Indicative Interventions for Anxious Youth in Schools

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Overview

- Anxiety Disorders in Youth
- CBT model for Anxiety
- Interventions in Schools

In General…

- Anxiety disorders among the most common mental health problems in youth
  - Prevalence rates 10% to 20% *(Chavira et al., 2004; Costello et al., 2004)*
- Children with internalizing disorders (such as anxiety) receive treatment less frequently than those with externalizing problems *(Garland et al., 2000)*
- Anxiety disorders are frequently comorbid with other anxiety and depressive disorders, and some types of externalizing disorders

Functional Impairment

In children:

- Difficulties in peer relationships
- Poor academic achievement
- Commonly comorbid with other disorders

In adults:

- Relationship impairment
- Physical health concerns
- Occupational disability
- Substance abuse

Anxiety Disorders

- **Separation Anxiety Disorder**
- **Generalized Anxiety Disorder**
- **Social Anxiety Disorder**
- Specific Phobia
- Panic Disorder
- Agoraphobia
- Obsessive Compulsive Disorder
- Post Traumatic Stress Disorder

Anxious Youth In Schools

- Problems may be less apparent than youth with behavioral disorders
- Children may appear perfectionistic; "good kids"; but can perform poorly in school *(Mychailyszyn et al., 2010).*
- Somatic complaints often frequent
  - Especially in minority youth *(Canino, 2004; Gee, 2004; Pina & Silverman, 2004)*
- Anxiety can also present as oppositional behavior, such as through avoidance of tasks or school refusal

School Refusal/Avoidance

- More than just “school jitters”
- Not to be confused with truant children
- Often symptom of deeper problem
- Affects 2-5% of children
  - Up to 28% of youth refuse school at some time
- Most common ages affected: 5-6, 10-11, or in times of transition
- Children with school refusal tend to be of average or above average intelligence

Impact of School Refusal

- Possible short term consequences include:
  - Declining academic performance & social alienation
  - Increased risk of legal trouble & financial expensve
  - Family conflict, potential child maltreatment & lack of supervision
- Possible long term consequences include:
  - Lower educational attainment & economic deprivation
  - Occupational and marital problems
  - Poor psychological functioning

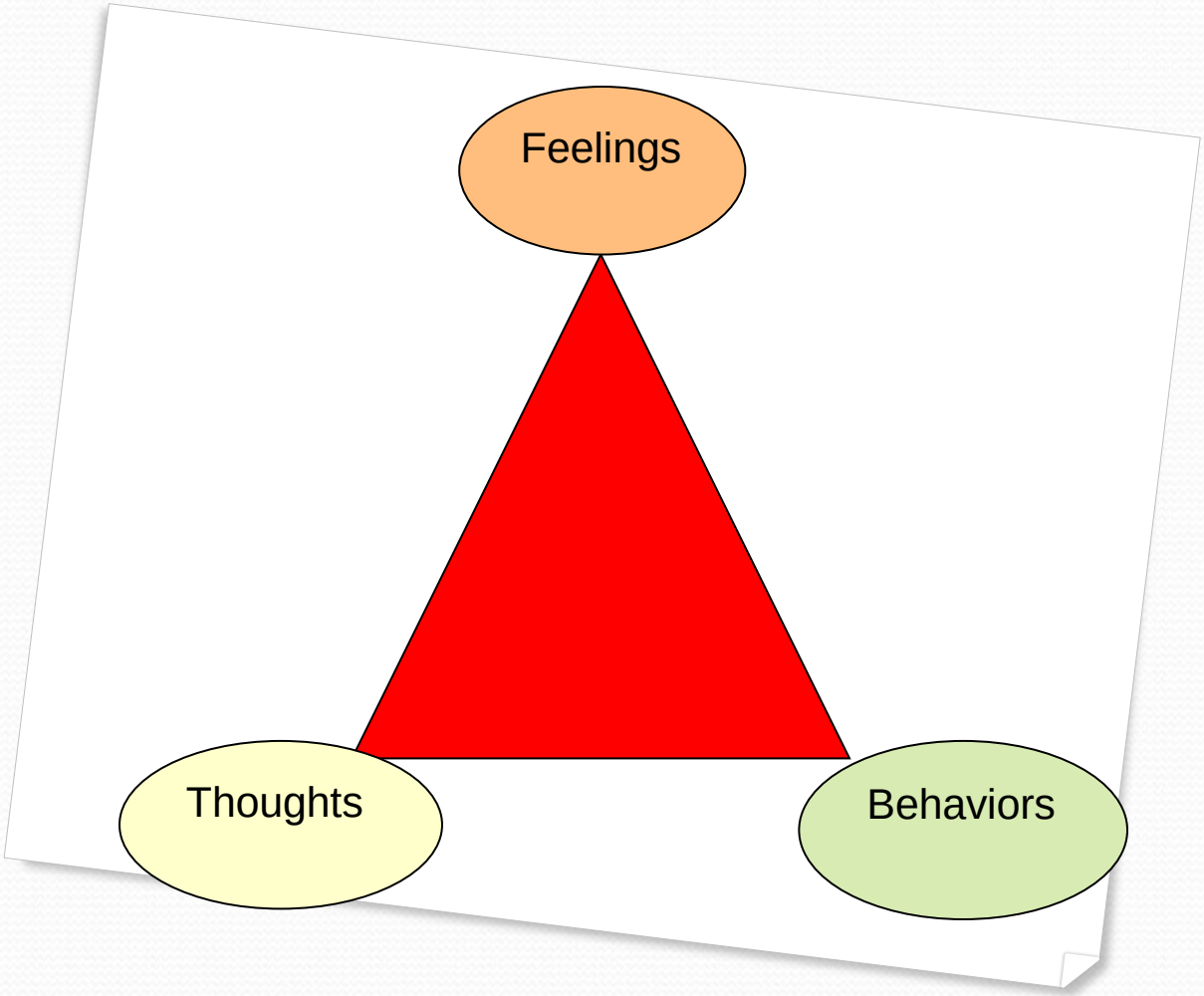
*Risk increases the longer the child remains out of school

