Mental Health in Schools
UCLA
Center
*Program and Policy Analysis**

Introductory Packet

Anxiety, Fears, Phobias, and Related Problems: Intervention and Resources for School Aged Youth

Revised 2015

Anxiety, Fears, Phobias, and Related Problems: Interventions and Resources

This introductory packet contains:

I. Classifying Anxiety Problems:
Keeping the Environment in Perspective as a Cause of
Commonly Identified Psychosocial Problems

A.   Labeling Troubled and Troubling Youth

B.   Common Behavior Responses to Environmental
Situations and Potentially Stressful Events

C.   Fact Sheet: Anxiety Disorders in Children and
Adolescents

I. Classifying Anxiety Problems

A large number of students are unhappy and emotionally upset; only a small percent are clinically depressed. A large number of youngsters have trouble behaving in classrooms; only a small percent have attention deficit or a conduct disorder. In some schools, large numbers of students have problems learning; only a few have learning disabilities. Individuals suffering from true internal pathology represent a relatively small segment of the population. A caring society tries to provide the best services for such individuals; doing so includes taking great care not to misdiagnose others whose "symptoms" may be similar, but are caused by factors other than internal pathology. Such misdiagnoses lead to policies and practices that exhaust available resources in ineffective ways. A better understanding of how the environment might cause problems and how focusing on changing the environment might prevent problems is essential.

A. Labeling Troubled and Troubling Youth

She's depressed.

> *That kid's got an attention deficit hyperactivity disorder.*

He's learning disabled.

What's in a name?   Strong images are associated with diagnostic labels, and people act upon these images. Sometimes the images are useful generalizations; sometimes they are harmful stereotypes. Sometimes they guide practitioners toward good ways to help; sometimes they contribute to "blaming the victim" -- making young people the focus of intervention rather than pursuing system deficiencies that are causing the problem in the first place. In all cases, diagnostic labels can profoundly shape a person's future.

Youngsters manifesting emotional upset, misbehavior, and learning problems commonly are assigned psychiatric labels that were created to categorize internal disorders.

Thus, there is increasing use of terms such as ADHD, depression, and LD. This happens despite the fact that the problems of most youngsters are not rooted in internal pathology. Indeed, many of their troubling symptoms would not have developed if their environmental circumstances had been appropriately different.

Diagnosing Behavioral, Emotional, and Learning Problems

The thinking of those who study behavioral, emotional, and learning problems has long been dominated by models stressing *person* pathology. This is evident in discussions of cause, diagnosis, and intervention strategies. Because so much discussion focuses on person pathology, diagnostic systems have not been developed in ways that adequately account for psychosocial problems.

Many practitioners who use prevailing diagnostic labels understand that most problems in human functioning result from the interplay of person and environment. To counter nature *versus* nurture biases in thinking about problems, it helps to approach all diagnosis guided by a broad perspective of what determines human behavior.

Toward a Broad Framework

A broad framework offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology. Such problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both.

Problems caused by the environment are placed at one end of the continuum (referred to as Type I problems). At the other end are problems caused primarily by pathology within the person (Type III problems). In the middle are problems stemming from a relatively equal contribution of environmental and person sources (Type II problems).

Diagnostic labels meant to identify *extremely dysfunctional problems caused by pathological conditions within a person* are reserved for individuals who fit the Type III category.

At the other end of the continuum are individuals with problems arising from factors outside the person (i.e., Type I problems). Many people grow up in impoverished and hostile environmental circumstances. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. (After environmental causes are ruled out, hypotheses about internal pathology become more viable.)

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of persons who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies. Toward the environment end of the continuum, environmental factors play a bigger role (represented as E<--->p). Toward the other end, person variables account for more of the problem (thus e<--->P).

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Problems Categorized on a Continuum Using a Transactional View of the Primary Locus of Cause

Problems caused by factors in the environment (E)	Problems caused equally by environment and person	Problems caused by factors in the the person (P)

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        E              (E<--->p)        E<--->P        (e<--->P)              P
        |---------------------------------------|---------------------------------------|
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Type I **problems**	**Type II** **problems**	**Type III** **problems**
•caused primarily by environments and systems that are deficient and/or hostile	•caused primarily by a significant *mismatch* between individual differences and vulnerabilities and the nature of that person's environment (not by a person's pathology)	•caused primarily by person factors of a pathological nature
•problems are mild to moderately severe and narrow to moderately pervasive	•problems are mild to moderately severe andpervasive	•problems are moderate to profoundly severe and moderate to broadly pervasive

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Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial problems. However, the above conceptual scheme shows the value of starting with a broad model of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward blaming the victim (Ryan, 1971). It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

There is a substantial community-serving component in policies and procedures for classifying and labeling exceptional children and in the various kinds of institutional arrangements made to take care of them. "To take care of them" can and should be read with two meanings: to give children help and to exclude them from the community.

Nicholas Hobbs

After the general groupings are identified, it becomes relevant to consider the value of differentiating subgroups or subtypes within each major type of problem. For example, subtypes for the Type III category might first differentiate behavioral, emotional, or learning problems arising from serious internal pathology (e.g., structural and functional malfunctioning within the person that causes disorders and disabilities and disrupts development). Then subtypes might be differentiated within each of these categories. For illustrative purposes: the figure on the next page presents some ideas for subgrouping Type I and III problems.

References

Bandura, A. (1978). The self system in reciprocal determination. *American Psychologist, 33*, 344-358.

Ryan, W. (1971). *Blaming the victim.* New York: Random House.

Categorization of Type I, II, and III Problems

Primary and secondary Instigating factors

Caused by factors in the environment (E) → **Type I problems (mild to profound severity)**

- **Learning problems**
  - Skill deficits
  - Passivity
  - Avoidance
- **Misbehavior**
  - Proactive
  - Passive
  - Reactive
- **Socially different**
  - Immature
  - Bullying
  - Shy/reclusive
  - Identity confusion
- **Emotionally upset**
  - Anxious
  - Sad
  - Fearful

(E⊘P) → **Type II problems** → Subtypes and subgroups reflecting a mixture of Type I and Type II problems

Caused by factors in the person (P) → **Type III problems (severe and pervasive malfunctioning)**

- **Learning disabilities**
  - General (with/without attention deficits)
  - Specific (reading)
- **Behavior disability**
  - Hyperactivity
  - Oppositional conduct disorder
- **Emotional disability**
  - Subgroups experiencing serious psychological distress (anxiety disorders, depression)
- **Developmental disruption**
  - Retardation
  - Autism
  - Gross CNS dysfunctioning

A Bit More About Type I, II, and III Anxiety Problems

When it comes to learning and performance at school, anxiety can be facilitative and disruptive.

All students are anxious at times; some more than others; some pervasively and chronically.

When anxiety is disruptive, it is associated with a host of cognitive, behavioral, and emotional problems. When the problems are pervasive and severe, they may be diagnosed as anxiety disorders. However, most students who have problems and appear or indicate that they are anxious are not disordered and should not be treated as having a psychopathological condition. And, in most instances, it is difficult to differentiate cause and effect.

For intervention purposes, students' anxiety problems can be viewed from a reciprocal determinist view of causality. Such a view emphasizes that behavior is a function of the individual transacting with the surrounding environment. This broad paradigm of causality offers a useful *starting* place for classifying behavioral, emotional, and learning problems in ways that avoid over-diagnosing internal pathology.

From this perspective, problems can be differentiated along a continuum that separates those caused by internal factors, environmental variables, or a combination of both. Problems caused by environmental factors are placed at one end of the continuum (referred to as Type I problems). Many students are growing up in stressful and anxiety provoking conditions (e.g., impoverished, disorganized, hostile, and abusive environmental circumstances). This includes home, neighborhood, and school. Such conditions should be considered first in hypothesizing what *initially* caused the individual's behavioral, emotional, and learning problems. After environmental causes are ruled out, hypotheses about internal pathology become more viable.

At the other end are problems caused primarily by pathology within the person (Type III problems). Diagnostic labels meant to identify *extremely* dysfunctional problems *caused by pathological conditions within a person* are reserved for individuals who fit the Type III category (e.g., generalized anxiety disorder [GAD], social anxiety disorder [SAD], obsessive compulsive disorder [OCD], Post Traumatic Stress Disorder [PTSD]). See the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (*DSM-5*) is for a description of diagnostic symptoms (http://www.psychiatry.org/dsm5).

To provide a reference point in the middle of the continuum, a Type II category is used. This group consists of students who do not function well in situations where their individual differences and minor vulnerabilities are poorly accommodated or are responded to hostilely. This includes students who are not as motivationally ready and capable as their classmates, those who are more active than teachers and parents want, those who learn better using multiple modalities than just by auditory and visual inputs, and so forth. The problems of an individual in this group are a relatively equal product of person characteristics and failure of the environment to accommodate that individual.

There are, of course, variations along the continuum that do not precisely fit a category. That is, at each point between the extreme ends, environment-person transactions are the cause, but the degree to which each contributes to the problem varies.

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Clearly, a simple continuum cannot do justice to the complexities associated with labeling and differentiating psychopathology and psychosocial/educational problems. However, the above conceptual scheme shows the value of starting with a broad paradigm of cause. In particular, it helps counter the tendency to jump prematurely to the conclusion that a problem is caused by deficiencies or pathology within the individual and thus can help combat the trend toward what William Ryan has dubbed "blaming the victim." It also helps highlight the notion that improving the way the environment accommodates individual differences may be a sufficient intervention strategy.

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Ways in Which Schools Contribute to Student Anxiety

Common sources of anxiety at school are interpersonal and academic related stressors. All students experience pressures to both conform and change (e.g., as a result of enforcement of rules, norms, and standards by peers, family, school staff).

Daily interpersonal interactions with teachers and other staff and peers are especially difficult for some students. Differences in background, appearance, language, social and emotional development, all can affect whether a student fits in or not. Not fitting in can lead to being isolated, rejected, and even bullied and coming to school each day fearful and anxious.

Relationships with peers are always on a student's mind. Concerns arise from such matters as not having enough friends, not having the right friends, not being in the same class as friends, experiencing peer pressure and interpersonal conflicts. And, there is the problem of bullying, which now has gone high tech (e.g., using the internet, cell phones) making the behavior easier, anonymous, and more prevalent.

While personal factors can affect relationships with teachers, classroom demands are more frequent sources of stress and anxiety (e.g., assignments, schedules, tasks). With test scores so heavily weighted and publicized, teachers are under great pressure to produce high test scores and that pressure is passed on to their students. The emphasis on enhancing school readiness and performance has filtered down to pre-school and kindergarten. A decade ago, kindergarten was a much more leisurely transition to first grade. And, of course, anxiety about being evaluated (e.g., tested and graded) is commonplace among students and can hinder performance.

Pressures in meeting academic demands also can be exacerbated by too many extracurricular activities. And for high school students, there is the added stress of college and career preparation. The overload of activities and demands can cut students off from essential supports, hamper sleep, interfere with learning and development, and affect physical and mental health.

Schools that do too little to address interpersonal and academic related stressors can expect a great many anxiety-related learning, behavior, and emotional problems.

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Examples of School Interventions for Anxious Students

Prevention

The first and often most important prevention strategies at a school are those that improve the environmental circumstances associated with anxiety. The focus on enhancing school climate highlights many facets of schools and schooling that need to be changed and are likely contributors to student anxiety. Relatedly, many student and learning supports are meant to address factors that are associated with student anxiety.

With respect to curricular programs, most of those designed to prevent problems have facets that are touted as preventing disruptive anxiety (e.g., those that promote assets and skills, resilience, resistance, mindfulness). For example, a widely cited program is called FRIENDS (http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=334). It is a universal prevention program that is implemented as part of the classroom curricula for all children. It emphasizes relaxation techniques, cognitive strategies, exposure exercises and encouragement of making friends and expanding social networks. It incorporates peer support and modeling to help students reduce social anxiety.

Schools can also help parents play a role in preventing anxiety at school. For instance, parents can help prepare their children for and adjust to transitions to the next grade and/or a new school (e.g., ensuring a good orientation and supporting first encounters with new surroundings and experiences, arranging for a peer buddy who can guide and support). Teachers also can help parents learn how to work collaboratively with the school to nurture and provide academic and social supports.

Minimizing Anxiety at School

From a psychological perspective, examples of what schools can do include minimizing threats to and maximizing strategies that enhance feelings of (a) competence, (b) self-determination, and (c) connections to significant others. Key in all this is a well-developed system of student and learning supports that helps to personalize instruction and provide special assistance (including accommodations) as needed. Such a system not only can provide a better instructional fit, it facilitates student transitions by providing academic and social supports and quickly addresses school adjustment problems. And it enhances home involvement and engagement in the student's schooling.

Corrective Interventions

In addition to addressing improvements in the school environment, schools can help correct *mild anxiety* problems and play a role in addressing anxiety *disorders*.

Mild Anxiety. Given that addressing student problems always involves mobilizing the student to play an active role, enhancing motivation, and especially intrinsic motivation, is a constant concern. Therefore, practices must be designed to account for motivation as an antecedent, process, and outcome consideration.

With respect to psychoeducational interventions, the emphasis is on such cognitive behavior strategies as teaching students to identify their anxiety symptoms (fear, coping responses) in various situations, learning how these are related to negative thoughts, physical sensations, and avoidance, and then mastering coping skills.

Another focus is on enhancing realistic thinking. It is common to overestimate the likelihood of the occurrence of negative outcomes and exaggerate the consequences of those outcomes. To

deal with the anxiety this causes, students are taught to identify such overestimates and use specific questions to evaluate them more realistically.

In addressing social anxieties, the emphasis usually is on social skills training. For example, one such program focuses on (1) initiating conversations, (2) maintaining conversations and establishing friendships, (3) listening and remembering, and (4) assertiveness. Peer assistants may be used to help create a positive experience for struggling students (e.g., peers bring students with mild anxiety to social events, clubs, have conversations with them in school situations).

Classmates also can help with desensitization strategies. For instance, if the student fears speaking in front of the class, the teacher can devise a desensitization approach with the student, such as initially having the student's record presentations to the class or have the work read aloud by a classmate**.** Following this phase, the student might increasingly do parts of the presentations with a classmate filling in the rest until the student works up to a solo performance.

Anxiety Disorders. While many students experience anxiety at school, a few who end up being diagnosed as having an anxiety disorder (e.g., SAD, OCD). Schools need to communicate and work collaboratively with primary providers who are treating such youngsters. As with all youngsters experiencing significant learning, behavior, and emotional problems, some special assistance (including accommodations) will be necessary. Primary providers and family members can provide information about what the school might do, and the school can provide information back based on the student's responses to school interventions.

As feasible, the school might help with exposure techniques for those diagnosed with generalized anxiety disorders and social anxiety disorders. For example, a student support staff member might work with a student to develop a fear hierarchy that rank orders the anxiety-provoking situations, beginning with the least-feared situation. Conducting exposure at school provides a realistic context and can tailor exposure situations based on the student's difficulties at school, With SAD, for instance, the student might meet with a teacher for clarification of academic material, approach a peer in the library or cafeteria, and so forth. Exposure sessions can utilize various school locations. Some common exposures for socially anxious students include accompanying a student to the cafeteria to initiate conversations with peers or to purchase and return food, ask questions of the librarian, visit the main office and speak to administrative staff, or seek out assistance from a teacher. With support, the student might join a club that matches her/his interests. Beside pursuing exposure techniques, student support staff can help a student evaluate the evidence for specific fears (e.g., about being treated badly by peers) and can help connect them with a peer buddy who is prepared to help

With respect to those diagnosed with obsessive-compulsive disorders, the focus is on how the school can help a student end an obsession or compulsion. This includes work with the student to identify less intrusive rituals (e.g., tapping one desk rather than every desk, encouraging use of an interrupter, helping the student evaluate evidence underlying fears of negative outcomes).

On the following pages is a description of two programs used at schools and references to sources for resources.

Examples of Two Programs that Have Been Used in Schools

Cool Kids. This program is a cognitive behavior therapy program that teaches children cognitive behavioral skills to combat anxiety. The program objectives are to (a) teach students to recognize emotions such as fear, stress and anxiety, (b) help challenge beliefs associated with feeling nervous, and (c) encourage gradual engagement with fearful activities in more positive ways. There is an additional component for parents that informs them of these principles and also teaches alternate ways of interacting with their child. The program has a number of additional components to be included, depending on the student's needs, including dealing with teasing, social skills training and problem solving. See

>http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=327
>http://www.kidsmatter.edu.au/primary/programs/cool-kids-school-version

Skills for Academic and Social Success (SASS). As summarized by Child Trends, this is a cognitive-behavioral school-based program designed to reduce children's anxiety. "SASS consists of 12, 40-minute weekly group sessions, two booster sessions, two 15-minute individual meetings, four weekend social events with prosocial peers, two 45-minute parent group meetings, and two 45-minute teacher meetings. In total, the program lasts for three months.

