Worries and Woes: Dealing with Anxiety Disorders in School Age Children

Week 5
Jack Hirose and Assoc. Webinar

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Week 5 Agenda

- Post Traumatic Stress Disorder

  (Trauma- and Stressor-Related Disorders)
  - In-vivo, virtual and prolonged exposure
- Generalized Anxiety Disorder
  - TX Planning: Safety behaviors, Worry Chains, Responsibility Pie

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Trauma and Stressor-Related Disorders

- Reactive Attachment Disorder
- Disinhibited Social Engagement Disorder
- Acute Stress Disorder
- Adjustment Disorders
- PTSD

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Trauma- and Stressor-Related Disorders

- Agreement that similar to anxiety disorders (reactivity, sensitivity)
- Similar to depressive disorders (numbing, detachment)
- Exposure to actual, threatened death/injury/ violation

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Definitions

- Acute trauma – single event, limited in time
- Chronic trauma – multiple and varied
- Complex trauma – used by some experts to describe chronic trauma and long-term impact
- Hyper vigilance – increased arousal, responsiveness to stimuli, scanning environment for threat
- Traumatic reminders – people, situation, sensation, feeling or thing

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Reactive Attachment Disorder

- Consistent pattern of inhibited, emotionally withdrawn behaviour
- Limited positive affect
- Episodes of unexplained irritability
- Pattern of extremes of insufficient care
- RO Autism spectrum
- Disturbance present < 5 yrs old
- Sx for > 12 months

Rare!

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Disinhibited Social Engagement

Pattern of overly friendly with strangers
Does not check back with caregivers
Due to social neglect/deprivation

Rare!

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Acute Stress Disorder

- Very similar to PTSD: exposure to threat/ death
- Time element:
  3 days ⟹ 1 month following exposure to trauma

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Adjustment Disorders

- Identifiable stressor within last 3 months
- Marked distress out of proportion to stressor
- Significant impairment in school, friends or at home

Examples: end of romantic relationship, illness or death of family*, natural disaster

* suicide risk elevated

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Post Traumatic Stress Disorder

Experience of traumatic event (perception that self or other at risk of serious injury, harm, or death)

Symptom Clusters (> 1 month):

1. Re-experiencing the traumatic event
   (e.g., intrusive memories, nightmares)
2. Avoidance and numbing
   (e.g., avoid reminders, emotionally detached)
3. Increased arousal
   (e.g., easily startled, sleep problems)
4. Changes in Cognition and Mood
   (e.g., self-blame, negative view of others)

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Causes of PTSD in Youth

**Data from National Center for PTSD

Car crashes
Natural Disasters: Floods, fires
School Shootings
War
Sibling/Friend's suicide
Seeing violence in community
Medical procedures
Refugee experiences

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Other possible causes

Abuse
- 65% Neglect
- 18% Physical abuse
- 10% Sexual abuse
- 7% Psychological abuse
  - bullying

**Thought 2/3 of abuse cases not reported

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Trauma in Pediatric Populations

- Child accidents and harm
  - 30% need medical attention
- Child abuse and neglect:
  - 27% of all maltreatment victims
- 1 out of 10 in outpatient clinic witness knife or shooting in the home

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The Scope of the Problem in Youth

15-43% Experience trauma

3-15% Develop PTSD (Girls)

1-6% Develop PTSD (Boys)

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Sub-type: Preschool PTSD

- Child < 6 yrs old
- Does not have to show distress at time of trauma
- Increased arousal Sx (irritability, outbursts of anger, extreme temper tantrums)
- Either avoidance or cognitive/mood change

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Mediating Factors

- Trauma
  - Nature/severity/proximity (how close child is to trauma)
- Child
  - Gender/history of psychiatric illness/resilience/locus of control/personal efficacy/tendency toward negative emotionality
- Pre Trauma factors
  - Family stability, history of psychiatric illness/socio economic factors
- Post Trauma factors
  - Family stability, coping and support/parents' reaction