Types of School Refusal

- Hallmark – Heterogeneous condition
- Important – What is the function of school refusal behavior?
  - To avoid school-related stimuli that provoke negative affectivity
  - To escape aversive social situations
  - To receive attention from others outside school
  - To obtain tangible rewards outside school

Cognitive-Behavioral Therapy

Work with patients to modify maladaptive thoughts, feelings and behaviors that develop and maintain psychological disorders.



Behavioral Features

- **Avoidance** maintains and worsens anxiety.
  - Tempting to avoid engaging with fears, but then child never fully experiences success over his/her fears
  - **Habituation**: occurs when the child is in the presence of the feared stimulus for long periods of time
    - Anxiety always decreases over time, and most often, the feared outcomes do not actually occur
- Operant learning perspective
  - Anxiety and avoidance may be positively reinforced in the child's environment

Incorporating Cognitions

- Child's sense of self-efficacy
  - Belief that they can cope with a feared object
- Child's cognitive biases, often reflecting:
  - Low evaluations of competency to cope with danger*(Bogels & Zigterman, 2000)*
  - High probability of negative outcomes/threat *(Barrett et al., 1996)*
  - More likely to attend to emotionally threatening stimuli *(Vasey & McLoed, 2001)*

The Role of the Family

- Anxious children often have anxious parents
  - Genetic impact
  - Anxious modeling

- Parents of children with anxiety disorders are theorized to be:
  - More over-controlling/over-protective
  - Less warm, more rejecting

Overview of Coping Cat Program

- Part 1
  - Child learns when he is anxious
  - Child learns coping skills
  - F-E-A-R Plan
- Part 2
  - Exposures: gradual and repeated practices to feared situations
- 2 Parent Sessions
- School involvement (if necessary)

Kendall, P. C., & Hedtke, K. (2006). *Cognitive-Behavioral Therapy for Anxious Children: Therapist Manual (3rd ed.)*. Ardmore, PA: Workbook Publishing. www.WorkbookPublishing.com

Part 1: Psychoeducation and Skill-building

- Build rapport; develop an understanding of his/her experience with anxiety
- Psychoeducation
  - Recognizing feeling
  - Physiological responses to anxiety
  - Explore parent/family variables that contribute
- Skill-building
  - Relaxation Training
  - Cognitive techniques
  - Problem-solving
  - Self-examination and self-reward

