# Don't Worry About it: Anxiety in Children and Adolescents in the Home and School

## 12 Hour Masterclass

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## Anxiety Understood

Topic 1 – Meghan Barlow, Ph.D.

## Topics Covered

- Heathy stress vs. anxious moments vs. interfering anxiety
- Causes of anxiety
- Assessment
- Core Components of anxiety
- Specific types of anxiety disorders
- Related conditions (OCD, Trichotillomania, and other habit disorders)
- Co-Occurring conditions

## Stress

- Normal and activating
- Locus of control**
- Perception of ability to cope, utilize resources**

## Anxious Moments

- Speed bumps
- Threat is unclear (very turbulent plane ride)
- Typical in many situations: new experiences, performance

## “Normal Anxiety”

- Protective
- Motivating
- Helpful

## "Disorder"

- Interference
- Paralyzing
- Stuck

## Anxiety and Cavemen

- The world was a dangerous place
- When they left the safety of their caves, had to be "on the lookout"
- Main goal = survival

## Fight or Flight or Freeze

- Fight
  - Temper tantrum
  - Lash out (physically or verbally)
- Flight
  - Avoidance
  - Escape
- Freeze
  - Shut down
  - Go blank
  - Withdraw

## Anxiety Disorder

- Hypervigilant and misread cues = "False Alarms"
- Meets specific criteria
- Causes impairment in functioning (gets in the way of being a ___ year old)
- Patterns, consistency, duration

## Anxiety Disorders

- Excessive *fear* (emotional response to real or perceived imminent threat)
- Excessive *anxiety* (anticipation of future threat)
- Related behavioral disturbances
- Specific disorders differ in the types of situations or objects that induce fear, anxiety, avoidance behavior, and cognitive ideation
- Differ from developmentally normative or anxious moments by being excessive or persisting beyond normative time periods

## Causes of Anxiety (Risk Factors)

- Genetics
- Wiring/Temperament
- Modeling/Social Learning
- Classical Conditioning
- Trauma
- Combination

## Wiring/Temperament

- Startle response
- Slow-to-warm up
- Introversion
- Behavioral inhibition
- Emotional reactivity
- Negative affectivity (neuroticism)
- Perseveration

APA, 2013; Dragon & Dragon, 2014; Fox & Pine, 2013

## Modeling/Social Learning

- Albert Bandura, 1977
- Anxiety develops through learning that occurs from observing others
- Learn to avoid, no opportunity to test and invalidate
- Bees/spiders, math, dentists' offices, germs, etc

## Classical Conditioning

- Watson, 1920s
- Looking at whether emotional responses could be classically condition (like Pavlov's dogs)
- Little Albert

## Trauma

- ACEs studies
- *Potentially* traumatic events

## Combination

- Genetic predisposition, activating event
- Genetic predisposition, modeling/social learning

## Is Anxiety on the Rise and Why?

- Qualitative data
- Statistics seem to support increase, but unclear
- Social media?
- Increased pressures?
- "Helicopter" parents (or worse – "Lawnmower" parents!)?
- Decreased stigma, increased diagnostic awareness

## Assessment

- Broadband rating scales (BASC, CBCL)
- Anxiety specific
  - Revised Children's Anxiety and Depression Scale (RCADS)
  - Youth (8-18) and parent versions
  - Subscales: separation anxiety disorder, social phobia, generalized anxiety disorder, panic disorder, obsessive compulsive disorder, and low mood
  - Version for anxiety in ASD
- Personality
- Behavioral observations/behavior samples (crying, tantrums, avoid)
- Interview with child/adolescent, parent
- Teacher data

## Core Components

- Thoughts
- Physiological Reactions
- Actions

## Types of Anxiety

- Generalized Anxiety
- Separation Anxiety
- Selective Mutism
- Specific Phobia
- Social Anxiety
- Panic Disorder

## Common Fears

- Fear of failure
- Fear of embarrassment (aka "looking bad")
- Fear of being left out
- Fear of letting others down
- Fear of "bad stuff"
- Fear of "gross stuff"

## Stressors

- Academic/College pressure
- Sports
- Extra-curriculars
- Peers
- Social media
- Current events
- Body image
- Family stressors
- Others' emotions
- Sexuality

## Generalized Anxiety

- Excessive anxiety and worry (apprehensive expectation) more days than not for at least 6 mo, about multiple events or activities
- Individual finds it difficult to control the worry
- Anxiety and worry associated with at least one of the following:
  - Restlessness, feeling keyed up or on edge
  - Easily fatigued
  - Difficulty concentrating, mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance
- Causes clinically significant distress/impairment
- Not attributable to physiological effects of a substance or other medical condition
- Not better explained by another mental disorder

## Generalized Anxiety Disorder

- Related to muscle tension, many feel shaky, twitching, trembling
- May also experience somatic symptoms (sweating, nausea, diarrhea) or have IBS, headaches
- Exaggerated startle response
- Females are 2x as likely to be diagnosed as males
- Prevalence of dx peaks in middle age and declines in later years of life
- In children and teens, worries tend to focus on performance and competence, even when not being evaluated by others
- May worry about punctuality or catastrophic events

## Generalized Anxiety Disorder

- Children with GAD may come across as "perfectionistic" and unsure of themselves
- Redo tasks if not "perfect"
- Seek reassurance and approval
- May be overdx in children – need to carefully assess for other anxiety disorder to see if better explanation

## Separation Anxiety

- Developmentally *inappropriate and excessive* fear or anxiety concerning separation from attachment figures with at least 3 of the following:
  - Recurrent, excessive distress with separation or anticipation of separation
  - Persistent, excessive worry about losing AF (or harm to them)
  - Persistent, excessive worry about untoward event causing separation
  - Persistent reluctance or refusal to go out and because of fear of separation
  - Persistent, excessive fear or reluctance about being alone or w/o AF
  - Persistent reluctance or refusal to sleep away from AF
  - Repeated nightmares involving separation
  - Repeated complaints of physical symptoms when separated

## Separation Anxiety

- Fear, anxiety, avoidance is persistent, lasting at least 4 weeks in children/adolescents and 6 months or more in adults
- Disturbance causes clinically significant distress/impairment
- Not better explained by another mental disorder

## Functional Consequences of SAD

- Limited independent activities
- Social withdrawal
- School avoidance/refusal
- Even when "in" school, frequent attempts to be picked up/go home, have parent stay
- Not going away to college
- Stressors on parents (job absences, limited social life, sleep)

## Separation Anxiety Disorder

- Most common anxiety disorder in children under 12 yo
- Decreases in prevalence from childhood to adolescence to adulthood
- Equally common in males and females in clinical samples, more common in females in community samples
- Majority of children with SAD do not grow up to have other anxiety disorders in lifetime
- Often develops after a stressor (i.e., a loss, change, disaster causing separation)
- Parental overprotection and intrusiveness may be associated
- Heritability estimated at 73%

## Separation Anxiety Disorder

- Cultural component – consider in assessment
- Differential diagnosis includes other anxiety disorders, bereavement, depression, ODD, psychotic disorders
- Highly comorbid with generalized anxiety disorder and specific phobia

## Selective Mutism

- Consistent failure to speak in specific social situations when there is an expectation for speaking (i.e., at school) despite speaking in other situations
- Interferes with educational or occupational achievement or with social communication
- Duration of at least 1 month (not limited to 1st month of school)
- Not attributable to lack of knowledge of, or comfort with, spoken language required
- Not better explained by a communication disorder and does not occur exclusively during ASD

## Selective Mutism

- May speak in home, around certain people, or only to certain people
- Might whisper, write, use non-verbals
- May be willing to participate in activities that don't require speech
- Might be associated with excessive shyness, worry about embarrassment, clingy behavior, social isolation, negativism, temper tantrums, mild oppositional behavior
- May occasionally be a communication disorder present, but *anxiety* present
- Relatively rare (0.03 – 1% in clinical and school samples), mostly young children
- No gender difference

## Selective Mutism

- Course is unknown – outgrow vs social anxiety disorder?
- Risk factors may include negative affectivity, behavioral inhibition, parental history of shyness, parental social inhibition, overprotective parents, social anxiety
- *May* have subtle receptive language difficulties, but still in average range
- May be shared genetic component between selective mutism ad social anxiety
- Differential dx includes communication d/o, neurodevelopmental d/o, psychotic d/o, social anxiety d/o

## School Related Problems

- Participation in class
- Showing mastery, asking questions
- Social relationships
- Getting needs met (i.e., illness, bathroom, help with materials)
- Can be demanding of 1:1 attention from teachers
- Can be demanding of 1:1 attention from specific classmate

## Specific Phobia

- Marked fear or anxiety about a specific object or situation
- Fear or anxiety may be expressed by crying, tantrums, freezing, clinging
- Phobic object almost always provokes immediate fear or anxiety
- Active avoidance or endured with intense fear or anxiety
- Fear/anxiety disproportionate with actual danger
- Persistent, lasting 6+ months
- Clinically significant distress/impairment
- Not better explained

## Common Phobias in School Children/Teens

- Animals (including insects, bees)
- Weather
- Blood-injection-injury
- Choking
- Vomiting
- Loud sounds
- Costume characters

## Specific Phobia

- Common for individuals to have multiple specific phobias, code separately
- Average individual with phobia fears 3 objects/situations
- 75% fear more than one situation/object
- Typically experience increase in physiological arousal anticipating or enduring exposure
  - Situational, natural/environmental, animal – sympathetic nervous system arousal
  - Blood-injection-injury – vasovagal fainting, near fainting response (initial brief acceleration of heart rate and elevation of heart rate, followed by deceleration

## Specific Phobia

- In US, 12 month prevalence is 5% for children, 16% in 13-17 year olds
- More common in females than males 2:1, but rates vary across different phobic stimuli
  - Animal, natural/environmental, situational – more common in females
  - Blood-injection-injury – near equal
- Sometimes develops after PTE (dog bite, plane landing), unexpected panic attack (which then leads to phobia of the situation), exposure to information (news coverage)
- Usually develops in early childhood, majority of cases before 10 yo
- Situational specific tends to have later age of onset

## Specific Phobia

- Phobias that develop in childhood/adolescence tend to wax and wane
- Risk factors include negative affectivity, behavioral inhibition, parental overprotectiveness, parental loss and separation, physical and sexual abuse, PTE, genetics, physiology
  - 1st degree relative with a specific phobia of animals more likely to have same specific phobia
  - Propensity to vasovagal syncope in individuals with blood-injury-injection
- 60% more likely to make a suicide attempt than individuals without the dx (but high comorbidity of phobia with personality d/o and other anxiety d/o)

## Specific Phobia

- Distress and impairment tends to increase with number of feared objects/situations
- May interfere with getting medical/dental care
- May interfere with health/dietary (fear of vomiting, choking)
- Differential dx includes agoraphobia, social anxiety, separation anxiety, panic disorder, OCD, trauma and stress related d/os, eating disorders, psychotic d/o
- Frequently associated with range of other d/os
- Increased risk for development of other d/os including other anxiety, mood, substance related d/os, somatic symptom and related d/os, and personality d/os

## Social Anxiety Disorder (Social Phobia)

- Marked fear or anxiety about social situations in which individual is exposed to possible scrutiny by others (social interactions, being observed, performing)
- Anxiety must occur with peers, not just adults
- Fear of acting in a way or showing anxiety symptoms that will be humiliating, will lead to rejection, will offend others
- Social situations almost always provoke fear or anxiety which may be expressed by crying, tantrums, freezing, clinging, shrinking, failing to speak
- Social situations are avoided or endured with intense fear or anxiety
- Fear is out of proportion to actual threat and sociocultural context

## Social Anxiety Disorder (Social Phobia)

- Fear, anxiety, avoidance is persistent, typically lasting 6+ months
- Clinically significant impairment/distress
- Not attributable to physiological effects of substance or medical condition
- Not better explained
- If another medical condition (obesity, disfigurement from burns) is present, fear, anxiety, or avoidance is excessive
- ** Specify if performance only

## Related School Challenges

- Reading aloud
- Participation in class discussion
- Answering/asking questions
- Eating, drinking during school hours
- Interacting with peers (i.e., for social/leisure purposes or group work)
- Presentations
- Posted work, grades, behavioral standings
- Attending in class
- Taking tests, exams in group

## Social Anxiety Disorder (Social Phobia)

- May be inadequately assertive, excessively submissive or less commonly, highly controlling in conversation
- May show rigidity in body posture, inadequate eye contact, or speak softly
- May be seen as shy or withdrawn, may be less open in conversations and disclose little about themselves
- Self-medication is common
- 12 month prevalence in US children and teens is approximately 7%
- Higher rates in females; more equivalent rates in clinical samples

