’s efficacy

Relaxation (continued)

- Positive imagery
- Focused breathing
- Progressive muscle relaxation
- Yoga
- Exercise
- Blowing bubbles
- Dance
- Music
- Tactile focus exercises

Relaxation and Affective Modulation

- Stress inoculation skills
- Children have hyperarousal
- Parents may identify with child and express it
- Thought stopping techniques: stop sign
- Changing channels to another thought
- Distractions
- Imagine yourself to sleep: relaxation tape
- Night light and review “will be safe”
- After 10 minutes of anxiety talk, 10-15 mins of Happy time talk before sleep

Treatment of Traumatic Grief in Children (Judith Cohen M.D.)

- Trauma symptoms related to traumatic nature of death
- Lost a loved one under traumatic circumstances
- “Stuck” on traumatic aspects of the death
- Unable to grieve in “typical fashion”
- Definition of Traumatic Grief

Cognitive Processing

- Cognitive Triad: Thoughts-Feelings-Behavior
- Connections and relating to everyday events
- Automatic thoughts may be inaccurate or unhelpful
- Changing these may lead to Feeling better and less self-defeating behaviors
- Parents assist children in cognitive processing of upsetting situations, and use this in everyday life for affective modulation

Direct Discussion of Trauma

Reasons we avoid this with children:
- Child discomfort
- Parent discomfort
- Therapist discomfort
- Legal issues

Reasons to directly discuss traumatic events:
- Gain mastery over trauma reminders
- Resolve avoidance symptoms
- Correction of distorted cognitions
- Model adaptive coping
- Identify and prepare for trauma/loss reminders
Creating the Trauma Narrative

- During several sessions, create a narrative of trauma, or life narrative for multiply traumatized
- Develop mastery over traumatic memories and reminders which have been avoided
- Gradually address “hot spots”
- Identify and correct cognitive distortions
- Repeated exposures (re-reading of narrative) decreases avoidance and allows mastery
- Contextualize traumatic experiences so that identity is not primarily that of a “victim”

Trauma Narrative (continued)

- Write a book about the trauma experience
- Start with an introduction about self
- Add details each week
- Can dictate to the therapist
- Review book to desensitize memories
- Help put trauma in context as just a part of child’s life
- At end of book note what have you learned, what would you tell others

Sharing the Trauma Narrative with the Parent

- During parent sessions, the trauma narrative is typically shared with the parent as it is being created by child
- Developmental/ confidentiality issues
- Parental mastery of avoidance and trauma reminders in parallel with child

Cognitive Processing of Trauma

- Identify child and parent cognitive distortions from narrative and elsewhere
- Cognitive processing techniques to replace with accurate and/or helpful thoughts
- Encourage parents to reinforce child’s more accurate/helpful cognitions
- Example: It’s my fault, I’ll never be like other kids, she’s lost her innocence, you can’t trust any men

In Vivo Mastery of Trauma Reminders

- Mastery critical for resuming devel trajectory
- If children are avoiding reminders which must be faced or reminders have generalized
- Parents and children identify reminders likely to trigger future trauma events
- In vivo exposure requires a plan and sticking to it
- Parent cooperation needed to make successful
- If avoidance is allowed to be reinforced, child will learn that fear is legitimate

Conjoint Child Parent Sessions

- Child-parent implementation of all components, especially trauma narrative, are culmination of TF-CBT model. Prepare parent prior to session.
- Share trauma narrative
- Enhance communication between child and parent
- Parent praises child for progress made in therapy
- Highlighting child and parent accomplishments
- Moving from therapist-child and therapist-parent to parent-child interactions during sessions
Enhancing Safety
- Identify safety skills to enhance
  Child and parent safety concerns in future
- Address safety concerns openly
- Sexual abuse: educate regarding healthy sexuality, body safety, appropriate and inappropriate touching
- Physical abuse or violence: education about bullying, appropriate discipline, problem solving, personal space
- Practice skills in joint sessions and at home: conjoint treatment may be needed

Modifying TF-CBT for Childhood Traumatic Grief (CTG)
-Psychoeducation child/parent: grief, bereavement
-Grieving the loss: What I miss (anagram)
-Addressing ambivalent feelings: What I don't miss
  -Preserving positive memories (memory box/book, collage, videotapes, involve parent)
  -Redefining relationship, interactive vs. memory
Making meaning of traumatic loss (learned? changed? different?)
-Joint parent-child sessions: The circle of life
Predict (triggers), Plan (for reminders), Permission (to grieve)

Abuse-Focused CBT (AF-CBT)
David Kolko, Ph.D.
- Education about abuse law and treatment
- Establish no-force agreement to discuss any new incidents involving use of force in family
- Discuss child’s exposure to emotional and physical abuse “force”: causes, characteristics, consequences
- Identify and challenge cognitive contributors: High expectations, distorted or negative thinking in caregivers. Child may blame self or feel parent supportive of aggression
- Teach affect management skills: manage/regulate anger and anxiety
- Behavior management strategies (caregivers) and social skill/support plans (child): training/practice
- Establish pro-social family communication and solve problems non-aggressively