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More likely to develop PTSD:

- Events that hurt others (rape, assault)
- More traumas = more likely PTSD develops
- Girls more likely to develop (~5x)
- Minorities have higher levels of PTSD? Or is due to minorities may go thru more traumas?
  - Urban centers marked by high levels of crime, violence, poverty
- PTSD looks different in different ages

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Symptoms of PTSD age 5-12

- May not have flashbacks, or remember all parts of trauma
- May put events of trauma in incorrect order
- May think "signs" trauma was going to happen ("Will I see signs again?" Must pay attention to avoid in future)
- Play may show repeated parts of trauma
- Regressive behaviour (thumb sucking, wetting bed)

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Symptoms of PTSD age 12-18

- More likely to show impulsive and aggressive behaviour (more so than children or adults)
- Can be similar to child behaviours but more likely similar to adult PTSD Sx

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AnxietyBC and PTSD

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Teen Symptoms

- Detachment from others (worried how I"ll behave)
- Flashbacks – can cause panic Sx
- Nightmares
- Avoid reminders of event
- Insomnia
- Loss of interest in life
- Anger
- Memory loss
- Feel "jumpy"
- Self medicate

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Other behaviours

(data from sexual abuse research)

- Self worth/concept lowered
- Lack of trust
- Out-of-place sexual behaviours
- Self-harm

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Evidence-Based Treatments for PTSD

- Cognitive Behavior Therapy
  - Prolonged exposure (PE)
  - Stress inoculation training (SIT)
  - Cognitive therapy (CPT)
- EMDR

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CBT

- Usually TF-CBT
  - Psychoeducation: Talk about memory/traumatic incident, Anxiety
  - Teach relaxation (lower worry, stress)
  - Assertiveness
  - Healthy thinking
  - Exposure
    - Imaginal and In vivo

Learn do not have to be afraid of memories

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Stress Inoculation Therapy

- Similar to Relapse Prevention method
- Anticipate stressful situations, know vulnerable times
- Be pro-active
- Have plan in place to avoid pitfalls (puzzle to be solved, not obstacle)

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Cognitive Processing (CPT)

- Evaluate thoughts
- Change upsetting thoughts
- Reduce self-blame
- Change way think about world
- Mobile app: CPT Coach (free, VA)

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EMDR (E Shapiro)

- Eye Movement Desensitization Reprocessing
- Limited studies with children
- Eye movement unnecessary

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Play Therapy

- *Possibly* useful especially for very young children
- Do not deal with trauma directly
- Games, drawings help to process memories

"There is insufficient evidence to determine the effectiveness of play therapy in reducing psychological harm among children who have developed symptoms of PTSD following traumatic exposures." (Am J Prev Med , 2008)

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CBITS

- Cog Beh Intervention for Trauma in Schools
  - Psychoeducation
  - Relaxation
  - Social problem solving
  - Cognitive restructuring
  - Exposure

** Evidence based, research from 2000 demonstrates lower PTSD, depression and other psychosocial dysfunction

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Refresher on Memory

- Brain is a modular system
- Some parts critical for retrieval or storage of memory and others are not
- Several memory storage systems in brain designed to store certain types of information:
  - Episodic memories/Explicit memories
  - Spatial
  - Muscular
  - Emotional

**Damage to 1 part does not necessarily impair other
Sometimes other modules can compensate

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Neuroscience

- Perhaps memories are stored by connections (synapses) between cells (neurons)
- Similar to rivers – connections keep forming until death
- Short term memory (STM)
- Long term memory (LTM)
- STM to LTM via consolidation – takes time and lots of rivers

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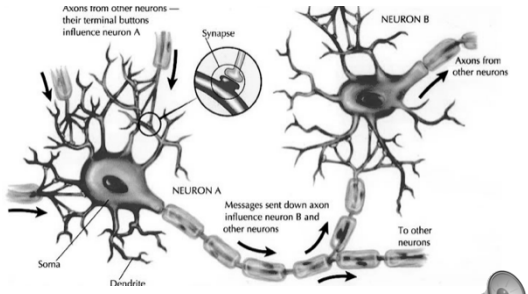
Neuron to neuron