## Social Anxiety Disorder (Social Phobia)

- 75% of individuals dx in US have age of onset between 8-15 yo
- Onset may follow stressful or humiliating social experience or may develop slowly without clear trigger
- Risk factors include behavioral inhibition, fear of negative evaluation, childhood adversity, genetic component
- Differential dx includes normative shyness, agoraphobia, panic d/o, GAD, separation anxiety d/o, specific phobias, selective mutism, depression, body dysmorphic d/o, delusional d/o, ASD, personality d/o, other mental or medical d/o, ODD

## Social Anxiety Disorder (Social Phobia)

- Often comorbid with other anxiety d/o, depression, substance use d/o, body dysmorphic d/o
- In children specifically, comorbid with ASD and selective mutism

## Panic Attacks = Abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time 4 or more occur

- Racing, pounding heart
- Sweating
- Trembling, shaking
- Sensations of shortness of breath or smothering
- Feelings of choking
- Chest pain, discomfort
- Nausea, abdominal distress
- Feeling dizzy, unsteady, light-headed or faint
- Chills or heat sensations
- Numbness or tingling
- Derealization (feelings of unreality) or depersonalization (being detached from self)
- Fear of losing control or "going crazy"
- Fear of dying

## Panic Disorder

- Recurrent, unexpected panic attacks
- At least one panic attack is followed by 1+month of one or both:
  - Persistent concern or worry about additional panic attacks or their consequences
  - A significant maladaptive change in behavior related to the attacks (avoidance of behavior/situations that might trigger an attack)
- Not attributable by physiological effects of a substance or medical condition
- Not better explained

## Related School Challenges

- Entering specific classrooms
- Entering specific areas in school (i.e., cafeteria, assemblies)
- Speaking in class, presenting
- Taking tests, exams in quiet room
- School trips
- Attending in class
- School refusal

## Panic Disorder

- Frequency and severity of panic attacks vary widely
- In US, 12 month prevalence is 2-3% in adolescents
- Rare in childhood, but adults with panic disorder trace ”fear spells” back to their childhood
- Risk factors include negative affectivity, anxiety sensitivity (disposition to believe that anxious sx are harmful), childhood sexual or physical abuse, smoking, increased identifiable stressors in time period preceding onset, genetic component, respiratory disturbance (asthma)
- Equivalent rates between gender

## Panic Disorder

- In individuals with panic disorder, caffeine, carbon dioxide, etc may provoke panic attacks
- Panic attacks and panic d/o associated with increased suicidality, even when comorbidities and childhood abuse are controlled
- Differential dx includes other anxiety d/os, substance/medication induced anxiety
- Frequently comorbid with other anxiety d/o (esp agoraphobia), depression, bipolar

## Related Conditions

- OCD
- Body Focused Repetitive Behaviors
- Post Traumatic Stress Disorder

## Obsessive-Compulsive Disorder

- Presence of obsessions, compulsions, or both
- Obsessions are defined by:
  - Recurrent and persistent thoughts, urges, images that are intrusive and unwanted
  - Attempts to ignore or suppress thoughts, urges, images or to neutralize
- Compulsions are defined by:
  - Repetitive bx or mental acts the individual feels driven to perform in response to obsession or according to rigid rules
  - Acts are aimed at preventing/reducing anxiety or preventing a dreaded event, but are not connected realistically or are clearly excessive
  - Young children may not be able to articulate aims of bx or mental acts

## Obsessive-Compulsive Disorder

- Obsessions or compulsions are time consuming or cause clinically significant distress/impairment
- Not attributable to a substance
- Not better explained
- * Level of insight and history of tics specified

## Trichotillomania

- Recurrent pulling on one's hair, resulting in hair loss
- Repeated attempts to decrease or stop pulling
- Causes clinically significant distress/impairment
- Not attributable to another condition
- Not better explained

## Other Body Focused Repetitive Behaviors

- Skin-picking
- Nail biting
- Cheek biting
- Lip picking
- Tongue chewing
- Hair sucking, eating, twisting

## Post Traumatic Stress Disorder (6 yo+)

- Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways:
  - Directly experiencing the event
  - Witnessing, in person, the event as it occurred to others
  - Learning that the traumatic event occurred to close family/friend. In cases of actual/threatened death of family/friend, the event must have been accidental or violent
  - Experiencing repeated/extreme exposure to aversive details of traumatic event (**does not usually apply to exposure through media)

## Post Traumatic Stress Disorder (6+ yo)

- Presence of one or more of the following intrusion sx associated with traumatic event beginning after traumatic event occurred:
  - Recurrent, involuntary, distressing memories (can see repetitive play with themes of trauma)
  - Recurrent distressing dreams related to trauma (children may have bad dreams without recognizing content)
  - Dissociative reactions (flashbacks)in which individual feels/acts as if trauma was recurring (in children, trauma specific reenactment may occur in play)
  - Intense or prolonged distress at exposure to internal or external cues that resemble or symbolize trauma
  - Marked physiological reactions to internal or external cues

## Post Traumatic Stress Disorder (6+ yo)

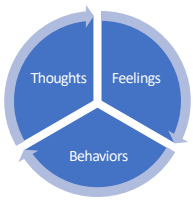
- Persistent avoidance of stimuli associated with trauma
- Negative alterations in cognitions and mood associated with trauma
- Marked alterations in arousal and reactivity associated with traumatic event
- Duration is longer than 1 month
- Clinically significant impairment/distress
- Not attributed to another condition or substance

Up Next: Therapeutic Approaches to Managing Anxiety

# Topic 2: Therapeutic Approaches to Managing Anxiety

## Cognitive-Behavioral Therapy

- Behavior Therapy
  - 1890s – Ivan Pavlov
  - 1920s - John Watson
  - 1930s - B.F. Skinner
- Cognitive Therapy
  - 1950s - Albert Ellis
    - Rational Emotive Behavior Therapy (REBT)
  - 1960s - Aaron Beck
  - 1980s – David Burns



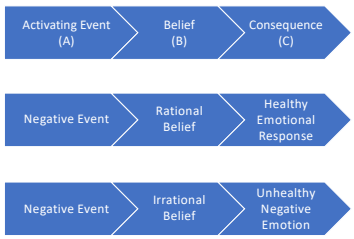
## Behavior Therapy: Common Techniques

- Reinforcement
  - Positive
  - Negative
  - Noncontingent
- Shaping
  - Teaching a new behavior
- Chaining
  - Teaching more complex series of behaviors
- Extinction
  - Used with Differential Reinforcement
- Punishment
  - Response Cost
  - Time-Out

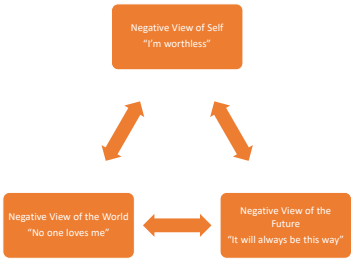
## Behavior Therapy: Common Techniques

- Token Economies
- Schedules of Reinforcement
- Modeling
- Parent and Peer Training
- Data Tracking
- Flooding
- Systematic Desensitization
- Aversion Therapy

## Cognitive Therapy: ABC Model



## Cognitive Therapy: Cognitive Triad




## Cognitive Therapy: Cognitive Distortions

- **All or Nothing Thinking**
- **Overgeneralization**
- **Mental Filter**
- **Discounting the Positive**
- **Jumping to Conclusions**
- **Magnification**
- **Emotional Reasoning**
- **'Should' Statements**
- **Labeling**
- **Personalization and Blame**

David D. Burns *The Feeling Good Handbook* (1999).

## Cognitive Therapy: Cognitive Distortions

**All or Nothing Thinking**

- You see things in black or white categories. There is no flexibility in your thinking. If a situation falls short of perfect, you see it as a total failure. *When a girl gets one question wrong on a test, she thinks, "I failed the test, there's no point on studying for anything else"*

- David D. Burns *The Feeling Good Handbook* (1999).

Cognitive Therapy: Cognitive Distortions

**Overgeneralization**

- You see a single negative event, criticism from a teacher, as a never-ending pattern of defeat by using words such as 'always' or 'never' when you think about it. *You ask a girl out and she says 'no'. You think, "No one likes me".*

- David D. Burns *The Feeling Good Handbook* (1999).

Cognitive Therapy: Cognitive Distortions

**Mental Filter**

- You pick out a single negative detail and dwell on it exclusively, so that your vision of all reality becomes darkened, like the drop of ink that discolors a glass of water. *Your parent tells you that you did a great job cleaning your room, but that you forgot to put <u>one</u> toy away. You ignore the compliment and only focus on what you did wrong.*

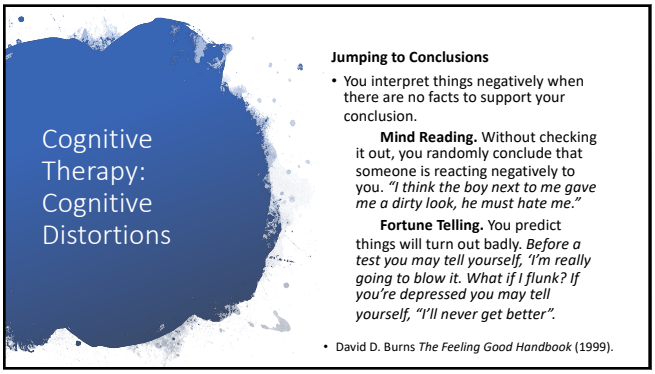
- David D. Burns *The Feeling Good Handbook* (1999).

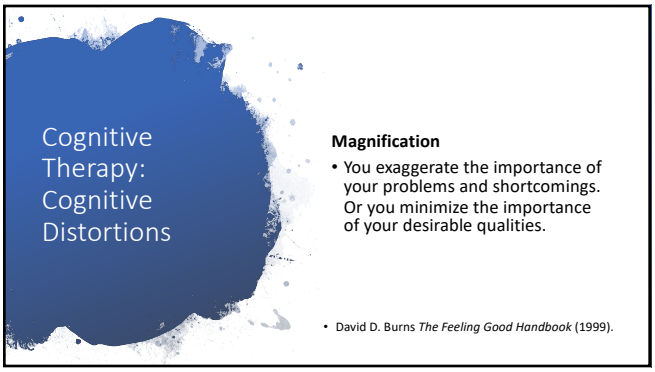
Cognitive Therapy: Cognitive Distortions

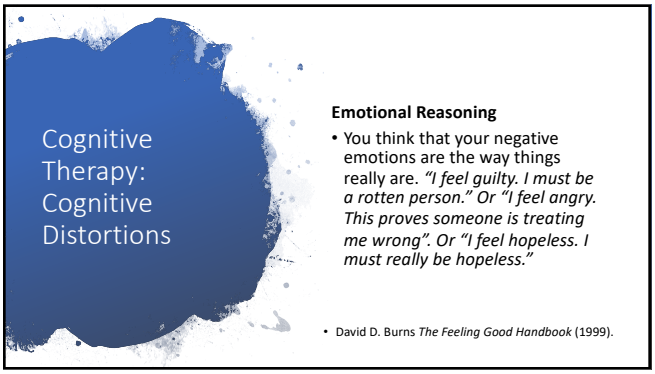
**Discounting the Positive**

- You reject positive experiences by insisting they 'don't count'. *If you do a good job, you may tell yourself that it was good enough or that anyone could have done as well.* Discounting the positive takes the joy out of life and makes you feel inadequate and unrewarded.

- David D. Burns *The Feeling Good Handbook* (1999).


Cognitive Therapy: Cognitive Distortions
Jumping to Conclusions
• You interpret things negatively when there are no facts to support your conclusion.
Mind Reading. Without checking it out, you randomly conclude that someone is reacting negatively to you. "I think the boy next to me gave me a dirty look, he must hate me."
Fortune Telling. You predict things will turn out badly. Before a test you may tell yourself, 'I'm really going to blow it. What if I flunk? If you're depressed you may tell yourself, "I'll never get better".
• David D. Burns The Feeling Good Handbook (1999).


Cognitive Therapy: Cognitive Distortions
Magnification
• You exaggerate the importance of your problems and shortcomings. Or you minimize the importance of your desirable qualities.
• David D. Burns The Feeling Good Handbook (1999).