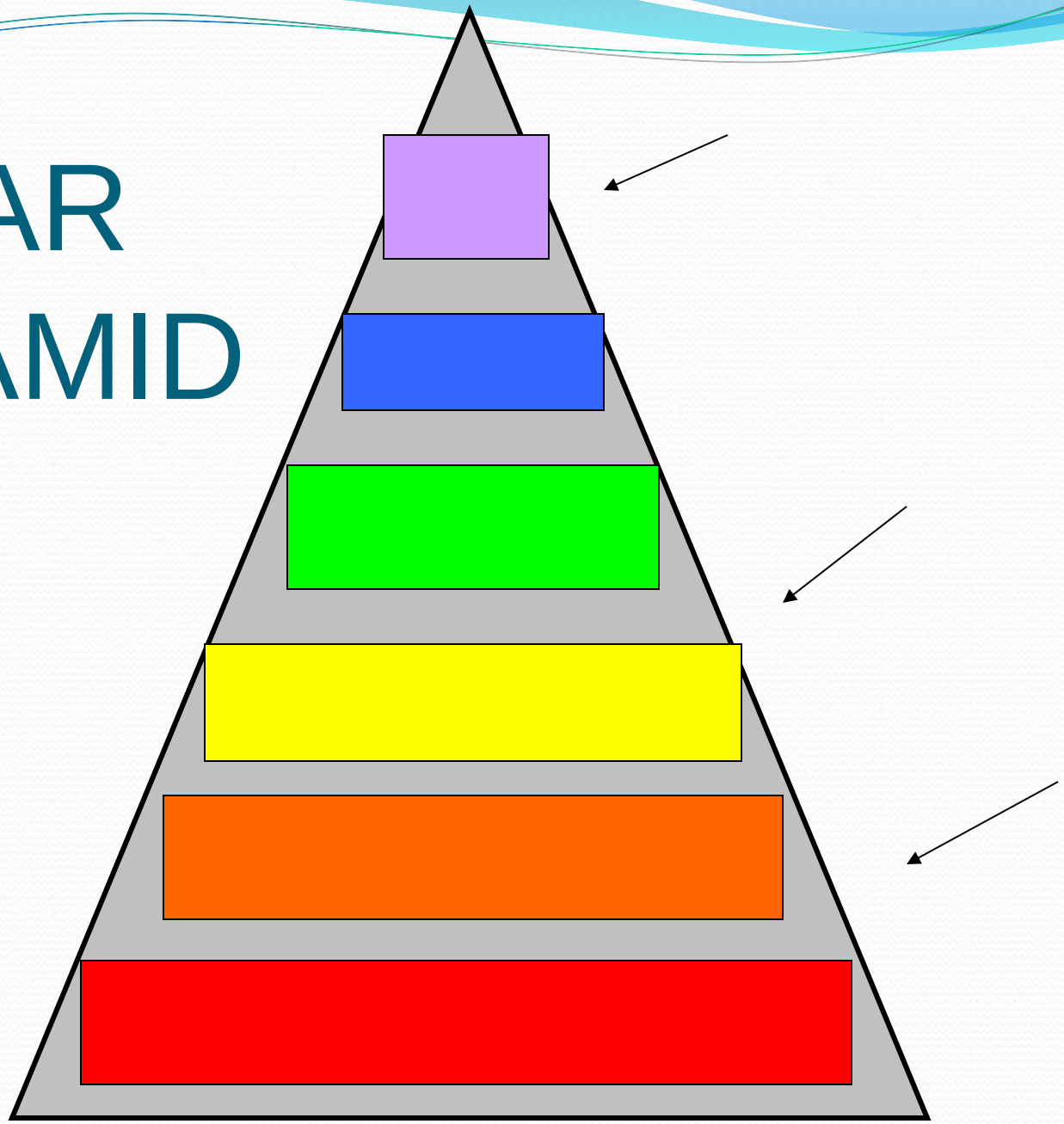
Feeling frightened?

Expecting Bad Things to Happen?

Actions & Attitudes that can help

Results & Rewards

FEAR PYRAMID



Part 2: Practice

EXPOSURES: *"We'll go places and do things!"*

- Anxiety provoking situations
- Aim is not to remove anxiety, but to be able to manage it, so child *should* experience anxiety.
- Opportunity to practice
- Gradual (step-by-step)
- Repetition is key!
- Stay in the situation until the anxiety decreases

Exposures

- Collaborating
  - Child knows exposure in advance and agrees
- In-session Preparation
  - Make F-E-A-R Plan specific to the exposure
  - Practice/Role-Play
- Processing Exposures
  - How does the child think he/she did?
  - Remember to reward the child after the exposure
- Exposures in and out of session

CBT for Youth Anxiety

- CBT is considered to be evidence-based in the treatment of anxious youth *(Silverman et al.,2008)*
- Kendall and colleagues
  - Three randomized controlled trials of Coping Cat with very positive results, including long-term maintenance of gains
  - CAMS: 2009: 81% improved with combination CBT & SSRI, 60% with CBT alone, 55% with SSRI alone, 24% placebo
- Independent research teams find similar results