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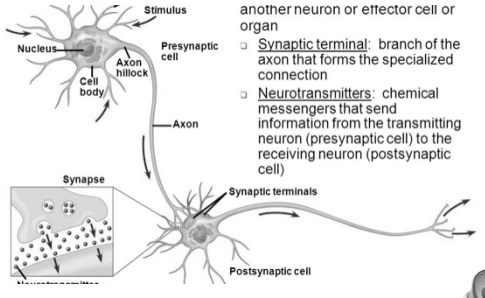
Synaptic junction



another neuron or effector cell or organ

- Synaptic terminal: branch of the axon that forms the specialized connection
- Neurotransmitters: chemical messengers that send information from the transmitting neuron (presynaptic cell) to the receiving neuron (postsynaptic cell)

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LTM

- Current thinking is long term memories are altered each time remembered, can be fragile and can change
- Needs to be reconsolidated
- New learning (new experiences) can counter-balance and outweigh older memories

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How Exposure works

- Reactivates trauma memories
- Puts into unstable state that needs reconsolidation
- Opportunity for reappraisal, reassessment, corrective information
- Client learns anxiety might be uncomfortable but not dangerous

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Facilitating Therapeutic Alliance

- Acknowledge client's courage in coming for treatment
- Communicate understanding of the client's symptoms
- Incorporate examples when describing the treatment (e.g., common reactions)
- Validate client's experience in empathic and non- judgmental manner
- May be the first time relating the trauma narrative; your reaction is important
- Work collaboratively
  Incorporate the client's judgment about pace and targets of therapy

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How to Present the Rationale

- Present the rationale for treatment clearly, making sure that client understands it.
- Encourage questions from client, and support rationale with examples, analogies or metaphors that fit the client's presentation.
- Show knowledge about PE and the research literature supporting its efficacy.
- Convey confidence in the treatment and in his/her ability to use it effectively.

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Psychoeducation

- Elicit from client his or her experience of PTSD symptoms and related problems
- Validate and normalize the client's experiences and symptoms in the context of PTSD
- Instill hope: help client to realize that a good deal of his/her distressing symptoms and problems are directly related to PTSD and much of this may improve as a function of treatment

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How to start

- Ask what child/teen knows
  - Silence sends message too horrible to talk about
  - Social media nearly ensures kids know more than you might expect
  - Listen for misinformation, underlying fears
  - Gently correct inaccurate information
  - Use simple language
  - Encourage the child to ask questions (very often will be about possibility of reoccurrence)
  - Limit media exposure

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Exposure

The two primary procedures are:

- Imaginal exposure and processing: repeated revising, recounting, and processing of the traumatic event.
- In-vivo exposure: repeated confrontation with situations, activities, places that are avoided because they are trauma reminders.

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Rationale for Imaginal Exposure

- Repeated revisiting of the trauma:
  - Helps process (digest) the trauma, (organize, make sense of it)
  - Helps distinguishing between "thinking" about the trauma and actually "re-encountering" it
  - Results in habituation, so that the trauma can be remembered without intense, disruptive anxiety
  - Fosters the realization that engaging in the trauma memory does not result in loss of control or "going crazy"
  - Enhances sense of self control and personal competence

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Implementing Imaginal Exposure

Standard Instructions are:

- Recall the memory with your eyes closed
- Imagine that the trauma is happening now
- Engage in the feelings that the memory elicits
- Describe the trauma memory in present tense
- Recount as many details as you can including events, thoughts, and feelings
- Repeat the narrative as many times as necessary in allotted time

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Therapist Involvement During IE

- Express empathy with client's distress, but keep comments to a minimum
- Titrate client's emotional response:
  - Probe for thoughts and feelings to encourage emotional engagement
  - If needed, may conduct revisiting with client's eyes open, and/or use past tense
- If client is distressed, periodically reassure client (e.g., "This is hard, but you are safe here." "You're doing a good job staying with it.")
- Allow sufficient time (20 min) after revisiting to discuss and process experience