Cognitive Therapy: Cognitive Distortions
Emotional Reasoning
• You think that your negative emotions are the way things really are. "I feel guilty. I must be a rotten person." Or "I feel angry. This proves someone is treating me wrong". Or "I feel hopeless. I must really be hopeless."
• David D. Burns The Feeling Good Handbook (1999).

Cognitive Therapy: Cognitive Distortions

**'Should' Statements.**

- You tell yourself that things *should* be the way you hoped or expected them to be. *After playing a difficult song on a piano, a very good pianist told herself 'I shouldn't have made so many mistakes'. This made her feel so bad that she quit practicing for several days.* 'Must', 'ought to's", and 'have tos' are similar offenders.

- David D. Burns *The Feeling Good Handbook* (1999).

Cognitive Therapy: Cognitive Distortions

**Labeling**

- Labeling is an extreme form of all-or-nothing thinking. *Instead of saying 'I made a mistake', you attach a negative label to yourself: "I'm a loser." You might also label yourself "a fool" or "a failure" or "a jerk."* These labels are useless thoughts that lead to anger, anxiety, frustration, and low self-esteem.
- You may also label others. *When some does something that makes you mad,, you may tell yourself: 'He's a dummy.'* Then you feel like the problem is in that person's 'character' instead of in what they're thinking or they're behavior. You see them as totally bad. This makes you feel mean and hopeless about improving things and leaves little room for good communication.

- David D. Burns *The Feeling Good Handbook* (1999).

Cognitive Therapy: Cognitive Distortions

**Personalization and Blame**

- Personalization occurs when you hold yourself personally responsible for an event that isn't entirely under your control. *A girl's parents get into heated arguments, and she thinks, 'If only I was a better daughter, my parents wouldn't fight.'* Personalization leads to guilt, shame, and feelings of inadequacy.
- Some people do the opposite. They blame other people or their situation for their problems, and they overlook ways that they might be contributing to the problem: one wants to get stuck with it.

- David D. Burns *The Feeling Good Handbook* (1999).

## Cognitive Therapy: Ways to Untwist Thinking

1. **Identify the Distortion**
2. **Examine the Evidence**
3. **The Double Standard Method**
4. **The Experimental Technique**
5. **Thinking in Gray**
6. **The Survey Method**
7. **Define Words**
8. **The Substitution Method**
9. **Finding the Cause**
10. **Plus-Minus List**

David D. Burns *The Feeling Good Handbook* (1999).

## Cognitive Therapy: Ways to Untwist Thinking

**Identify the Distortion**

- Write down your negative thoughts so you can see which of the ten forms of twisted thinking you're caught up in. This will make it easier to think about the problem in a more positive and realistic way.

- David D. Burns *The Feeling Good Handbook* (1999).

## Cognitive Therapy: Ways to Untwist Thinking

**Examine the Evidence**

- Instead of thinking your negative thought is true, examine the actual evidence for it. *For example, if you feel that you never do anything right, make a list of several things you have done right.*

- David D. Burns *The Feeling Good Handbook* (1999).

Cognitive Therapy: Ways to Untwist Thinking

**The Double Standard Method**

- Instead of putting yourself down in a harsh way, talk to yourself in a kind way, like the way you would talk to a friend.

- David D. Burns *The Feeling Good Handbook* (1999).

Cognitive Therapy: Ways to Untwist Thinking

**The Experimental Technique**

- Do an experiment to test if your negative thought is correct. *For example if you think there are monsters under your bed, take a look!*

- David D. Burns *The Feeling Good Handbook* (1999).

Cognitive Therapy: Ways to Untwist Thinking

**Thinking in Gray**

- Instead of thinking about your problems in all-or-nothing extremes, grade things on a scale of 0 to 100. When things don't work out as well as you hoped, think about the experience as a small success rather than a complete failure. See what lessons you can learn.

- David D. Burns *The Feeling Good Handbook* (1999).

Cognitive Therapy: Ways to Untwist Thinking

**The Survey Method**

- Ask people questions to find out if your thoughts and attitudes are realistic. *For example, if you feel like its weird to be scared or nervous when meeting new people, you can ask your parents or friends if they have ever felt that way.*

- David D. Burns *The Feeling Good Handbook* (1999).

Cognitive Therapy: Ways to Untwist Thinking

**Define Words**

- When you label yourself "a loser" or "a fool", ask, *"What is the definition of a fool?"* You will feel better when you see that there is no such thing as a 'fool' or a 'loser'.

- David D. Burns *The Feeling Good Handbook* (1999).

Cognitive Therapy: Ways to Untwist Thinking

**The Substitution Method**

- Simply substitute words that are less harsh or emotional this method is helpful for 'should' statements. Instead of telling yourself, '*I shouldn't have made that mistake*' you can say '*It would be better if I hadn't made that mistake.*'

- David D. Burns *The Feeling Good Handbook* (1999).

## Cognitive Therapy: Ways to Untwist Thinking

**Finding the Cause**

- Instead of automatically assuming that you are "bad" and blaming yourself entirely for a problem, think about the many things that may have contributed to it. Focus on solving the problem instead of using up all your energy blaming yourself and feeling guilty.

- David D. Burns *The Feeling Good Handbook* (1999).

## Cognitive Therapy: Ways to Untwist Thinking

**Plus-Minus List**

- List the pluses and minuses of a feeling (*like getting angry when your brother or sister take your toy*), or a negative thought (like "*No matter how hard I try I always mess up*"). You can also use the Plus-Minus list to change a self-defeating belief such as, "*I must always try to be perfect.*"

- David D. Burns *The Feeling Good Handbook* (1999).

Worksheet

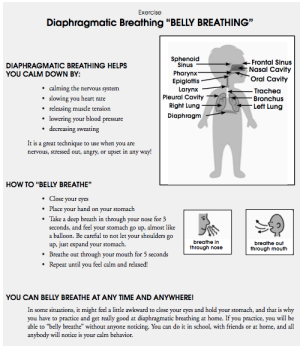
**Thought Chart: Rational Response**

**Directions:** Complete the information below to change the cognitive distortion into a rational response. An example has been provided to help you.

| Situation | Emotion | Automatic Thought | Cognitive Distortion | Rational Response | Outcome |
|---|---|---|---|---|---|
| **Describe situation that occurred.** | **Label the feeling and rank how strong it is on a scale from 1 to 10.** | **Write down the thought you had.** | **Identify the cognitive distortion or twisted thinking pattern.** | **Identify a way to untwist your thinking and then write rational thought.** | **Label your feeling and rank how strong it is on a scale from 1 to 10.** |
| Mom tells me to get off video game | Frustrated - 8 | She never lets me finish a game. | Over-generalization | Examined the evidence – she did let me finish the game last Monday. I'll ask her when I can finish the game. | Frustrated – 5 |
| | | | | | |

## Self-Regulation and BioFeedback

- Self-regulation is the process of guiding one's own thoughts, behaviors, and feelings to reach goals
  - Physical, emotional, and thought regulation
- Biofeedback is self-regulation
  - Enables the individual to learn how to change physiological activity to improve health and performance
  - Instruments measure physiological activity such as brainwaves, heart function, breathing, muscle activity, and skin temperature.
  - Instruments then provide feed back information to the user



Exercise

**Diaphragmatic Breathing "BELLY BREATHING"**

**DIAPHRAGMATIC BREATHING HELPS YOU CALM DOWN BY:**

- calming the nervous system
- slowing you heart rate
- relaxing muscle tension
- lowering your blood pressure
- decreasing sweating

It is a great technique to use when you are nervous, stressed out, angry, or upset in any way!

Sphenoid Sinus
Pharynx
Epiglottis
Larynx
Pleural Cavity
Right Lung
Diaphragm
Frontal Sinus
Nasal Cavity
Oral Cavity
Trachea
Bronchus
Left Lung

**HOW TO "BELLY BREATHE"**

- Close your eyes
- Place your hand on your stomach
- Take a deep breath in through your nose for 5 seconds, and feel your stomach go up, almost like a balloon. Be careful to not let your shoulders go up, just expand your stomach.
- Breathe out through your mouth for 5 seconds
- Repeat until you feel calm and relaxed!

breathe in through nose

breathe out through mouth

**YOU CAN BELLY BREATHE AT ANY TIME AND ANYWHERE!**

In some situations, it might feel a little awkward to close your eyes and hold your stomach, and that is why you have to practice and get really good at diaphragmatic breathing at home. If you practice, you will be able to "belly breathe" without anyone noticing. You can do it in school, with friends or at home, and all anybody will notice is your calm behavior.

**Positive Imagery Script**

Lie or sit in a comfortable position. Feel your body against the chair and begin to focu on your breathing. Be aware of the in-breath. . . aware of the out-breath. . . breathing in, feeling calm, breathing out, and feeling at peace.

Now I'd like you to see yourself in a very special place. . . It could be a real place – a place you may have actually been – a beautiful spot in nature or comfortable spot in your own home. Your special place may be an imaginary place – a place in fairy tales – indoors or outdoors – it doesn't really matter. Should more than one place come to mind, allow yourself to stay with one of them.

The only thing that matters is that it is a place in which you are completely comfortable and safe. . . you feel comfortable and safe. Appreciate this scene with all your senses. Hear the sounds – smell the aromas, feel the air as it caresses your skin – experience the ground securely under you – touch and feel the whole environment that you are in.

Notice the colors that surround you. What is the temperature? Is it warm? Is it cold? Are you alone or are you with another person or people. Notice the qualities of the place that make it safe and comfortable.

Look around you to see if there is anything else that would make this place more safe for you. . . perhaps something that you need to remove from the place or something you need to bring in. . . and then notice how your body feels in this place. . . and now take some time to enjoy this feeling of safety in this special place. . .

Now thank yourself for taking the time. . . perhaps promising yourself and reassuring yourself that you will visit this place or some other place on your own, whenever you need to.

When you're ready. . . at your own pace. . . let your breathing deepen. . . very gradually let the awareness of your body against the floor or the chair return. . . and when you are ready. . . gently open your eyes.

**Progressive Muscle Relaxation**

**Directions:** *Relaxation skills* may help you cope with stress, anger, illness, sleep problems, injury or pain. Relaxation exercises are designed to help you recognize and reduce body tension.

As you complete each exercise, think about each group of muscles. Notice the difference between the tight and relaxed muscles. If a feeling *of tightness continues in any group of muscles after you have repeated the exercise several times, focus again on relaxing that particular muscle group. Your whole body should feel loose and relaxed.*

**Legs**

Sit or lie down with your legs straight. Point your toes toward your head. Hold this position and feel the tightness in your calf muscles. Relax your muscles and let your entire leg go limp. Focus on making your calf as loose as you can. Repeat this exercise.

Lift and extend both legs until you can feel the tightness in your thigh muscles. Hold this position, feel the tightness of your thigh muscles. Relax until all of the tightness in your thigh muscles is gone. Repeat this exercise. Try to keep your feet and ankles relaxed while you are tightening your thighs.

**Chest and Abdomen**

Take a deep breath and fill your lungs with air. Hold the air in your lungs. Feel the tightness in your chest and abdominal muscles. Now release the air and relax. Breath normally. Notice how easily the air moves when you are relaxed. Repeat this exercise.

Relax for a few seconds, then tighten, the muscles in your abdomen. Hold this position feeling the tightness of the muscles. Release your abdominal muscles and relax, breathing normally again. Repeat this exercise.

**Hands and Arms**

Make your hand into a fist; close your fist tightly and hold it closed. Feel the tightness in the muscles of your hand and forearm. Now relax your hand. Let it go limp and wiggle your fingers. Feel the tightness leave your hand and fingers. The muscles in your hand and forearm should feel relaxed. Remember to hold the relaxed position longer than the tense position. Do this exercise two times on each hand.

**Upper Arms**

Keeping your hands relaxed and arms straight, raise your hands to shoulder height. Bend your arms at the elbows so that your hands rise up; tighten the muscles in your upper arms. Count to 5 and then lower your arms until your hands hang limply at your sides. Notice how relaxed your muscles feel as you count to 5 again. Make your arms as loose as you can. Repeat this exercise.

**Shoulders**

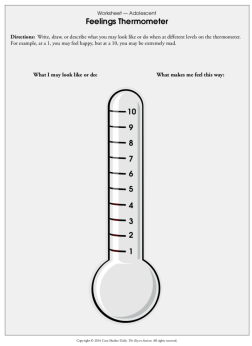
Raise your shoulders to your ears and notice the tightness in the muscles in your shoulders and neck. Hold this position and think about how your muscles feel. Relax and drop your shoulders to their normal position. Relax your shoulders even more, letting them drop toward the floor. Notice the difference between the feeling of tightness and the feeling of relaxation. Repeat this exercise.

