A Model for Treating Children and Adolescents in Integrated Health Care

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Objectives

- By the end of this session,
  - participants will be able to employ simple tools that are free and readily available to assess symptoms of depression, anxiety, and ADHD.
  - participants will be able to apply basic key Biodyne Model principles to treat children and adolescents and their families in primary care settings.
  - participants will be able to identify key methods of interfacing with physicians and other medical providers to coordinate interventions in primary care settings.
  - participants will be able to apply key techniques for working in a primary care setting.

Introduction

- Integrated health care has been a movement for a number of years and will continue to grow dramatically in the next few years
- In the 1950s Dr. Nicholas Cummings was hired as Chief Psychologist, by Kaiser Permanente, to provide psychological services to patients using their services
  - It was based on a hunch that providing psychological services, would help to reduce overutilization by some patients
- In the early 1950s, the Baden Street Settlement House in Rochester, N.Y. set up a health center that was integrated

Introduction, cont.

- In January 1973, the Anthony Jordan Health Center was opened to take over the Baden Street Settlement House's health center's activities as a fully integrated health center
  - Later it became a Federally Qualified Health Center
- In the case of children, specifically, the first documented initiative I could find was for the pediatric and the psychiatric services of Albert Einstein College of Medicine to collaborate in the training of pediatric residents
- So, the word is finally getting around!!
- And it only took 60 years!!

Why Integrated Health Care?

- A large number of people have psychological needs
- A disproportionate number of them present for services at primary care medical offices and other medical services
- Many of these receive a prescription for antidepressants
  - Providers may have some training in the prescription of some psychotropic medications, but lack training in providing behavioral health services

Why Integrated Services, cont.

- When a PCP decides to make a referral for specialty behavioral health care, only 30-40% of these follow through to see a professional in another office.
- On the other hand, if the referral is made to a Behavioral Care Provider (BCP) in the same office, the rate of follow-through increases to 70-80%
- Integrated behavioral health care is less costly. (Typical savings range between 20 and 40%, called the “medical cost offset.”)

Why Integrated Health Care? cont.

- Integrated Health Care refers to the collaboration of health and behavioral health care professionals in the provision of health services.
  - A detailed treatment of this is beyond the scope of today's presentation.
  - Suffice it to say for now that there is a continuum of integration ranging from:
    - Two providers in different locations communicating about a mutual patient (coordinated care model). (Hunter et al. 2009)
    - In the middle there is on-site collaboration (co-located care model and care management model)
    - At the other end, there is a fully integrated team of people who share one medical record per patient, and who work together following a combined treatment plan (integrated care model)

Why Integrated Health Care? cont.

- For purposes of this presentation, we will be discussing a fully integrated health care team that includes a primary care physician or provider (PCP) and a behavioral care provider (BCP), in what is becoming known as a “medical home.”
  - Other team members may include:
    - A nurse practitioner or physician’s assistant,
    - A dietician,
    - A pharmacist
    - Other allied health care providers

The Warm Hand-Off

- When a PCP identifies a patient who could benefit from a referral to a BCP, he/she initiates the contact by bringing in and introducing the BCP.
  - The patients are referred to the BCP by the PCP in what is called a "hand-off."
  - http://youtu.be/umif1TDdKrM

    - (Dr. Peter Van Houten and Ms. Jennifer Sayle, Sierra Family Health Center)
    - As you can see there are several components to this.
    - And you can see that the structure is similar across presenting issues.

BCP's Role

- After the "Warm Handoff," the BCP initiates services
- He/she can follow a model that was developed by Hunter et al. (2009)
  - It's called the five A's:
    - Assess
    - Advise
    - Agree
    - Assist
    - Arrange
- When me move on to the specific approaches, we will use this model as guideline

The Hallway Conversation

- If you look at an initial session in an integrated health care setting you can see that there are two bookends, to use a metaphor.
  - One bookend is the Warm Hand-Off.
  - The other bookend is the Hallway Conversation.
- The Hallway Conversation, for lack of a better term (in fact it should not occur in the hallway, but often does), is when the BCP reconnects with the PCP or referring agent, communicates the result of the assessment and discusses a recommended treatment plan. (This meeting is crucial; leaving notes in a chart is not helpful)