Group sessions cover five components: psychoeducation, realistic thinking, social skills training, exposure, and relapse prevention. Psychoeducation is addressed in the first group session where group leaders discuss commonly feared social situations and cognitive, somatic, and behavioral symptoms of social anxiety with the youth. In the second group session, realistic thinking is the focus as group leaders discuss the relationship between thoughts, feelings, and behavior and overestimating negative outcomes. Social skills training takes place over four group sessions emphasizing initiating conversations, maintaining conversations and establishing friendships, listening and remembering, and assertiveness through role discussion and role-play. During the exposure component, group leaders address the need for exposure to situations. Students develop a Fear Hierarchy of avoided situations. During each exposure session, group leaders select items from the Fear Hierarchy to gradually address the youth's fear. After the session, the youth discuss the experience and are provided feedback. Relapse prevention is the final session, and in it group leaders prepare youth for potential setbacks. Booster sessions, where youth progress is monitored, occur monthly for two months after the group sessions.

During the two individual meetings with the group leaders, youth can discuss goals and issues that interfere with progress. The four social events are intended to be fun activities (bowling, picnic, etc.) to provide youth an opportunity to practice social skills. The social events are aided by teacher-nominated students (peer assistants) who have exhibited helpful, friendly, and/or kind behavior. Peer assistants create a positive experience during the social event as well as helping the youth practice their skills during the week. Parent meetings include information about symptoms, psychoeducation, common reactions, and encouragement to refrain from being excessively reassuring to their child and allowing them to avoid situations. Teacher meetings include education about social anxiety, collaboration on areas of social difficulty, and progress feedback."

>http://www.childtrends.org/?programs=skills-for-academic-and-social-success#sthash.cCblhJnY.dpuf

Sources for Resources

For specific recommendations of what schools might do to minimize disruptive anxiety, see:

Our Center's Online Clearinghouse Quick Find on:
>*Anxiety* -- http://smhp.psych.ucla.edu/qf/anxiety.htm

Listed there, for example, are links to such Center documents as:
>*Anxiety, Fears, Phobias, and Related Problems: Intervention and Resources for School Aged Youth* – an intro packet -- http://smhp.psych.ucla.edu/pdfdocs/anxiety/anxiety.pdf

>*Back-to-School Anxiety* -- http://smhp.psych.ucla.edu/pdfdocs/backtoschanx.pdf

Also listed are links to such general internet resources as:
>*Schoolpsychiatry.org* –
>http://www2.massgeneral.org/schoolpsychiatry/info_anxiety.asp#interventions_school

>InformED's *Why you need to manage student stress and 20 ways to do it.*
By Julie Nedeen (2013). http://www.opencolleges.edu.au/informed/features/why-you-need-to-manage-student-stress-and-20-ways-to-do-it/

References Used in Preparing this Resource

Adelman, H., & Taylor, L. (2010). *Mental health in schools: Engaging learners, preventing problems, and improving schools.* Thousand Oaks, CA: Corwin Press.

Barret, P. (2008). *Preventing and treating anxiety in children and youth.* Autism Resilience Development, Inc. http://www.friendsrt.com/

Bostic, J. (2010). Interventions for Obsessive Thoughts. *Schoolpsychiatry.org.* http://www2.massgeneral.org/schoolpsychiatry/inter_ocd_thoughts.asp

Duckworth, K. (2014). Anxiety disorders in children and adolescents. *NAMI.* http://www.nami.org/Content/ContentGroups/Helpline1/Anxiety_Disorders_in_Children_and_Adolescents.htm

Fisher, P.H., Warner C., Klein R.G. (2004). Skills for social and academic success: a school-based intervention for social anxiety disorder in adolescents. *NCBI,* 7(4), 241-249. http://www.ncbi.nlm.nih.gov/pubmed/15648278

McLoone, J., Hudson, J.L., & Rapee, R.M. (2006). Treating anxiety disorders in school setting. *Education and Treatment of Children, 29* (2), 219-242.

McLoone, J., Hudson, J.L., & Rapee, R.M. (2006). Treating anxiety disorders in a school setting. *Education and Treatment of Children, 29* (2). http://www.freepatentsonline.com/article/Education-Treatment-Children/149622756.html

Mifsud, C., & Rapee, R. M. (2005). Early intervention for childhood anxiety in a school setting: Outcomes for an economically disadvantaged population, *Journal of the American Academy of Child and Adolescent Psychiatry*, 44, 996-1004.

Perini, S. J., Wuthrich, V.M., & Rapee, R.M. (2013). "Cool kids" in Denmark: commentary on a cognitive-behavioral therapy group for anxious youth. *Pragmatic Case Studies in Psychotherapy*, 9(2), 359-370.

Ryan, J. L., & Warner, C. (2012). Treating adolescents with social anxiety disorder in schools. *NCBI,* 21(1). http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3259736/

Scott, E. (2014). Stressful schedules and school anxiety. *About Health.* http://stress.about.com/od/studentstress/a/school_anxiety_2.htm

Souma, A., Rickerson, N., Burgstahler, S. (2012). Academic accommodations for students with psychiatric disabilities. http://www.washington.edu/doit/Brochures/Academics/psych.html

Wood, J. (2006). Effect of anxiety reduction in children's school performance and social adjustment. *Developmental Psychology, 42,* 345-349.

I. Classifying Anxiety Problems

> ## *B. Environmental Situations and Potentially Stressful Events*

The American Academy of Pediatrics has prepared a guide on mental health for primary care providers. The guide suggests that commonly occurring stressful events in a youngsters life can lead to common behavioral responses. Below are portions of Tables that give an overview of such events and responses.

Environmental Situations and Potentially Stressful Events Checklist

Challenges to Primary Support Group
    Challenges to Attachment Relationship
    Death of a Parent or Other Family Member
    Marital Discord
    Divorce
    Domestic Violence
    Other Family Relationship Problems
    Parent-Child Separation

Changes in Caregiving
    Foster Care/Adoption/Institutional Care
    Substance-Abusing Parents
    Physical Abuse
    Sexual Abuse
    Quality of Nurture Problem
    Neglect
    Mental Disorder of Parent
    Physical Illness of Parent
    Physical Illness of Sibling
    Mental or Behavioral disorder of Sibling

Other Functional Change in Family
    Addition of Sibling
    Change in Parental Caregiver

Community of Social Challenges
    Acculturation
    Social Discrimination and/or Family Isolation

Educational Challenges
    Illiteracy of Parent
    Inadequate School Facilities
    Discord with Peers/Teachers

Parent or Adolescent Occupational Challenges
    Unemployment
    Loss of Job
    Adverse Effect of Work Environment

Housing Challenges
    Homelessness
    Inadequate Housing
    Unsafe Neighborhood
    Dislocation

Economic Challenges
    Poverty
    Inadequate Financial Status

Legal System or Crime Problems

Other Environmental Situations
    Natural Disaster
    Witness of Violence

Health-Related Situations
    Chronic Health Conditions
    Acute Health Conditions

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American

Common Behavioral Responses to Environmental Situations and Potentially Stressful Events

INFANCY-TODDLERHOOD (0-2Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
N/A
Emotions and Moods
Change in crying
Change in mood
Sullen, withdrawn
Impulsive/Hyperactive or Inattentive Behaviors
Increased activity
Negative/Antisocial Behaviors
Aversive behaviors, i.e., temper tantrum, angry outburst
Feeding, Eating, Elimination Behaviors
Change in eating
Self-induced vomiting
Nonspecific diarrhea, vomiting
Somatic and Sleep Behaviors
Change in sleep
Developmental Competency
Regression or delay in developmental attainments
Inability to engage in or sustain play
Sexual Behaviors
Arousal behaviors
Relationship Behaviors
Extreme distress with separation
Absence of distress with separation
Indiscriminate social interactions
Excessive clinging
Gaze avoidance, hypervigilant gaze...

MIDDLE CHILDHOOD (6-12Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
Transient physical complaints
Emotions and Moods
Sadness
Anxiety
Changes in mood
Preoccupation with stressful situations
Self -destructive
Fear of specific situations
Decreased self-esteem
Impulsive/Hyperactive or Inattentive Behaviors
Inattention
High activity level
Impulsivity
Negative/Antisocial Behaviors
Aggression
Noncompliant
Negativistic
Feeding, Eating, Elimination Behaviors
Change in eating
Transient enuresis, encopresis
Somatic and Sleep Behaviors
Change in sleep
Developmental Competency
Decrease in academic performance
Sexual Behaviors
Preoccupation with sexual issues
Relationship Behaviors
Change in school activities
Change in social interaction such as withdrawal
Separation fear
Fear of being alone
Substance Use/Abuse...

EARLY CHILDHOOD (3-5Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
N/A
Emotions and Moods
Generally sad
Self-destructive behaviors
Impulsive/Hyperactive or Inattentive Behaviors

Inattention
High activity level
Negative/Antisocial Behaviors
Tantrums
Negativism
Aggression
Uncontrolled, noncompliant
Feeding, Eating, Elimination Behaviors
Change in eating
Fecal soiling
Bedwetting
Somatic and Sleep Behaviors
Change in sleep
Developmental Competency
Regression or delay in developmental attainments
Sexual Behaviors
Preoccupation with sexual issues
Relationship Behaviors
Ambivalence toward independence
Socially withdrawn, isolated
Excessive clinging
Separation fears
Fear of being alone

ADOLESCENCE (13-21Y)
BEHAVIORAL MANIFESTATIONS

Illness-Related Behaviors
Transient physical complaints
Emotions and Moods
Sadness
Self-destructive
Anxiety
Preoccupation with stress
Decreased self-esteem
Change in mood
Impulsive/Hyperactive or Inattentive Behaviors
Inattention
Impulsivity
High activity level
Negative/Antisocial Behaviors
Aggression
Antisocial behavior
Feeding, Eating, Elimination Behaviors
Change in appetite
Inadequate eating habits
Somatic and Sleep Behaviors
Inadequate sleeping habits
Oversleeping
Developmental Competency
Decrease in academic achievement
Sexual Behaviors
Preoccupation with sexual issues
Relationship Behaviors
Change in school activities
School absences
Change in social interaction such as withdrawal
Substance Use/Abuse...

* Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care (1996). American Academy of Pediatrics

Normal Anxiety

What's Normal Anxiety

Even in the best of situations, all children experience some anxiety in the form of worry, apprehension, dread, fear or distress. Occasional nervousness and fleeting anxieties occur when a child is first faced with an unfamiliar or especially stressful situation. It can be an important protection or signal for caution in certain situations. In fact there are specific expected fears that accompany each stage of child development.

Anxiety: Normal and Necessary

From toddlers to teens, life's challenges may be met with a temporary retreat from the situation, a greater reliance on parents for reassurance, a reluctance to take chances, and a wavering confidence. Typically these concerns will resolve when the child learns to master the situation or the situation changes. Incorporating their newfound abilities, whether it is mastering a new school, the neighborhood pool, taking tests, encountering dogs, kids move on from their fears and have no lasting ill-effects. Parents can facilitate a child's successful adjustment to a new challenge by: (1) being accepting of the child's concerns, (2) listening to the child's perceptions, and gently correcting misinformation, and (3) patiently encouraging a child to approach a feared situation one step at a time until it is becomes familiar and manageable.

Typical Childhood Fears

Infancy

In response to a growing ability to differentiate familiar faces (parents) from unfamiliar, stranger anxiety (clinging and crying when a stranger approaches) develops around 7-9 months and typically resolves by end of first year.

Early Childhood

As a healthy attachment to parents grows, separation anxiety (crying, sadness, fear of desertion upon separation) emerges around one year and improves over the next 3 years, resolving in most children by the end of kindergarten. As children's worlds expand, they may fear new and unfamiliar situations, and real and imagined dangers from big dogs, to spiders, to monsters. Children from age 3-6 are trying to master what is real and what is not, and until this is resolved, they may have difficulty with costumed characters, ghosts, and supernatural beings. While trying to master fears of what could be they may struggle with the dark, the basement, closets, and under the bed. As a child learns how to manage and put aside these fears, their ability to sleep alone will be secured.

School Aged Children

Each year, with access to new information, children begin to fear real world dangers-fire drills, burglars, storms, illness, or drugs. With experience, they learn that these risks can exist as remote, rather than imminent dangers. In middle school, the growing importance of social status leads to social comparisons and worries about social acceptance. Concerns about academic and athletic performance, and social group identification are normal. Learning about various physical and mental health diseases in school may lead to some temporary concerns about risk and safety. Teenagers continue to be focused on social acceptance, but with a greater concern for finding a group that reflects their chosen identity. Concerns about the larger world, moral issues and their future successes are common.

When You Should be Concerned

Anxiety is considered a disorder not based on what a child is worrying about, but rather how that worry is impacting a child's functioning. The content may be "normal" but help is needed when a child is experiencing too much worry or suffering immensely over what may appear to be insignificant situations, when worry and avoidance become a child's automatic response in many situations, when they feel constantly keyed up, or when coaxing or reassurance are ineffective in moving them through. For these children anxiety is not protecting them, but rather preventing them from fully participating in typical activities of daily life-school, friendships, academic performance.

Problem Anxieties

Unremitting anxiety lasting for weeks or months at a time can cause physical distress in the form of headaches, stomachaches, nausea, vomiting and sleeplessness, Difficulty sleeping, reluctance to go to school or elsewhere outside of the child's comfort zone, crying jags, tantrums and clinginess are common. Anxiety can also interfere with a child's concentration and decision-making. An anxious child's thinking is typically unrealistic, catastrophic and pessimistic. They may seek excessive reassurance and yet the benefit of that reassurance is fleeting. Irritability and anger can also be red flags for anxiety when a child becomes frustrated by the stress of worry, or worn down from sleep deprivation. For some children, feeling "different" from other kids can be an additional source of concern.

The Anxious Child

All children experience anxiety. Anxiety in children is expected and normal at specific times in development. For example, from approximately age 8 months through the preschool years, healthy youngsters may show intense distress (anxiety) at times of separation from their parents or other persons with whom they are close. Young children may have short-lived fears, such as fear of the dark, storms, animals, or a fear of strangers. Anxious children are often overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities. Parents should not dismiss a child?s fears. Because anxious children may also be quiet, compliant and eager to please, their difficulties may be missed. Parents should be alert to the signs of severe anxiety so they can intervene early to prevent complications. There are different types of anxiety in children.

Severe anxiety problems in children can be treated. Early treatment can prevent future difficulties, such as loss of friendships, failure to reach social and academic potential, and feelings of low self-esteem. Treatments may include a combination of the following: individual psychotherapy, family therapy, medications, behavioral treatments, and consultation to the school.

If anxieties become severe and begin to interfere with the child s usual activities, (for example separating from parents, attending school and making friends) parents should consider seeking an evaluation from a qualified mental health professional.

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http://www.adaa.org/living-with-anxiety/children/childhood-anxiety-disorders

Childhood Anxiety Disorders

Generalized Anxiety Disorder

If your child has generalized anxiety disorder, or GAD, he or she will worry excessively about a variety of things such as grades, family issues, relationships with peers, and performance in sports. Learn more about GAD.

Children with GAD tend to be very hard on themselves and strive for perfection. They may also seek constant approval or reassurance from others.

Panic Disorder

Panic disorder is diagnosed if your child suffers at least two unexpected panic or anxiety attacks—which means they come on suddenly and for no reason—followed by at least one month of concern over having another attack, losing control, or "going crazy." Learn more about panic disorder and panic attacks.

Separation Anxiety Disorder

Many children experience separation anxiety between 18 months and three years old, when it is normal to feel some anxiety when a parent leaves the room or goes out of sight. Usually children can be distracted from these feelings.

It's also common for your child to cry when first being left at daycare or pre-school, and crying usually subsides after becoming engaged in the new environment.

If your child is slightly older and unable to leave you or another family member, or takes longer to calm down after you leave than other children, then the problem could be separation anxiety disorder, which affects 4 percent of children. This disorder is most common in kids ages seven to nine.

When separation anxiety disorder occurs, a child experiences excessive anxiety away from home or when separated from parents or caregivers. Extreme homesickness and feelings of misery at not being with loved ones are common.

Other symptoms include refusing to go to school, camp, or a sleepover, and demanding that someone stay with them at bedtime. Children with separation anxiety commonly worry about bad things happening to their parents or caregivers or may have a vague sense of something terrible occurring while they are apart.

Social Anxiety Disorder

Social anxiety disorder, or social phobia, is characterized by an intense fear of social and performance situations and activities such as being called on in class or starting a conversation with a peer. Learn more about social anxiety disorder.

This can significantly impair your child's school performance and attendance, as well as his or her ability to socialize with peers and develop and maintain relationships.

- *Watch this **VIDEO:*** Rose, a teen, speaks about her social anxiety and how cognitive-behavioral therapy (CBT) helped her.

Selective Mutism

Children who refuse to speak in situations where talking is expected or necessary, to the extent that their refusal interferes with school and making friends, may suffer from selective mutism.