**Neck**

Move your head forward until your chin touches your chest. Notice the tension in the front of your neck, but especially in the back of your neck. Gradually put your head back in an upright position. Now put your head back as far as it will go, as if you were going to touch your head to your back. Notice where it is tense. Gradually put your head back in an upright position. This is the least tense position. While still in the relaxed position, tilt your head to the right, as if you were going to touch your head to your right shoulder. Bring your head back to the relaxed position. Now tilt your head to the left shoulder. Bring your head back to the relaxed position. Notice the difference when those muscles are loose and relaxed. Repeat exercise.

**Face**

Next, wrinkle your nose. Hold the position for five seconds and relax your face. Now tighten the muscles around your mouth and cheeks by putting your face in a forced smile. Your lips should be hard against your face. Notice how those muscles feel tight and tense. Gradually relax your face. Repeat the exercise.


Worksheet — Adolescent

**Feelings Thermometer**

**Directions:** Write, draw, or describe what you may look like or do when at different levels on the thermometer. For example, at a 1, you may feel happy, but at a 10, you may be extremely mad.

**What I may look like or do:** | **What makes me feel this way:**

10 9 8 7 6 5 4 3 2 1

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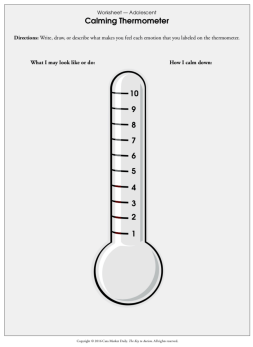
Worksheet — Adolescent

**Calming Thermometer**

**Directions:** Write, draw, or describe what makes you feel each emotion that you labeled on the thermometer.

**What I may look like or do:** | **How I calm down:**

10 9 8 7 6 5 4 3 2 1

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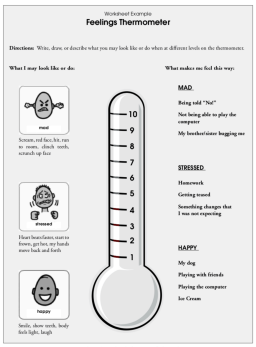
Worksheet Example

**Feelings Thermometer**

**Directions:** Write, draw, or describe what you may look like or do when at different levels on the thermometer.

**What I may look like or do:** | **What makes me feel this way:**

mad
Scream, red face, hit, run to room, clinch teeth, scratch up face

frustrated
Heart beats faster, start to frown, get hot, my hands sweat back and forth

happy
Smile, show teeth, body feels light, laugh

10 9 8 7 6 5 4 3 2 1

**MAD**
Being told "No"
Not being able to play the computer
My brother/sister bugging me

**STRESSED**
Homework
Getting teased
Something changes that I was not expecting

**HAPPY**
My dog
Playing with friends
Playing the computer
Ice Cream

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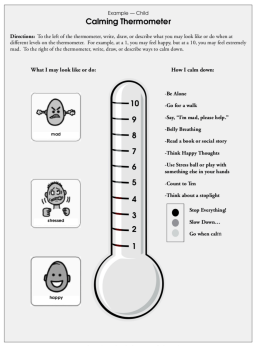
Example — Child

**Calming Thermometer**

**Directions:** To the left of the thermometer, write, draw, or describe what you may look like or do when at different levels on the thermometer. For example, at a 1, you may feel happy, but at a 10, you may feel extremely mad. To the right of the thermometer, write, draw, or describe ways to calm down.

**What I may look like or do:** | **How I calm down:**

mad
frustrated
happy

10 9 8 7 6 5 4 3 2 1

- Be Alone
- Go for a walk
- Say, "I'm mad, please help."
- Belly Breathing
- Read a book or social story
- Think Happy Thoughts
- Use Stress ball or play with something else in your hands
- Count to Ten
- Think about a stoplight
  - Stop Everything!
  - Slow Down...
  - Go when calm

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## Types of Biofeedback

**Brain waves**
This type uses scalp sensors to monitor your brain waves using an electroencephalograph (EEG).

**Breathing**
During respiratory biofeedback, bands are placed around your abdomen and chest to monitor your breathing patterns and respiration rate.

**Muscle contraction**
This type involves placing sensors over your skeletal muscles with an electromyograph (EMG) to monitor the electrical activity that causes muscle contraction.

**Heart rate**
This type uses finger or earlobe sensors with a device used to detect blood volume changes. Or sensors placed on your chest, lower torso or wrists use an electrocardiograph (ECG) to measure your heart rate and how your heart rate varies.

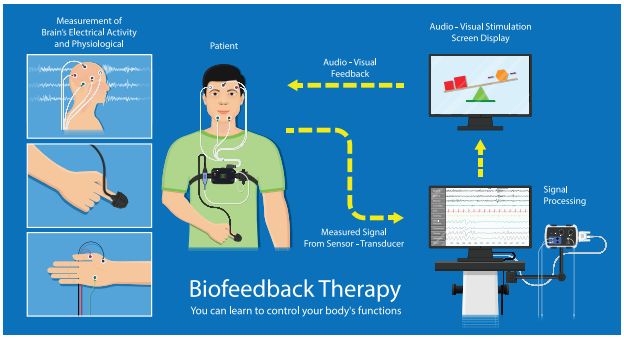
**Sweat gland activity**
Sensors attached around your fingers or on your palm or wrist with an electrodermograph (EDG) measure the activity of your sweat glands and the amount of perspiration on your skin, alerting you to anxiety.

**Temperature**
Sensors attached to your fingers or feet measure blood flow to your skin. Because your temperature often drops when you're under stress, a low reading can prompt you to begin relaxation techniques.

## Biofeedback Devices

Biofeedback equipment is classified by the Food and Drug Administration (FDA) as a **Class II Medical Device**

Most apps or software programs are unregulated systems and not considered biofeedback



# Topic 3: Additional Therapeutic Approaches to Managing Anxiety

## Exposure Response Prevention (ERP)

- Used to Treat Obsessive-Compulsive Disorder
  - First study by Meyer (1966)
- "ERP aims to break this cycle of symptoms by eliminating rituals and avoidance, thereby teaching patients how to tolerate distress without engaging in counterproductive behaviors and providing "corrective information" that challenges people's existing fear response." (Hezel & Simpson, 2019)

## Exposure Response Prevention (ERP)

- Exposure
  - Facing or confronting one's fears repeatedly until the fear subsides
  - Individual is gradually exposed to situations that cause anxiety (least situation first – direct or imagined)
  - Once habituation occurs, the fearful response is diminished and will eventually be *extinguished*
- Response Prevention
  - Goal is to refrain from compulsions, avoidance, or escape behaviors that people with OCD engage in to reduce anxiety
  - Individuals learn to resist the compulsion. Extinction occurs once these behaviors are no longer rewarded and prevented.

## Exposure Response Prevention (ERP)

- Assessment and Treatment Planning Phase
  - The clinician:
    - Provides psychoeducation about OCD and its treatment
    - Collects information about the patient's symptoms
  - The patient and clinician work together to identify stimuli that trigger the person's obsessive thoughts and subsequent distress:
    - External (situations, objects, people, etc.)
    - Internal (thoughts and physiological reactions)
  - Record the client's obsessions and compulsions
  - Discuss the functional relationship between the two
  - Identify the feared outcome if the rituals are not performed.
  - Create a fear hierarchy
    - Rank different situations in order from least to most distressing as measured by subjective units of distress (SUDs).

## Exposure Response Prevention (ERP)

- Subsequent Treatment Sessions:
  - Clinician coaches client to confront situations on fear hierarchy while refraining from engaging in compulsions
  - Client engages in both in vivo and imaginal exposures
  - Post-exposure processing
    - Reviews client's experience and what they learned
  - Client does homework (practice exposures)
  - Moves up fear hierarchy
  - Relapse Prevention Planning

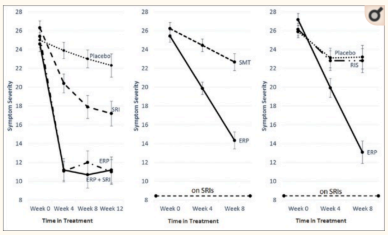



Figure 1

Effectiveness of exposure and response prevention versus other treatments. SRI – Serotonin reuptake inhibitor; ERP – Exposure and response prevention; SMT – Stress management therapy; RIS – Risperidone; symptom severity was assessed with the Yale–Brown Obsessive-Compulsive Scale (Y-BOCS); error bars – Standard error

Hezel & Simpson (2019).

## Mindfulness

- Being in the present
- A moment-by-moment awareness of our thoughts, emotions, bodily sensations, and surrounding environment
- A common cited definition: “mindfulness is the awareness that arises through “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally” (King and colleagues, 2011).
- Rooted in ancient spiritual traditions now used in Western psychology and medicine

## Mindfulness: Mindfulness-Based Stress Reduction

- Kabat-Zinn (1982; 1990)
- Group-Based Intervention
- 8-10 week course on meditation instruction and training
- 2 to 2 1/2 hours per week
- Home mindfulness practice encouaged
- Attend an all-day intensive mindfulness meditation retreat

## Mindfulness: Mindfulness-Based Stress Reduction

- A review of several randomised controlled trial studies found that MBSR reduces self-reported levels of anxiety, depression, anger, rumination, general psychological distress, including perceived stress, cognitive disorganization, post-traumatic avoidance symptoms and medical symptoms). (See King and Colleagues, 2011 for full review).

## Mindfulness: Mindfulness-Based Cognitive Therapy (MBCT)

- Segal and colleagues (2002)
- eight-week, manualized group intervention program
- Integration of Mindfulness-Based Stress Reduction and Cognitive Therapy
- Several randomized controlled studies have reported reduced relapse rates in depression and improved depressive symtpoms. (See King and Colleagues, 2011 for full review).

## Mindfulness: Dialectical Behavior Therapy (DBT)

- Linehan (1993)
- Borderline Personality Disorder
- Individual therapy
- Group Skills (Mindfulness taught)
- Telephone consultation between therapist and client
- Consultation Team Meetings for therapists
- Over 11 controlled studies have demonstrated positive outcomes. (See King and Colleagues, 2011 for full review).

## Mindfulness: Acceptance and Commitment Therapy (ACT)

- Hayes and Colleagues (1999)
- ACT teaches skills that increase the client's willingness to come into fuller contact with their experiences, recognize their values, and commit to behaviors that are consistent with those values

## Mindfulness: Acceptance and Commitment Therapy (ACT)

- Six Core Treatment Processes (mindfulness taught in first four):
  - Acceptance
  - Defusion
  - Contact with the present moment
  - Self as context
  - Values
  - Committed action

## Mindfulness: Acceptance and Commitment Therapy (ACT)

- Several randomized controlled studies have found ACT to be effective in treating depression, anxiety, impulse control disorders, schizophrenia, substance abuse and addiction, and workplace stress. (See King and Colleagues, 2011 for full review).

## Group Therapy

- Many manualized group therapy programs have been supported in the research in treating anxiety.
- What are the benefits of group versus individual treatment?
  - They feel less alone
  - Practice social skills
  - Immediate feedback from others
  - Modeling and observing behaviors
  - Sense of helping others
  - Cost effective

## Family Therapy

- Parent Programs
  - The therapist's intervention remains youth focused in working with the parents, teaching the parents skills to use with their children
- Parent therapies
  - The therapist's work is not directly focused on the youth and instead centers around the parents' behaviors
- Specific research-based interventions (see Palitz & Kendall, 2020 for a review):
  - The Child Anxiety Tales (CopingCatParents.com)
  - Parent-Child Interaction Therapy (PCIT)
  - The SPACE program (Supportive Parenting for Anxious Childhood Emotions)

## Psychopharmacology

- CBT considered the "gold standard"
- Selective Serotonin Reuptake Inhibitors (SSRIs) effective in treating anxiety, similar to CBT
- Research indicates that when youth are treated with the combination of these interventions, the response rate increases from 55% (SSRIs alone) or 60% (CBT alone) to 80% (SSRIs and CBT combined)
- CBT is considered the first intervention for anxiety by the American Academy of Child and Adolescent Psychiatry, and medication can be added on following a course of CBT if that is deemed appropriate for the individual youth. (Palitz & Kendall, 2020).