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Processing the Imaginal Exposure

- Provide positive feedback and acknowledgment of the client's courage and ability to confront these painful memories
- Ask the client to express her thoughts and feelings about the imaginal revisiting of this traumatic experience (e.g., "What was that like for you?")
- Normalize and help her understand her reactions and behaviors in the trauma and its aftermath
- Comment on change in SUDS within or across sessions (or lack thereof, if indicated)

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The Advantage of Prolonged Exposure

- Has the largest number of studies supporting its efficacy and effectiveness
- Effective with the widest range of trauma populations
- Studied in many independent centers in the US and around to world
- Widely disseminated in the US and abroad;
- Effectiveness in the hands of non-experts has been documented in several studies

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How to Implement In Vivo Exposure

Homework Assignment:

Begin with assigning exposure to situations that evoke moderate levels of anxiety (e.g., SUDS = 5)

Instruct the client to remain in each situation for 30 minutes, or until s/he feels more comfortable

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Example In Vivo Hierarchy (teen)

Staying at home alone in the middle of the day	5
Driving to a friend's home in a safe neighborhood in daytime	6
Driving to a friend's home in a safe neighborhood after dark	7
Walking down a street in own neighborhood	7.5
Staying alone in her room with door locked	8
Walking with a friend outside school	8.5
Walking alone outside school during daytime	9
Walking alone outside school at night	10

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Fear Hierarchy - child

Riding in a car through same intersection as accident	**10**
Driving to intersection, stopping car	9
Drive 1 block off of intersection	8
Observing other cars go thru intersection	7
Walking through intersection	6
Walking to intersection but turning around before entering	5
Imaginal exposure: telling what happened	3
Drawing picture of car accident	1-2

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Dissociation Subtype of PTSD

- Feelings of derealization (world is not real)
- Depersonalization (oneself is not real)
- Confronted with overwhelming experience from which escape is not possible – allows person to continue functioning
- Usu increased comorbidity with other psychological disorders
- Usu increased functional impairment

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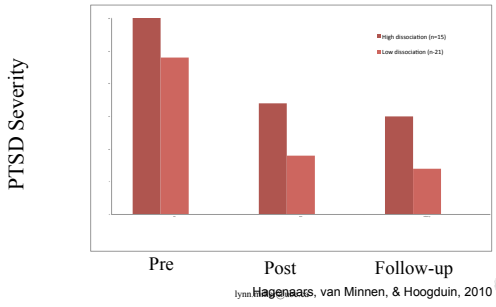
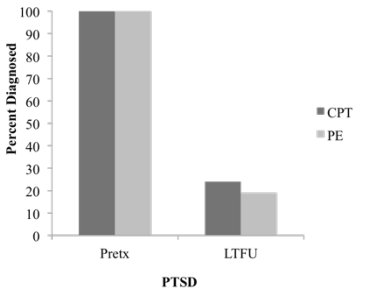
The Efficacy of PE with High and Low Dissociations



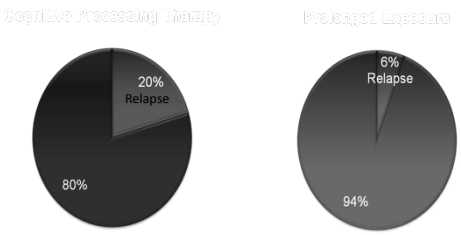
lynn.miller@ubc.ca Hagenaars, van Minnen, & Hoogduin, 2010

5-year Follow-up in PE and CPT



lynn.miller@ubc.ca Resick et al. 2008

Percent Relapse of PE and CPT Completers at 5-10 year Follow-up



There was a trend for PE to have less relapse than CPT at LTFU, $X^2(1, N = 75$ 3.8, $p = .057$.

