



When F.E.A.R. Plans Fail

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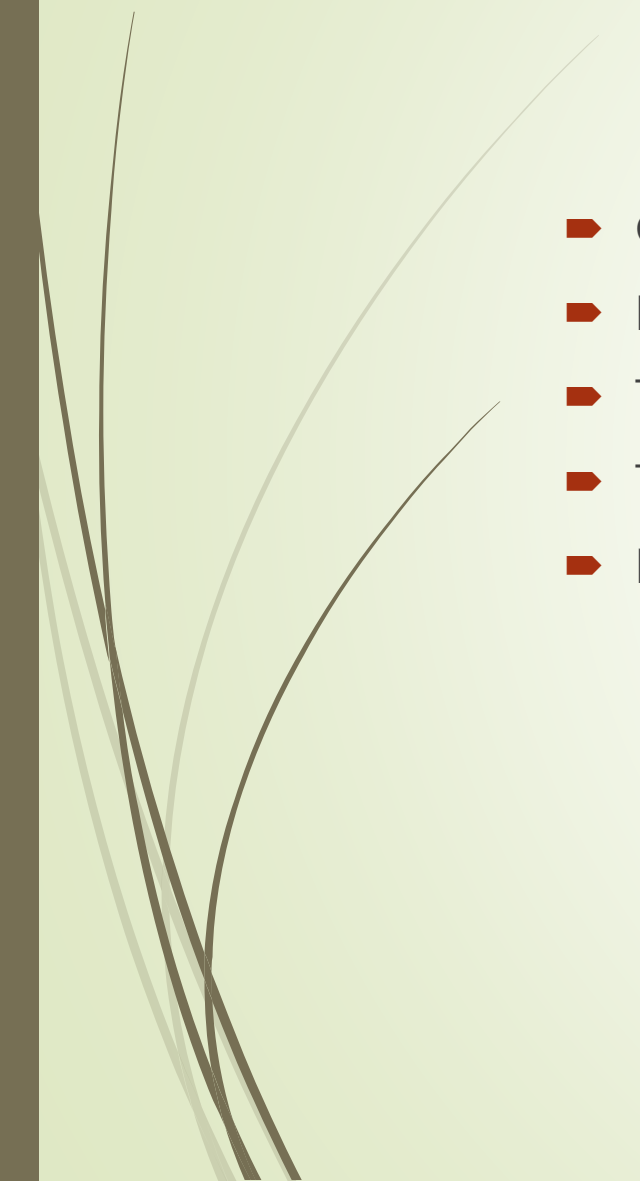


Learning Objectives

- ▶ To learn about common reasons why F.E.A.R. plans don't always work in the cognitive behavioral treatment of anxious children and youth
 - ▶ To discuss new developments in medication management of anxious children and youth—note: all off-label
 - ▶ To formulate exposure plans and parenting strategies for particularly challenging sub-groups
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1. Reasons for F.E.A.R. plan failure

- Child issues
 - Parent issues
 - Therapist issues
 - Treatment issues
 - Noise in the system (the larger social environment)
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Child Issues

- ▶ Cognitive problems: can't do CBT as per manual
- ▶ Motivation problems: won't do CBT as per manual
- ▶ Developmental issues affecting CBT as per manual
- ▶ High severity of anxiety/impairment
- ▶ Severe externalizing comorbidity

Solutions: a) adapt the manual or how you use it (see 'CBT with Children: A Guide for the Community Practitioner'; b) do something else first or concurrently—usually either medication or environmental changes (home and/or school)



Developmental Periods



- More behavioral approach (vs. cognitive) and more need to work with parents in preschoolers
- Optimal cognitive flexibility ages 7 to 9 years
- Death as permanent age 8 (give or take a year)
- Abstract reasoning in adolescence—more evidence needed for self-talk to work; more hypotheticals can sometimes increase worries
- Reliance on peers in adolescence—you may represent a parental figure
- Good communication with at least one adult should still be fostered in adolescence—for when the text to the BFF goes unanswered right after a romantic break-up



Parent Issues

- ▶ Can't commit to regular appointments
- ▶ High expressed emotion in home environment
- ▶ Unpredictable/unstable home environment
- ▶ Parental anxiety affecting treatment