## Psychopharmacology

- Effective SSRIs
  - Sertraline (Zoloft)
  - Fluvoxamine (Luvox)
  - Fluoxetine (Prozac, Sarafem)
  - Paroextine (Paxil, Brisdelle, Pexeva)
  - Venlafaxine (Effexor)
  - Duloxetine (Cymbalta, Irenka)

(see Wehry et al., 2015, for full review)

## Psychopharmacology

- Tricyclic Antidepressants
  - Used less frequently due to side effects, frequent cardiac monitoring, and lethality in overdose
- Benzodiazepines
  - Fewer research studies

(see Wehry et al., 2015, for full review)

## Treating Comorbid Symptoms

- Sleep Disturbance
- Poor Diets
- Tics, Skin Picking, and Hair Pulling
- Inattentiveness
- Impulsivity
- Sensory Issues
- Social difficulties

## Sleep Distubance

- Education
- Small Steps
- Tracking Behaviors
- Rewards

## Poor Diets

- Education
- Changing Irrational Thoughts
- Tracking of Behaviors
- Rewards


## Tics, Skin Picking, and Hair Pulling

- Habit reversal training is an established evidence-based intervention (McGuire et al., 2015).
  - Psychoeducation
  - Awareness Training
  - Competing Response
  - Generalization Training
  - Self-Monitoring
  - Relaxation Training
  - Function-based Assessment
  - Function-based Intervention
  - Behavioral rewards
  - Review of Tic Difficulties
  - Relapse Prevention
- What to Do When Bad Habits Take Hold by Dawn Huebner, PhD

## Inattentiveness and Impulsivity

- Many times anxiety can look like symtpoms of ADHD.
- Determine if symptoms are related to anxiety or ADHD or both.
- Treat with Cognitive-Behavioral Therapies
- Environmental modifications
  - Organizational strategies
  - Visuals
  - Breaks

## Sensory Issues

- High anxiety can cause sensory overload.
  - Difficulty focusing due to competing sensory input
  - Extreme irritability
  - Restlessness and discomfort
  - Urge to cover your ears or shield your eyes from sensory input
  - Feeling overly excited or "wound up"
  - Stress, fear, or anxiety about your surroundings
  - Higher levels than usual of sensitivity to textures, fabrics, clothing tags, or other things that may rub against skin
- CBT, Self-Regulation Techniques
- Provide visuals (schedules, timelines, checklists) so they can focus if overwhelmed
- Take more breaks
- Have client communicate the need for sensory items (e.g., headphones, fidgets, seat cushion, dim lights, etc.).

## Social Difficulties

- Social skills programs in the natural environment
- Mentoring/teaching social skills to younger individuals
- Bibliotherapy
- Social Stories

# Topic 4: Empirically Validated Manualized Treatment Programs

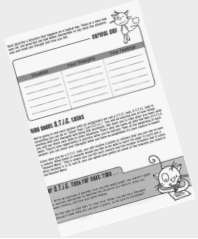
## COPING CAT

- "Empirically supported treatment" for separation anxiety disorder, social anxiety disorder, and generalized anxiety disorder (Kendall, 1994, Walkup et al., 2008).
- Numerous randomized controlled studies in US and several other countries have been conducted (Kendall et al., 2011).
- Maintenance effects maintained in longitudinal studies (Kendall et al., 2004).
- Also effective in treating anxiety in those with high functioning autism (McNally and colleagues, 2013).

## Coping Cat

- Philip Kendall, Ph.D., ABPP and associates- Temple University
  - The Coping Cat Workbook, Second Edition
    - Ages 8-13, 16 sessions
  - Cognitive-Behavioral Therapy For Anxious Children: Therapist Manual, Third Edition
  - The Coping Cat Parent Companion
  - The CAT Project
    - Ages 14-17
  - Therapist Manual for Group Treatment
- Use Manual as guiding template, not rigid cookbook.
- All Coping Cat, Therapist Manual, Parent Companion, and CAT Project material in this presentation reprinted with permission by Philip Kendall.

## Coping Cat – Session 1

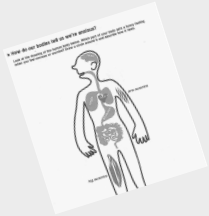


- Introduction
  - Building Rapport and treatment orientation
  - Goals:
    - Build Rapport
    - Orient child to the program
    - Encourage/support the child's participation
    - Assign an initial simple S.T.I.C task – "Show That I Can"
    - Engage in a fun end-of-session activity

## Coping Cat – Session 2


- Recognizing Feelings
  - Identifying anxious feelings
  - Goals:
    - Build Rapport
    - Review STIC task from session 1
    - Introduce the concept that different feelings have different physical expressions
    - Normalize the experiences fears and anxiety
    - Begin to construct a hierarchy of anxiety-provoking situations
    - Assign STIC task

## Coping Cat – Session 3




- How Does My Body React?
  - Identifying somatic responses to anxiety
  - Goals:
    - Review STIC task from Session 2
    - Discuss specific somatic reactions to anxiety
    - Practice identifying somatic responses
    - Introduce the "F" step (FEAR)
      - Feeling Frightened?
    - Prepare the child for the upcoming parent session
    - Assign STIC task

## Coping Cat – Session 4

- Parent Meeting
  - First meeting with parents
  - Goals:
    - Provide additional information about treatment
    - Provide parents an opportunity to discuss their concerns
    - Learn more about the situations in which the child becomes anxious
    - Offer specific ways the parents can be involved in the program

## Coping Cat – Session 5

- Let's Relax
  - Relaxation training
  - Goals:
    - Acknowledge the parent session
    - Review the STIC task from Session 3
    - Introduce the idea that many somatic feelings associated with anxiety involve muscle tension
    - Introduce the idea of relaxation and practice relaxation techniques
    - Develop the child's awareness of how and when relaxation might be useful
    - Practice relaxation via coping modeling and role-play
    - Practice relaxation with the child's parents
    - Assign STIC task

## Coping Cat – Session 6

- What Am I Thinking?
  - Identifying anxious self-talk and learning to challenge thoughts
  - Goals:
    - Review STIC task from Session 5
    - Introduce the concept of thoughts (self-talk)
    - Discuss self-talk in anxiety-provoking situations (anxious self-talk)
    - Differentiate anxious self-talk from coping self-talk
    - Introduce the "E" Step
      - Expecting bad things to happen?
    - Practicing coping self-talk
    - Assign STIC task

## Coping Cat – Session 7

- What Should I Do?
  - Reviewing anxious and coping self-talk and developing problem solving skills
  - Goals:
    - Review STIC task from Session 6
    - Review and discuss the first 2 steps in the FEAR plan
    - Introduce the "A" step
      - Attitudes and actions that can help
    - Discuss the concept of problem solving
    - Practice problem solving in anxious situations
    - Assign STIC task

## Coping Cat – Session 8

- How Am I Doing?
  - Introducing self-evaluation and self-reward and reviewing skills already learned
  - Goals
    - Review STIC task from Session 7
    - Introduce the "R" step
      - Results and rewards
    - Discuss the concept of self-rating and reward
    - Practice making self-ratings and rewarding oneself for effort
    - Review the FEAR plan
    - Apply the FEAR plan
    - Review the fear hierarchy and discuss exposure tasks
    - Acknowledge upcoming parent session
    - Assign STIC task

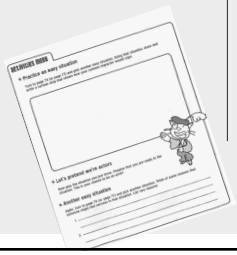
## Coping Cat – Session 9

- Parent Meeting
  - Second meeting with parents
  - Goals:
    - Provide additional information about the second half of treatment (i.e., exposure tasks)
    - Provider parents an opportunity to discuss their concerns
    - Learn more about the situations in which the child becomes anxious
    - Offer specific ways the parents can be involved in the second half of treatment

## Coping Cat – Session 10

- Start Practicing
  - Practicing in low anxiety-provoking situations using exposure tasks
  - Goals:
    - Review STIC task from Session 8
    - Review the idea of progressing from learning new skills to practicing new skills
    - Practice using imaginal exposure in low anxiety-provoking situations
    - Practice in-vivo exposure task in low anxiety-provoking situations
    - Briefly review relaxation exercises
    - Plan an exposure task(s) for Session 11
    - Assign STIC task

## Coping Cat – Session 11



- More Practice
  - Practicing in low anxiety-provoking situations using exposure tasks
  - Goals:
    - Review STIC task from Session 10
    - Continue practicing in-vivo exposure task in low anxiety-provoking situations
    - Plan exposure task(s) for Session 12
    - Assign STIC task

## Coping Cat – Session 12

- More Practice
  - Practicing in moderate anxiety-provoking situations using exposure tasks
  - Goals:
    - Review STIC task from Session 11
    - Practice using imaginal exposure in moderately anxiety-provoking situations
    - Practice in-vivo exposure task in moderate anxiety-provoking situations
    - Plan exposure task(s) for Session 13
    - Assign STIC task

## Coping Cat – Session 13

- It's Getting Tougher
  - Practicing in moderately anxiety-provoking situations using exposure tasks
  - Goals:
    - Review STIC task from Session 12
    - Practice using in-vivo exposure task in moderate anxiety-provoking situations
    - Plan exposure task(s) for Session 14
    - Assign STIC task

## Coping Cat – Session 14

- Let's Practice Some More
  - Practicing in high anxiety-provoking situations using exposure tasks
  - Goals:
    - Review STIC task from Session 13
    - Practice using imaginal exposure in high anxiety-provoking situations
    - Practice in-vivo exposure task in high anxiety-provoking situations
    - Plan exposure task(s) for Session 15
    - Assign STIC task

## Coping Cat – Session 15

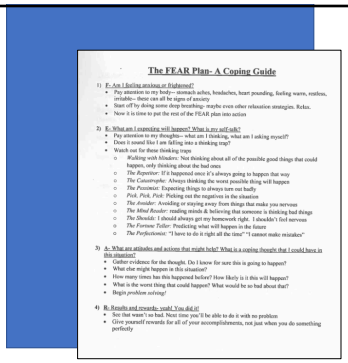
- Another Chance to Practice
  - Practicing in high anxiety-provoking situations using exposure tasks
  - Goals:
    - Review STIC task from Session 14
    - Practice in-vivo exposure task in moderate anxiety-provoking situations
    - Plan a closing exposure task for Session 16
    - Discuss briefly the end of treatment
    - Assign STIC task

## Coping Cat – Session 16

- You Did It!!
  - Practicing in high anxiety situations, producing the commercial, and terminating treatment
  - Goals:
    - Review STIC task from Session 15
    - Conduct a final exposure task in a high anxiety-provoking situation
    - Have fun producing the "commercial"
    - Review and summarize the treatment program and bring closure to the therapeutic relationship

## Coping Cat Parent Companion

- Used for parent when treating the child
- Education about anxiety and treatment
- Reads like a book about what is happening in each session.
- Gives relaxation scripts for parents to use with their child
- Educates about rewards during the program
- FEAR Plan – A Coping Guide



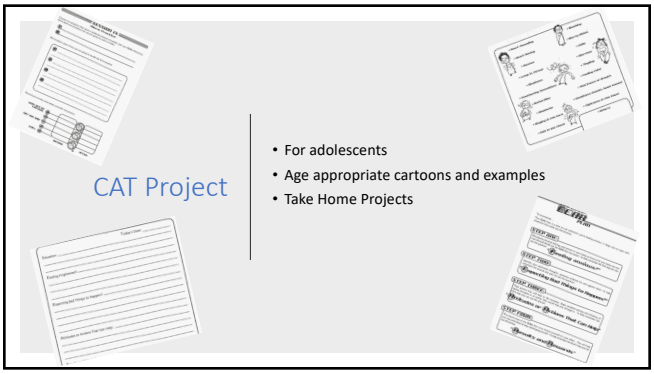
**The FEAR Plan- A Coping Guide**

1) F- Am I feeling anxious or frightened?
   - Pay attention to my body-- stomach aches, headaches, heart pounding, feeling warm, restless, irritable-- these can all be signs of anxiety
   - Start off by doing some deep breathing- maybe even other relaxation strategies. Relax.
   - Now it is time to put the rest of the FEAR plan into action