Family Behavior Patterns (D. Kolko):
Changing Thoughts and Behaviors

<table>
<thead>
<tr>
<th></th>
<th>Cognitive</th>
<th>Affective</th>
<th>Behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Spills Milk</td>
<td>He’s clumsy, bad, trying to annoy me</td>
<td>Anger Disgust Impatience</td>
<td>Hurt Child Refuse to give child more milk</td>
</tr>
<tr>
<td>Child Spills Milk</td>
<td>It was an accident</td>
<td>Displeasure Patience</td>
<td>Help child clean up Refill milk</td>
</tr>
</tbody>
</table>

Example: Problem-Solving Skills
(David Kolko PhD, AACAP 2005)
- 1: Is There Problem? Feel bad, inconvenienced
- 3: What Do We Want? Be constructive
- 4: What Can We Do? Brainstorm
  Alternatives to old, familiar ways
- 5: What Are Consequences of Each Choice?
  Evaluate pros and cons
- 6: What Are We Going to Try?
  Pick solution, evaluate outcomes, revise

Multimodal Treatment of PTSD in Children and Adolescents
**Treatment of PTSD: A Multimodal Approach**

- Triage to identify children at risk for PTSD after a traumatic event
- Cognitive-behavioral therapy
- Psychiatric medications
- Supportive therapy for child and family
- Group treatment when appropriate
- Interventions for school and community
- Early interventions (secondary prevent)

**PTSD: Psychological Treatment**

- Psychoeducation (what to expect, grief)
- Direct exploration of trauma (using relaxation and desensitization tools)
- Evaluation and reconsideration of cognitive assumptions (such as “my fault” and “nothing is safe now”)
- Including parents or supportive others (monitor symptoms, learn behavioral techs, course, manage own recovery)

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**PTSD: Working with the School and Community**

- Psychoeducation
- Coordinate treatment planning
- Review traumatic reminders and intrusive thoughts in various settings
- Supportive and behavioral interventions to de-escalate problem behaviors
- Maintain safety and prevent recurrence
- Involve in monitoring progress with school and peers

**Factors that Impair Detection in Children and Adolescents**

- Need information from multiple sources
- Parents may downplay or deny impact of trauma on the child
- Children under-report and deny PTSD symptoms (increased risk for impulse control problems and sleep complaints)
- Experience pressure to talk about trauma, but difficult to talk with parents & peers about trauma, emotional impact

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**Factors That Make A Parent’s Role More Challenging**

- Difficult to gauge level of child’s distress
- Young child may hide feelings due to confusion/fear about normal grief (parents need to ask how is it going)
- Parental distress, disagreement, changing roles during and after trauma influence child’s behavior and recovery
- Child’s coping/behavior may disrupt family functioning

**Factors That Make a Parent’s Role More Challenging (cont.)**

- Irritability, inhibition, & aggression can strain sibling and peer relationships
- Coping with traumatic reminders and associated anxiety and avoidance
- Parents or other adults may have unrealistic time frame for child or family recovery. “Just cope with it” message.
- Parents struggling to cope as well. Discussions may increase anxiety.
Parents and Caregivers are Critical to Recovery

- Emotional health and coping of parents or caregivers is critical
- Parent may experience anxieties, fears of seeking help for self and child
- Stigma of seeking help (viewed negatively by family and friends, concerns about trust, talking with strangers, & confidentiality)
- Professionals assist parents to get help

Medication Treatment for Childhood Anxiety Disorders

Medications for Childhood Anxiety Disorders

- SSRIs: only medications well-supported by placebo-controlled studies: SAD, GAD, SoPh
- Consider comorbid disorders
- Consider family history of medication tx
- Try several SSRIs before alternative meds
- No clear guidelines when more than one medication needed to manage anxiety
- Initiate one medication at a time
- Start low and go slow, monitor side effects closely

Serotonin Reuptake Inhibitors

- Randomized placebo-cont trials of SSRIs' short-term efficacy & safety for anxiety dx
- Fluvoxamine - Social phobia, SAD, GAD (RUPP, 2001)
- Fluoxetine - GAD, Social phobia, SM (Birmaher et al, 2003; Black and Uhde, 1994)
- Sertraline - GAD (Rynn et al, 2002) and GAD, SAD, Soc Ph (CAMS, 2008)
- Paxil - Social phobia (Wagner et al, 2004)
- Panic disorder - small open label and chart review with SSRIs showed improvement

SSRI’s for Anxiety Disorders

- Side effects: stomachache, increased activity level, insomnia, agitation/disinhibition at higher doses
- Less often diarrhea, headaches, tics, cramps/twitching, hypomania, sexual side effects. Ask patient to wear sunscreen.
- Start at a low dose and increase slowly based on treatment response and side effects
- Can increase dose one month
- Can take several weeks to 2 months to see full effect (may see initial result quickly)