Solutions: the emotion & parental anxiety can sometimes be addressed in treatment (or treatment used to nudge parents toward help for themselves or the family dynamics); stability is essential, so CBT must wait if unresolved custody/access issues; regular appointments are essential, so CBT must wait if the family has more pressing issues



Parent/Family Issues

- ▶ Separated family and differences in approach to symptoms in different households
- ▶ The family where you must have a problem to get attention
- ▶ The child as “black sheep” who is not expected to get better
- ▶ “We believe in therapy” (i.e., therapist magically fixes feelings, without any behavior management or other parental intervention)
- ▶ “We reason with our children” (fine when everyone is calm, but not in the middle of a panic attack or temper tantrum)



Parenting Pearls



- ▶ Don't sweat the small stuff
- ▶ Work on one or two situations at a time consistently, with empathic encouragement ("I know this seems hard, but you can do it!")
- ▶ Use charting so you don't forget & to show the child he/she is making progress; attach a small reward to it if needed
- ▶ Expect '2 steps forward 1 step back' and focus on the 'forward'
- ▶ Less talk, less negative emotion
- ▶ It doesn't matter if it's anxiety or behavior: if you want to encourage it, praise it; if you want to discourage it, ignore it (unless severe--and then use time out, privilege withdrawal, natural consequence, etc.)
- ▶ When in doubt, just breathe (kids can't think when highly anxious so talking just makes it worse)
- ▶ Also see "Keys to Parenting Your Anxious Child"



Therapist Drift

- ▶ Vague goals in relation to baseline (assuming you've done one)
- ▶ Unclear expectations of child, parents, treatment
- ▶ Long gaps between appointments
- ▶ Lack of follow-up on homework
- ▶ Too little session structure
- ▶ Overly rigid use of manual
- ▶ Too little time with parents
- ▶ “CBT forever” vs discussing termination clearly

Also see “CBT with Children & Adolescents: A Guide for the Community Practitioner”



Treatment Issues

- ▶ Lack of generalization outside the office (use those concrete reminders!)
- ▶ Lack of persistence over time (parental support is essential here)
- ▶ Difficulty designing effective exposures (which are not always spelled out in the manuals)
- ▶ Difficulty finding meaningful positive reinforcement
- ▶ CBT is interfering with school, affecting attendance & motivation
- ▶ CBT is interfering with exposure activities (e.g., Drama for a socially anxious child; overnight camping with scouts for separation anxiety)



The Larger Social Environment

- ▶ School problems (e.g., family vs. school conflict, learning disability)
- ▶ Bullying or cyber-bullying
- ▶ Poverty (nutrition, transit, work shifts, divided parental attention)
- ▶ Lifestyle: exercise habits, sleep habits, energy drinks & other substances, excessive video gaming
- ▶ Lack of community support (divided parental attention; attendance affected due to sibling issues)
- ▶ Also see parenting tip sheets on www.katharinamanassis.com



Common school accommodations

- ▶ Also see “GAD in the Classroom”
- ▶ Individualized Education Plan
- ▶ Quiet place to go if anxious; quiet place for tests
- ▶ Extra time on tests or assignments (caution: can sometimes make perfectionists worse)
- ▶ Chunking or reduced quantity of work
- ▶ Organizational aids
- ▶ A consistent person (MSW, SERT, etc.) who can work with the child/family especially if gradual re-integration needed, or behavioral plan



2. Medications in Anxious Children/Youth

- ▶ Combination treatments seem to work best (CAMS & Sertraline, RUPP trial for Fluvoxamine, TADS in depression—CBT alone didn't shine, POTS in OCD)
- ▶ CBT reduces relapse risk when medication stopped, is important to include with treatment resistant depression (TORDIA), and may be sufficient in some mildly affected or young children
- ▶ When increasing dose, anxiety typically responds first, then depression, and OCD last & partial response (so sometimes augment with atypicals in OCD)
- ▶ Behavioral activation is more common in children than adults across disorders and across specific medications (theoretically highest for fluoxetine & paroxetine; least for fluvoxamine but every child is different)
- ▶ Tricyclics have been shown NOT to work in depressed youth, so stick to SSRIs or venlafaxine in this population
- ▶ When 2 or more medications are not tolerated, consider IMPACT study (CAMH)