Children suffering from selective mutism may stand motionless and expressionless, turn their heads, chew or twirl hair, avoid eye contact, or withdraw into a corner to avoid talking.

These children can be very talkative and display normal behaviors at home or in another place where they feel comfortable. Parents are sometimes surprised to learn from a teacher that their child refuses to speak at school.

The average age of diagnosis is around 5 years old, or around the time a child enters school.

- Visit online: Selective Mutism Group

Specific Phobias

A specific phobia is the intense, irrational fear of a specific object, such as a dog, or a situation, such as flying. Common childhood phobias include animals, storms, heights, water, blood, the dark, and medical procedures.

Children will avoid situations or things that they fear, or endure them with anxious feelings, which can manifest as crying, tantrums, clinging, avoidance, headaches, and stomachaches. Unlike adults, they do not usually recognize that their fear is irrational. Learn more about phobias.

Obsessive-compulsive disorder (OCD) and posttraumatic stress disorder (PTSD) are closely related to anxiety disorders, which some may experience at the same time, along with depression.

Obsessive-Compulsive Disorder (OCD)

OCD is characterized by unwanted and intrusive thoughts (obsessions) and feeling compelled to repeatedly perform rituals and routines (compulsions) to try and ease anxiety. Learn more about OCD.

Most children with OCD are diagnosed around age 10, although the disorder can strike children as young as two or three. Boys are more likely to develop OCD before puberty, while girls tend to develop it during adolescence.

Posttraumatic Stress Disorder (PTSD)

Children with posttraumatic stress disorder, or PTSD, may have intense fear and anxiety, become emotionally numb or easily irritable, or avoid places, people, or activities after experiencing or witnessing a traumatic or life-threatening event. Learn more about PTSD.

Not every child who experiences or hears about a traumatic event will develop PTSD. It is normal to be fearful, sad, or apprehensive after such events, and many children will recover from these feelings in a short time.

Children most at risk for PTSD are those who directly witnessed a traumatic event, who suffered directly (such as injury or the death of a parent), had mental health problems before the event, and who lack a strong support network. Violence at home also increases a child's risk of developing PTSD after a traumatic event.

Updated September 2015

DSM-5: Changes to the Diagnostic and Statistical Manual of Mental Disorders
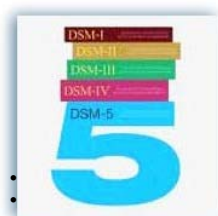
Diagnostic and Statistical Manual of Mental Disorders (DSM) is the standard classification of mental disorders used by mental health providers in the United States. It contains a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. health care system.

En Español:

Hoja Informativa DSM-5
El Instituto de Investigación Psicológica (IPsi)

Revisions Published in 2013

The American Psychiatric Association has announced that *DSM-5,* the new edition of the *Diagnostic and Statistical Manual of Mental Disorders,* incorporates significant scientific advances in more precisely identifying and diagnosing mental disorders. *DSM-5* provides a common language for patients, caregivers, and clinicians to communicate about the disorders.

Some of the categories for anxiety disorders have changed. These changes will not affect your ability to find treatment or your current health insurance. Ask your therapist or doctor about how the new criteria may provide a more accurate way to characterize symptoms and assess severity.

- Download fact sheets about the disorders from the American Psychiatric Association.

Anxiety and Depression Refinements

Much has remained the same in the areas of anxiety and depression, with refinements of criteria and symptoms across the lifespan. Some disorders included in the broad category of anxiety disorders are now in three sequential chapters: Anxiety Disorders, Obsessive-Compulsive and Related Disorders, and Trauma- and Stressor-Related Disorders. This move emphasizes the distinctiveness of each category while signaling their interconnectedness. (See list below.)

One significant change is the developmental approach and examination of disorders across the lifespan, including children and older adults. Some conditions are grouped together as syndromes because the symptoms are not sufficiently distinct to separate the disorders. Others have been split apart into distinct groups.

The *DSM-5* is not a treatment guide, and it will not affect the availability of treatments for patients and their loved ones.

- Find a Therapist
- Learn more about treatments for anxiety and depression.

DSM-5 Disorders
Anxiety Disorders
Separation Anxiety Disorder
Selective Mutism
Specific Phobia
Social Anxiety Disorder (Social Phobia)
Panic Disorder
Panic Attack (Specifier)
Agoraphobia
Generalized Anxiety Disorder
Substance/Medication-Induced Anxiety Disorder
Anxiety Disorder Due to Another Medical Condition
Other Specified Anxiety Disorder
Unspecified Anxiety Disorder

II. *The Broad Continuum of Anxiety Problems*

A. Developmental Variations
B. Problems
C. Disorders

The American Academy of Pediatrics has produced a manual for primary care providers that gives guidelines for psychological behaviors that are within the range expected for the age of the child, problems that may disrupt functioning but are not sufficiently severe to warrant the diagnosis of a mental disorder, and disorders that do meet the criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders.

Just as the continuum of Type I, II, and III problems presented in Section 1A does, the pediatric manual provides a way to describe problems and plan interventions without prematurely deciding that internal pathology is causing the problems. The manual's descriptions are a useful way to introduce the range of concerns facing parents and school staff.

In addition to using material from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care* **published by the American Academy of Pediatrics throughout Part III, we also have incorporated fact sheets from major agencies and excerpted key information from journal articles to provide users with a perspective of how the field currently presents itself.**

II. The Broad Continuum of Anxiety Problems

> # A. Developmental Variation Within the Range of Expected Behaviors for That Age Group

DEVELOPMENTAL VARIATION

Anxious Variation

Fears and worries are experienced that are appropriate for developmental age and do not affect normal development.

Transient anxious responses to stressful events occur in an otherwise healthy child and they do not affect normal development.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Normal fears of noises, heights, and loss of physical support are present at birth. Fear of separation from parent figures and fear of strangers are normal symptoms during the first years of life. The latter peaks at 8 to 9 months. Feeding or sleeping changes are possible in the first year. Transient developmental regressions occur after the first year. Scary dreams may occur.

Early childhood
By age 3 years, children can separate temporarily from a parent with minimal crying or clinging behaviors. Children described as shy or slow to warm up to others may be anxious in new situations. Specific fears of thunder, medical settings, and animals are present.

Middle Childhood
In middle childhood, a child with anxious symptoms may present with motor responses (trembling voice, nail biting, thumb sucking) or physiologic responses (headache, recurrent abdominal pain, unexplained limb pain, vomiting, breathlessness). Normally these should be transient and associated with appropriate stressors. Transient fears may occur after frightening events, such as a scary movie. These should be relieved easily with reassurance.

Adolescence
Adolescents may be shy, avoid usual pursuits, fear separation from friends, and be reluctant to engage in new experiences. Risk-taking behaviors, such as experimentation with drugs or impulsive sexual behavior, may be seen.

SPECIAL INFORMATION

Clinicians should attempt to identify any potential stressful events that may have precipitated the anxiety symptoms (...).

Difficulty falling asleep, frequent night awakenings, tantrums and aggressiveness, and excessive napping may reflect anxiety.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

Note: dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

B. Problems--Behaviors Serious Enough to Disrupt Functioning with Peers, at School, at Home, but Not Severe Enough to Meet Criteria

PROBLEM	COMMON DEVELOPMENTAL PRESENTATIONS

Anxiety Problem

An anxiety problem involves excessive worry or fearfulness that causes significant distress in the child. However, the behaviors are not sufficiently intense to qualify for an anxiety disorder or adjustment disorder with anxious mood.

Infancy and Early Childhood
In infancy and early childhood, anxiety problems usually present with a more prolonged distress at separation or as sleep and feeding difficulties including anxious clinging when not separating.

Middle Childhood
In middle childhood, anxiety may be manifest as sleep problems, fears of animals, natural disasters, and medical care, worries about being the center of attention, sleep-overs, class trips, and the future (see Sadness and Related Symptoms cluster). Anxiety may involve some somatic symptoms such as tachycardia, shortness of breath, sweating, choking, nausea, dryness, and chest pain (...). Environmental stress may be associated with regression (loss of developmental skills), social withdrawal, agitation/hyperactivity, or repetitive reenactment of a traumatic event through play. These symptoms should not be severe enough to warrant the diagnoses of a disorder and should resolve with the alleviation of the stressors.

Adolescence
In adolescence, anxiety may be manifest as sleep problems and fears of medical care and animals. Worries about class performance, participation in sports, and acceptance by peers may be present. Environmental stress may be associated with social withdrawal, boredom (see Sadness and Related Symptoms cluster), aggressiveness, or some risk-taking behavior (e.g., indiscriminate sexual behavior, drug use, or recklessness).

SPECIAL INFORMATION

Anxiety problems have a number of different clinical presentations including persistent worries about multiple areas in the child's life, excessive or unreasonable fear of a specific object or situation, fear of situations in which the child has to perform or be scrutinized by others, excessive worry about separation from parents, or anxiety following a significant, identifiable stressor.

Separation difficulties may be prolonged if inadvertently rewarded by parents and can result in a separation anxiety disorder.

Parental response to the child's distress or anxiety is a key factor in the assessment of anxiety problems. The extent of the child's anxiety may be difficult to assess and the primary care clinicians should err on the side of referral to a mental health clinician if there is uncertainty about the severity of the condition.

*Adapted from The Classification of Child and Adolescent Mental Diagnoses in Primary Care. (1996) American Academy of Pediatrics

Note: dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

DISORDER

Generalized Anxiety Disorder

This disorder is characterized by at least 6 months of persistent and excessive anxiety and worry. Excessive and persistent worry occurs across a multitude of domains or situations, such as school work, sports, or social performance, and is associated with impaired functioning. The disorder is often associated with somatic and subjective/behavioral symptoms of anxiety (see Special Information).

Social Phobia

This phobia involves a marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The person recognizes the fear is excessive or un-reasonable. Avoidance of the situation leads to impaired functioning.

Specific Phobia

Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation. Exposure to the phobic stimulus provokes an immediate anxiety response. In individuals under 18 years, the duration is at least 6 months. The anxiety associated with the object/situation is not better accounted for by another mental disorder.

*Adapted from *The Classification of Child and Adolescent Mental Diagnoses in Primary Care*. (1996) American Academy of Pediatrics

Note: dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

COMMON DEVELOPMENTAL PRESENTATIONS

Infancy
Rarely diagnosed in infancy. During the second year of life, fears and distress occurring in situations not ordinarily associated with expected anxiety that is not amenable to traditional soothing and has an irrational quality about it may suggest a disorder.

The fears are, for example, intense or phobic reactions to cartoons or clowns, or excessive fear concerning parts of the house (e.g., attic or basement).

Early Childhood
Rarely diagnosed in this age group. In children, these disorders may be expressed by crying, tantrums, freezing, or clinging, or staying close to a familiar person. Young children may appear excessively timid in unfamiliar social settings, shrink from contact with others, refuse to participate in group play, typically stay on the periphery of social activities, and attempt to remain close to familiar adults to the extent that family life is disrupted.

Middle Childhood and Adolescence
Symptoms in middle childhood and adolescence generally include the physiologic symptoms associated with anxiety (restlessness, sweating, tension) (...) and avoidance behaviors such as refusal to attend school and lack of participation in school, decline in classroom performance or social functions. In addition, an increase in worries and sleep disturbances are present.

SPECIAL INFORMATION

Generalized anxiety disorder

Severe apprehension about performance may lead to refusal to attend school. This must be distinguished from other causes of refusal, including realistically aversive conditions at school (e.g., the child is threatened or harassed), learning disabilities (...), separation anxiety disorder (see below), truancy (the child is not anxious about performance or separation), and depression (see Sadness and Related Symptoms cluster). To make these diagnoses in children, there must be evidence of capacity for social relationships with adults. Because of the early onset and chronic course of the disorder, impairment in children tends to take the form of failure to achieve an expected level of functioning rather than a decline from optimal functioning. Children with generalized anxiety disorder may be overly conforming, perfectionists and unsure of themselves and tend to redo tasks because of being zealous in seeking approval and requiring excessive reassurance about their performance and other worries.

DISORDER	COMMON DEVELOPMENTAL PRESENTATIONS

Separation Anxiety Disorder

Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached.

Infancy
Not relevant at disorder level.

Early and Middle Childhood
When separated from attachment figures, children may exhibit social withdrawal, apathy, sadness, difficulty concentrating on work or play They may have fears of animals, monsters, the dark, muggers, kid-nappers, burglars, car accidents; concerns about death and dying are common. When alone, young children may report unusual perceptual experiences (e.g., seeing people peering Into their room).

Adolescence
Adolescents with this disorder may deny feeling anxiety about separation; however, it may be reflected in their limited Independent activity and reluctance to leave home.

Panic Disorder

This disorder Involves recurrent unexpected (uncued) panic attacks. Apprehension and anxiety about the attacks or a significant change in behavior related to the attack persists for at least 1 month. A panic attack is a discrete episode of intense fear or discomfort with sudden onset combining the following psychological symptoms— a sense of impending doom, fear of going crazy, and feelings of unreality—with somatic symptoms such as shortness of breath/dyspnea, palpitations/tachycardia, sweating, choking, chest pain, nausea, dizziness, paresthesia.

Infancy
Not relevant at disorder level.

Early Childhood
In children, these disorders may be expressed by crying, tantrums freezing, clinging, or staying close to a familiar person during a panic attack.

Middle Childhood
Panic attacks may be manifested by symptoms such as tachycardia shortness of breath, spreading chest pain, and extreme tension.

Adolescence
The symptoms are similar to those seen in an adult, such as the sense of impending doom, fear of going crazy, feelings of unreality and somatic symptoms such as shortness of breath, palpitations, sweating, choking, and chest pain.

SPECIAL INFORMATION

Separation anxiety disorder must be beyond what is expected for the child's developmental level to be coded as a disorder. In infancy, consider a developmental variation or anxiety problem rather than separation anxiety disorder. Worry about separation may take the form of worry about the health and safety of self or parents.

Separation anxiety disorder may begin as early as preschool age and may occur at any time before age 18 years, but onset as late as adolescence is uncommon. Use early onset specifier if the onset of disorder is before 6 years. Children with separation anxiety disorder are often described as demanding, Intrusive, and in need of constant attention which may lead to parental frustration.

Separation anxiety disorder is a common cause of refusal to attend school. Parental difficulty in separating from the child may contribute to the clinical problem (...). A break down in the marital relationship (marital discord) and one parent's over-involvement with the child is often seen (...). Children with serious current or past medical problems (...) may be overprotected by parents and at greater risk for separation anxiety disorder. Parental illness and death may also increase risk.

Note: dots (...) indicate that the material has been abridged at that point or that the original text refers to another section of the resource that is not included in this guide.

III. Interventions for Anxiety Problems

A. Accommodations to Reduce Anxiety Problems

B. Assessment

C. Empirically Supported Treatments for Anxiety Problems

D. General Discussion of Treatment/Medications

E. School Avoidance: Reactive and Proactive

III. Interventions for Anxiety Problems

A. Accommodations to Reduce Anxiety Problems

Welcoming Strategies for Newly Arrived Students & Their Families
(http://smhp.psych.ucla.edu/pdfdocs/practicenotes/welcomingstrategies.pdf)

Starting a new school can be scary. Those concerned with mental health in schools can play important prevention and therapeutic roles by helping a school establish a welcoming program and ways to provide ongoing social support.

Special attention must be directed at providing Office Staff with training and resources so they can create a welcoming and supportive atmosphere to everyone who enters the school. And, of course, there must be workshops and follow-up assistance for teachers to help them establish welcoming procedures and materials.

Start simple. For example, assist teachers in establishing a few basic ways to help new students feel welcome and part of things, such as

• giving the student a *Welcome Folder*

   A folder with the student's name, containing welcoming materials and information, such as a welcome booklet and information about fun activities at the school.

• assigning a *Peer Buddy*

   Train students to be a special friend
   > to show the new student around
   > to sit next to the new student
   > to take the new student to recess and lunch to meet schoolmates

Some parents are not sure how to interact with the school. Two ways to help new parents feel welcome and a part of things are to establish processes whereby teachers

• invite parents to a *Welcoming Conference*

   This is meant as a chance for parents to get to know the teacher and school and for the teacher to facilitate positive connections between parent and school such as helping the parents connect with a school activity in which they seem interested. The emphasis is on *Welcoming* -- thus, any written material given out at this time specifically states WELCOME and is limited to simple orientation information. To the degree feasible, such material is made available in the various languages of those likely to enroll at the school.

• connect parents with a *Parent Peer Buddy*

   Identify some parents who are willing to be a special friend to introduce the new parent around, to contact them about special activities and take them the first time, and so forth.

The following list are additional examples of prevention-oriented welcoming and social support strategies for minimizing negative experiences and ensuring positive outreach.

1. **FRONT DOOR**: Set up a Welcoming Table (identified with a welcoming sign) at the front entrance to the school and recruit and train volunteers to meet and greet everyone who comes through the door.