SSRI’s for Anxiety Disorders

- Discuss black-box warning with family
- Choice of SSRI: side effects, duration of action, pt compliance, positive response in relative
- Assess somatic symptoms prior to initiating
- May consider mediation free trial after stability for 1 year, during low-stress period, with monitoring for relapse (Pine, 2002)
SSRIs: Side Effects by Age
- Activation and vomiting more in children versus adolescents (Safer & Zito 2006)
- Children (especially females) with higher exposure to Fluvoxamine at similar doses
- Behavioral disinhibition noted in some SM med studies with younger children (Carlson et al 1999; Sharkey & McNicholas 2006)

SSRIs in Young Children
- Start very low in young children and go slow to reduce side effects and increase tolerance to initial and temporary side effects
- Fluoxetine liquid 20mg/5ml can start at 0.5-2.0 mg/day
- Sertraline liquid 20mg/1ml can start at 2.5-5mg/day
- Monitor for activation, behavioral disinhibition along with other side effects

SSRIs for Selective Mutism
- 12 week placebo-controlled study for Fluoxetine mean dose of 0.6mg/kg (Black and Uhde, 1994) 6 children, ages 6-14, with SM and Social Phobia Improved significantly on parent and teacher rating relative to placebo but still with SM symptoms (with minimal side effects)
- Open trial of 21 children ages 5 to 14 with SM supports Fluoxetine in graduated doses. 76% improved in anxiety and speech, inversely correlated with age (Dummit et al., 1997)
- Sertraline in 5 children with SM with low side effects, general benefits (Carlson et al., 1999)
- Longer trials with more individual dosing needed

Other Antidepressants
- Tricyclic antidepressants (SAD, Social phobia)
  - Conflicting results exc Clomipramine for OCD
- Clomipramine (TCA & non-selective SRI)
  - Can augment at low doses with SSRI. Requires cardiac monitoring, EKG, blood levels. Side effects can be significant: sedation, dizziness. OCD, ADHD, tics.
- Other Antidepressants (GAD, Social phobia)
  - Venlafaxine (2 placebo-cont studies w/XR: Rynn et al 2007; Tourian et al 2004)
  - Noradrenergic and SSRI. Second line treatment as SSRI alternative or augment. Panic, ADHD.

Other Medications for Anxiety
- Buspirone (GAD)
  - No published controlled studies.
  - Adverse side effects: lightheadedness, headache, dyspepsia.
  - Higher peak plasma levels in children vs adolescents. May be tolerated at 5-30mg in teens and 5-7.5mg in children, twice daily
  - May be an alternative to SSRIs for GAD in youth. Controlled studies needed.
  - May augment SSRIs.

Other Medications for Anxiety
- Benzodiazepines
  - Clonazepam: benzo most used in youth
  - Small controlled studies did not show efficacy
  - Short-term use for school refusal, SAD, Panic disorder to supplement SSRI or allow acute participation in CBT(exposure)
  - Risks of dependence long-term, half-life
  - Contraindication in teens w/ substance abuse
  - Side effects: sedation, disinhibition, cognitive impairment, difficulty with discontinuation
  - Long-term use in GAD or severe chronic anxiety if other alternatives exhausted
Other Medications for Anxiety

Guanfacine or Clonidine

- No controlled studies for anxiety disorders
- Consider w/ SSRI when anxiety w/ significant autonomic arousal and/or restlessness
- Baseline EKG, BP and pulse monitoring
- Severe rebound hypertension with abrupt discontinuation
- Tourette’s, ADHD, Trichotillomania, other impulse-control disorders, Bipolar, PTSD

B-Blockers
- Consider for focused performance anxiety (No trials in youth)

Medications for Comorbidity

- **Depression**: Impairment, SSRI, monitor suicidal risk, CBT (Fluoxetine recommended)
- **ADHD**: First choice stimulants and beh tx. If stimulants exacerbate insomnia or anxiety, Atomoxetine second line, also Buproprion and Venlafaxine. Guanfacine or clonidine (get EKG) for hyperactivity/ impulsivity and sleep struggles.
- **Alcohol abuse**: Caution against benzos
- **Bipolar disorder**: SSRIs may exacerbate, but can be introduced at low doses once stable

Medications for ADHD: Summary of Options

- First choice stimulants and behavioral treatment (MTA study). Monitor appetite, weight, growth, tics, sleep, mood swings.
- If stimulants exacerbate insomnia or anxiety, try Atomoxetine (NE). Monitor liver, cardiac.
- Consider Buproprion third line (dopamine/NE)
- Guanfacine or clonidine with EKG, BP, pulse for hyperactivity/ impulsivity and sleep
- Venlafaxine (SSRI/NE)
- Tricyclics considered with EKG, cardiac monitoring, and blood levels
- Consider combination of meds for ADHD

Decision-Tree

- Partner with family in decision-making
- Consider symptoms severity
- Overlapping symptoms: restlessness, difficulty sleeping, inattention
- Treating comorbid disorders
- Family history of success with certain meds
- Monitor medication side effects and impact on comorbid disorder
- Dose-based side effects minimized by maximizing behavioral treatment and structuring home and school environment