Evidence in other conditions

- ▶ Black & Uhde/Carlson (small trials): fluoxetine/sertraline > placebo for Selective Mutism
- ▶ Oerbeck et al.: Younger children with selective mutism (<7) often respond to CBT alone; only 33% do once they are 7+
- ▶ PTSD—several small trials; not very convincing; SSRIs may augment CBT effects so worth considering if debilitating symptoms
- ▶ Anxiety in ASD: small, open trials for citalopram & buspirone (anecdotally, I've had several young ones with 'transition tantrums' on fluoxetine)
- ▶ School avoidance: small trials suggest that combining medication and behavioral/cognitive behavioral treatment is best (Bernstein et al.)
- ▶ Better evidence for stimulants in ADHD + Anxiety (risk of activation on SSRI: ?anxiety due to poor frontal regulation versus hypersensitive amygdala)



Explaining why it is needed

- ▶ We only give these medications to people whose anxiety problems, mood problems, or OCD are interfering regularly in their lives
- ▶ For children, this usually means daily or almost daily impairment in school, at home (including sleep/eating problems), or socially
- ▶ Children can also fall behind their peers in development if they are impaired in one of these areas for a long time, which can leave them vulnerable to other mental health problems later (e.g., depression)
- ▶ We always look at a balance of possible risks versus possible benefits, both for medication and also for not medicating
- ▶ In my judgment, the possible benefits of medication outweigh the possible risks at this point in your child's life
- ▶ You will probably be told at the pharmacy that this is “off label” in children



Why this particular medication

- ▶ Fluoxetine: Best evidence for depression and also for selective mutism; comes in a minty sweet liquid for kids who can't swallow pills; long half-life means you can create intermediate doses easily by adjusting how much is taken per week; no withdrawal reaction if you miss a dose so be careful
- ▶ Fluvoxamine: Least activating of the SSRIs, good evidence for anxiety
- ▶ Sertraline: Best evidence for OCD & good evidence for anxiety, not very activating, can tell if dose gets too high (loose stools)
- ▶ Citalopram: Some evidence for depression, most weight-neutral, least effect on glycemic index, fewest interactions with other medications, arrhythmia risk at doses >40mg (which are sometimes needed in OCD)
- ▶ Escitalopram: teens like it, but difficult to finely titrate dose in kids
- ▶ Paroxetine: short half-life (bid dose & withdrawal risk) so I avoid it
- ▶ "Family history of response": no real evidence for this, but it may augment placebo effect



How we will monitor

- ▶ We will do a baseline of your child's most distressing/impairing symptoms (frequency, intensity, duration, ability to manage/carry on—let's quantify!)
- ▶ We will get baseline from both child and parent, and teacher too if symptoms occur at school
- ▶ Some children report more verbally; others on questionnaire (MASC, CDI, YBOCS)
- ▶ Change is often gradual (like watching grass grow) and the people around the child may notice it first; good days & bad days are the norm, with good ones becoming more frequent over time
- ▶ We “start low and go slow” with dosage to minimize the risk of side effects
- ▶ Because 6 weeks is a long time to wait, I often adjust dose every 3 weeks (might go slightly high, but at least the child doesn't suffer for months)



Dosages

- ▶ Fluoxetine, citalopram, and paroxetine all go in 5-10mg increments; fluvoxamine and sertraline go in 25mg increments; escitalopram in 5mg; can reduce the size of the increment if history of adverse reactions (e.g., alternating 10mg/20mg fluoxetine capsules to create 15mg)
- ▶ BEWARE of accidental liquid Prozac overdose (4mg/mL, so 10mL=40mg)
- ▶ Starting dose is lower the smaller the child, but the final dose may be in the adult range (rapid metabolism, high volume of distribution) and there is no exact formula by body weight
- ▶ Some slow metabolizers respond at low doses; more common in Asians
- ▶ Preschoolers: 6mg of liquid fluoxetine, increase in 2mg increments
- ▶ School age: 10mg of fluoxetine or 25mg of sertraline to start
- ▶ Adolescents: 20mg fluoxetine or 50mg sertraline to start



Will my child be on this forever, and what will that do to him/her?