Medical Culture

- It is important to learn about the culture of medical practice
  - Necessary to learn the language; hence, study medical pathophysiology
  - Necessary to learn values
    - In a medical setting, people take care of each other's health
    - So they may ask you to do the same
    - You can't refuse, but you also need to set good boundaries
  - Necessary to learn the style
    - Oral communication preferred over written communication
    - Prompt, timely communication
    - Time is of the essence; hence the 50 min. hour becomes the 25 min half-hour
    - Clear-cut, concrete suggestions or treatment plan

The Biodyne Model

As we will see later, the BCP's job during the initial session following the Biodyne Model, is more complex than would appear in this description.

- The Biodyne Model refers to both,
  - A model for integrated care, (O'Donahue, Cummings, Cucciare, Runyan & Cummings, 2006) and
  - A psychotherapy model

The Role of the BCP

- As a psychotherapy approach, the Biodyne Model refers to method of conducting therapy using techniques meant to facilitate a rapid connection with the client and the identification of issues that have implications for how to approach treatment.
  - This method is referred to as Focused Psychotherapy Throughout the Life Cycle
  - The basic information appears in the book *Focused Psychotherapy: A Casebook of Brief, Intermittent Psychotherapy Throughout the Life Cycle* by Nick Cummings, Ph.D.,Sc.D. and Mike Sayama, Ph.D.

The Biodyne Model: Introduction

- “Focused Psychotherapy” refers to the fact that the approach is designed to work on one issue or one set of related issues at a time.
- “Brief” refers to the fact that psychotherapy should be efficient as well as focused, and is generally brief.
- “Throughout the life cycle” is used to emphasize the similarity with primary health care. A patient comes in to see a PCP with a specific set of symptoms, receives the applicable treatment, returns for follow up one or more times, and is then discharged. The patient is likely to return again at a later date with a different presenting problem. The approach of the Biodyne Model is similar.

The Biodyne Model Introduction, cont.

- In this approach to psychotherapy, anxiety is considered “the fundamental psychological problem.”
  - When our defenses (or coping abilities) have been breached, we experience anxiety and feel threatened.
  - As we feel threatened, we regress to earlier methods of coping that were ingrained at a young age (the repetition compulsion).
  - That method of coping was a solution at that time, but at a later age, it becomes the problem instead of the solution.

Structuring the Initial Session

- Structuring the episode:
  - Who's presenting?
  - Why now?
  - What for?
  - How?
    - Answering these questions will allow the therapist to structure the episode of care,
    - Connect quickly with the client,
    - And avoid pitfalls that derail treatment.

The Biodyne Model, cont.

- 1) Who's presenting?
  - There are two broad categories that are very useful in distinguishing the type of person presenting for treatment. Defense mechanisms can be divided into two kinds:
    - Onion
    - Garlic
  - This is a metaphor based on what happens when a person eats foods containing a lot of one or the other of these ingredients.
  - The general therapeutic axiom: TREAT GARLIC BEFORE ONION.
    - Guilt is the salient characteristic of the onion person, while
    - Denial is at the core of the garlic dynamic
      - You cannot treat a person who is in denial by working on their guilt issues

Garlic vs. Onion, cont.

- As it applies to children,
  - Internalizing problems, depression, anxiety and phobias, are in the onion category
  - Externalizing problems or behavior problems, such as Oppositional Defiant Disorder, Conduct Disorder, enuresis, encopresis, eating disorders, substance abuse, are garlic
- You cannot treat garlic as onion, therefore, garlic children require behavioral interventions, while onion children require can benefit from traditional psychotherapy methods

Implicit Contract

- 3) Implicit Contract:
  - Just as helpful as knowing the Why Now in assessing the motivation of the client, is knowing the Implicit Contract.
  - In group dynamics, we would call this the Hidden Agenda.
  - It is important to deal with the Implicit Contract for the same reason it is important to deal with the Hidden Agenda: Nothing is going to get done, unless you take it into account.
  - Examples:
    - The woman who wants to bring her children for you to see them in order to reassure her that they are not being harmed by her divorce (when she is planning to try to get sole custody)
    - The teenager who is using drugs. His/her implicit is usually, “Get my parents off my back without my having to quit.”