Treatment of PTSD: Medications

- Treat significant depression and anxiety
- Increased risk for suicide
- SSRI’s (Antidepressants)
  - For anxiety, depression, core symptoms
- Guanfacine or Clonidine
  - For hyperarousal, impulsivity, startle
- Antipsychotics (such as Risperidone)
  - For dissociation, brief psychosis, severe aggression
    (monitor AIMS or DISCUS, glucose, weight)
- Meds can reduce severity of symptoms so child can engage in therapy and exposures

Medications for Comorbid Autism Spectrum Disorders

- Consider SSRI’s when obsessive features, perseveration, rituals, anxiety, depression, irritability prominent
- Guanfacine or Clonidine may assist with impulsivity, explosiveness, restlessness
- Other meds such as antipsychotics and mood stabilizers may be used for aggression and severe symptoms
Multimodal Treatment of Comorbid ADHD

- Add Behavioral Modification
- Combination Med Management
- Work with parents and school

Anxiety & ADHD: Similar and Overlapping Symptoms

- Restlessness
- Inattention and concentration problems
- Difficulty sleeping
- Need to keep busy
- Irritability, easily upset (impulsivity vs. avoidance)
- Low frustration tolerance (impatience vs. perfectionism)
- Tantrums

Multimodal (Comprehensive) Treatment Approach for ADHD

- Parent and child education about diagnosis and treatment
- Behavior management techniques
- Medication
- School programming and supports

Monitor Treatment Progress with Validated Symptom Measures

- ADHD: parent and teacher report Conner’s Form
- CBCL or BASC broadband symptoms for ADHD and comorbid disorders: self-report, parent and teacher report

Behavioral Modification

- Behavioral Modification is the only non-medical treatment for ADHD with a large scientific evidence base

Behavioral Programming for Children with ADHD

- Structure environments at home and school
- Clarify expectations, goals, rewards, consequences
- Positive reinforcement & response costs
- Using time outs and 1-2-3 Magic
- Establishing consistency and coordination between caregivers
- Communication between home and school
Behavioral Interventions for ADHD
- Being consistent in all settings and over time
- Using positive reinforcement
- Teaching problem-solving
- Teaching communication and self-advocacy skills
- Involve children, especially teenagers, in school planning and treatment teams

Behavioral Modification
- ABC’s of Behavioral Modification:
  - Antecedents: before targeted behaviors
  - Behaviors: Child does, parents and teachers want to change
  - Consequences: happen after behaviors
- Parents and teachers learn to change their antecedents (how to give commands) and consequences (how to react to child when obeys or disobeys command) to change the child’s behavior. Modeling too.

Behavioral Mod for ADHD
- Parent, teacher and child interventions carried out at same time
- Start with achievable goals in small steps
- Be consistent: different times, people, places
- Continue behavioral interventions long-term
- Teaching new skills to child (and parents) is gradual process and improvement takes time

Behavioral Mod for ADHD: Getting Started
- Identify target behaviors (negative behaviors or new skills needed)
- Problem areas where ADHD impacts child
  - School: completes work, follows rules
  - Home: plays well w/sib, obeys parent request
- Implement coordinated behavioral programming in home and school
- Parents and teachers modify A’s and C’s
- Responses are monitored closely and interventions modified as appropriate

Parent Training: Home Interventions
- Establish house rules and structure
- Ignore mild inappropriate behavior (choose battles) and praise appropriate behavior (5:1)
- Give appropriate commands
  - Get child’s attention
  - Specific & brief
  - Use command not question language
  - State consequences & follow-through
- Daily charts
- Point/token system with both reward and cost components

Home Interventions (Continued)
- “Grandma’s Principle” (“first homework, then tv”) “when…then”
- Homework hour
- Time out from positive reinforcement (do not reward negative behavior)
- Planning ahead and working with children in public places
- School-home note system for rewarding behavior at school and tracking homework
- Parent training or behavioral family therapy
Child Interventions for ADHD: Peer Relationships

- Usually in groups outside therapist's office
- Systematic teaching of social skills
- Social problem solving
- Other behavioral skills important to children: sports skills (teamwork) and board game rules (taking turns, sharing)
- Decreasing undesirable and antisocial behavior
- Developing a close friendship (protective effect over time)

Treatment for Peer Problems is Complex!