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Therapist Self-Care

- Remind yourself of what you tell the client:
  - Memories are not dangerous
  - PE works!
- Focus on the client – do the therapy
  - Therapist is not processing trauma in same way as client
- Extinction learning works for you, too
- You will learn to develop tolerance for client distress
- Work with a team, when possible
  - Have consultation and support of other therapists who also do trauma work
  - Discuss impact and coping strategies with others

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Generalized Anxiety Disorder

- Persistent tendency to worry excessively and uncontrollably about a variety of themes
  - *school work*
  - *family/friends*
  - *pets*
  - *world events*
  - *being late*
  - *personal belongings*
- associated with high intolerance of uncertainty
- associated with muscle tension, sleep problems, irritability, fatigue and difficulty concentrating or making decisions

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More Symptoms

- Overly self-critical
- Avoid activities where they feel cannot perform perfectly
- Lots of reassurance seeking (parents, teachers, caregivers)
- Somatic complaints
- Worries about personal and family safety

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Take on adult-size worry

- Will eavesdrop on adult conversations
- Will peer over shoulder when writing a check
- Adults will regret telling child information as child will ruminate, bring up in future

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Red Flags

- Excessive, unrealistic fears about day-to-day activities
- "What if?" spans into future
- Uncontrollable worry about performance
- Difficulty concentrating – what's next?
- Low risk-taking
- Perfectionism
- Fear hurt other's feelings

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BACKGROUND INFORMATION: GAD (adult)

- 3% 1-year prevalence; 5% lifetime prevalence
- Diagnosed in 10-25% of those presenting at anxiety disorders clinics
- ~ 60% female in clinical samples
  many symptomatic since childhood but adult onset in face of particular stressor is not unusual (some evidence for bimodal age of onset)
- ~70% of individuals with GAD have another diagnosis, most commonly depression or dysthymia (~55%) , social phobia and simple phobia

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BACKGROUND INFORMATION: GAD

- Associated with somatic symptoms (e.g., chest pain, chronic fatigue, irritable bowel syndrome, tension headache and chronic medical illness (e.g., hypertension, diabetes, heart disease)
- Least common anxiety disorder in mental health care settings BUT most common anxiety disorder in primary care settings
- Chronic but fluctuating course

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Diagnostic Reliability of GAD

- Compared to other anxiety d/o, GAD has poor diagnostic reliability
- Unclear boundaries with OCD, social phobia and hypochondriasis (Health Anxiety)
- Shared diagnostic features with other DSM d/o

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Good questions to ask

- Does your parent think you worry too much?
- Would your friend worry as much as you if they were in the same situation?
- When all is going well, do you worry that things will change?
- Do your worries appear for no apparent reason or out of the blue?

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More good questions to ask

- Do you begin to worry as soon as you are not busy?
- Once you start to worry, do you have trouble changing your thoughts?
- Trouble stopping worrying?
- What strategies do you use to distract? (listen/prompt ideas such as going for a walk or calling a friend) to stop worrying?

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Worry themes

- The majority worry about "everything"
- Most common are relationships, work/school, future and finances
- Worry about minor matters is specific to GAD (e.g., will I need paper this week?)

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Treatment overview

- Education
- Worry awareness training
- Coping with uncertainty
- Reevaluating beliefs about worry
- Problem-solving training
- Cognitive exposure
- Relapse prevention

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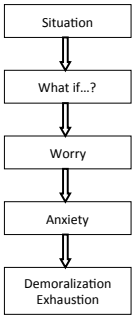
GAD Basic Model



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Worry Awareness Training

Clients keep a **daily "worry diary"** that they fill out at three pre-set times during the day between sessions

Date and Time	Situation	Worry (What if?)	Anxiety 0-10
Wed., Jan 17 3 pm	Text while walking home	Mom ok? Alternate possibility: Lab partner needing info	8
Thurs, Jan 18, 9am	Heard police siren outside of classroom	School intruder? Alternate possibility: Speeding car	10

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Intolerance of Uncertainty (IOU)