2. **FRONT OFFICE**: Work with the Office Staff to create ways to meet and greet strangers with a smile and an inviting atmosphere. Provide them with welcoming materials and information sheets regarding registration steps (with appropriate translations). Encourage the use of volunteers in the office so that there are sufficient resources to take the necessary time to greet and assist new students and families. It helps to have a designated registrar and even designated registration times.

3. **WELCOMING MATERIALS**: Prepare a booklet that clearly says WELCOME and provides some helpful info about who's who at the school, what types of assistance are available to new students and families, and offers tips about how the school runs. (Avoid using this as a place to lay down the rules; that can be rather an uninviting first contact.) Prepare other materials to assist students and families in making the transition and connecting with ongoing activities.

4. **STUDENT GREETERS**: Establish a Student Welcoming Club (perhaps the student council or leadership class can make this a project). These students can provide tours and some orientation (including initial introduction to key staff).

5. **PARENT/VOLUNTEER GREETERS:** Establish a General Welcoming Club of parents and/or volunteers who provide regular tours and orientations (including initial introduction to key staff). Develop a Welcoming Video.

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6. **WELCOMING BULLETIN BOARD:** Dedicate a bulletin board (somewhere near the entrance to the school) that says WELCOME and includes such things as pictures of school staff, a diagram of the school and its facilities, pictures of students who entered the school during the past 1-2 weeks, information on tours and orientations, special meetings for new students, and so forth.

7. **CLASSROOM GREETERS**: Each teacher should have several students who are willing and able to greet strangers who come to the classroom. Recent arrivals often are interested in welcoming the next set of new enrollees.

8. **CLASSROOM INTRODUCTION**: Each teacher should have a plan to assist new students and families in making a smooth transition into the class. This includes ways to introduce the student to classmates as soon as the student arrives. (Some teachers may want to arrange with the office specified times for bringing a new student to the class.) An introductory Welcoming Conference should be conducted with the student and family as soon as feasible. A useful Welcoming aid is to present both the student and the family member with Welcoming Folders (or some other welcoming gift such as coupons from local businesses that have adopted the school).

9. **PEER BUDDIES**: In addition to the classroom greeter, a teacher can have several students who are trained to be a special buddy to a new student for a couple of weeks (and hopefully thereafter). This can provide the type of social support that allows a new student to learn about the school culture and how to become involved in activities.

10. **OUTREACH FROM ORGANIZED GROUPS**: Establish a way for representatives of organized student and parent groups (including the PTSA) to make direct contact with new students and families to invite them to learn about activities and to assist them in joining in when they find activities that appeal to them.

11. **SUPPORT GROUPS**: Offer groups designed to help new students and families learn about the community and the school and to allow them to express concerns and have them addressed. Such groups also allow them to connect with each other as another form of social support.

12. **ONGOING POSITIVE CONTACTS**: Develop a variety of ways students and their families can feel an ongoing connection with the school and classroom (e.g., opportunities to volunteer, positive feedback regarding participation, letters home that tell "all about what's happening")

For more on this topic, see the Center's on-line clearinghouse quick find search topic:
Transition Programs/Grade Articulation/Welcome
http://smhp.psych.ucla.edu/qf/p2101_01.htm

III. Interventions for Anxiety Problems

A. Accommodations to Reduce Anxiety Problems (cont.)

Back-to-School Anxiety

What is normal anxiety when entering a new school year?

When vacations come to an end, it is not surprising to hear moans and groans from children as their television programs are interrupted by commercials promoting the beginning of year savings for school supplies and clothing. With the first day of school approaching, it is common for kids to feel some apprehension. The new school year means the end of extensive leisure time and the beginning of new challenges and responsibilities. A new teacher, classroom, and schedule, in addition to a harder curriculum and a higher expectation for academic performance are enough cause for anxiety. Moreover, these challenges are sometimes accompanied by additional obstacles, such as having to adjust to an entirely new school. It is safe to say that the majority of students see the approaching school year as both an academic and social challenge; some see it as quite stressful (Sirsch, 2003).

When is anxiety excessive? How can you tell?

There are some students who are paralyzed by the anxiety of returning to school, perceiving the event as an academic and social threat, in which the stressful situation is anticipated as harmful and fearful (Lazarus 1991). According to the Anxiety Disorders Association of America, one child in every eight suffers from an anxiety disorder. With that being said, a teacher with a classroom of 25 can expect to have about 2 to 3 children with high anxiety levels.

Anxiety is considered excessive when it interferes with a child's well-being and ability to learn. High levels of anxiety are often apparent in a child's behavior, such as temper tantrums and refusals to attend school. Excessive anxiety can lead to school avoidance. It can also manifest as physical symptoms, such as trouble breathing, nausea, headaches, and stomach aches. A child who expresses such symptoms should see a physician, as well as having special attention from his or her teacher and probably a support staff member such as a school psychologist or counselor (Peach, 2011).

Separation anxiety is to be expected, particularly among those just starting kindergarten. Indeed, some children experience great emotional distress when asked to spend extended periods with anyone other than his or her parents or guardians

Identifying high anxious students involves taking note of students who display behavior, learning, and/or emotional problems; special attention should be paid to those who are frequently absent and disconnected from peers and school activities.

Help them with anxiety reducing information and support. Anxiety may manifest as uncertainty and a fear that the worst will happen. To mitigate this, it is important that teachers be aware of students' concerns and address them with supportive measures (Avant, Gazelle, & Faldowski, 2011). Children often need more information that conveys that what is expected for their level of schooling is within their grasp; parents need to be informed and mobilized about these matters as well.

Some of this can be done before the start of the term. For example, some uncertainty can be reduced by familiarizing students with what they will be encountering. School tours during the spring or summer help acquaint them with the layout, key places and persons on the campus, schedules, and so forth. Also during the summer, some schools encourage students to come to the campus by offering movies, concerts, summer classes, and sporting events.

Plan. Particularly important is that student and learning support staff plan for the arrival of new students, with special attention to those who will struggle with the transition. Teachers can plan ways to reduce student uncertainty by designing classroom routines and schedules that will be experienced as motivating and nonthreatening.

At the Elementary School Level. At all times, the key is: *be aware of students concerns and keep parents engaged.* Schools should make parents aware of the anxieties children are likely to experience. They should encourage parents to have open discussions with their children about their feelings on starting school so they are better able to address concerns. As many concerns stem from uncertainties, schools should inform parents of what is and is not expected of their child at a particular grade level and clarify ways to counter fears (Kendrick, online). Encouraging a dialogue between a child and the person they are closest to is an important step in supporting a child suffering from heightened levels of anxiety. Part of such a dialogue might include listing a child's fears on one side of a paper and writing "facts" on the other side (Peisner, 2011).

Schools also can help parents be aware of the signs of anxiety so that they can effectively intervene. Tamar Chansky stresses: "if your child is having difficulty sleeping, asking lots of 'what if' questions, crying, clinging, or whining more than usual, these may be signs of anxiety" (reported in Peisner, 2011).

Schools can encourage parents to normalize their child's fears (e.g., explaining to the child that it is natural to be worried and that even teachers feel nervous at the beginning). Moreover, parents can be encouraged to explain that they will feel more at ease as they become more accustomed to their new educational environment.

Teachers for young children know that building positive relationships can serve as a preventive measure for back-to-school anxiety. Researchers certainly support this. "Children with whom kindergarten teachers reported a positive relationship were rated in spring of grade 1 as better adjusted than was predicted on basis of identical ratings from the fall of kindergarten year" (Pianta et al. 1995). "Classrooms with supportive emotional climates ... buffer anxious solitary children from risk for social and emotional difficulties" (Spangler et al. 2011).

At the Middle and High School Level. Again, the key is to *be aware of students concerns and keep parents engaged and well-informed* about transition concerns. This includes providing parents with the knowledge necessary to reassure their children and to notice early signs of anxiety.

Researchers stress that "support for the transition from elementary school to middle school ... needs to begin late in elementary school (perhaps the entire grade 5) and to continue throughout the summer and into the first semester or year of middle/junior high school" (Anderson et al. 2000). The same goes for those starting high school. Transitional programs often are described as having three major components:

- procedural – the type of early orientation steps outlined above

- academic – it is often recommended that transition programs incorporate a structured study skills class that encourages students to take more responsibility for their learning (Dillon, 2008)

- social – social supports can be designed to help students fit in and make friends (Akos, 2006).

With respect to a support system, there are roles to be played by administrators, teachers, parents, and students. For example, an older student that made a successful transition the previous year can be particularly helpful serving as a model and a support for the new student (Ferguson & Bulach, 1997).

One recent installment to the middle school and high school system is assigning incoming students to a "family" or "academy" within the new school. This can facilitate transition by building a sense of community and belonging. Also, to heighten feelings of community and belonging, students can be encouraged to participate in organizations, clubs, and teams (Anderson et al., 2000).

"Children in classrooms with highly supportive emotional climates may increasingly become a cohesive group over the course of the academic year. Such cohesion may result when the teacher promotes mutual respect and inclusion among all students in the class" (Avant et al. 2011). Moreover, students in supportive classrooms are reported to engage in significantly less avoidance behavior than students in ambiguous or nonsupportive environments (Patrick et al. 2003). Students who feel that they are appreciated and are contributing something to their campus help create a fulfilling learning environment and successful transitions.

Some Resources and References

Center Resources

For more on all this, see the following Center resources:

Common Psychosocial Problems of School Aged Youth: Developmental Variations, Problems, Disorders and Perspectives for Prevention and Treatment.
http://smhp.psych.ucla.edu/pdfdocs/psysocial/entirepacket.pdf

Transitions: Turning Risks into Opportunities for Student Support
http://smhp.psych.ucla.edu/pdfdocs/transitions/transitions.pdf

Supporting Successful Transition to Ninth Grade
http://smhp.psych.ucla.edu/pdfdocs/practicenotes/transitionsninthgrade.pdf

Transitions to and from Elementary, Middle, and High School
http://smhp.psych.ucla.edu/pdfdocs/transitionstoandfrom.pdf

Welcoming and Involving New Students and Families
http://smhp.psych.ucla.edu/pdfdocs/welcome/welcome.pdf

Addressing School Adjustment Problems
http://smhp.psych.ucla.edu/pdfdocs/**adjustment**problems.pdf

Cited and Other References

Akaos, P. & Galassi, A.P. (2004). Middle and high school transitions as viewed by students, parents, and teachers. *Professional School Counseling.* http://findarticles.com/p/articles/mi_m0KOC/is_4_7/ai_n6033397/

Anderson, L. et al. (2000). School transitions: Beginning of the end or a new beginning? *International Journal of Educational Research, 33,* 325-339.

Barber, B. & Olsen, J. (2004). Assessing the transitions to middle and high school. *Journal of Adolescent Research, 19*, 3-30.

Bohan-Baker, M. & Little, P. (2002). *The transition to kindergarten: A review of current research and promising practices to involve families.* Harvard Family Research Project. http://www.gse.harvard.edu/hfrp/

Dillon, N. (2008). The transition years. *American School Board Journal, 195*, 16-19.

Duchesne, S. et al. (2009). Early adolescent attachment to parents, emotional problems, and teacher-academic worries about the middle school transition. *Journal of Early Adolescence, 29,* 743-766

Fryson, S. (2008). Using discourse analysis and psychological send of community to understand school transitions. *Journal of Community Psychology, 36*, 452-467.

Kendrick, C. (online). Talking to children about their school anxiety. *Family Education.* Http://school.familyeducation.com/back-to-school/anxiety/37623.html

LaParo, K. et al. (2000) Teachers' reported transition practices for children transitioning into kindergarten and first grade. *Exceptional Children, 67*, 7-20.

Legters, N. & Kerr, K. (2001). *Easing the transition to high school: An investigation of reform practices to promote ninth grade success.* The Civil Rights Project. http://www.civilrightsproject.ucla.edu/

Lorain, P. (online). *Transition to middle school.* National Education Association. Http://www.nea.org/tools/16657.htm

Mizelle, N. (1999). *Helping middle school students make the transition into high school*. KidSource. Http://www.kidsource.com/education/middlehigh.html

Mizelle, N. & Irvin, J. (2000). *Transition for middle school into high school*. National Middle School Association. http://www.nmsa.org

Patrick, H. et al (2003). How teachers establish psychological environments during the first days of school. *Teachers College Record, 105*, 1521-1558.

Peach, S. (2011). *Coping with back to school anxiety*. UNC Healthcare. Http://news.unchealthcare.org.

Peisner, L. (2011). Back to school anxiety a problem for kids. *The Atlanta Journal Constitution*, 3/3/2011. Http://www.ajc.com

Pianta, R. et al. (1995). The first two years of school: teacher-child relationships and deflections in children's classroom adjustment. *Development and Psychopathology, 7,* 295-312.

Sirsch, U. (2003). The impending transition for primary to second school: Challenge or threat? *International Journal of Behavioral Development 27*, 385-395.

Smith, J. (2006) *Transition from middle school to high school*. National Middle School Association. http://www.nmsa.org

Spangler A.T. et al. (2011). Classroom emotional climate as a moderator of anxious solitary children's longitudinal risk for peer exclusion: a child X environment model. *Developmental Psychology*, advance online publication.

Theriot, M & Dupper, D. (2010). Students discipline problems and the transition from elementary to middle school. *Education and Urban Society, 42*, 205-222.

III. Intervention for Anxiety Problems

B. Assessment

Abstract from: Evidence-based assessment of anxiety and its disorders in children and adolescents. Silverman, W.K., & Ollendick, T.H. (2005). *J Clin Child Adolesc Psychol. 34,* 380-411. http://www.ncbi.nlm.nih.gov/pubmed/16026211

We provide an overview of where the field currently stands when it comes to having evidence-based methods and instruments available for use in assessing anxiety and its disorders in children and adolescents. Methods covered include diagnostic interview schedules, rating scales, observations, and self-monitoring forms. We also discuss the main purposes or goals of assessment and indicate which methods and instruments have the most evidence for accomplishing these goals. We also focus on several specific issues that need continued research attention for the field to move forward toward an evidence-based assessment approach. Finally, tentative recommendations are made for conducting an evidence-based assessment for anxiety and its disorders in children and adolescents. Directions for future research also are discussed.

Abstract from: Assessment and treatment of anxiety disorders in children and adolescents. Connolly, S.D., Suarez, L., & Sylvester, C. (2011). *Curr Psychiatry Rep. 13*, 99-110. http://www.ncbi.nlm.nih.gov/pubmed/21225481

This article reviews the current screening and assessment tools for anxiety disorders in children and adolescents, as well as evidence-based treatment interventions for these disorders. The following anxiety disorders are discussed: separation anxiety disorder, generalized anxiety disorder, specific phobia, panic disorder, social anxiety disorder (social phobia), and selective mutism. There are several well-studied screening and assessment tools to identify childhood anxiety disorders early and differentiate the various anxiety disorders. Evaluations of baseline somatic symptoms, severity, and impairment ratings of the anxiety disorders, and collecting ratings from several sources is clinically helpful in assessment and treatment follow-up. Cognitive-behavioral therapy (CBT) has been extensively studied and has shown good efficacy in treatment of childhood anxiety disorders. A combination of CBT and medication may be required for moderate to severely impairing anxiety disorders and may improve functioning better than either intervention alone. Selective serotonin reuptake inhibitors are currently the only medications that have consistently shown efficacy in treatment of anxiety disorders in children and adolescents. Despite proven efficacy, the availability of CBT in the community is limited. Current research is focusing on early identification of anxiety disorders in community settings, increasing the availability of evidence-based interventions, and modification of interventions for specific populations.

III. Intervention for Anxiety Problems

B. Assessment (cont.)

Table of All Screening Tools & Rating Scales

The Massachusetts General Hospital's School Psychiatry Program & Madi Resource Center provide a table of screening tools and rating scales. It is online at http://www2.massgeneral.org/schoolpsychiatry/screeningtools_table_print.asp .

The screening tools and rating scales highlighted are for use as an aid in measuring a young person's "mental health symptoms, and/or measure progress after interventions are put in place at school or at home."

As descibed:

"For each screening tool or rating scale, the table indicates: the age range for the instrument, who completes the instrument, the number of items in the instrument and how long it takes to complete, and whether free access is available on line.

To help you decide whether a screening tool or rating scale might be appropriate to use with respect to a particular child, you can click on the DETAIL link next to the tool or scale. The DETAIL pages give more detailed information about the tool or scale, including a color-coded summary of who the instrument is designed for (i.e., parents, teachers, students, and/or clinicians). The DETAIL pages also provide direct links to view, download, or order the tools and scales. The DETAIL pages are organized by symptom, so, for example all the screening tools and scales for anxiety are on the anxiety DETAIL page.

Cautions

Please keep in mind the following cautions:

- Use of the screening tools and rating scales does not produce a diagnosis. Rather, the tools and scales point toward the types of mental health disorders that may be worthwhile to consider as a cause of a child's or adolescent's emotional or behavioral difficulties.