The Implicit Contract

- The Implicit Contract is often fantasy-laden or what Freud called "primary process" thinking.
- If the Implicit Contract is shared at all (or "implied" is another adjective), it is often shared in a very casual way.
  - By definition, it is not stated explicitly.
  - It often has the tone of a teaser in the form of a half-expressed thought.
  - Sometimes it's mentioned casually, as an after-thought.
  - At other times it comes at the end of the session ("door knobbing")
  - But it could just as easily be brought up at the beginning
  - If by the end of the session, you haven't heard it, it is important that you try to figure it out and/or you take a guess at it.
    - Sometimes you get what Adler called "the recognition reflex:" a very slight non-verbal gesture indicating a reaction.

The Implicit Contract, cont.

- Sometimes you want to confront it directly, but at other times, especially when it signifies “resistance” you don’t want to confront it immediately.
  - With garlic people, confronting it is not very useful because it leads to denial.
  - Not taking account of the Implicit Contract almost always will result in prolonging therapy.
- In the case of children in primary care, you have at least three Implicits:
  - The PCP or medical provider who referred the patient
  - One or two for the parent(s)
  - The child’s
  - It is important to have a clear understanding of these for each party

References:

- Cummings, N.A., & Sayama, M. (1995). *Focused Psychotherapy: A Casebook of Brief Intermittent Psychotherapy Throughout the Life Cycle.* New York, N.Y.: Brunner-Mazel.
- Duncan, B.L., Miller, S.C., Wampold, B.E., and Hubble, M.A. (Eds.) (2010) *The Heart and Soul of Change.* (2nd Edition). Washington, DC: American Psychological Association.
- Hunter et al. *Integrated Behavioral Health in Primary Care.* (required text)

Children in Primary Care

- In primary care we have three facets:
  - Mental/behavioral Health Issues
  - Physical/medical Health Issues
  - The combination of the two
- The most common reason for referral to a Behavioral Care Provider is that children who are out of control
  - Non-compliant children constitute 50% of caseloads (Evans, 2010)
  - These include Attention-Deficit/Hyperactivity Disorder, Oppositional Defiant Disorder, and may also include Autism Spectrum Disorder

Attention-Deficit/Hyperactivity Disorder

- We'll start with ADHD, as this is probably the most common presenting problem
- Assessment:
  - Thorough developmental history
  - DSM-IV Criteria
    - Inattention
    - Hyperactivity
    - Impulsivity
    - Symptoms have to cause significant impairment
    - Have to occur in at least two settings
    - Before age 7

ADHD, Assessment, cont.

- Three types:
  - Inattentive
    - Females more often have the Inattentive Type
  - Hyperactive-Impulsive
    - Not very commonly seen
  - Combined Type
    - Males more often represented in the Combined Type
  - Ratio of 2:1::males:females
  - About 80% of cases are inherited
  - The other 20% are related to a variety of causes (hypoxia at birth a common one)
  - Salient symptoms vary depending on the age

ADHD, Assessment, cont.

- The gold standard of rating scales is the Conners Scales
  - Conners Parent Rating Scale-Revised: Long Form (CPRS-R:L)
    - Has a Spanish language version
  - Conners Teacher Rating Scale-Revised: Long Form (CTRS-R:L)
  - Both have Spanish language versions
  - Normed for children of various age groups (3 to 18) and for males and females
  - For ages 12-18 there is also the Conners-Wells Adolescent Self-Report Scale-Long Form (CASS-L)
  - They have a number of subscales that are very helpful in ruling out other disorders
  - There is now a Conners 3, which has a narrower age range.
  - http://psychcorp.pearsonassessments.com/HAIWEB/Cultures/en-us/Productdetail.htm?Pid=Conners_3

ADHD Assessment, cont.