2) E- What am I expecting will happen? What is my self-talk?
   - Pay attention to my thoughts-- what am I thinking, what am I asking myself?
   - Does it sound like I am falling into a thinking trap?
   - Watch out for these thinking traps
     - *Walking with blinders:* Not thinking about all of the possible good things that could happen, only thinking about the bad ones
     - *The Repetitive:* If it happened once it's always going to happen that way
     - *The Catastrophe:* Always thinking the worst possible thing will happen
     - *The Pessimist:* Expecting things to always turn out badly
     - *Pick, Pick, Pick:* Picking out the negatives in the situation
     - *The Avoider:* Avoiding or staying away from things that make you nervous
     - *The Mind Reader:* reading minds & believing that someone is thinking bad things
     - *The Shoulds:* I should always get my homework right. I shouldn't feel nervous
     - *The Fortune Teller:* Predicting what will happen in the future
     - *The Perfectionist:* "I have to do it right all the time" "I cannot make mistakes"

3) A- What are attitudes and actions that might help? What is a coping thought that I could have in this situation?
   - Gather evidence for the thought. Do I know for sure this is going to happen?
   - What else might happen in this situation?
   - How many times has this happened before? How likely is it this will happen?
   - What is the worst thing that could happen? What would be so bad about that?
   - Begin *problem solving!*

4) R- Results and rewards- yeah! You did it!
   - Yes- that wasn't so bad. Next time you'll be able to do it with no problem
   - Give yourself rewards for all of your accomplishments, not just when you do something perfectly



## CAT Project

- For adolescents
- Age appropriate cartoons and examples
- Take Home Projects

## FRIENDS BY DR. PAULA BARRETT

- FRIENDS is a series of Resilience programs developed by Professor Paula Barrett.
- The programs aim to increase social and emotional skills, promote resilience, and preventing anxiety and depression across the lifespan
- Recognized in an evidence-based review conducted by the **World Health Organization** for the prevention and treatment of childhood and adolescent anxiety and depression.
- Program used throughout the world

## FRIENDS

**F = Feelings** (empathy training and self-regulation)
**R = Remember to relax** (relaxation; mindfulness strategies)
**I = I can try my best** (changing unhelpful to helpful thinking)
**E = Explore Coping Step Plans and strategies for finding helpful solutions** (choosing thumbs up actions instead of thumbs down actions)
**N = Now reward yourself for trying your best** (choosing interpersonal rather than material rewards)
**D = Don't forget to practice** (choose to use the FRIENDS skills and give back to the community)
**S = Stay calm** (values-based role models and support networks)

## FRIENDS

- Specific skills that are taught are based on the following principles:
- Our body is our FRIEND, and tells us when we are feeling worried by giving us clues so that we can choose to think helpful thoughts and practise thumbs up choices.
- We are FRIENDS to ourselves when we choose positive, helpful thoughts and thumbs up actions such as relaxation and mindfulness strategies
- It is important to learn to be our own FRIEND and reward ourselves when we try our best.
- It is important to think of our FRIENDS and values-based role models/support networks when we are making choices about our thumbs up actions

## FRIENDS

- FUN FRIENDS – 4-7
- FRIENDS FOR LIFE – AGES 8-11
- FRIENDS RELIENCE – AGES 12-15
- ADULT RELIENCE – AGES 16+

## *Social Effectiveness Therapy for Children (SET-C)* BY Deborah C. Beidel

- ***Social Effectiveness Therapy for Children (SET-C)*** is a comprehensive behavioral treatment program that combines group social skills training, peer generalization sessions, and individual exposure therapy sessions for the treatment of social phobia in children and adolescents
- The goals of are:
  - Enhance social interaction skills
  - Reduce social anxiety
  - Enhance and expand friendships

## *Social Effectiveness Therapy for Children*

- Group social skills training includes:
  - Basic conversational skills
  - Getting along with peers
  - Assertiveness
  - Telephone skills
- Program uses basic behavioral strategies including instruction, modeling, behavior rehearsal, feedback, and positive reinforcement.
- The group consists of 6 participants and two therapists.
- 12 weeks

## Social Effectiveness Therapy for Children

- Peer generalization sessions
  - Sessions allow peers to practice social skills with typically developing peers in naturalistic settings (pizza parlors, miniature golf, etc.).
  - Requires clinicians to arrange for typically developing children to meet the group at an activity (miniature golf course) and supervise a 90-minute activity.
  - The activity is not structured further other than to direct typically developing peers to "buddy up" with the children in the group – talking to them and participating with them in the activity.

## Social Effectiveness Therapy for Children

- Individual exposure sessions
  - The therapist develops a hierarchy of the child's social fears (reading aloud, talking to a peer, asking questions of adults, etc.)
  - Exposure is conducted on one item during the individual session.
  - The therapist does not progress to the next item until there is habituation of the first item.
  - Homework given

## Social Effectiveness Therapy for Children

- Several peer-reviewed and randomized control trial studies indicating effectiveness of SET-C in treating social phobia.
- Results maintained for 5 years

(Beidel et. al., 2000, 2005, 2007)

## Cool Kids Child and Adolescent Anxiety Management Program

- Cool Kids* Heidi Lyneham, Ph.D.
- Ages 6-18
- The goals of ***Cool Kids*** are to:
  - Reduce the symptoms and amount of life interference caused by anxiety.
  - Reduce avoidance.
  - Reduce family distress.
  - Increase confidence.
  - Improve peer relationships.
  - Increase engagement in extra-curricular activities.

## Cool Kids Child and Adolescent Anxiety Management Program

- Services Involve Family/Support Structures:
  - This program involves the family or other support systems in the individual's treatment: For children under 12, parents attend every session. For adolescents, parents attend most sessions. Parents learn how to manage children differently, how to manage their own anxieties, and how to help their child implement their new skills outside the therapy sessions.
- Recommended Intensity:
  - Individual format: Eight hour-long weekly sessions followed by two hour-long biweekly sessions Group format: Eight two-hour long sessions followed by two two-hour long sessions
- Recommended Duration:
  - 12 weeks

## Cool Kids Child and Adolescent Anxiety Management Program

- Psychoeducation: understanding anxiety and components of treatment
- Cognitive restructuring: "learning to act like a detective and gather evidence about whether feared events are really highly likely"
- Parent skills: goal in helping parents to manage their anxious child better and reducing their urge to control and overprotect; also teaching parents strategies to help manage their own anxious feelings
- In-vivo exposure: developing "stepladders" for the child that allows them to gradually face their fears and learn that feared events are unlikely to happen and that they can cope
- Social skills: learning to skills to engage better with people and to act more assertively with peers
- Improved coping strategies: skills to deal with teasing and bullying, relaxation and reducing poor coping such as drug-taking, and problem solving

## STAND UP, SPEAK OUT

- Anne Marie Albano and Patricia Marten DiBartolo
- Used for Adolescents ages 13 - 18
- Group treatment
- Client workbook and Therapist Guide, Cognitive-Behavioral Therapy for Social Phobia in Adolescents.
- Workbook provides educational information, worksheets, tips for problem solving, and at-home exercises. Age-appropriate and engaging, this workbook is easy-to-read and includes space for keeping session notes, as well as forms for tracking progress.

## Other OCD Resources

- Talking Back to OCD by John March
- What to do When your Brain Gets Stuck by Dawn Huebner, PhD

## Other Resources

- Websites
- Books

# Topic 5: Anxiety in the School

Meghan Barlow, Ph.D.

## Anxiety: "The Great Masquerader"

- Shying away
- Shutting down
- Not participating
- Crying
- Leaving the classroom
- Out of seat
- Temper tantrums
- Inflexible

## Anxiety: "The Great Masquerader"

- Physical aggression
- Work refusal
- Physical complaints
- Frequent urination
- Seeking reassurance, repetitive ?

## "The Great Masquerader"

- ADHD
- Oppositional Defiant Disorder
- Disruptive Behavior Disorder
- Anger Problems
- Learning Disorder
- Autism

## Anxiety from Classroom Demands

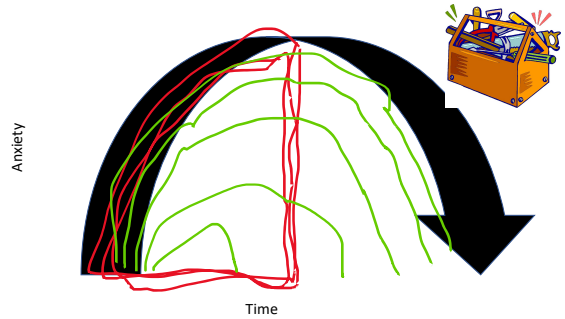
- Tests
- Behavior
- Performance

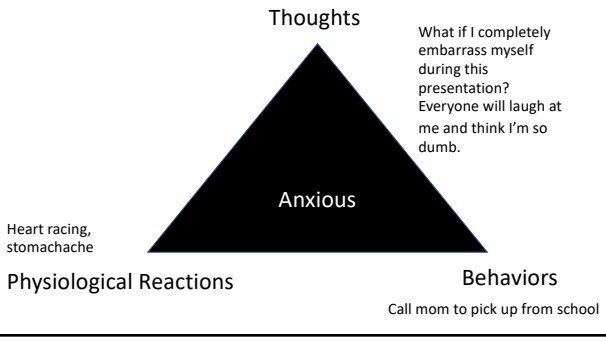
## Anxiety the Impacts School Functioning

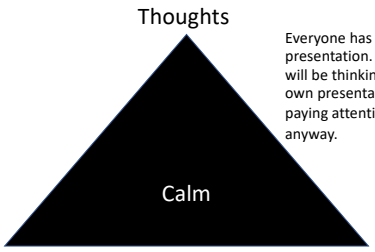
- Separation
- Panic
- OCD

## We Can

- Focus on social emotional learning
- Teach problem solving
- Acceptance of wide range of feelings
- Teach skills to quiet and calm
- Normalize anxious moments and healthy stress
- Put supports in place and shape as needed
- Understand habituation curve
- Understand anxiety triangle






Everyone has to do a presentation. Most people will be thinking about their own presentation or not paying attention to me, anyway.

Take deep breaths

Prepare, then get it over with!

## Automatic Negative Thoughts

- Mind Reading
- All or Nothing
- Catastrophizing
- Blame Game
- Overgeneralizing ("but he said…")
- Moodeasoning
- Zooming in on the Negative
- "I can't"
- The Shoulds
- Fortune Telling

## Changing Thoughts

## Changing Physiology

- Deep breathing
- Yoga
- Meditation
- Guided Imagery
- Muscle Relaxation
- Aromatherapy
- Acupressure
- Exercise
- Music

## Changing behaviors

- Ask: What do I do when I feel this way? Am I getting stuck, avoiding, or paralyzed? What actions can I take to:
  - Move forward
  - Solve my problem
  - Get in a calmer state so I can take more helpful action

## GAD - School Related Challenges

- Completing homework in reasonable amount of time
- Trouble sleeping (reviewing day, anticipating next day)
- Attending in class
- Performance on tests
- Interacting with peers
- Behavior in school
- Behavior at home, afterschool

## SAD – School Related Challenges

- Limited independent activities
- School avoidance/refusal
- Even when "in" school, frequent attempts to be picked up/go home, have parent stay
- Not going away to college
- Stressors on parents (job absences, limited social life, sleep)

## Selective Mutism – School Related Challenges

- Participation in class
- Showing mastery, asking questions
- Social relationships
- Getting needs met (i.e., illness, bathroom, help with materials)
- Can be demanding of 1:1 attention from teachers
- Can be demanding of 1:1 attention from specific classmate

## Specific Phobia –School Related Challenges

- Depends on phobia
- Avoidance of places, activities, situations (i.e., recess)
- Disruptions
- Attention focused on phobia
- Absences

## Social Anxiety Disorder - School Related Challenges

- Reading aloud
- Participation in class discussion
- Answering/asking questions
- Eating, drinking during school hours
- Interacting with peers (i.e., for social/leisure purposes or group work)
- Presentations
- Posted work, grades, behavioral standings
- Attending in class
- Taking tests, exams in group

## Panic - School Related Challenges

- Entering specific classrooms
- Entering specific areas in school (i.e., cafeteria, assemblies)
- Speaking in class, presenting
- Taking tests, exams in quiet room
- School trips
- Attending in class
- School refusal

## OCD - School Related Challenges

- Can take over attention
- Can make completing work/tests difficult or impossible (erasing, rewriting, redoing)
- Limit work according to compulsions (i.e., specific number of words, even numbers)
- Can limit engagement with environment, materials
- Time out of class (i.e., bathroom rituals)
- Restrict eating, drinking to prevent situations/places (i.e., bathroom)

## BFRBs – School Related Challenges

- Often causes embarrassment
- Takes up a lot of mental energy
- Can be distracting, disruptive
- Can draw attention from peers, teasing
- Actual pulling, picking can be time consuming (in or out of class)
- For some, increases with stress/anxiety

## PTSD – School Related Challenges

- Might interfere with attention
- Can be triggered by assignments (i.e., books) and interfere with work completion, participation in class
- Can interfere with attendance

## Giftedness

- Visualization
- Memory
- High sensitivity, empathy
- Highly perceptive
- Ability to see multiple potential consequences
- Think deeply about subjects (i.e., current events, problems of the world)
- Aware of differences from peers

## Stress-Contagion Theories

- Oberle, Schonert-Reichl (2016): students' morning cortisol levels significantly varied between classrooms; teacher burnout significantly reduced the unexplained variability – suggests teachers' job related stress is linked to students' physiological stress regulation
- Chicken or the egg?