- A particular "score" does not mean that a child has a particular disorder – these screening tools and rating scales are only one component of an evaluation.

- Diagnoses should be made only by a trained clinician after a thorough evaluation.

- Symptoms suggestive of suicidal or harmful behaviors warrant immediate attention by a trained clinician."

The section of the Table that focuses on anxiety is reproduced on the following page.

Table of All Screening Tools & Rating Scales

Anxiety Symptoms

Screening Tool / Rating Scale	For Ages (Years)	Who Completes Checklist: Number of Items	Time to Complete (Minutes)	View Free Online
Spence Children's Anxiety Scale (SCAS) DETAIL	2.5-6.5 8-12	Parent: 35-45 Student: 34-45	5-10	YES
Revised Children's Manifest Anxiety Scale (RCMAS-2) DETAIL	6-19	Student: 37	10	
Depression and Anxiety in Youth Scale (DAYS) DETAIL	6-19	Parent: 45 Teacher: 30 Student: 40	10 5-10 15-20	
Beck Anxiety Inventory for Youth (BYI) DETAIL	7-14	Student: 20	5-10	YES
Beck Anxiety Inventory (BAI) DETAIL	7+	Parent, Student, Clinician: 21		
Self-Report for Childhood Anxiety Related Emotional Disorders (SCARED) DETAIL	8+	Parent, Student: 41	5	YES
Multidimensional Anxiety Scale for Children (MASC) DETAIL	8-19	Student: 39 (Short Version: 10)	15 5	
State-Trait Anxiety Inventory for Children (STAIC) DETAIL	9-12	Clinician: 40	10-20	
Endler Multidimensional Anxiety Scales (EMAS) DETAIL	12-17	Student:	25	
Anxiety Disorders in Children: A Test for Parents DETAIL	12-17	Parent: 15	5	YES
Anxiety Disorders in Adolescents: A Self-Test DETAIL	12-17	Student: 18	5	YES

Social Anxiety Symptoms

Screening Tool / Rating Scale	For Ages (Years)	Who Completes Checklist: Number of Items	Time to Complete (Minutes)	View Free Online?
Liebowitz Social Anxiety Scale-Child Adolescent version (LSAS-CA) DETAIL	7+	Parent, Student, Clinician: 24	10-20	YES
Social Phobia and Anxiety Inventory for Children (SPAI-C) DETAIL	8-14	Student: 26	20-30	

III. Intervention for Anxiety Problems

C. Empirically Supported Treatments

In an effort to improve the quality of treatment, the mental health field is promoting the use of empirically supported interventions.

ABSTRACT

Anxiety disorders are the most common mental health disorder among children and adolescents. We examined 111 treatment outcome studies testing 204 treatment conditions for child and adolescent anxiety published between 1967 and mid-2013. Studies were selected for inclusion in this review using the PracticeWise Evidence-Based Services database. Using guidelines identified by this journal (Southam-Gerow & Prinstein, 2014), studies were included if they were conducted with children and/or adolescents (ages 1-19) with anxiety and/ or avoidance problems. In addition to reviewing the strength of the evidence, the review also examined indicators of effectiveness, common practices across treatment families, and mediators and moderators of treatment outcome. Six treatments reached well-established status for child and adolescent anxiety, 8 were identified as probably efficacious, 2 were identified as possibly efficacious, 6 treatments were deemed experimental, and 8 treatments of questionable efficacy emerged. Findings from this review suggest substantial support for cognitive-behavioral therapy (CBT) as an effective and appropriate first-line treatment for youth with anxiety disorders. Several other treatment approaches emerged as probably efficacious that are not primarily CBT based, suggesting that there are alternative evidence-based treatments that practitioners can turn to for children and adolescents who do not respond well to CBT. The review concludes with a discussion of treatments that improve functioning in addition to reducing symptoms, common practices derived from evidence-based treatments, mediators and moderators of treatment outcomes, recommendations for best practice, and suggestions for future research.

http://effectivechildtherapy.org/content/anxiety-problems-disorders

Anxiety Problems & Disorders

The symptoms of fear, worry, and anxiety are commonly experienced by children and adolescents who suffer from anxiety problems and disorders. Please refer to the sections below (as well as to the right menu box) for more information about these difficulties and to learn about the best-supported treatment options.

What is Anxiety?

Anxiety is a negative emotion that involves feeling nervous, scared, afraid, or worried. Usually we feel anxious when we think something bad is about to happen.

When Does Anxiety Become a Problem?

Although everyone experiences anxiety, some people begin to feel anxious and/or worried so much that it makes them feel really uncomfortable and starts to disrupt their lives. Clinically significant anxiety (i.e., anxiety needing clinical attention) among children and adolescents can be described as an extreme response to a situation or event that a young person perceives as threatening and is out of proportion to the actual danger. This anxious response frequently includes thoughts of impending harm or danger, heightened arousal such as increased heart rate and rapid breathing, and often the avoidance of situations or events that cause discomfort. The experience of a child or adolescent suffering from clinically significant anxiety can lead to considerable distress and interference with his/her daily activities at school, at home, or with his/her peers. While deciding whether or not your child needs help with anxiety, it is important to interpret your child's behavior in light of his/her developmental level. In other words, is your child's anxiety response more severe, more intense, or longer lasting than would be age-appropriate?

As can be seen below, cognitive behavioral therapy (CBT) currently has the most research evidence for the treatment of general symptoms of anxiety in young people. This treatment can be administered in a variety of different formats, each of which has varying levels of research support.

Anxiety - General symptoms

Works Well **What does tthis mean?**	*None*
Works **What does this mean?**	• *Individual CBT* • *Group CBT (without parents)* • *Group CBT with parents* • *Social skills training* • *Exposure treatment*
Might Work **What does this mean?**	• *Individual CBT with parents* • *Group CBT with parental anxiety management for anxious parents* • *Family CBT* • *Parent group CBT* • *Group CBT with parents plus internet*
Unknown/Untested	*N/A*

D. General Discussion of Treatment/Medications

From the National Institute of Mental Health:

http://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml

About Anxiety Disorders?

Occasional anxiety is a normal part of life. You might feel anxious when faced with a problem at work, before taking a test, or making an important decision. Anxiety disorders involve more than temporary worry or fear. For a person with an anxiety disorder, the anxiety does not go away and can get worse over time. These feelings can interfere with daily activities such as job performance, school work, and relationships.

There are a variety of anxiety disorders. <u>Collectively they are among the most common mental disorders</u> (http://www.nimh.nih.gov//health/statistics/prevalence/any-anxiety-disorder-among-adults.shtml).

Types of Anxiety Disorders

There are three types of anxiety disorders discussed on this website:

<u>Generalized Anxiety Disorder (GAD)</u> (http://www.nimh.nih.gov//health/topics/generalized-anxiety-disorder-gad/index.shtml)
<u>Panic Disorder</u> (http://www.nimh.nih.gov//health/topics/panic-disorder/index.shtml)
<u>Social Anxiety Disorder (Social Phobia)</u> (http://www.nimh.nih.gov//health/topics/social-phobia-social-anxiety-disorder/index.shtml)

Signs and Symptoms

Unlike the relatively mild, brief anxiety caused by a specific event (such as speaking in public or a first date), severe anxiety that lasts at least six months is generally considered to be problem that might benefit from evaluation and treatment. Each anxiety disorder has different symptoms, but all the symptoms cluster around excessive, irrational fear and dread.

Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. In some cases, these other problems need to be treated before a person can respond well to treatment for anxiety.

While some symptoms, such as fear and worry, occur in all anxiety disorders, each disorder also has distinctive symptoms. For more information, visit:

<u>Generalized Anxiety Disorder (GAD)</u> (http://www.nimh.nih.gov//health/topics/generalized-anxiety-disorder-gad/index.shtml)
<u>Panic Disorder</u> (http://www.nimh.nih.gov//health/topics/panic-disorder/index.shtml)
<u>Social Anxiety Disorder (Social Phobia)</u> (http://www.nimh.nih.gov//health/topics/social-phobia-social-anxiety-disorder/index.shtml)

Diagnosis and Treatment

Anxiety disorders are treatable. If you think you have an anxiety disorder, talk to your doctor.

Sometimes a physical evaluation is advisable to determine whether a person's anxiety is associated with a physical illness. If anxiety is diagnosed, the pattern of co-occurring symptoms should be identified, as well as any coexisting conditions, such as depression or substance abuse. Sometimes alcoholism, depression, or other coexisting conditions have such a strong effect on the individual that treating the anxiety should wait until the coexisting conditions are brought under control.

With proper treatment, many people with anxiety disorders can lead normal, fulfilling lives. If your doctor thinks you may have an anxiety disorder, the next step is usually seeing a mental health professional. It is advisable to seek help from professionals who have particular expertise in diagnosing and treating anxiety. Certain kinds of cognitive and behavioral therapy and certain medications have been found to be especially helpful for anxiety.

You should feel comfortable talking with the mental health professional you choose. If you do not, you should seek help elsewhere. Once you find a clinician with whom you are comfortable, the two of you should work as a team and make a plan to treat your anxiety disorder together.

In general, anxiety disorders are treated with medication, specific types of psychotherapy, or both. Treatment choices depend on the type of disorder, the person's preference, and the expertise of the clinician.

People with anxiety disorders who have already received treatment should tell their clinician about that treatment in detail. If they received medication, they should tell their doctor what medication was used, what the dosage was at the beginning of treatment, whether the dosage was increased or decreased while they were under treatment, what side effects occurred, and whether the treatment helped them become less anxious. If they received psychotherapy, they should describe the type of therapy, how often they attended sessions, and whether the therapy was useful.

Often people believe that they have "failed" at treatment or that the treatment didn't work for them when, in fact, it was not given for an adequate length of time or was administered incorrectly. Sometimes people must try different treatments or combinations of treatment before they find the one that works for them.

Most insurance plans, including health maintenance organizations (HMOs), will cover treatment for anxiety disorders. Check with your insurance company and find out. If you don't have insurance, the Health and Human Services division of your county government may offer mental health care at a public mental health center that charges people according to how much they are able to pay. If you are on public assistance, you may be able to get care through your state Medicaid plan.

For additional resources for getting information and assistance, please visit <u>NIMH's Help for Mental Illness</u> (http://www.nimh.nih.gov//health/find-help/index.shtml) webpage.

Medication

Medication does not necessarily cure anxiety disorders, but it often reduces the symptoms. Medication typically must be prescribed by a doctor. A psychiatrist is a doctor who specializes in mental disorders. Many psychiatrists offer psychotherapy themselves or work as a team with psychologists, social workers, or counselors who provide psychotherapy. The principal medications used for anxiety disorders are antidepressants, anti-anxiety drugs, and beta-blockers. Be aware that some medications are effective only if they are taken regularly and that symptoms may recur if the medication is stopped.

Choosing the right medication, medication dose, and treatment plan should be based on a person's individual needs and medical situation, and done under an expert's care. Only an expert clinician can help you decide whether the medicine's ability to help is worth the risk of a side effect. Your doctor may try several medicines before finding the right one.

You and your doctor should discuss:

How well medicines are working or might work to improve your symptoms.
Benefits and side effects of each medicine.
Risk for a serious side effects based on your medical history.
How likely the medicines will require lifestyle changes.
Costs of each medicine.
Other alternative therapies, medicines, vitamins, and supplements you are taking and how these may affect your treatment.
How the medication should be stopped. Some drugs can't be stopped abruptly but must be tapered off slowly under a doctor's supervision.

For more information, please visit <u>NIMH's Medications Health Topic webpage</u> (http://www.nimh.nih.gov//health/topics/mental-health-medications/mental-health-medications.shtml). Please note that any information on this website regarding medications is provided for educational purposes only and may be outdated. Information about medications changes frequently. Please visit the (http://www.nimh.nih.gov//health/topics/mental-health-medications/mental-health-medications.shtml)FDA website for the latest information on warnings, patient medication guides, or newly approved medications. (http://www.nimh.nih.gov//health/topics/mental-health-medications/mental-health-medications.shtml)

Psychotherapy

Psychotherapy (sometimes called "talk therapy") involves talking with a trained clinician, such as a psychiatrist, psychologist, social worker, or counselor, to understand what caused an anxiety disorder and how to deal with it.

Cognitive Behavioral Therapy (CBT)

CBT can be useful in treating anxiety disorders. It can help people change the thinking patterns that support their fears and change the way they react to anxiety-provoking situations.

For example, CBT can help people with panic disorder learn that their panic attacks are not really heart attacks and help people with social phobia learn how to overcome the belief that others are always watching and judging them. When people are ready to confront their fears, they are shown how to use exposure techniques to desensitize themselves to situations that trigger their anxieties.

Exposure-based treatment has been used for many years to treat specific phobias. The person gradually encounters the object or situation that is feared, perhaps at first only through pictures or tapes, then later face-to-face. Sometimes the therapist will accompany the person to a feared situation to provide support and guidance. Exposure exercises are undertaken once the patient decides he is ready for it and with his cooperation.

To be effective, therapy must be directed at the person's specific anxieties and must be tailored to his or her needs. A typical "side effect" is temporary discomfort involved with thinking about confronting feared situations.

CBT may be conducted individually or with a group of people who have similar problems. Group therapy is particularly effective for social phobia. Often "homework" is assigned for participants to complete between sessions. If a disorder recurs at a later date, the same therapy can be used to treat it successfully a second time.

Medication can be combined with psychotherapy for specific anxiety disorders, and combination treatment has been found to be the best approach for many people.

Some people with anxiety disorders might benefit from joining a self-help or support group and sharing their problems and achievements with others. Internet chat rooms might also be useful in this regard, but any advice received over the Internet should be used with caution, as Internet acquaintances have usually never seen each other and false identities are common. Talking with a trusted friend or member of the clergy can also provide support, but it is not necessarily a sufficient alternative to care from an expert clinician.

Stress management techniques and meditation can help people with anxiety disorders calm themselves and may enhance the effects of therapy. There is preliminary evidence that aerobic exercise may have a calming effect. Since caffeine, certain illicit drugs, and even some over-the-counter cold medications can aggravate the symptoms of anxiety disorders, avoiding them should be considered. Check with your physician or pharmacist before taking any additional medications.

The family can be important in the recovery of a person with an anxiety disorder. Ideally, the family should be supportive but not help perpetuate their loved one's symptoms. Family members should not trivialize the disorder or demand improvement without treatment.

D. General Discussion of Treatment/Medications (cont.)

ANXIETY AND DEPRESSION ASSOCIATION OF AMERICA
ADAA

http://www.adaa.org/living-with-anxiety/children/treatment

Treatment

Living and Thriving

Managing Anxiety

Personal Stories

Ask and Learn

Children and Teens
  Childhood Anxiety
  Disorders
  Anxiety and Depression
  Podcasts About Children
  and Teens
  Treatment
  Tips for Parents and
  Caregivers
  Anxiety Disorders at
  School
  School Refusal
  Test Anxiety
  News and Research

College Students

Women

Older Adults

Military & Military Families

Like other medical conditions, anxiety disorders tend to be chronic unless properly treated. Most kids find that they need professional guidance to successfully manage and overcome their anxiety.

Several scientifically proven and effective treatment options are available for children with anxiety disorders. The two treatments that most help children are cognitive-behavioral therapy and medication.

Your doctor or therapist may recommend one or a combination of treatments. Learn how to choose a therapist for your child.

No one treatment method works best for every child; one child may respond better, or sooner, to a particular method than another child with the same diagnosis. Read treatment FAQs.

Cognitive-behavioral therapy (CBT)
Cognitive-behavioral therapy, or CBT, is a type of talk therapy that has been scientifically shown to be effective in treating anxiety disorders. CBT teaches skills and techniques to your child that she can use to reduce her anxiety.

Your child will learn to identify and replace negative thinking patterns and behaviors with positive ones. He will also learn to separate realistic from unrealistic thoughts and will receive "homework" to practice what is learned in therapy. These are techniques that your child can use immediately and for years to come.

The therapist can work with you to ensure progress is made at home and in school, and he or she can give advice on how the entire family can best manage your child's symptoms.

CBT is generally short-term—sessions last about 12 weeks—but the benefits are long-term. Read treatment FAQs.

Other forms of therapy
- Acceptance and commitment therapy, or ACT, uses strategies of acceptance and mindfulness (living in the moment and experiencing things without judgment) as a way to cope with unwanted thoughts, feelings, and sensations.
- Dialectical behavioral therapy, or DBT, emphasizes taking responsibility for one's problems and helps children examine how they deal with conflict and intense negative emotions.

Medication
Prescription medications can be useful in the treatment of anxiety disorders. They are also often used in conjunction with therapy. In fact, a major research study found that a combination of CBT and an antidepressant worked better for children ages 7-17 than either treatment alone.