Pharmacotherapy for Anxiety Disorders

- Medication
  - SSRI's, such as Zoloft®, help regulate neurotransmitters (chemical messengers in the brain)
  - Generally well-tolerated
  - Onset of effects takes about 4-8 weeks
  - Approved by the Food and Drug Administration for children and adolescents with OCD
  - Should be managed by a pediatrician or psychiatrist

Dissemination of CBT

- CBT for childhood anxiety is now a well-established treatment *(Walkup et al., 2008)*

- Despite this, CBT is highly underutilized in the community *(Gunter et al., 2010; Shafran et al., 2009)*
  - The internalizing nature of anxiety may cause it to be overlooked
  - Exposure tasks may have misconceptions surrounding their use *(Olatunji, Deacon & Abramowitz, 2009).*
  - Many families may have limited access to care *(Collins et al., 2004)*

- Important to consider organizational culture and climate before dissemination can take place *(Glisson et al., 2008)*

Potential Reasons for Low Use

- Among U.S. children with emotional/behavioral problems, only 20-50% receive services *(Farmer et al., 2003)*
  - Most of this is provided by schools *(Canino et al., 2004)*, but is it evidence-based?
- Barriers to children's mental health care in the U.S. often include: *(Owens et al., 2002)*
  - Structural constraints (e.g., cost, transport, time)
  - Stigmas surrounding mental illness
  - Life stressors

Levels of Intervention

- Universal Prevention: for entire populations
  - Example: vaccinating all children under age 2
- Selective Preventive Interventions: for those with risk factors
  - Example: working with children of depressed mothers
- **Indicated Preventive Interventions**: for those at-risk exhibiting some symptoms
  - Example: working with school-children who evidenced anxiety symptoms from a screener

From Mzarek & Haggerty (1994)

CBT in Schools

- Agencies around the world increasingly recognizing a link between children's mental health and educational achievement
  - US Surgeon General's Report on Children's Mental Health
  - Council of Australian Governments
  - UK Departments for Education and Skills and Children, Schools and Families

Mychailyszyn et al. (2011); Elkins et al. (2011)

Benefits of CBT in Schools

- Maximize access to interventions by reaching young people where they spend most of their time
- Increased opportunity for early detection/prevention
- Reduce common obstacles that typically prevent youth from receiving care
- Opportunities to intervene in the setting where problems most often occur *(Ginsburg et al., 2008)*
  - Potential for greater impact on everyday lives of youth
- Often provides much more affordable care for families

Barriers to CBT in Schools

- Questions regarding which CBT treatments to use and who can deliver them
- Universal prevention techniques require teachers
- Typically CBT programs call for rigorous training and ongoing supervision/support *(Beidas & Kendall, 2010)*
- Possibility for negative stigma/labels among youth receiving services
- Must promote mental health services without detracting from educational objectives

Overcoming Barriers

- Utilize "flexible implementation" by studying school's organizational culture and climate
- Consider alternative delivery models, such as computer-assisted CBT *(Kendall et al., 2011)*
- Perhaps teach CBT skills within the curriculum
  - Distinguish between accommodations & interventions *(Schultz et al., 2011)*
- Work around school agendas and schedules (e.g. before/after school, during "specials")

Overcoming Barriers

- Adapt sessions to fit 30-minute time requirements
- Involve parents through phone calls and after-school meetings *(Flanagan, 2011)*
- Apply "stepped care" for youth with more severe & complicated presentations
- Problem-solve around difficulties with exposure tasks

Findings on School-based CBT

- School-based anxiety interventions are generally effective compared to control *(Mychailyszyn et al., in press)*
  - Skills for Social and Academic Success program *(Masia Warner et al., 2007)*
  - FRIENDS program *(Lowry-Webster et al., 2001)*
  - Cool Kids Program *(Mifsud & Rapee, 2005)*
  - Modular CBT for anxious youth *(Ginsburg et al., 2012)*

Future Directions

- Focus on feedback loops *(Fixen, 2005)* from the schools
  - Importance of assessing organizational variables and approaching each school differently
  - "Bottom-up" versus "Top-down" approach
- Determine modes of delivery most effective for schools
  - Computer-assisted CBT
  - Modular-based approaches
- What are the most effective training and supervision techniques *(i.e., Stark et al., 2011)*
- Overcoming barriers (e.g., limited time, resources)