## Creating a Classroom Culture

## Cultivating "The Yes Brain" – Siegel & Bryson


Empathy


Resilience


Balance


Insight

## Develop and Communicate Priorities

- Make a mantra (and BELIEVE it!)
  - "We are problem-solvers;" "we are risk-takers;" "we are respectful and kind to others and to ourselves;" "we make mistakes and we learn from them"
- Present it (to kids and parents) and teach it (to parents and kids)
- Repeat it
  - Just because and in teachable moments
- Reflect on it
  - Personally and with students
- Make sure your messages are consistent with your mantra

## Consistent Messages

- Comments on report cards
- Attitude towards tests and grades
- What do you give attention to? What do you celebrate?
- How do you respond to requests/approaches?
- Attitude toward homework
- Feedback about mistakes
- Focus on awareness – "I wonder what's happening here?"
- How you structure classroom time

## Use Language Intentionally

- Reflect on what went well
- Ask if any areas of improvement were noted
- Generate ideas about how to improve/what plans can be made/what can be tried
- Test reflections – what do you think this score can be attributed to?

## Teach Problem Solving Skills

- Define the problem
- Brainstorm possible solutions
- Evaluate possibilities
- Decide on approach
- Try it
- Evaluate it and repeat if necessary
- Find teachable moments – academic, social, classroom decisions, classroom behavior
- Model it

## Teach Feelings, Normalize

- Younger children – story books specific to this
- Older children – discussions from text
- Teachable moments
- Model
- Prompt wondering about feelings
- "Sometimes students feel…"
- "You might be feeling…"
- "…and that's ok…"
- "…and if so, you can…"

## Lessons/Prompts to Address Feelings Specifically

- Describe a time when you felt _____.
- What kinds of things were you thinking that made you feel _____?
- What did you do when you felt _____?
- Did doing those things change the way you felt? How so?

But what do I do if the answers scare me?

## Don't Panic!

- Be "the pilot"
- Validate and thank
- Express concern and desire to help
- Collaborate to decide who to bring in
- Utilize resources (i.e., school counselor, hotlines)
- Be the bridge
- Check in – don't have to "get into it"

## Teach Perspective Taking

- How could you look at this from someone else's point of view?
- How could you look at it from another point of view?
- The Farmer's Luck
- Zoom

# Interventions in the Classroom

## Teach Emptying the Cup

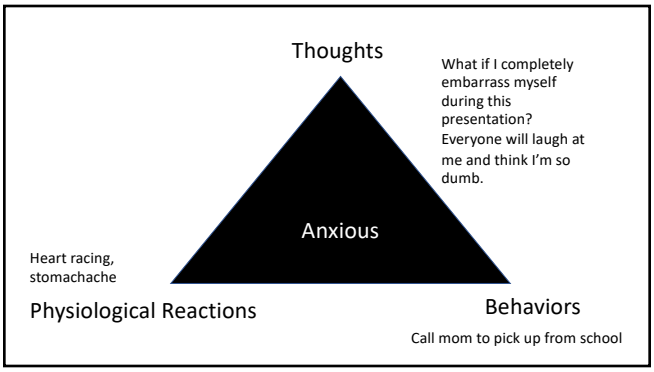
- Alexander and the Terrible, Horrible, No Good, Very Bad Day
- We all have to practice recognizing when our cups are getting full and how to empty them little by little
- Go wild with it!

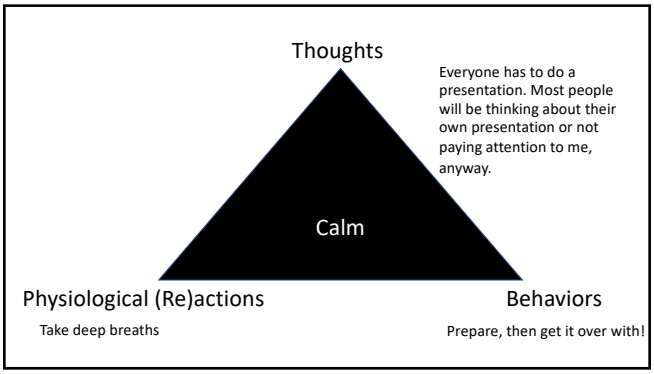
## Interventions

- Locus of control
- Perception of ability to cope & utilize resources

## Keep in Mind

- Brain is not in “thinking” mode
- Have a plan (sometimes that alone helps significantly!)
- Default checklists
- Sense of control, involvement



Find a point, focus on what can be done.

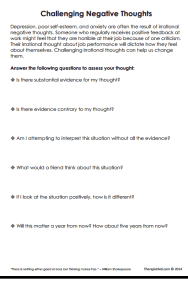
## Changing Thoughts

- Unhelpful thoughts to realistic, believable, and helpful thoughts
- Bad coach to good coach
- Like editing a paper

## Automatic Negative Thoughts

- Teach types, label it
- Identify ANTs when they occur (or after)
- Challenge ANT
- Edit thought
- Repeat as much as needed!

## Writing assignments, worksheets, reflections challenging ANTs



**Challenging Negative Thoughts**

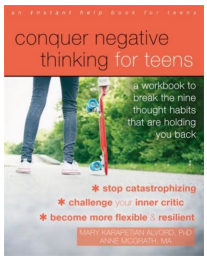
Depression, poor self-esteem, and anxiety are often the result of irrational negative thoughts. Someone who regularly receives positive feedback at work might feel that they are horrible at their job because of one criticism. That irrational thought about job performance will dictate how they feel about themselves. Challenging irrational thoughts can help us change them.

**Answer the following questions to assess your thought:**

- Is there substantial evidence for my thought?
- Is there evidence contrary to my thought?
- Am I attempting to interpret this situation without all the evidence?
- What would a friend think about this situation?
- If I look at the situation positively, how is it different?
- Will this matter a year from now? How about five years from now?

"There is nothing either good or bad, but thinking makes it so." – William Shakespeare

PositiveMed.com © 2014




## Teachable Moments

- Point out ANTs in texts, characters; point out helpful thoughts
- Analyze, ask questions, wonder how thinking impacted future behaviors; question what might have happened had the thinking been different
- Point out ANTs as they come up in class, edit into more realistic and helpful thoughts

## Flipside Challenge

- When someone catches a "zooming in on the negative" ANT, they call out "flipside challenge!"
- Others are challenged to find the flipside (i.e., positive)
- *Be sensitive to perceived criticism

## Managing Thoughts

## Get Out Of Your Head and On Paper

- Index cards
- As fast as your thoughts come, dictate or write worry thoughts on index cards
- Once "all" thoughts are on cards, sort them
  - A thought I can edit
  - A problem to solve
  - A worry I'll probably have for awhile and I'll just come back to it later

## Schedule Time To Worry

- Create a "worry time"
- Any question can be asked, any worry thought can be discussed
- Outside of "worry time," do not give worries any attention
- Make worries wait - say to yourself, "ok, I'll think about that at worry time." You can write it down if you want and put it in a "worry box."
- Set a timer to review and sort worry thoughts
- Move on to something else
- If you don't need to fill up "worry time" going over worry thoughts, use it for something fun (at least for a little bit!)

## Your Brain is Like YouTube

- Thoughts are like videos
- X out and click on a new one
- Expect pop ups, buffering, ads

## Changing Physiology

- Calming Your Body
- What Relaxes You?

## Changing Physiology - Relaxation

- Deep breathing
- Yoga
- Meditation
- Guided Imagery
- Muscle Relaxation
- Aromatherapy
- Acupressure
- Exercise
- Music

## Breathing

- Diaphragmatic or “belly” breathing
- Balloon breaths
- 4-7-8 breathing

## Movement

- Yoga
- Stretching
- Go Noodle
- Music and movement
- Moving like different animals
- Natural opportunities

## Meditation and Mindfulness

- Finding Your Peace
- Listening to the chime
- Listening for sounds around
- www.gozen.com

## Guided Imagery

Utilize all senses

Create your own script

Many recordings easily found online

## Muscle Relaxation

- "Tense" and "relaxed" are mutually exclusive
- Progressive Muscle Relaxation: Train your muscles to tense and relax
  - Scripts for young children
  - Scripts for teens/adults
- Autogenic Muscle Relaxation: Train your muscles to relax
  - "Letting Go"

## B.A.A.M. – Mastnardo, 2017

- Breathing
- Acupressure
- Aromatherapy
- Movement
- Teaching self-care techniques to manage anxiety in classroom, social situations, and at home
- Baamtechnique.com

## Music

BACKGROUND MUSIC

"MOOD MUSIC"

FOR ASSOCIATIONS

CAN USE WITH VISUALIZATIONS

## Changing Actions

Behaviors to decrease anxiety

## Grounding Techniques

- 5-4-3-2-1: 5 things you see, 4 things you can touch, 3 things you can hear, 2 things you can smell, 1 thing you can taste
- Name 5: fast food restaurants, bands you listen to, places you've visited, books you've read, etc..
- Math games: doubles, count backward
- Name the alphabet
- Recite something

## Break Behaviors

- Take a walk
- Go get a drink of water
- Sharpen a pencil
- Take a bathroom break
- Draw, scribble, doodle, color it in
- Read
- "Calm corner"

Remember, it's a break…not an escape or avoidance.

## Tolerating Behaviors


Chew gum


Fidget


Focus gaze


Blinders

## Exposure

- Repeated
- Graduated
  - Individualized
  - Thoughtful
  - What will make this step easier to tolerate?
- Flooding*
- Desensitization

## Rewards and Celebrations

- Biggest reward is relief
- Use rewards for following plan & trying tools if motivating
- Celebrate sensitively (there can be a sweet spot!)

## Up Next: Developing Plans for Managing Anxiety at School

# Topic 6: Developing Plans for Managing Anxiety at School

Meghan Barlow, Ph.D.

## Common Scenarios

- Teacher thinks there's an issue, parents haven't mentioned it
- Teacher thinks there's an issue, parents don't
- Parent thinks there's an issue, teacher doesn't
- Student raises the issue
- Classmates raise the issue

## Communicating With Families

- Better position if you set a classroom culture with parents, too
- Use language wisely – notice, seems, sometimes, wonder; avoid labeling, assuming or concluding
- Give behavioral examples
- Express positive feelings towards student, + goal

## Communicating with Families

- Be open
- Listen
- Be aware that there is a side you may not see
- Look through that lens and try it on
- Avoid making judgments
- Express positive feelings toward student, reaffirm goals
- Ask what helps, asks what makes it harder

## Communicating with Families

- Come to an agreement
- Keep communication open
- Plan to assess, collect data
- Involve student as much as possible in discussions, plans

## Assessing the Problem

- Define the problem, where/what is the interference?
- Figure out who needs to be involved in assessing
- Communicate with outside providers, enlist outside providers if necessary
- Complete evaluation if necessary
- Develop a clear understanding of the fears, worries, anxiety as well as triggers
- Develop clear understanding of thoughts, physiological, behaviors

## Develop Goals

- Describe current functioning based on assessing the problem
- Long term goals – where do you eventually want the student to be?
- Short term goals – how can you break down into a more manageable first step?
  - Remember you can shape behaviors
  - Think locus of control
  - Think perceived ability to cope
  - Think big picture…in order to help with "The full cup," may not address entire problem at once.

## Plans Need to Make Sense

- Knowing what you know about anxiety, will this plan work?
- Are you intervening to help anxiety or removing triggers?
- Individualize, do not rubber stamp
- Can this realistically be implemented?
- Communicate concerns as "problems to solve" or "potential limitations" and think through what to do

## Time extensions?

"Off duty" signals?