Medication can be a short-term or long-term treatment option, depending on how severe your child's symptoms are and how he or she responds to treatment.

It is also essential to let your doctor know about other prescription or over-the-counter medications your child takes, even if it is for a short period.

Selective serotonin reuptake inhibitors (SSRIs) are currently the medications of choice for the treatment of childhood and adult anxiety disorders. The U.S. Food and Drug Administration (FDA) has approved the use of some SSRIs for the treatment of pediatric obsessive-compulsive disorder.

Other types of medications, such as tricyclic antidepressants and benzodiazepines, are less commonly used to treat children. Read treatment FAQs.

A warning from the FDA
The FDA issued a warning in October 2004 that antidepressant medications, including SSRIs, may increase suicidal thoughts and behavior in a small number of children and adolescents. However, the FDA has not prohibited or removed these medications, and no suicides were reported in the studies that led to the warning.

Helping Children and Teens With Anxiety Disorders and Depression

Effective therapy for children

Children with depression and ADHD

Generalized Anxiety Disorder (GAD)

Obsessive-Compulsive Disorder (OCD)

Panic Disorder & Agoraphobia

Posttraumatic Stress Disorder (PTSD)

Social Anxiety Disorder

Specific Phobias

Depression

You should not necessarily refuse to give your child medication, but you should watch for signs of depression and talk to your child's doctor or therapist about any concerns. Untreated anxiety disorders in children increases the risk for depression, social isolation, substance abuse, and suicide.

Side effects
SSRIs are generally tolerated with few side effects. The most commonly reported physical side effects include headache, stomachache or nausea, and difficulty sleeping.

Before prescribing medication, your child's physician must determine the presence of any physical symptoms that may be related to medical problems or reflect anxiety. Make sure the physician reviews side effects with you and your child before starting an SSRI and monitors for symptoms at follow-up visits.

Remember that a small number of children may develop more serious side effects, such as thoughts about suicide.

III. Intervention for Anxiety Problems

D. General Discussion of Treatment/Medications (cont.)

From: *Mental Health Medication* (National Institute of Mental Health --2015)
http://www.nimh.nih.gov/health/topics/mental-health-medications/mental-health-medications.shtml

What medications are used to treat anxiety disorders?

Antidepressants, anti-anxiety medications, and beta-blockers are the most common medications used for anxiety disorders.

Anxiety disorders include:

>Generalized anxiety disorder (GAD)
>Panic disorder
>Social anxiety disorder.

Antidepressants

Antidepressants were developed to treat depression, but they also help people with anxiety disorders. SSRIs such as fluoxetine, sertraline, escitalopram, paroxetine, and citalopram are commonly prescribed for panic disorder, OCD, PTSD, and social anxiety disorder. The SNRI venlafaxine is commonly used to treat GAD. The antidepressant bupropion is also sometimes used. When treating anxiety disorders, antidepressants generally are started at low doses and increased over time.

Some tricyclic antidepressants work well for anxiety. For example, imipramine is prescribed for panic disorder and GAD. Clomipramine is used to treat OCD. Tricyclics are also started at low doses and increased over time.

MAOIs are also used for anxiety disorders. Doctors sometimes prescribe phenelzine, tranylcypromine, and isocarboxazid. People who take MAOIs must avoid certain food and medicines that can interact with their medicine and cause dangerous increases in blood pressure. For more information, see the section on medications for treating depression. .

Benzodiazepines (anti-anxiety medications)

The anti-anxiety medications called benzodiazepines can start working more quickly than antidepressants. The ones used to treat anxiety disorders include:

>Clonazepam, which is used for social phobia and GAD
>Lorazepam, which is used for panic disorder
>Alprazolam, which is used for panic disorder and GAD.

People can build a tolerance to benzodiazepines if they are taken over a long period of time and may need higher and higher doses to get the same effect. Some people may become dependent on them. To avoid these problems, doctors usually prescribe the medication for short periods, a practice that is especially helpful for people who have substance abuse problems or who become dependent on medication easily. If people suddenly stop taking benzodiazepines, they may get withdrawal symptoms, or their anxiety may return. Therefore, they should be tapered off slowly.

Buspirone is an anti-anxiety medication used to treat GAD. Unlike benzodiazepines, however, it takes at least two weeks for buspirone to begin working.

Clonazepam, listed above, is an anticonvulsant medication. See FDA warning on anticonvulsants under the bipolar disorder section. .

Beta-blockers

Beta-blockers control some of the physical symptoms of anxiety, such as trembling and sweating. Propranolol is a beta-blocker usually used to treat heart conditions and high blood pressure. The medicine also helps people who have physical problems related to anxiety. For example, when a person with social phobia must face a stressful situation, such as giving a speech, or attending an important meeting, a doctor may prescribe a beta-blocker. Taking the medicine for a short period of time can help the person keep physical symptoms under control.

What are the side effects?

See the section on antidepressants for a discussion on side effects.
http://www.nimh.nih.gov/health/topics/mental-health-medications/mental-health-medications.shtml#part_149861
The most common side effects for benzodiazepines are drowsiness and dizziness. Other possible side effects include:
> Upset stomach
> Blurred vision
> Headache
> Confusion
> Grogginess
> Nightmares.

As noted above, long-term use of benzodiazepines can lead to tolerance (needing more of the medication to get the same effect) and dependence. To avoid these problems, doctors usually prescribe the medication for short periods. Recent research has found that benzodiazepines are prescribed especially frequently for older people. See the section on older adults for information on medication use in this age group.

Possible side effects from buspirone include:
> Dizziness
> Headaches
> Nausea
> Nervousness
> Lightheadedness
> Excitement
> Trouble sleeping.

Common side effects from beta-blockers include:
> Fatigue
> Cold hands
> Dizziness
> Weakness.

In addition, beta-blockers generally are not recommended for people with asthma or diabetes because they may worsen symptoms.

Like benzodiazepines, buspirone and beta-blockers are usually taken on a short-term basis for anxiety. Both should be tapered off slowly. Talk to the doctor before stopping any anti-anxiety medication.

III. Intervention for Anxiety Problems

E. School Avoidance, Reactive and Proactive

From: Continuing Education Unit II: Follow-Up Reading Managing and Preventing School Misbehavior and School Avoidance

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An enhanced conceptual base of the full range of factors causing student problems builds on contemporary motivational theory. School avoidance behavior, like the misbehavior described above, can be understood in terms of students' attempts to act in ways that make them feel in control, competent, and connected with significant others. The action may be overt, such as a direct refusal to attend, or covert, such as passive withdrawal and feigned illness.

The importance of distinguishing the underlying motivation for school avoidance behavior can be illustrated by thinking about three students who are school refusers.

Although others think Janet is afraid to attend school, in fact her avoidance is motivated by a desire to stay home with her mother. That is, she is proactively seeking to maintain her sense of relatedness with home and family. In contrast, Jeff refuses to attend as a direct protest against school rules and demands because he experiences them as a threat to his sense of self-determination; his avoidance is reactive. Joe's avoidance also is reactive; he lacks the skills to do many of the assigned tasks and becomes so anxious over this threat to his competence that he frequently runs out of the classroom.

Differentiating Among School Avoiders

In a study of school avoiders, Taylor and Adelman (1990) differentiated 5 groups. Of the five, four involve student proactive and reactive motivation; the fifth reflects a variety of needs related to family dynamics and events that may or may not result in a student wanting to avoid school.

As with most subgroupings, the categories are not mutually exclusive.

1. Proactive attraction to alternatives to school. There are many aspects of a student's life at home and in the community that compete with school. For instance, there are children who miss school primarily because they want to stay home to be with a parent, grandparent, or younger sibling or because they have become hooked on TV programs or other favorite activities. And, of course, among junior and senior high students, there often is a strong pull to hang out with peers (truants and dropouts). From an intrinsic motivational perspective, such proactive attraction can occur because a youngster finds these circumstances produce feelings of relatedness, competence, or control over one's life that are much greater than those experienced at school.

2. Reactive avoidance of experiences at school that lead to feelings of incompetence or lack of relatedness (including lack of safety). In contrast to proactive avoidance, reactive avoidance (in its many forms) is to be anticipated whenever a student expects events to be negative and to result in negative feelings. Two specific areas of concern in this respect are events that lead to feelings of incompetence or lack of relatedness (including lack of safety) in the school context. In particular, it is not surprising that students who expect to encounter significant failure/punishment in their efforts to meet others' or their own academic and social standards come to perceive school as a threatening place. Such expectations may arise not only for individuals who have actual disabilities and skill deficits, but for any

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student who experiences standards for learning, performance, and behavior that exceed her or his ability. These youngsters report feelings of embarrassment, of being different, of not being liked, of being left out, of being abused. Some avoid school whenever kickball is on the schedule because they know no one wants them on their team. Some refuse to attend because another student has singled them out to bully. And there are some who have moved to a new school and find they are not accepted by the peer group with whom they identify.

3. Reactive avoidance to control by others at school. When one feels that others are exerting inappropriate control, there may be a psychological reaction that motivates efforts to restore one's feeling of self-determination. There are a significant number of instances where school avoidance is an expression of a power struggle between teacher and student or parent and child. The more the teacher or parent tightens the limits and punishes the individual, the more the youngster seems committed to showing s/he can't be controlled. Some adopt the idea of refusing to go to school. In such cases, the more the parents threaten, take away privileges, and punish, the more the child's determination grows. The struggle often becomes a literal wrestling match to get a resistant child from the bed, into clothes, out to the car, and finally through the classroom door. Some parents and teachers end up winning a particular battle, but they usually find the struggle for control continues on many other fronts.

4. Reactive avoidance in response to overwhelming anxiety/fear. Although they represent a minority of the many youngsters who avoid school, for some individuals the term "phobic" is appropriate. Again, in some instances, the extreme anxiety/fear may be a reaction to expectations about finding oneself in circumstances where one will feel incompetent, lacking control, or loss (separation) or lack of relatedness to significant others. In true phobias, however, even the student's assessment of objective reality does not match his or her high degree of anxiety and fear. Such students report pervasive symptoms (e.g., sleeping problems, anxiety produced vomiting, uncontrollable crying). In addition, not uncommonly they have parents who themselves report strong fears and phobic behaviors. Even with extensive accommodations by teachers and parents, the fears of these students often continue to interfere with attending school, thus requiring major therapeutic intervention.

5. Needs related to family members and events. Parents have a number of reasons for keeping their youngsters home from school. For instance, some students are frequently absent because they have to babysit with younger siblings or be with ailing or lonely parents or grandparents. Crises in the home, such as death, divorce, or serious illness, can cause parents to keep their children close at hand for comfort and support. Under such circumstances, some youngsters are attracted to the opportunity to stay home to meet a parent's special needs or become frightened that something bad will happen to a family member when they are at school. Moreover, when life at home is in turmoil, students may feel they cannot bear the added pressure of going to school. Thus, crises at home, and a variety of other underlying family dynamics, can produce emotions in a youngster that lead to motivation for avoiding school.

Unfortunately, whatever the initial cause of nonattendance, the absences become a problem unto themselves. Of specific consequence is the fact that students quickly fall behind in their school work; grades plummet; there is a mounting sense of hopelessness and increased avoidance. Among adolescents, increasing avoidance can transition rapidly into dropping out of school.

As a note of caution, it is also important to alert staff to the fact that not all school avoidance stems from psychoeducational causes. For example, in one school avoidance case, the student complained of stomach pain. The parents, counselor, school nurse, school psychologist, and the student herself assumed this simply was a physical symptom of anxiety related to pressure at school. However, the school nurse insisted on a thorough physical examination that found the pain was a pre-ulcer symptom. Medication controlled the symptom, and regular school attendance resumed.

Intervention Overview

Work with school avoidance cases involves four facets: assessment, consultation with parents, consultation with teachers, and counseling with students and their families. Understanding school avoidance from the perspective of the type of motivational ideas discussed above profoundly influences the approach to each of these tasks. The following examples are illustrative.

Corrective Interventions. In general, motivationally-oriented analyses of school avoidance allow interveners to offer parents, teachers, and the student an intervention responsive to the motivational underpinnings of school avoidance behavior. For instance, based on motivational data, parents and teachers can be helped to facilitate environment and program changes that account for a youngster's need to feel self-determining, competent, and related. Such changes may include (a) identifying activity options to attract a proactive school avoider, b) eliminating situations leading to reactive avoidance, and (c) establishing alternative ways for a student to cope with circumstances that cannot be changed. In counseling students, first focus on the individual's underlying motivation for avoidance (e.g., factors instigating, energizing, directing, and maintaining the motivation), explore motivation for change, clarify available alternatives with the student and significant others, and then facilitate action. It should be stressed that a motivational orientation does not supplant a focus on skill development and remediation. Rather, it places skill instruction in a motivational context and highlights the importance of systematically addressing motivational considerations in order to maximize skill development.

More specifically, the intervention focus for students behaving reactively, includes reducing reactance and enhancing positive motivation for attending school. That is, the fundamental enabling (process) objectives are (1) minimizing external demands for performing and conforming (e.g., eliminating threats) and (2) exploring with the student ways to add activities that would be nonthreatening and interesting (e.g., establishing program the majority of which emphasizes intrinsically motivating activities). For example, if Joe is concerned about a inability to handle assignments, steps are taken to match assignments to his current capabilities and provide help that minimizes failure and remedies deficits handicapping progress. If the problem stems from lack of interest in the current school program, the focus is on increasing the attractiveness of school by finding or creating new activities and special roles. If the avoidance truly is a phobic reaction, ongoing family counseling is indicated, as is extensive school consultation in pursuit of the type of expanded accommodation and support the student needs.

For youngsters whose avoidance is proactively motivated, staying home to watch TV or to hang out with friends, running around with gangs, and participating in the drug culture can be much more interesting and exciting than usual school offerings. This probably accounts for why proactive school avoidance can be so difficult to counter. Fundamentally, the objectives in trying to counter proactively motivated avoidance involve exploring and agreeing upon a program of intrinsically motivating activity to replace the student's current school program. The new program must be able to produce greater feelings of self-determination, competence, and relatedness than the activity that has pulled the youngster away from school. To these ends, alternatives must be nonthreatening and interesting and often will have to differ markedly from those commonly offered. For instance, such students may be most responsive to changes in program content that emphasize their contemporary culture (e.g., sports, rock music, movies and TV shows, computer games, auto mechanics, local events), processes that deemphasize formal schooling (e.g., peer tutoring, use of nonstandard materials), and opportunities to assume special, positive role status (e.g., as a student official, office monitor, paid cafeteria worker). Such personalized options and opportunities usually are essential starting points in overcoming proactive avoidance.

Starting or returning: the crucial transition phase. As avoiders are mobilized to start or return to school, it is critical to ensure the entry transition phase is positive. For instance, it is sometimes necessary to plan on only a partial school day schedule. This occurs when it is concluded that full

day attendance would be counterproductive to enhancing intrinsic motivation for school.

It also is critical not to undermine a new or returning student's emerging hope about feeling accepted, in control, and competent at school. Such students tend to be skeptical and fearful about whether they will fit in and be accepted. Often their worst fears come true. Two system characteristics commonly found to work against successful entry for school avoiders are (1) lack of a receptive atmosphere and (2) lack of special accommodation.

It seems obvious that school avoiders need to feel welcomed when enrolling in or returning to school. Yet, students and parents often report negative encounters in dealing with attendance office procedures, personnel who are unaware of the problem and special entry plans, and students and staff who appear hostile to the plans that have been made.

To counter such negative experiences, a key strategy is to arrange for one or more on-site advocates who increase the likelihood of a welcoming atmosphere by greeting the student and guiding her or him through the transition phase. One such advocate needs to be a professional on the school staff who will provide procedural help (with attendance and new schedules) and who can sensitize key personnel and students to the importance of a positive reception. A student advocate or peer counselor also is desirable if an appropriate one can be found.

It also must be recognized that many proactive and reactive avoiders, upon first entering or returning to school, do not readily fit in. This is especially true of those whose pattern of deviant and devious behavior contributed to school avoidance in the first place. For such students, teachers must not only be willing to offer attractive and nonthreatening program alternatives, they must be willing temporarily to structure wider limits than most students typically are allowed.