Definition: low tolerance for the possibility of a negative outcome in the future, however small the probability of its occurrence

Research findings:

- individuals with **GAD have a lower tolerance** of uncertainty than non-clinical worriers and other anxiety disorder clients.
- Changes in the level of tolerance of uncertainty have been linked to changes in level of worry in time-series analyses

IOU is considered to be an important maintaining factor for worries

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Analogy for Targeting IOU

- GAD as an "allergy" to uncertainty
- People who are intolerant of uncertainty **try to avoid, get around or eliminate uncertainty** in a variety of ways, for example, by **engaging in worry behaviours** such as excessive checking or reassurance-seeking (e.g., getting the opinion of someone else before acting).
- However, it is impossible to eliminate all uncertainty from life so **treatment aims to gradually increase tolerance of uncertainty** (like a series of allergy shots)

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Manifestations of I.O.U "worry behaviours"

Manifestations of intolerance of uncertainty may include:

- avoidance of new or unfamiliar activities
- finding imaginary obstacles to doing things
- procrastinating
- not delegating tasks to others
- making only partial commitments to things
- looking for excessive information before proceeding with action
- reassurance seeking
- double checking
- overprotecting others

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Homework Ideas

Examples:

Leaving for school 10 minutes early (instead of 30) to be certain to be on time

Buying an item without fully researching it

Ordering a meal that you have never had before at a restaurant

Not calling one's parent on the cell phone to be certain he has not been in a car accident, etc.

Wearing clothes never worn before

Application: help clients to identify manifestations of intolerance of uncertainty in their lives & design behavioural tasks to help clients build tolerance

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Positive & Negative Beliefs about Worry

People with GAD believe that worrying is more useful than people who are low or moderate worriers.

Examples of positive beliefs about worry include:

- worrying helps to find solutions to problems
- worrying helps motivate one to get things done
- worrying offers protection from negative emotions
- worrying, in and of itself can prevent negative outcomes (magical thinking)
- worrying is a positive personality trait (e.g., makes me a caring daughter)

If you think worrying is useful, you are more likely to do it!

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Re-evaluating beliefs about worry

- List of positive beliefs about worry
  - 'proof' that the belief is true
  - 'counter proof' that the belief is false

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Re-evaluation

Worry	"Proof" belief is true	"Proof" belief is false
My mom hasn't texted me	If I worry about this it means I love my mom	I love my mom no matter if she texts or not
I have to review my homework 5 times before going to bed	My grades are pretty good, and it is because I review my homework	My grades are pretty good because I'm a good student
My grandmother is old	If I worry about my grandmother it means I'm a really good grand daughter	I'm a good grand daughter because I call her once a week

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Challenging Overestimations of Danger
(fire at school)

Step	Chance	Cumulative Chance
1. Bunson burner in lab	1/10	
2. Spark falls on floor	1/10	
3. Carpet/floor catches on fire	1/10	
4. Floor starts to burn and I don't notice	1/100	
5. Too late to help	1/100	1/ 10,000,000

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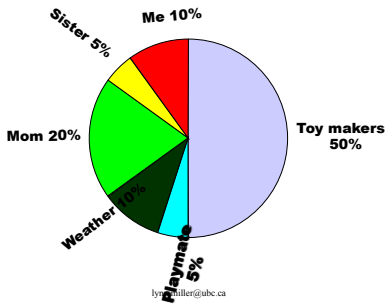
Challenging responsibility with pie charting
(afraid to ride bike)



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Family Environment

- Parents of anxious children are more likely to:
  - Reciprocate child avoidance
  - Provide negative feedback
  - Restrict child behavior
  - (FEAR effect: Family Enhancement of Avoidance Response)

So?

Teach constructive problem solving!

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Problem-solving Skills

Research suggests no deficiencies in skills per se, however clinical observations often suggest otherwise.

Review and practice of problem-solving techniques based on work of Nezu & D'Zurilla.