- NOT just more opportunities for social interactions without practicing skills needed
- Child needs careful instruction in social and problem-solving skills
- Needs supervised practice in peer settings
- Needs to receive rewards and consequences for appropriate peer interactions

School Interventions: Accommodations for 504 Plan

- Proximity to teacher
- Preferential seating (quiet, low distractions)
- Eye contact before directions
- Clear and simple directions for homework and assignments
- Tape recorder or give student copy of notes
- Behavior management techniques (including positive reinforcement)
- Praising others for good behavior
- Posting daily class routines

School Interventions (504 Plan)

- Work modifications- reduce # homework problems without reducing level/content
- Active learning environment
- Daily Home-School Report Card
- “Good News” home contacts
- Testing accommodations: quiet, extra time
- Assignment notebook
- Nurse or administrator to oversee meds
- Meeting with the school counselor/therapist

Classroom Behavioral Management

- Classroom rules and structure
- Praise appropriate behaviors and choose battles carefully (praise to negative 5:1)
- Appropriate commands and reprimands
- Individual accommodations and structure for the child
- Proactive interventions to increase academic performance
- “When...then” contingencies
- Daily school-home report card
- Behavior chart and/or reward and consequence program

Anxiety and Mood Disorders

Modifying treatment interventions
### Anxiety and Mood disorders
- Bipolar diagnosis should be made carefully due to overlapping symptoms with more common disorders: ADHD, PTSD, RAD
- High rate of anxiety disorders in children with bipolar disorder, not vice versa
- Ask about family history of bipolar disorder prior to treatment planning

### Anxiety and Bipolar
- Intensity of anxiety can be extreme and persistent for long periods in bipolar child
- Mood cycling that is not just related to anxiety-provoking stimuli
- Grandiosity can impact safety
- Chronic irritability common
- Hard to tolerate minor frustrations, easily upset and then remains irritable
- Child cannot explain mood shift, irritability and unable to change it
- Aggressive verbal or physical behavior
- Sleep disturbance: can sleep very little without feeling tired

### Anxiety and Bipolar Disorder: Treatment Planning
- Stabilize bipolar disorder first
- Then see if anxiety disorder or ADHD still evident
- SSRI’s and stimulants can exacerbate bipolar disorder, but can be used cautiously once bipolar is stable

### Anxiety and Bipolar: Modifications to CBT
- Child and Family Focused CBT (CFF-CBT)
- PMDC at UIC with RAINBOW groups
- Cannot do skill building unless child is calm
- Meds and psycho-education for parents critical
- Learning calming, de-escalation skills, reducing power struggles
- Monitor mood and learn affect regulation skills: parents modeling calm demeanor when child is upset
- Positive self-statements, increasing empathy toward child
- Reducing over-stimulation and breaks when needed at home and school
- Every day is a new day: not holding grudges
- Understanding chronic irritability

### Anxiety & Developmental Disorders
- Modifying CBT to fit child’s developmental level/abilities

### CBT : Modifications for DD
- Modify cognitive restructuring to be consistent with cognitive level of child
- Use language appropriate for child
- Behavioral strategies emphasized
- Lots of scripting and role-play
- Set realistic expectations, goals
- Use visual tools if worksheets, etc. are too complex
- Barometer rather than thermometer or develop one especially for child
- Frequent positive reinforcement with concrete rewards
Treatment for Comorbid Autism Spectrum and Anxiety Disorders

- Asperger’s
- Other Autism Spectrum

Anxiety and Autism Spectrum Disorders

- Anxiety-like responses are a common associated feature in children with ASD
- The majority of children with autism without intellectual delay or with Asperger’s (HFA) have anxiety disorders (47-84%)
- Children with HFA are able to identify their own and other’s thoughts (recent theory of mind research) and may benefit from CBT for anxiety disorders

Understand and Utilize Strengths

- Children with Asperger’s may have NVLD and self-initiated guided imagery challenging
- However, children with autism often have stronger nonverbal skills and benefit from emphasizing nonverbal/visual tools in CBT
- Evaluate which sensory skills are strengths: music, tactile, visual, auditory
- Utilize strengths in treatment and incorporate into CBT

Consider Developmental Fxn

- Use language child can understand
- Incorporate child’s own words or pictures for “anxiety” or “fear”
- Set reasonable goals and expectations
- Help child to develop sense of self-competence and internal locus of control
- Help families shift away from power struggles in treatment process

Remember each child has strengths and weaknesses along a spectrum

- Do not assume lack of empathy or lack of interest in others
- “Theory of mind” is not an absolute concept for a given child
- Many children with autism suffer with anxiety and further risk for depression

Autism and Anxiety: Classroom Considerations

- Anxiety may increase performance fears, expectations for self
- Multiple short academic breaks with relaxing activities as rewards in-between (modify usual approach for children with autism)
- If using group speech therapy need to be matched with similarly-functioning peers
- Use thermometer, other visual means to gauge child’s anxiety/feeling overwhelmed, revise academic tasks accordingly
Emphasize Meeting, Greeting, and Social Skills

- Incorporate social skills training
- Provide opportunities for learning and practicing skills
- Scripting of verbal responses, role-play
- Frequent positive reinforcement
- Graded social exposures
- Work on sharing, taking turns, listening to others
- Again utilize strengths and interests
- Pragmatic aspects of language in speech

Modifications to CBT for Anxiety Disorders for Children with HFA

- Chalant, Rapee, Carroll (J Aut Dev Dis 2007) with modified “Cool Kids” CBT program
- 47 children with HFA aged 8-13 with treated with CBT (28) or WLC (19) for 12-session group CBT of 6-8 children/group
- 4 sess to introduce and role-play strategies
- 5 sessions for practice and weekly exposures
- 3 monthly booster sessions
- CBT flexibly adapted to visual and concrete learning style of children with HFA