IV.   A Quick Overview of Some Basic Resources
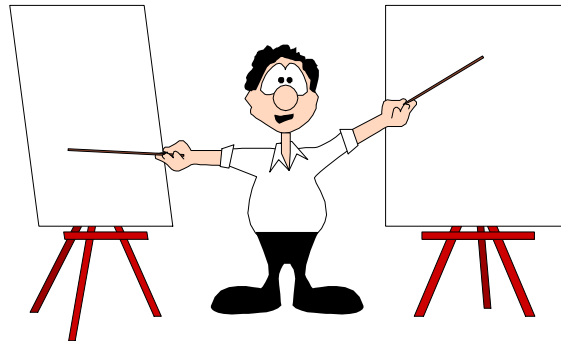
A. A Few Additional References

B. Agencies

C. Center Quick Finds

IV. A Quick Overview of Some Basic Resources

A. A Few Additional References

Affrunti, N. W., & Ginsburg, G. S. (2012). Exploring parental predictors of child anxiety: The mediating role of child interpretation bias. *Child & Youth Care Forum, 41,* 517–527. http://dx.doi.org/10.1007/s10566-012-9186-6

Affrunti, N. ,Woodruff-Borden, J. (2013). The associations of executive function and temperament in a model of risk for childhood anxiety. *Journal of Child and Family Studies* http://dx.doi.org/10.1007/s10826-013-9881-4

Bar-Haim, Y. (2010). Research review: attention bias modification (ABM): A novel treatment for anxiety disorders. *Journal of Child Psychology and Psychiatry, and Allied Disciplines, 51*, 859–870. http://dx.doi.org/10.1111/j.1469-7610.2010.02251.x

Boat, T.F., & Wu, J.T. (Eds) (2015). *Mental disorders and disabilities among low-income children.* Committee to Evaluate the Supplemental Security Income Disability Program for Children with Mental Disorders; Board on the Health of Select Populations; Institute of Medicine; The National Academies of Sciences, Engineering, and Medicine. http://www.nap.edu/login.php?record_id=21780&page=http%3A%2F%2Fwww.nap.edu%2Fdownload.php%3Frecord_id%3D21780

Britton, J., Bar-Haim, Y., Clementi, M. et al. (2013). Training-associated changes and stability of attention bias in youth: Implications for attention bias modification treatment for pediatric anxiety. *Developmental Cognitive Neuroscience, 4,* 52–64. http://dx.doi.org/10.1016/j.dcn.2012.11.001

Caporino, N. E., Brodman, D. M., Kendall, P. C., Albano, A. M., Sherrill, J., Piacentini, J., & Walkup, J. T. (2013). Defining treatment response and remission in child anxiety: Signal detection analysis using the pediatric anxiety rating scale. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*, 57–67.

Carthy, T., Horesh, N. , Apter, A., & Gross, J. (2010). Patterns of emotional reactivity and regulation in children with anxiety disorders. *Journal of Psychopathology and Behavioral Assessment, 32*, 23–36. http://dx.doi.org/10.1007/s10862-009-9167-8

Creswell, C., Murray, L., Stacey, J., & Cooper, P. (2011). Parenting and child anxiety. In: W. K. Silverman, & A. P. Field (Eds.), *Anxiety disorders in children and adolescents*. (2nd ed., pp. 299–322). Cambridge: Cambridge University Press

Hudson, J. L., Dodd, H. F., & Bovopoulos, N. (2011). Temperament, family environment and anxiety in preschool children. *Journal of Abnormal Child Psychology, 39*, 939–951. http://dx.doi.org/10.1007/s10802-011-9502-x

Hudson, J. L., Doyle, A. M., & Gar, N. (2009). Child and maternal influence on parenting behavior in clinically anxious children. *Journal of Clinical Child & Adolescent Psychology, 38,* 256–262. http://dx.doi.org/10.1080/15374410802698438

Johnco, C. J., Salloum, A., Lewin, A. B., McBride, N. M., & Storch, E. A. (2015). The impact of comorbidity profiles on clinical and psychosocial functioning in childhood anxiety disorders. Psychiatry Research, http://dx.doi.org/10.1016/j.psychres.2015.07.027

Kendall, P. C., Compton, S. N., Walkup, J. T., Birmaher, B., Albano, A. M., Sherrill, J., & Piacentini, J. (2010). Clinical characteristics of anxiety disordered youth. *Journal of Anxiety Disorders, 24*, 360–365. http://dx.doi.org/10.1016/j.janxdis.2010.01.009

Langley, A. K., Falk, A., Peris, T., Wiley, J. F., Kendall, P. C., Ginsburg, G., & Piacentini, J. (2014). The child anxiety impact scale: Examining parent- and child-reported impairment in child anxiety disorders. *Journal of Clinical Child & Adolescent Psychology, 43*, 579–591. http://dx.doi.org/10.1080/15374416.2013.817311

Lebowitz, E. R., Scharfstein, L., & Jones, J. (2014). Child-report of family accommodation in pediatric anxiety disorders: Comparison and integration with mother-report. *Child Psychiatry and Human Development*, http://dx.doi.org/10.1007/s10578-014-0491-1

Lebowitz, E. R., Woolston, J., Bar-Haim, Y., Calvocoressi, L., Dauser, C., Warnick, E., et al. (2013). Family accommodation in pediatric anxiety disorders. *Depression Anxiety, 30,* 47–54. http://dx.doi.org/10.1002/da.21998

McLeod, B. D., Wood, J. J., & Avny, S. B. (2011). Parenting and child anxiety disorders. In: D. McKay, & E. A. Storch (Eds.), *Handbook of child and adolescent anxiety disorders* (pp. 213–228). New York, NY: Springer.

Muris, P., Debipersad, S., Mayer, B. (2013) Searching for danger: On the link between worry and threat-related confirmation bias in children. *Journal of Child and Family Studies, 23,* 604–609.

Rapee, R. M. (2012). Family factors in the development and management of anxiety disorders. *Clinical Child and Family Psychology Review, 15,* 69–80. http://dx.doi.org/10.1007/s10567-011-0106-3

Schleider, J. L., Ginsburg, G. S., Keeton, C. P., Weisz, J. R., Birmaher, B., Kendall, P. C., & Walkup, J. T. (2014). Parental psychopathology and treatment outcome for anxious youth: roles of family functioning and caregiver strain. *Journal of Consulting and Clinical Psychology*, http://dx.doi.org/10.1037/a0037935

Thompson-Hollands, J., Kerns, C. E., Pincus, D. B., & Comer, J. S. (2014). Parental accommodation of child anxiety and related symptoms: Range, impact, andcorrelates. *Journal of Anxiety Disorders, 28*, 765–773. http://dx.doi.org/10.1016/j.janxdis.2014.09.007

Verhoeven, M., Bögels, S. M., & van der Bruggen, C. C. (2012). Unique roles of mothering and fathering in child anxiety; moderation by child's age and gender. *Journal of Child and Family Studies, 21*, 331–343. http://dx.doi.org/10.1007/s10826-011-9483-y

B. Agencies

Anxiety Disorders Association of America (ADAA) – http://www.adaa.org/

Anxiety Network International – http://www.anxietynetwork.com

Mental Help Net (MHN) – www.mentalhelp.net

National Anxiety Foundation – http://www.lexington-on-line.com/naf.html

National Institute of Mental Health (NIMH) – http://www.nimh.nih.gov

National Mental Health Consumers' Self-Help Clearinghouse – www.mhselfhelp.org

NIMH Anxiety Disorders Education Program – http://www.nimh.nih.gov

Ross Center for Anxiety and Related Disorders, Inc. – www.rosscenter.com

UCLA Child/Adolescent OCD, Anxiety & Tic Disorders Program – www.npi.ucla.edu/caap/

Quick Find On-line Clearinghouse

C. Center Quick Finds

The Center's Quick Find Online Clearinghouse offers a fast and convenient way to access Centert resources and to link to resources from others.
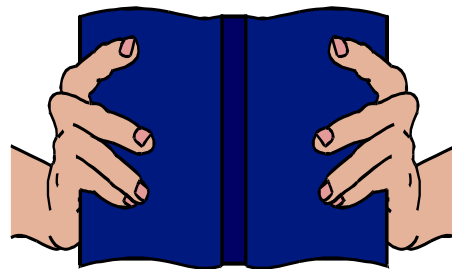
> http://smhp.psych.ucla.edu/quicksearch.htm
> http://smhp.psych.ucla.edu/qf/p2108_06.htm

TOPIC: *Anxiety* – http://smhp.psych.ucla.edu/qf/anxiety.htm

TOPIC: *School Avoidance* –
http://smhp.psych.ucla.edu/qf/schoolavoidance.htm

TOPIC: *Post Traumatic Stress* – http://smhp.psych.ucla.edu/qf/ptsd.htm

V. A Few More Fact/Information Resources

>School Refusal
>Panic Disorder
>Selective Mutism

School Refusal

School refusal describes the disorder of a child who refuses to go to school on a regular basis or has problems staying in school.

Symptoms

Children with school refusal may complain of physical symptoms shortly before it is time to leave for school or repeatedly ask to visit the school nurse. If the child is allowed to stay home, the symptoms quickly disappear, only to reappear the next morning. In some cases a child may refuse to leave the house.

Common physical symptoms include headaches, stomachaches, nausea, or diarrhea. But tantrums, inflexibility, separation anxiety, avoidance, and defiance may show up, too.

Reasons

Starting school, moving, and other stressful life events may trigger the onset of school refusal. Other reasons include the child's fear that something will happen to a parent after he is in school, fear that she won't do well in school, or fear of another student.

Often a symptom of a deeper problem, anxiety-based school refusal affects 2 to 5 percent of school-age children. It commonly takes place between the ages of five and six and between ten and eleven, and at times of transition, such as entering middle and high school.

Children who suffer from school refusal tend to have average or above-average intelligence. But they may develop serious educational or social problems if their fears and anxiety keep them away from school and friends for any length of time.

- Related: When Kids Refuse to Go to School

What Parents Can Do

"The most important thing a parent can do is obtain a comprehensive evaluation from a mental health professional," says ADAA board member Daniel Pine, MD, who directs research on anxiety disorders in children and adolescents at the National Institute of Mental Health.

That evaluation will reveal the reasons behind the school refusal and can help determine what kind of treatment will be best. Your child's pediatrician should be able to recommend a mental health professional in your area who works with children.

Meanwhile, keep your children in school. Missing school reinforces anxiety rather than alleviating it. The following tips will help you and your child develop coping strategies for school anxieties and other stressful situations.

- Expose children to school in small degrees, increasing exposure slowly over time. Eventually this will help them realize there is nothing to fear and that nothing bad will happen.
- Talk with your child about feelings and fears, which helps reduce them.
- Emphasize the positive aspects of going to school: being with friends, learning a favorite subject, and playing at recess.
- Arrange an informal meeting with your child's teacher away from the classroom.
- Meet with the school guidance counselor for extra support and direction.
- Try self-help methods with your child. In addition to a therapist's recommendations, a good self-help book will provide relaxation techniques. Be open to new ideas so that your child is, too.
- Encourage hobbies and interests. Fun is relaxation, and hobbies are good distractions that help build self-confidence.
- Help your child establish a support system. A variety of people should be in your child's life—other children as well as family members or teachers who are willing to talk with your child should the occasion arise.
- Learn about your child's anxiety disorder and treatment options. Find out more about children's anxiety disorders.

Panic Disorder In Children And Adolescents

Panic disorder is a common and treatable disorder. Children and adolescents with panic disorder have unexpected and repeated periods of intense fear or discomfort, along with other symptoms such as a racing heartbeat or feeling short of breath. These periods are called "panic attacks" and last minutes to hours. Panic attacks frequently develop without warning.

Symptoms of a panic attack include:

- Intense fearfulness (a sense that something terrible is happening)
- Racing or pounding heartbeat
- Dizziness or lightheadedness
- Shortness of breath or a feeling of being smothered
- Trembling or shaking
- Sense of unreality
- Fear of dying, losing control, or losing your mind

More than 3 million Americans will experience panic disorder during their lifetime. Panic disorder often begins during adolescence, although it may start during childhood, and sometimes runs in families.

If not recognized and treated, panic disorder and its complications can be devastating. Panic attacks can interfere with a child's or adolescent's relationships, schoolwork, and normal development. Attacks can lead to not just severe anxiety, but can also affect other parts of a child's mood or functioning. Children and adolescents with panic disorder may begin to feel anxious most of the time, even when they are not having panic attacks. Some begin to avoid situations where they fear a panic attack may occur, or situations where help may not be available. For example, a child may be reluctant to go to school or be separated from his or her parents. In severe cases, the child or adolescent may be afraid to leave home. As with other anxiety disorders, this pattern of avoiding certain places or situations is called "agoraphobia." Some children and adolescents with panic disorder can develop severe depression and may be at risk of suicidal behavior. As an attempt to decrease anxiety, some adolescents with panic disorder will use alcohol or drugs.

Panic disorder in children can be difficult to diagnose. This can lead to many visits to physicians and multiple medical tests that are expensive and potentially painful. When properly evaluated and diagnosed, panic disorder usually responds well to treatment. Children and adolescents with symptoms of panic attacks should first be evaluated by their family physician or pediatrician. If no other physical illness or condition is found as a cause for the symptoms, a comprehensive evaluation by a child and adolescent psychiatrist should be obtained.

Several types of treatment are effective. Specific medications may stop panic attacks. Psychotherapy may also help the child and family learn ways to reduce stress or conflict that could otherwise cause a panic attack. With techniques taught in "cognitive behavioral therapy," the child may also learn new ways to control anxiety or panic attacks when they occur. Many children and adolescents with panic disorder respond well to the combination of medication and psychotherapy. With treatment, the panic attacks can usually be stopped. Early treatment can prevent the complications of panic disorder such as agoraphobia, depression and substance abuse.

For more information about panic disorder, visit the National Institute of Mental Health''s website at www.nimh.nih.gov or call 1-800-64-PANIC .

See also: The Freedom from Fear's website www.freedomfromfear.org

A Personal Look at a Student's Selective Mutism

Juliana Ferri, a UCLA undergraduate working at our Center knew a family whose child was diagnosed as manifesting selective mutism. She decided she wanted to learn more about the topic. To this end, she reviewed the literature, observed and met with the child (referred to here as Sara), and interviewed Sara's mother and teacher. The following shares what she learned and is offered as an information resource for teachers, parents and others wanting a brief introduction to the problem.*

> Selective mutism in children is relatively rare. It affects fewer than 1% of the population (occurring slightly more often among girls). It has been described as a complex problem that manifests as a child controlling where and to whom she chooses to speak. The behavior causes difficulty for and often is confusing to parents, teachers, peers, and the person experiencing the problem.
>
> Sara is an 8 year old third grader who, from early on, was shy and seen as unusual. When she entered preschool, she did not learn and perform as well as her classmates. Soon, while she spoke to those at home and to neighborhood kids, the children and teachers heard not a word from her. This continued for several years.
>
> Sara's first teachers continuously tried different strategies in hope of getting even one word out of her. Psychologists and speech therapists were asked to help. As Sara continued not to speak and performed poorly at school, her problems compounded, and additional interventions were introduced.
>
> As a result of the perseverance of her family and her latest school, Sara is no longer manifesting selective mutism and is progressing academically and socially. (See the Appendix for the perspectives of her mother and current teacher.)

*

What Does Selective Mutism Look Like?

The literature delineates several criteria for diagnosing selective mutism. The defining behavior is a **consistent failure to speak in some situations where speaking is appropriately expected** (such as school) while speaking elsewhere (such as at home).

The failure to speak in a given situation must persist for at least a month (and not be limited to the first month of school during which many young children may show a reluctance to speak).

Other related behaviors:

>"clamming up" or looking down when spoken to

>refusing to participate

>socially isolating self or avoiding social situations where speaking is required

Sometimes the child may try to communicate with gestures (head nodding/shaking, pulling/ pushing).

The behavior generally is seen as a response to anxiety or fear of social embarrassment or as a product of social isolation. Another possibility is that it is motivated by a desire to assert one's autonomy and control.

The diagnosis is inappropriate when the problem stems from (a) lack of knowledge of the spoken language required in the situation, (b) embarrassment related to a communication disorder such as stuttering, or (c) severe emotional disturbance.

Selective Mutism is Often Misdiagnosed

As with all diagnoses, it's imperative that a child be professionally assessed. The assessment must rule out language, speech, and hearing problems as primary factors instigating a child's failure to speak when the situation calls for talking. For example, it is common for a child who has a speech impediment to be anxious/fearful about "sounding funny" in front of peers and teachers.

> "Selective Mutism is sometimes erroneously mistaken for Autism. The striking difference between the two is that Autistic individuals have limited language ability, while individuals experiencing Selective Mutism are capable of speaking and normally do so in comfortable situations." *Selective Mutism Foundation.* http://www.selectivemutismfoundation.org/

Not speaking at school, of course, can be a major barrier to academic progress and developing social relationships. This, in turn, can compound a student's problems. It also can lead to additional diagnoses such as that of learning disabilities. Learning difficulty, whatever its source, can produce social and communication withdrawal because of performance anxiety, worry, and fear (e.g., of making errors, especially in front of classmates). However, if there were no early indications of this, it may be that the learning problems are mainly a product of the factors that caused the selective mutism and/or of the selective mutism itself.

Addressing Selective Mutism at School and at Home

It is very rare that a child is *just* "mute"; there is usually an underlying cause which should be identified. If the cause or causes are still factors in the problem, the intervention plan should address them. Home and classroom changes may be needed. Accommodations and other interventions that lower stress, anxiety, and raise self-esteem all can be helpful.