"I'm not saying no…"

- Continue working with parents, student
- Play it out verbally, express concerns related to feasibility, best interest of student, how it will help anxiety
- Make contingency plans

Managing Specific Problems

## School Refusal

- Completely absent from school for periods of time
- Attend part of the day, either leaving early or skipping classes
- Chronic tardiness
- Attend school, but have intense morning misbehavior (refusal to wake up, get in car, move) in order to be absent
- Display unusual distress during school days and beg to get picked up, stay home the next day, etc.

Kearney and Albano, 2007 *When Children Refuse School*

## School Refusal

- Get a thorough assessment
- Involve outside mental health or medical professional, not only truancy
- Is something/some aspect of school being avoided?
  - Learning, academic demands
  - Peers/social
  - Teacher
- Is leaving home/some aspect of what's at home being avoided?
- Is something on the way being avoided?
- Is depression a part of the problem?

## School Refusal

- What is the student doing instead of going to school?
- Identify the *function* of refusing school
  - Avoid school related objects/situations that provoke negative affectivity
  - Escape aversive social and/or evaluative situations at school
  - Receive or pursue attention from significant others outside of school
  - Obtain/pursue tangible rewards outside of school
  - Multiple functions?
  - Changing functions?

## Plan for School Refusal

- Monitor/log daily behavior
- Address underlying causes as needed
- Provide supports if needed
  - Ex., School refusal to avoid discomfort associated with reading aloud, completing school work independently, evaluations – Suspected undiagnosed LD. Assessment completed and LD identified. Labeled, helped student and teachers understand the 2e profile, put supports in place to assist with reading & compensation.

## Plan for School Refusal – Avoiding - Affectivity

- Address underlying anxiety
  - Psychoeducation
  - Continued assessment – anxiety and avoidance hierarchy, rating scales
  - Teach relaxation and breathing
  - Systematic desensitization using easier item on hierarchy, imaginal desensitization
  - In vivo exposures, graduated exposures
  - Fade “safety signals”

## Plan for School Refusal – Escape Social/Evaluative Situations

- Psychoeducation – social anxiety
- Create anxiety and avoidance hierarchy
- Teach changing automatic negative thoughts
- Exposures, role plays, practice changing thoughts

## Plan for School Refusal - Parents

- Address *function* if necessary
- Follow guidelines – send to school unless fever, vomiting, lice (keep it simple), get medical advice in some circumstances
- Get help outside school for psychoeducation, practice
- Help understand rationale, it's hard for parents to see kids anxious – feels "mean"
- Helping vs. traumatizing

## Separating from Parents

- Can be developmentally typical, many kids have a hard time initially and then get used to it; others SAD
- In early grades, may need classroom culture to support – make drop off routine clear, help parents understand what to do if their child seems hesitant, invite parents to give teachers notice if they think it will be an issue
- Make it quick, keep moving, keep it positive
- Have routines to orient and engage students – give jobs to do!

## Plans for Separating from Parents

- Get student input: "Seems like you have a hard time leaving your mom to come into class in the morning. What's up?"
- Validate and empathize
- Get more info: "Do you feel like that all day or does it get better after awhile?" "What do you think helps it to feel better?"
- Align and agree to create a plan

Sometimes the info you get makes the next step very clear. Separating is hard, but maybe because worried about walking into noisy classroom. Allowing early drop off helped student get comfortable before class entered.

Is that an intervention for anxiety or helping student avoid? Big picture: student had a lot of anxieties and ASD. So many pieces of the day were challenging. This allowed him to start the day with an empty cup vs. a full cup.

## Plans for Separating for Parents

- Brainstorm ideas
  - Picture of parents
  - Worry stone
  - Bravery bracelet
  - Comfort object
  - Distractions
  - Helpful thoughts, "It's a false alarm. No danger. I know I'll feel better by announcements."
  - Joke/treat from parent at desk
  - Joke book; parent working on a joke, too

## Plans for Separating From Parents

- Involve parents – agree on plan with roles clear
- When does worry/anxiety start?
- Other times besides school that is hard to separate (i.e., bedtime, friends' houses, parents out, etc.)?
- See if other parent, someone else can do drop off
- See if can be dropped off with a friend
- Recs for Parents – stay calm, positive but not overly affectionate, keep it light, provide a "bridge" or security item, consult therapist

## Plans for Separating From Parents

- Stay aligned, avoid punitive or threatening approaches
- Remember to think about long term goal and short term goals
- Think about what *is* happening now and how student can take little steps to get closer to long term goal
- Focus may or may not be getting student into classroom – may need to initially work on the separation part – might be allowed to help Principal with announcements, have a chat with music teacher
- Graduated exposure

Should students with trouble separating be allowed to call parents to "check in" during the school day?

## Selective Mutism

- Communication among teacher, parents, school psych/team, outside clinician
- Assessment
  - Understand role, if any, of communication deficit
  - Understand role of anxiety
  - Understand the interference it causes (i.e., asking for help, feeling sick, etc.)
- Cycle of negative reinforcement maintaining SM
  - Prompted to speak, inhibits/expresses discomfort, others perceive discomfort, someone rescues, everyone feels better…
- CBT and pharmacotherapy (SSRI)

Walkup et al., 2008; www.selectivemutism.org

## Plan for Selective Mutism

- Psychoeducation (child and parents) – anxiety, negative reinforcement
- Figure out baseline and long term goal, break down into smaller steps - scaffolding
- Teach relaxation, changing thoughts, anxiety management strategies
- Develop and strengthen rapport, eliminate initial demands/pressure for speaking
  - Pick activities that are enjoyable
  - Get comfortable without verbal responses

## Plan for Selective Mutism

- Graduated exposure
- Role play, scripting
- Build comfort! (Don't forget about technology, videos!)
- Ask questions wisely (yes/no vs open ended vs forced choice)
- Respond wisely (avoid excessive praise, drawing a lot of attention to verbalizations – find the sweet spot)
- Give enough wait time for a response
- Rewards, home and school
- Do not punish

## Teacher Plan for Selective Mutism

- Create a classroom culture of inclusion
- Initially avoid demands for response – instead think descriptive statements
- Avoid mind reading
- Practice how to respond to classmates' comments – jump in with PR
  - Talk with family, student, agree on plan
  - Present child with SM as a whole kid, include that student can and does talk, but doesn't always feel comfortable talking everywhere and with everyone.
  - Focus on the practice/effort and what will make it easier for student to get comfortable
  - Individual follow ups if needed

## Teacher Plan for Selective Mutism

- Help engage in play, connect with peers
- Offer small groups
- Initially accept nonverbal responses
- Track progress, look for small steps
- May need to consider signals for bathroom, getting help, identifying choice/preferences
- May need to consider alternate assessments in some situations
- May need to consider how to alter activities like "star student," presentations, etc.

## Parent Plan for Selective Mutism

- Communicate openly and freely with school (when/where is your child most comfortable, what kinds of things does your child mention about school, what does your child like about school, what concerns does your child talk to you about?)
- Work with school to communicate message to class
- Help foster peer relationships – play dates
- Work with outside clinician to help guide, address anxiety

## OCD

- Obsessions or Compulsions can interfere with attention, work completion, comprehension
- Germs, handwriting, certain words, breaking rules, accidentally doing something "bad" or "mean," picturing teacher naked, toileting clean up, numbers, specific number of words on a line, lines in a paragraph, pens for notes, food contamination, checking with teacher, checking materials/organizing materials
- May or may not be obvious to others; parents/family may need to communicate with school, school may need to communicate with parents/family

## OCD

Very high achieving, conscientious high school student. Participates in class, does well on assignments, hard time finishing tests. At home, spends several hours on assignments (much more than would be expected), interfering with sleep. Feels exhausted most of the time. Worries about grades, tests, performance. Very focused on getting into elite college and pursuing a career requiring an advanced degree. History of social anxiety. Spent months working on stress and time management, changing thoughts (re: school pressures/"failing" and social interactions).

## OCD

- Doorknob confession about brother's germs led to acknowledging school/work related "habits"
  - Handwriting too big/small
  - Increments of 5

## Plan for OCD - Clinical

- Understand glitches and tricks
  - "All done switch"
  - Brain sorter
  - Disappearing just right feeling
  - Maybe game
- Psychoeducation, identifying, teach talking back, teach being the boss
- Teach distress tolerance, distraction

What to Do When You Brain Gets Stuck: A Kid's Guide to Overcoming OCD, Dawn Huebner, Ph.D.

## Plan for OCD in Schools

- Work with team - outside clinician, family, student
- Understand that OCD can be "hidden" and can look like behavior problems
- Psychoeducation – understand exposure and response prevention, teachers/parents don't need to walk on eggshells
- Think carefully about how the student needs to get through the day
- Hierarchies, priorities, supports in place (not avoidance)

## Typing vs handwriting?

## Plan for OCD in School - Hierarchies

- Rate urges, distress, interference
- Individual will be able to work on "low level" obsessions/compulsions first
- Team (including student) can identify what they feel interferes most with functioning, but this will likely not be first target for intervention

## OCD and ASD

- Middle school student. Mother reached out, stating that student spends hours showering at night. Getting ready in the morning takes hours, often tardy to school. Handwashing and bathroom take up good part of morning. Turns on and off faucet with her feet. Uses 1-2 rolls of toilet paper every time she goes to the bathroom. Elaborate splashing routine when washing hands. Face and hands raw from washing. Student also described needing an even number of words per line, needing it to line up a specific way on the paper. Felt she needed to indicate (+) or (-) before integers. Out of class for a good portion of the day washing hands, cleaning up after going to the bathroom.

## OCD and ASD

- Attempted to keep her in classroom, allowed her to use sink at back of class – disruptive and noisy
- Guidance counselor trying to set time limits in the bathroom – led to behavior problems
- At home, behavior problems, such significant distress mom would let student go through routine – was often very late to school

## OCD and ASD

- What we did: psychoeducation, develop rapport and understanding of individual
- Special interests: Star Wars, musicals/music, French Revolution
- Obsessions/Compulsions: Contamination, getting sick, "just right" feelings
- Developed anxiety/urge intensity rating scales
- Taught relaxation/distraction, using special interests
- Exposure and response prevention
- ***Set expectations for change VERY low at home and school

## OCD and ASD

- In office, began ERP with handwashing
- Accompanied pt to wash hands in office kitchen
- As pt began her washing ritual, would start conversation about music; would signal for her to interrupt ritual and stop so we can go listen to the song I mentioned
- Would move on and then later debrief
- Practiced this type of ERP several times and began to assign home practices
- Pt developed an interest in Howard Hughes and we used this to our benefit

## OCD and ASD

- Pt making progress, doing well in sessions but difficulty generalizing in home setting (family factors involved)
- Pt stopped drinking/eating during the day to eliminate need for bathroom and handwashing
- Pt began taking SSRI and continued 1-2 sessions per week practicing and expanding on ERPs
- Switched school schedule to start the day with favorite class (history)
- Plan at school – teacher would chat with her before the bell rang. She really looked forward to these chats and wanted to get to school on time, got engaged and engrossed in conversation, morning handwashing at school resolved

## OCD and ASD

- Began to be able to work our way up through the hierarchy and eventually pt improved significantly. Very little distress/interference reported

## Panic Attacks

- Out of the blue, predictable triggers, anticipatory anxiety
- Moments of sudden and intense, overwhelming fear or anxiety
- Can be obvious to others, can be undetected
- Trips to the bathroom, nurse
- “Checking out”

## Plan for Panic Attacks

- Address underlying anxiety/triggers as needed (i.e., tests)
- Create long term goal and short term goals
- Teach distress tolerance, grounding, name it to tame it
- Allow a safety net – permission to leave class, signal to teacher
- Consider “trigger warnings”
- Track and monitor to continue assessment to be able to address underlying anxiety
- Work with student, family, outside providers to be sure plan supports anxiety management as opposed to reinforces anxiety

## Panic Attacks

- High school student raped by ex-boyfriend. Disclosed rape to clinician and parents, did not want to report to authorities/school. Triggered by scenes from books assigned in English class and resulting discussions. Pt experienced panic attacks and could generally ride them out – fairly infrequent, she had strategies to cope. At the end of school year, found out she would be in the same class with perpetrator in the fall. Lots of anticipatory anxiety, lots of worry about potential panic attacks, worried about how she would manage, if it would be embarrassing.

## Should she change classes?

## Remember

- You know anxiety, you know how it works
- Get to know the individual and the situation with an in-depth assessment
- Understand the big picture – what else is going on for this student, what are long term goals
- Implement interventions with sensitivity and kindness toward student and parents
- Modify, adjust, shape as needed