- Problem identification & definition
- Goal Formulation/Selection
- Generation of Alternatives/Brainstorming
- Consideration of Consequences & Decision-Making
- Solution Implementation & Verification/Evaluation

May need to repeat the process more than once!

Application: choose a made-up problem then use a real, current problem to demonstrate problem solving steps.

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Create problem and teach steps

- How to spend $10,000 in one hour
- Travelled some place and have no underwear and no money
- Stuck in remote town and no way to get home

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Cognitive Avoidance and Neutralization

- **Cognitive avoidance:** avoiding distressing thoughts or images by suppression or distraction
- **Neutralization:** voluntary attempt to decrease discomfort when confronted with distressing thoughts or images (e.g., telling self that it won't happen, or it won't be that bad if it does)
- In the short term, these strategies can help to diminish distress (which negatively reinforces avoidance/neutralization) but in the long term they serve to **maintain worry** (e.g., rebound effects of suppression; interference with habituation)
- **Demonstrate via "pink elephant" experiment**

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Targeting Avoidance/Neutralization

- **Repeated prolonged exposure to worry or "core fear"** until habituation occurs
- Draft brief exposure scenario about their core fear, in the present tense, incorporating details from the five senses to help create a vivid image, without neutralizing elements.
- Clients read their scenario over and over again onto a 30-45 minute tape which is then played back during their at-home exposures
- Application: Clients complete daily home exposures on the same scenario until habituation occurs (e.g., distress consistently below 2/10) & then move on to next worry.

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Cognitive Restructuring (Helpful thinking)

Come up with some helpful, brave thoughts with the child. Write them down.

- *I will be OK! This feeling won't last forever.*
- *What would (my friend) do?*
- *The anxiety is just trying to scare me! I don't have to listen.*
- *I'm the boss, NOT my anxiety.*
- *It's just my alarm going off. It's just my body trying to protect me.*
- *This feeling won't last forever. I'll be OK.*
- *I can feel anxious and still do it. I can be brave!*

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Cognitive Coping Cards

= Portable reminders of helpful thoughts

I can do some breathing now to relax

What's my evidence for this thought?

I'm in charge, NOT my anxiety!

That's just my anxiety talking; I don't need to listen!

Is there another way I can think about this?

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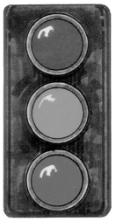
Green and Red Thoughts

GREEN

- I can do it!
- I can ask for help
- It doesn't matter what others think
- I am brave!



RED

- I can't do it!
- It is too hard!
- They will laugh at me
- I am stupid!

(www.pathwayshrc.com.au, Fun Friends Pr

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Helping Teens Challenge Unrealistic Thoughts

- *What has happened in the past/before?*
- *What else could happen?*
- *What's the worst thing that could happen?*
- *How could you handle it if it happened?*
- *Are you forgetting the positives/good parts?*
- *Did you try/do your best?*
- *Don't other people make mistakes?*
- *What would you tell your friend?*

KEY: What's the evidence?

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Important to Remember about "Unhelpful" and "Helpful" Thoughts

- **It's *okay* to have scary thoughts** – everybody does. But we want to have them less often. What's important is what we **do** with worries.
- **Helpful, brave thoughts need to be *realistic*.** They do not mean we are lying to ourselves.
- **Brave thoughts don't always necessarily make you feel *good***, but they can make you feel *better,* especially in very difficult situations.
- **Changing scary thoughts to brave thoughts *takes effort*.** It requires constant *practice*, *persistence* and *encouragement*.