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General Treatments*

From: Robert L. Schum (2002) Selective Mutism: An Integrated Treatment Approach
http://www.asha.org/Publications/leader/2002/020924/020924ftr.htm

"A two-pronged approach to treatment is recommended for children who are mute at school:

- individual psychotherapy to help reduce the general anxiety and to practice better communication skills;

- a behavioral program at school to slowly shape increasingly appropriate communication.

An effective program involves a slow, systematic program that rewards successive approximations of social interaction and communication. Mute children cannot be tricked, cajoled, or commanded to speak. These approaches to resolving mutism invariably fail.

Any attempt at improved communication and interaction needs to be noted and reinforced, even if it is nonverbal. This includes making eye contact, following directions, and nonverbal participation in group activities. The successive steps in this approach often need to be quite small. The lack of speech is only the most obvious and dramatic sign of the underlying anxiety. Improvement of the mutism is predicated on a generalized reduction of anxiety. Therefore, reduction of other anxiety symptoms is important and relevant to the treatment of mutism at school."

*Some professionals also use antidepressant and anti-anxiety medications. The use of such medication with young children always is controversial.

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Some things for teachers to consider

As with any student who is having problems, it is important to understand as much about the causes as is feasible. And, all efforts to intervene benefit from a teacher who ensures that the classroom environment is a caring and nurturing place.

Moreover, it is essential to avoid interventions that are counterproductive. Too often, the mistake is made of pressuring the child to speak. This can exacerbate the mutism (e.g., prolonging the problem, causing further embarrassment and fear).

Teachers need to work with a team including student support staff, parents, and others who can help plan and implement a set of effective interventions to address the student's selective mutism and related problems.

In the classroom:

>**the plan needs to play out as a continuous personalized process and proceed in gradual steps that maintain a good match motivationally and developmentally.** In the beginning, this means establishing some form of nonverbal communication for the student to use (e.g., nodding, shaking the head, pointing). It also means setting guidelines and rules that don't enhance the student's anxiety. (Sara's teacher noted: "I don't make her speak, but I do require her to at least mouth the words when we are reading". In the classroom they have a general behavior chart for all students, but Sara would never get punished for not speaking.);

>**the student needs to understand the plan and, as feasible, be a partner in its development and implementation;**

>**the student needs to understand that support/help is always available from the teacher, other adults, and classmates.** Such support should be designed to enhance the student's feelings of competence, self-determination, and relatedness to others;

>**classmates need to understand the situation and be encouraged to interact positively with the student;**

>**everyone needs to help minimize anxiety-producing situations** (e.g., activities that threaten the student's feelings of competence, self-determination, and relatedness to others);

>**everyone needs to help establish opportunities for anxiety reducing interventions;**

>**an increasing emphasis should be on reducing reliance on extrinsic rewards in order to maximize intrinsic motivation** (e.g., providing diverse learning options that are of personal interest and enabling student choice).

Some things for parents to consider

First and foremost, don't dwell on past parenting mistakes. The focus needs to be on addressing the current problem.

The following are recommendations frequently made by experts in the field:

- **Ensure a comfortable, caring, and supportive atmosphere at home and accept the child for who s/he is so that the child can move past anxiety/fear and communicate with speech. Especially important is to avoid use of threats or punishment to elicit speech.**

- **Engender feelings of competence, self-determination, and relatedness through offering enjoyable enrichment opportunities that encourage but do not force social interactions and interpersonal communication. The key is always to gradually promote such involvement, while avoiding encounters that produce debilitating anxiety.**

- **Observe your child in the classroom to determine if it is appropriately supportive**.

- **Work with your child's teacher and student support staff to create a plan for addressing the problem.**

- **Monitor the situation to ensure that your child's school is providing the proper resources and adjusting the plan as necessary.**

- **Pursue opportunities to use anxiety reducing interventions.**

- **Seek additional outside professional help as indicated** (e.g., for help in addressing the student's problems, for family trauma or conflict, for advice and support in working with the school).

- **Seek a support network for yourself** (e.g., to help with your anxiety, fears, and frustration).

Among children, the causes and processes of selective mutism vary. However what is most common, and what was very much witnessed in Sara's case, is anxiety and discomfort. The key is to find the approach that best fits in order to decrease the child's anxiety and restore a level of comfort in which the youngster feels both motivated and able to speak.

A Recent Review and Reference Lists

Selective mutism: A review and integration of the last 15 year. By A.G. Viana, D.C. Beidel, & B. Rabian (2009). *Clinical Psychology Review 29,* 57–67.
http://www.sciencedirect.com/science/article/pii/S0272735808001360

Selective Mutism: Selected References & Resources
http://www.selectivemutism.org/resources/library/References%20and%20Resources/SM%20Resources.pdf

Selective Mutism Reference List (from the Selective Mutism Information and Research Assoc)
http://www.selectivemutism.org/resources/library/References%20and%20Resources/SM%20Reference%20List%20from%20SMIRA.pdf)

Also, see the Center's Online Clearinghouse on *Anxiety*
http://smhp.psych.ucla.edu/qf/anxiety.htm

Resources

Selective Mutism Group ~ Childhood Anxiety Network: For locating treatment resources, events, reading resources, to donate and volunteer and to tell your story.
http://www.selectivemutism.org/

 Selective Mutism Anxiety Research and Treatment (SMart) Center: For evaluation and treatments resources, school-based services, and workshops and trainings.
http://www.selectivemutismcenter.org/

The Selective Mutism Treatment and Research Center: For characteristics, diagnostic criteria, causes, parent, teacher and therapist information, FAQs, testimonials and research findings.
http://www.selective-mutism.org/

 Selective Mutism Foundation: For common myths, advice, school and higher education resources, research ethics, summer camps, 504 plans, healthcare professionals, teen volunteer opportunities, managing SSI, peer support. http://www.selectivemutismfoundation.org/

 American Speech-Language-Hearing Association: Selective Mutism: For signs, symptoms, diagnosis, treatment and helpful resources.
http://www.asha.org/public/speech/disorders/selectivemutism.htm/

 Selective Mutism Online: Connecting SM Individuals, Family Members, and Friends: For research such as Do's and Don'ts of Working with Children with SM, connecting with professionals, connecting with others affected by SM, forum, parent blogs, and videos.
http://selectivemutismonline.com/

 iSpeak: An online support group for young people and adults with Selective Mutism.
http://www.ispeak.org.uk/

Perspectives from Sara's Mother and Teacher

While only one case, the perspectives shared by Sara's mother and teacher provide a personal dimension to understanding the problem. This is especially so given that Sara's mother indicated that she was formerly a selective mute.

About Sara's mother's perspective

Selective mutism of course takes a toll on all involved. Sara's mother went through many tribulations in addressing her daughter's problems. Naturally, it is difficult for parents not to blame themselves. Sara's mother found it very frustrating to see her receive such poor grades. She tried not to add to the problem by punishing her.

Sara's mother indicated that the child talked slightly when first attending preschool, but quickly stopped talking at school. She did continue to talk at home and to her neighborhood friends. Her mother describes her development as always being "unusual" (e.g., slow in walking and in general learning processes, very shy). To her mother, it was not a huge shock that Sara stopped speaking in school. When she asked Sara about this, the child was indifferent and simply said she did not want to. Her mother tried explaining that Sara needed to speak to learn and make friends; Sara remained unconcerned.

The first school Sara attended did not have the resources necessary in order to help her. Her mother recalls having gone through many troubling, stressful, and unhelpful processes at the school. "They not only gave Sara a hard time, but me as well. They basically said Sara was being stubborn instead of saying she actually had a disability." In attempting to protect her child, she strongly disagreed with the school's characterization and explained that Sara was capable of talking but was anxious in the classroom because she did not understand what she was being taught. The mother was further aggravated by the school's recommendation of medication. The principal's view was that medication would help, but the mother responded that "Sara's primary care physician told me not to medicate her because she would begin speaking on her own when she was comfortable." Accoding to the mother: "Child Protective Services was called because I wouldn't medicate Sara." The case was closed. Sara's mother decided to change schools.

At the new school, her mother wanted to hold Sara back hoping that would decrease the learning anxiety, but the school felt it would be a problem because Sara was so tall. They recommended that Sara be placed in a special education class. Her mother was apprehensive about this, fearing that those in such a class would be intimidating to Sara. So the decision was to enroll her in her regular grade level class and provide a speech therapist. While she did begin speaking to the speech therapist (after building a comfort level with her). Sara still did not speak in the classroom. (Her teacher tried to give her easier homework, but her anxiety did not abate.) So, despite wariness about the move, Sara's mother agreed to place her in a special education class.

The special education class has several aids who provide Sara with necessary special attention. Sara went from getting zeros on spelling tests to getting 100%. Sara soon resumed speaking in class.

According to her mother, it was most definitely Sara's anxiety that was hindering her, "she was afraid she was going to say something wrong, and she gave up trying to learn because it was at way too high of a level for her." She thinks Sara will eventually be moved back into a regular classroom in the future "but it will be a process for sure."

A final recommendation from Sara's mother to other parents: "Most definitely keep a teacher involved and don't ever allow a school system to make you feel like you are the only one at fault, because it is a school's responsibility to work with you. If a school is not working for you, move right away. I believe I kept Sara at her first school for much too long, and I think she got even worse while she was there." She also added that she hopes that schools will be more aware of selective mutism; specialists at schools should have proper resources and knowledge of knowing how selective mutism makes a child feel.

About Sara's current teacher's perspective

Placing Sara in a special education was a difficult and unsure decision. Would being with students functioning at a lower level than Sara help or further hinder her academic progress?

The special education teacher, Ms. R, had never heard of "Selective Mutism." She immediately researched the topic and saw it as challenge. She had other students who were extremely shy and began working with Sara in the same way.

Communication for both Sara and others in the class, of course, was a considerable concern. Ms. R's first thought was that Sara's inability to speak was due to extreme anxiety thus forcing her to speak was not a good idea. "I put no pressure on her to speak, but had her communicate through writing notes, or nodding her head to yes or no questions." With respect to the need to establish guidelines and rules without putting pressure on Sara, Ms. R. indicated: "I don't make her speak, but I do require her to at least mouth the words when we are reading, or if she doesn't read, I will have her read with me." In the classroom, they have a general behavior chart for all students, but Sara would never get punished for not speaking.

Sara's behavior was certainly unusual to her classmates and Ms. R. had students ask her "Why doesn't she talk?" She explained that Sara could hear perfectly and about the importance of acceptance and support and speaking with her even though she was unable to talk with them. She told them Sara would speak when she became comfortable in class. For the first three months in the classroom, Sara "clammed up" whenever someone spoke to her, but she did communicate by nodding and pointing.

Every child is of course unique and requires individual methods. Sara came to Ms. R. confused, anxious, fearful of being wrong, and of performing at a lower level

than her classmates. In her class now, she is given much more attention with several aids and a caring teacher. For Ms. R., the key to Sara was encouragement, support, and to avoid pressure. The special education class provided Sara with a sense of comfort where she wasn't embarrassed.

Progress: A breakthrough for Sara began in music class. She started humming everywhere -- as she walked around, as she completed class work. Ms. R. indicate that everyone, including classmates, wanted to "jump with joy" about this. Ms. R. decided it was best not to "make a huge deal" because it might embarrass Sara.

Sara is still a work in progress. She now talks to everyone in her classroom, but on the playground she only talks to the students she knows. She still needs a "buddy" to go with her when speaking to adults with whom she is unfamiliar. Recently, she asked Ms. R if she could have the "Calendar Job" which requires her to present in front of the classroom. When the time came, Sara was not quite ready. Ms. R. asked, "Do you want me to do it with you?" Sara shook her head; "Next time?" asked Ms. R. Sara smiled and nodded.

From the teacher's perspective, will Sara ever return to the regular classroom? Ms. R. says, "I really, really hope so." While progress is gradual, she believes that there is only good to come for Sara.

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What does Sara say about all this?

Sara is very sensitive about the topic and to facilitate sharing during a brief interview, she was asked to draw pictures of a sad face and a happy face and then to point to how she felt.

How did she feel at school today? She pointed to the happy face.

How did she like her new classroom? She pointed to the happy face.

How did she feel in her old classroom? She frowned and pointed to the sad face.

I asked her to draw a picture of how she feels about Ms. R. She drew a picture of the two of them holding hands.

When I asked her to draw a picture of her and her second grade teacher, she refused to draw a picture.

I asked why? She responded with, "She called on me." I asked, "Was your hand raised?" She shook her head with a frown.

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# VI. *Keeping Anxiety and Related Problems in Broad Perspective-*

$\mathcal{A}$nxiety and related problems are often key factors interfering with school learning and performance. As a result, considerable attention has been given to interventions to address such problems. Our reading of the research literature indicates that most methods have had only a limited impact on the learning, behavior, and emotional problems seen among school-aged youth. The reason is that for *a few,* their reading problems stem from unaccommodated disabilities, vulnerabilities, and individual developmental differences. For many, the problems stem from socioeconomic inequities that affect readiness to learn at school and the quality of schools and schooling.

If our society truly means to provide the opportunity for all students to succeed at school, fundamental changes are needed so that teachers can personalize instruction and schools can address barriers to learning. Policy makers can call for higher standards and greater accountability, improved curricula and instruction, increased discipline, reduced school violence, and on and on. None of it means much if the reforms enacted do not ultimately result in substantive changes in the classroom and throughout a school site.

Current moves to devolve and decentralize control may or may not result in the necessary transformation of schools and schooling. Such changes do provide opportunities to reorient from "district-centric" planning and resource allocation. For too long there has been a terrible disconnection between central office policy and operations and how programs and services evolve in classrooms and schools. The time is opportune for schools and classrooms to truly become the center and guiding force for all planning. That is, planning should begin with a clear image of what the classroom and school must do to teach all students effectively. Then, the focus can move to planning how a family of schools (e.g., a high school and its feeders) and the surrounding community can complement each other's efforts and achieve economies of scale. With all this clearly in perspective, central staff and state and national policy can be reoriented to the role of developing the best ways to support local efforts as defined locally.

At the same time, it is essential not to create a new mythology suggesting that every classroom and school site is unique. There are fundamentals that permeate all efforts to improve schools and schooling and that should continue to guide policy, practice, and research.

For example:
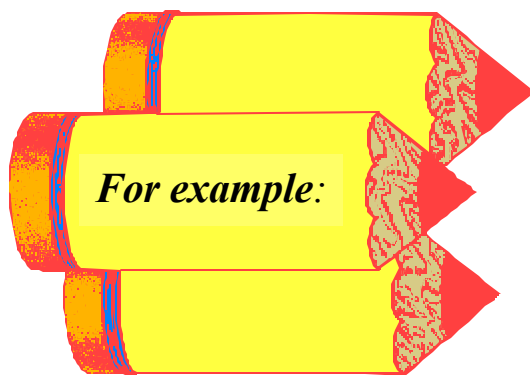
• The curriculum in every classroom must include a major emphasis on acquisition of basic knowledge and skills. However, such basics must be understood to involve more than the three Rs and cognitive development. There are many important areas of human development and functioning, and each contains "basics" that individuals may need help in acquiring. Moreover, any individual may require special accommodation in any of these areas.

• Every classroom must address student motivation as an antecedent, process, and outcome concern.

• Remedial procedures must be *added* to instructional programs for certain individuals, but only after appropriate nonremedial procedures for facilitating learning have been tried. Moreover, such procedures must be designed to build on strengths and must not supplant a continuing emphasis on promoting healthy development.

• Beyond the classroom, schools must have policy, leadership, and mechanisms for developing school-wide programs to address barriers to learning. Some of the work will need to be in partnership with other schools, some will require weaving school and community resources together. The aim is to evolve a comprehensive, multifaceted, and integrated continuum of programs and services ranging from primary prevention through early intervention to treatment of serious problems. Our work suggests that at a school this will require evolving programs to (1) enhance the ability of the classroom to enable learning, (2) provide support for the many transitions experienced by students and their families, (3) increase home involvement, (4) respond to and prevent crises, (5) offer special assistance to students and their families, and (6) expand community involvement (including volunteers).

• Leaders for education reform at all levels are confronted with the need to foster effective scale-up of promising reforms. This encompasses a major research thrust to develop efficacious demonstrations and effective models for replicating new approaches to schooling.

• Relatedly, policy makers at all levels must revisit existing policy using the lens of addressing barriers to learning with the intent of both realigning existing policy to foster cohesive practices and enacting new policies to fill critical gaps.

Clearly, there is ample direction for improving how schools address barriers to learning. The time to do so is now. Unfortunately, too many school professionals and researchers are caught up in the day-by-day pressures of their current roles and functions. Everyone is so busy "doing" that there is no time to introduce better ways. One is reminded of Winnie-The-Pooh who was always going down the stairs, bump, bump, bump, on his head behind Christopher Robin. He thinks it is the only way to go down stairs. Still, he reasons, there might be a better way if only he could stop bumping long enough to figure it out.