Group CBT for Anxiety & HFA: Modifications to standard CBT

- Extended program: over 6 months
- More visual aides and structured worksheets
- More concrete exercises and less emphasis on communication skills
- Relaxation and exposure emphasized
- Exposure tasks given as family homework
- Simplified cognitive component: identified helpful and unhelpful thoughts rather than generating their own
- Still required ability to identify thought in self & others
- Parent-based group CBT concurrently

Results of Group CBT for Children with Anxiety and HFA

- After treatment, 71% (20 of 28 children) no longer had primary anxiety disorder versus 0% (0 of 19 children) in WLC
- Significant reductions in anxiety symptoms from self, parent, and teacher report
- Look further at modifications in children with lower functioning autism spectrum

Clinical Vignettes: Treatment Planning

- Consider severity and impairment
- Consider comorbid disorders
- Consider age, developmental stage, family hx
- Consider family stressors and resources
- Consider educational needs

Case Example: Clarence

GAD, SAD, Social Phobia
ADHD, LD
Social skills deficit
Case Example: Clarence (history)
- 8 year old boy with ADHD, referred for severe “sleep anxiety” and meets criteria for GAD, SAD, Social Phobia, OCD traits.
- Anxiety became significant after robbery of family property 2 years ago: credit cards stolen. Some PTSD features.
- Father travels often with job. Father with possible OCD traits, low frustration tolerance for Thomas. Thomas overly dependent on mother.
- Anxiety at night sometimes makes it hard to even sleep well in mother’s room (no one resting in family)
- ADHD, severe and LD impacting academic and social at school (irritating to other children)
- Anxiety limits social activities: fearful of being away from mother, assertiveness skills and social skills poor (bullied by students at school)

Example: Clarence (Treatment)
- ADHD combined type interfered with CBT. Required numerous med trials responded to combination of Strattera, Adderall (XR and regular) and Guanfacine (appetite suppression, increased irritability, increased anxiety on various ADHD meds)
- Various SSRI’s tried: tended to get hyperarousal, irritable on several with good results on Celexa.
- Positive reinforcement chart set up with clear rewards and consequences.
- Worked on power struggles and active ignoring.
- Established team with mother, school, and therapist.

Example: Clarence (Treatment)
- Relaxation: deep breathing, muscle relaxation, and imagery (light blue, beach scene)
- Positive self-talk: fears other children think he is stupid, do not want him as a friend, want him to feel bad.
- Fears of robbers breaking into house at night and killing him and family. Any sounds would trigger this. How likely? What else could sounds be? Safety of community? Alternative thoughts
- Systematic desensitization to move toward sleeping outside mother’s bed, in her room, in the hall, on floor in his room, in his bed.
- Attending sports practice, parties with friends, having playdates at home and at friend’s house

Clarence (Treatment)
- Social skills training and assertiveness training to address response to bullying along with coordination with school to monitor.
- Learning meeting and greeting, how to treat play date, tolerating small frustrations with peers
- Ignoring verbal bullying, responding with humor, monitoring reactions on face and body to potential bullies. Getting help from adults when needed.
- Family treatment to address need for acceptance from father. Work on gaining competence versus dependence on mother.
- New social and interpersonal challenges of adolescence

Clarence: Highlights
- Treat predominant or most impairing symptoms first: comorbidity
- Listen to family’s major concerns: “sleep anxiety”
- Consider social functioning as an important outcome

Case Example: Jordan

PTSD in young child
A Case Example Young Child: Impact on the Child and Family

- Jordan was a 5 year old boy who lived with his maternal GM and attended kindergarten.
- He was referred by his pediatrician for poor sleep over the past year.
- He was soiling his underwear, though he was fully toilet trained for the previous two years.

Case Example: Family History

- Family history was significant for repeated domestic violence between biologic parents.
- His father also had history of alcohol abuse.
- At age 4, parents engaged in an argument that led to gun violence in which his father killed his mother and younger sibling.
- Jordan hid under sib’s crib, escaped injury, but was splashed with blood.

Case Example: Functioning at Home

- Recurrent nightmares of a man chasing him with a gun and unable to get away.
- Unprovoked tantrums at home and school with intense rage, restlessness, aggression towards adults & children
- Distant, unable to engage with relatives
- Often quiet, uninterested in activities

Case Example: Functioning at School

- Sad and withdrawn at school
- Uninterested in play with classmates
- Solitary play with repetitive themes of fighting and repeated shooting, death
- Poor concentration/attention in class
- Poor academic progress

Case Example: Mental Status Exam

- Engaged in repetitive themes of aggressive play with animal families, parents and children often hurt or killed
- Did not speak in session (was able to speak prior to trauma)
- Appeared sad, became animated during aggressive play
- No evidence of hallucinations

Case Example: Functioning of Primary Caregiver (Mat GM)

- Intense anger toward his father for murdering her daughter and grandchild
- Fears that his aggression would lead to turning into his father
- Struggling with her own traumatic grief
- Pushed away his efforts to contact father (imprisoned)
- Found his sadness and withdrawal difficult to tolerate
Case Example: Traumatic Reminders and Triggers

- Bars on gym ceiling at school: Reminders of bars on siblings crib, prison bars
- Paint or stains on his hands, clothes: repeated handwashing, blood stains
- If grandmother raised her voice or reprimanded him: quickly tearful and withdrawn

Case Example: Multimodal Treatment

- **Individual treatment with child**
  - He developed sense of safety and trust in therapy so he could eventually share his fears, share recollections of trauma through play, and eventually speak
  - Medications considered: low dose SSRIs
  - Psychological testing to evaluate cognitive and educational problems

Case Example: Multimodal Treatment (Cont.)