- ▶ We never say 'forever' because there are new treatments being developed all the time, and some children do get better at using coping strategies with CBT and/or maturation
- ▶ Evidence suggests that depressed teens need to be on at least a year, and usually anxious kids do better with this too as it allows time to build confidence; OCD treatment is often longer term but up to 50% do come off medication eventually
- ▶ We will monitor at least every 6 months and determine if a dosage increase is needed (usually for growth) or if your child is doing well enough to decrease the dose and see how he/she handles this; gradual decreases (e.g. monthly) will ensure that the child is on the minimum needed
- ▶ I rarely taper children in the summer, as September is usually stressful
- ▶ Amotivation is the only long-term side effect documented, and it responds to dosage reduction or discontinuing medication



3. Exposure Variants for Challenging Presentations

- ▶ Degrees or frequency of support/accompaniment
- ▶ Proximity to what is feared
- ▶ Degree of threat of stimulus/situation
- ▶ Time in the feared environment (20min + & q2days minimum)
- ▶ Degree of positive reinforcement depending on difficulty (gives child the option of progressing more quickly)
- ▶ Increasing what can be done despite anxiety
- ▶ Decreasing time away from stimulus due to anxiety
- ▶ Predictable/random exposure (the latter is always harder)
- ▶ Decreasing or postponing unhealthy coping—eg. worry time



Rumination



- ▶ There is a different worry every day, or long periods of time just spent thinking and worrying
- ▶ Get out of your room & get active! Problem-solve re: specific activities & specific times of day, then follow-up to make sure they happen
- ▶ If amenable, teach mindfulness techniques (watching thoughts “like cars on the highway”, not fighting them or following them, just letting them come and go, recognizing you are more than your thoughts)—also see Kabat-Zinn tapes
- ▶ Both mindfulness and activity are actually exposure exercises for GAD: exposure to uncertainty (can’t predict the future, only trust that one will deal with it when the time comes)



Perfectionism



- ▶ About self: practice “fast and sloppy” work (with teacher agreement of course), with positive reinforcement for tolerating this
- ▶ Reframe mistakes positively (‘mistakes are good, they help us grow, they teach us what we need to know’)
- ▶ With teens, do a cost/benefit analysis: perfectionism slows you down, results in procrastination (when you don’t think you can do something well enough you put it off), causes ‘tunnel vision’: can actually increase mistakes in whatever tasks you are NOT currently focused on
- ▶ About others: results in tantrums and preoccupation with fairness; “run your own race” vs. comparing; to quote Mick Jagger: “you can’t always get what you want, but if you try sometimes you get what you need”—focus on what you need most, not everything you want/think you deserve
- ▶ Encourage SNAP to walk away; positive reinforcement of tantrum-free days



School Avoidance

- ▶ Add medication to CBT (Bernstein et al. showed it helps)
- ▶ Usually need a contact person at school to ensure consistency & follow-up
- ▶ Focus on parent motivation, not just child motivation—long-term view of what is in the child's best interest; how would life be different if the child attended (+ and -); it's not the school's job to facilitate attendance/eliminate all stress so child is comfortable attending
- ▶ Motivational interviewing for teens (too big to drag); find a “carrot” at school (e.g., helping with younger kids; meeting with a career mentor)
- ▶ Keep everyone calm and persistent (what works vs. who at fault)
- ▶ Non-family adults can often bring & drop off more easily
- ▶ Alternative schools are preferable to home schooling
- ▶ Consider a trial of work for long-term school-refusing teens



Severe shyness/SM

- ▶ For age 7 and up, add medication (Oerbeck et al., 2014), as CBT has <33% chance of working on its own
- ▶ Create a “no lose” situation for gradual approximations of speech (e.g., can I share this terrific idea with the class? This is so well-written...can you read it for us?)
- ▶ Five minutes a day 1:1 with the teacher...sometimes need a parent present initially & teacher just overhears—Also see McHolm et al.
- ▶ Factual, 1-word answers are easiest; some speak more on the way out the door (when self-consciousness is reduced)
- ▶ Script and rehearse social situations/performances
- ▶ Find out what type of person/situation is least threatening
- ▶ One buddy can result in ‘leap-frogging’ to other friendships

Questions?