Incorporating Technology

- Sync homework on phones
  - Write homework activities on phone
  - Enable ringer for reminder
  - Set time/days
  - Client reports back SUDS score, ability to conduct experiment

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The importance of homework

- Much of the change occurs between sessions
- Exercise analogy
- Predictor of success

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Test (Academic) Anxiety

Unifying formulation for the anxiety learners experience in schools (Cassady, 2010)

Special Populations:
Stereotype (SES, Sex, Race), LD, Gifted

Context Specific: test anxiety, technology-based

Content Specific: math, science

Career/Relevance of consequences

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Epidemiology

- Test anxiety rising since use of "high-stakes" tests in decision making (TestEdge National Demonstration Study)
- 10-40% of students have debilitating test anxiety (Clark & Burg, 2000; King & Ollendick, 1989)
- Can start as young as 7 yrs old
- 26% of high school students are handicapped by test anxiety "often" or "most of the time" (TestEdge National Demonstration Study)

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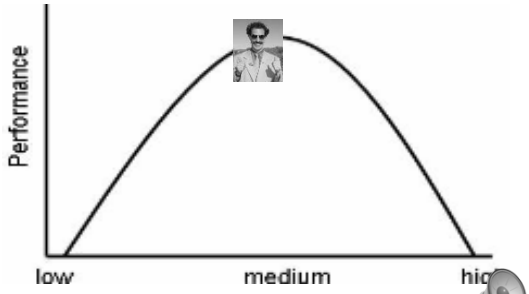
Optimal Levels of Anxiety



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Physical Symptoms

- Dizziness
- Headache
- Rapid heartbeat
- Perspiration
- Nausea
- Tics
- Flushing
- Difficulty sleeping
- Enuresis

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Behavioural Symptoms

- Off task behaviour (fidgeting, squirming, staring, rapid speech)
- Frequent comments about the test
- Faking illness
- Absent on test day
- Cheating

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Cognitive Symptoms

- Prefers to take tests outside of class time
- Negative self statements
- Pessimistic expectations
- Negative peer comparisons
- Difficulty with concentration and memory

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Test Preparation (Cassady: www.academicanxiety.org)

- Study skills and strategies
- Study time and efficiency
- Self-regulation
- Positive classroom climate
- Relaxation and attribution training

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Perfectionism

- Tendency to become highly anxious about making mistakes
- Procrastination
- Low frustration tolerance, gives up easily
- Overly cautious and thorough in tasks
- Tend to catastrophize

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More behaviours

- Motivated by fear of failure, gain acceptance
- Mistakes proof of not being good enough
- Impacts well-being and self concept
- Lots of power struggles and tantrums
- Fears lead to giving up easily, avoid new things

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Gain perspective

- Research famous people who failed
- Praise effort
- Set priorities (easy and difficult homework)
- Allot time (cannot give 100% to everything)
- Model uncertainty: “I don’t know”, “Oops! I goofed”
- No: “We are a family of perfectionists!”

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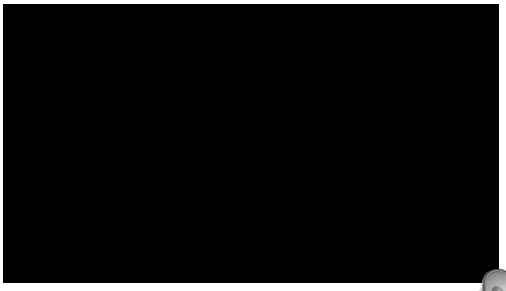
What a gift! (So perfectionism doesn’t follow us into adulthood)



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Be curious!

- Have child talk about mistakes and express grief, anger, sadness
- Learn from mistakes
- Talk about coping and forgiveness
- Avoid comparisons to other kids, siblings
- Help set realistic standards
- Humans make mistakes

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More perfection defeating strategies

- Id goal

General	Specific
Be less detail oriented	Tell stories to other kids without every detail
	Hand in report no longer than assigned
	Only check homework once

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Become more realistic

- Mom late picking me up from school
  - Perfectionistic thoughts:
    - Mom should never be late
    - I should not have to wait
  - Alternative thoughts:
    - It's ok for Mom to be late sometimes
    - It is ok to be kept waiting sometimes
    - If I were ok with waiting I"d be less upset when she does arrive

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Finally….

- Reward mistakes
- Make it fun

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Week 5 Review

- PTSD
  - PE works!
  - Get supervision
- GAD
  - Target IOU
  - Target perfectionism

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