- **Working with Caregiver**
  - Grandmother involved in sessions to balance nurturing and limit-setting
  - Family sessions to improve communication
  - Treatment for grandmother’s struggles with traumatic grief. Family group for traumatic loss and medication helped. Learning to care for her own needs.

Case Example: Multimodal Treatment

- **Working with school and community**
  - Identify triggers and traumatic reminders and reduce tantrums, overwhelming anxiety with behavioral interventions, tools
  - Monitor progress in inattention/conc and academic functioning
  - Increase positive interactions with peers, school staff. Encourage positive reinforcement.

PTSD in a School-Age Child

Jose is a 7 y.o. Hispanic male who witnessed significant domestic between parents as young child.
- Father was argumentative, physically and verbally abusive toward mother
- Father’s relatives injured mother as well
- Maternal relatives tried to take child from mother
- Father in prison, violent crimes against women
- Pt lives with mother and stepfather
Jose: Presenting Symptoms and Memories of Trauma

- In earlier therapy focused on protecting mother: drew pictures of self strong, muscular, with super powers
- Pt quiet, anxious, withdrawn, bouts of tearfulness, clings to mother, school refusal
- Nightmares, intrusive thoughts at school
- Separation anxiety, fears mother hurt or killed
- Memories emerge of car rides with father during his crimes, son often left alone in car or in alley
- Social isolation, wants to be with mother
- Memories of severe domestic violence

Jose: Mother’s Struggles and PTSD

- Mother anxious, depressed
- Overwhelmed by nightmares, memories, intrusive thoughts, persistent fears of physical violence
- Struggles to set limits at appropriate times, easily tearful herself when son is upset, angry
- Worries that son will turn out like his father when Jose gets angry, impatient, demanding
- Will keep stepfather from setting limits, delivering consequences, “protects” Jose

Jose: Course of Treatment

- Treatment for mother’s PTSD
- Assist mother with setting up structure, positive reinforcement in home environment, basic parenting skills impacted by violence
- Teach relaxation, anxiety reduction skills
- Address cognitive distortions, fears of persistent violence and Jose’s concerns that mother needs him to protect her.
- Realistic safety concerns: legal system, jail visits
- Assist mother with self-advocacy
- Once Jose improved, mother inconsistent with treatment

Jose Returns to Treatment

- Mother marries stepfather
- Biological father in the news for additional crimes: the age of DNA testing

Mother continues to struggle with consistent limit-setting and son’s anger. Unreasonable but persistent fears he will turn out like his father (looks just like him)

Case example: Jimmy

Selective Mutism
Social Anxiety Disorder

Expanding Safety zone

- From clinic to school
  - Select transition agent(s) - parent, therapist, sibs, even classroom teacher
  - Select strategies
  - Select sequence of exposures
- From home to school
  - Select transition agent(s) - parent, sibs, classmates, teacher
  - Select strategies
  - Select sequence of exposures
13 Stages in the Emergence of Speech at School

- C. Cunningham’s work; adapted by Kenny, Fung, Mendlowitz
- Helps to establish intermediary goals in tx
- Have parents, teachers rate at what stage child is at different points in treatment
- Way to monitor progress

13 Stages in Speech Emergence in School (least to most)

1: Complete mutism at school
2: Participates nonverbally
3: Speaks to parent at school (usually when teachers or students are absent)
4: Peers see child speaking (but don’t hear)
5: Peers overhear child speaking
6: Speaks to Peer through Parent or Sib
7: Speaks softly or whispers to one peer
8: Speaks to one peer w/ normal volume
9: Speaks softly or whispers to several peers
10: Speaks in normal voice to several peers
11: Speaks softly or whispers to teacher
12: Speaks in normal voice to teacher
13: NORMAL SPEECH IN SCHOOL

Case example: Jimmy

4 1/2 yo male, living with parents, bilingual Spanish-English
Normal pregnancy, development
Shy temperament: SM since age 2.
Comorbidities: Social Phobia, Speech Articulation disorder
Family history of: GAD, Social Phobia, Depression, Alcohol Abuse, Speech therapy in father

Jimmy (cont’d)

- Regular pre-school
- Stage 1-2 for speech emergence
- Accepted by a few classmates, afraid of teacher
- School felt he would “grow out of it”

Jimmy - Expanding Safety Zone from Home to Clinic

- CBT approach, adapted for young child
- Positive sticker chart
- Medication
  - CBT emphasis on behavioral (due to young age) with some use of superhero themes
  - Anxiety shrunk as super Jimmy grew stronger
  - Used play, drawings, and nature walks as medium of engagement
  - Deep breathing, beach imagery, petting stuffed animal, sound of shell to help with relaxation
  - Rewarded regularly, often for his efforts at home and in session. Rewarded for practicing and success with exposures.
Jimmy- Expanding Safety Zone to Clinic Continued

- Pt relieved that anxiety had a name and that he could conquer it (worry monster- big green blob). Attacked it in drawings on dry-erase board and puppet play
- Individual to parallel play to cooperative play
- Parents, brother, cousin in session
- Described aloud Jimmy’s activities during play
- Initiated Zoloft liquid at 5mg and eventually up to 30mg with significant improvement in nonverbal communication, initiating social interactions, whispering, and then speaking
- Worked on eye contact, volume of speech, greeting skills, assertiveness skills. Angry expression hardest.
- Practiced social skills with visits to office “neighbors” in the clinic

Jimmy- Expanding Safety Zone to School

- Reviewed various school environments for best “fit”. Decided to change schools based on structured social opportunities available
- Psychoeducation with school team and parents
- Set up brief, frequent play dates at home with peers from school with parents utilizing strategies & sequence used in therapy
- Parents coached Jimmy on coping strategies - “belly breathing” when feeling anxious, to relax

Jimmy- Expanding Safety Zone to School Continued

- First: parent and Jimmy visit school playground
- Then, parent and J visited classroom alone
- Then, parent and J visited with cousin in classroom
- Then parent, J, cousin, and teacher
- Pt talking to cousin in classroom
- Eventually speaking with teacher and classmates
- Currently: Stage 13
- New focus: Initiating social interactions in crowded places

Jimmy: Highlights

- Psychoeducation for parents and educators very important
- Treating parental anxiety and assisting with reactions of relatives, parents’ frustrations
- Utilizing “Stages” approach coupled with CBT to conceptualize successive approximations & monitor tx progress
- Aim to expand safety zone from home to school and from clinic to school by identifying transition agent(s), strategies, & sequence of exposures

References for Parents and Teachers

- Helping Your Anxious Child (Rapee, Wignall, Spence, Cobham, 2008)
- Freeing Your Child from Anxiety (Chansky, 2004)
- Keys to Parenting Your Anxious Child (Manassis, 1996)
- Helping Your Child with Selective Mutism (M CHolm, Cunningham, Vanier, 2005)

References for Children

- What To Do When You Worry Too Much (Huebner & Matthews, 2005)
- A Boy and a Bear: The Children’s Relaxation Book (Lori Lite, 1996)
- Blink, Blink, Clop, Clop: Why Do We Do Things We Can't Stop? An OCD Storybook (Moritz & Jablonsky, 2001)
- Anxiety Disorders (for middle and high school students: Connolly, Simpson & Petty, 2005)
References for Clinicians

- Treating Anxious Children and Adolescents (Rapee, Wignall, Hudson & Schniering, 2000)
- Practice Parameter for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders (JAACAP 2007)
- Phobic and Anxiety Disorders in Children and Adolescents (Ollendick & March, 2004)
- The Developmental Psychopathology of Anxiety (Vasey & Dadds, 2001)

CBT Anxiety Therapy Manuals

- Coping Cat (Phillip Kendall) and CAT (for adolescents)
- How I Ran OCD Off My Land (John March)
- Social Effectiveness Training for Children (SET-C: Beidel & Morris) - for Social Phobia

RESOURCES

- National Child Traumatic Stress Network: www.musc.edu/tfcbt; www.nctsnet.org
- Anxiety Disorders Association of America (ADAA): www.anxiety.org
- SM Group- Child Anxiety Network: www.selectivemutism.org
- Association for Behavioral and Cognitive Therapies: www.abct.org
- Obsessive Compulsive Foundation: www.ocfoundation.org
- Boston University anxiety clinic: www.childanxiety.net

MORE RESOURCES

- www.chadd.org for ADHD in children and adults
- www.bpkids.org for Child and adolescent bipolar foundation
- Website for PMDC at UIC (pediatric mood disorders clinic) and RAINBOW program through www.uic.edu at 312/996-7723
- ocfoundation

UIC Pediatric Stress and Anxiety Disorders Clinic

Evidence-based Evaluation & Treatment

- Assess history from parent, child, and school
- Administer ADIS-C.
- Individualized Treatment Planning
- Cognitive Behavioral Therapy
- Medication in combination with CBT
- Parent Guidance, Family Treatment, Groups
- Monitor school progress
- Work with community providers and resources

UIC Ped Stress and Anxiety Disorders Clinic: Early Intervention and Prevention

- School-based programming for staff and students
- Professional education & development
- Consultation to community providers
- Stress management skills
- Parent guidance
- Research in risk factors, educational programming, and adaptation of evidence-based interventions