- In Primary Care, the most commonly used rating scale is the Vanderbilt ADHD Rating Scale
  - Based on the DSM-IV Criteria
  - Not normed, simply validated based on the criteria
  - Cover inattention, hyperactivity and impulsivity and conduct/behavior symptoms
  - Also some information about school problems in order to establish that there is the necessary level of impairment
  - Parent's Version: https://vchtest.mc.vanderbilt.edu/uploads/documents/DIAGNOSTIC_PARENT_RATING_SCALE(1).pdf
  - Teacher's Version: http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/adhd.pdf

ADHD, Advise

- Advise
  - Once you have determined that the child qualifies for the diagnosis of ADHD then you need to Advise the parent(s)
    - It's important to cover the necessary treatment information:
      - The two most effective methods of treatment
      - Pros and cons of each
        - » Generally we advise parents to wait at least six weeks before prescribing medications
        - » Children will learn more behavioral skills if this is done first.
        - » If medications are still needed, they are likely to require a lower dosage

ADHD, Advise, cont.

- Parents will usually have many questions
  - Important to allay any guilt they may feel (They did not cause this)
  - They will have many questions about medications (Is it addictive? does that mean that they prone to drug addiction when they grow up? Will they have to take it all their lives?)
  - Also what it means in practical terms (Will they have it all their lives?)
  - Explanation that this disorder is really about deficits in Executive Functions

ADHD, Agree

- Once you have answered all of their questions, it's time to obtain their agreement to the treatment plan
- The treatment plan should include several components:
  - Whether or not medications are to be tried
  - Parent education
  - The behavioral treatment approach (more on this later)
  - Coordination with the school and other community organizations if necessary
- After obtaining agreement, you should have the Hallway Conversation with the PCP to summarize your findings and to discuss the treatment plan.

ADHD, Assist

- The Assist portion of the approach refers to providing the help required
  - For younger children, this means mostly parenting information about how to help with homework, organization, minimizing distractions, managing chores, social skills
  - Usually, there are many behavior problems whether the child also has ODD or not
    - 60% of children with ADHD also have a comorbid diagnosis of ODD or CD
    - In order:
      - » Inattentive Type
      - » Combined Type without ODD
      - » Combined Type with ODD
  - Behavior Modification is the gold standard, which we will cover later

ADHD, Assist, cont.

- If you have the luxury of a parenting group, this is ideal
  - The parenting group can be information and education about ADHD
  - Parenting techniques
  - Or combined

ADHD, Arrange

- Arranging consists of making the necessary arrangements to implement the treatment plan
  - Typically, this involves writing letters, contacting teachers, school psychologists and principals to arrange for appropriate academic accommodations
  - This includes implementation of Section 504 plans or ADA-supported Individual Education Plans
  - It may also include other providers, including the PCP, if he or she is not already integrated as part of the treatment team

ODD/Conduct Disorder

- Assess
  - The same instruments, namely, Conners can be helpful in assessing children for ODD
    - Other possibilities include the Child Behavior Checklist (CBC/Achenbach) or the Achenbach System of Empirically-Based Assessment (ASEBA)
      - http://childbehaviorchecklist.com/
    - Or the Behavior Assessment System for Children-Second Edition (BASC-2)
      - www.pearsonassessments.com/**basc**.aspx
  - This diagnosis is usually easier to make

ODD, Advice

- After proper diagnosis, explain the diagnosis to the parents
  - Usually, reading the DSM-IV criteria is an easy way to start the conversation
  - Then discuss the possible treatments
  - These children require behavioral interventions (in the Biodyne Model, they would be considered “garlic”)
    - They are in denial
    - They are only going to change if encouraged to change by behavioral methods (i.e. Behavior Modification)

ODD, Agree and Assist

- Agree
  - After explaining the diagnosis and treatment,
  - Obtain agreement on the treatment plan
  - It is possible to teach parents the basics of Behavior Modification in a few short sessions, and then follow up to assure proper application
- Assist
  - What follows is a short course in teaching parents how to use behavior modification techniques

Basics of Behavior Modification

- Target behavior: the behavior that has been selected for modification. For parents use: “Pinpoint”
  - You can pinpoint two to four behaviors.
  - Pinpoint refers to the description of the behavior in terms that anybody involved can agree that is the behavior intended for modification.
- Decide on an intervention:
  - Either DRO or direct reinforcement
  - Either an immediate reinforcer or a conditioned reinforcer
- Decide on a set of reinforcers (or Menu). If the parents are stuck, use the Premack Principle.

Behavior Modification

- Problems:
  - Parents are reinforcing different behaviors: Make sure that they have clearly pinpointed the behavior and agreed to that.
  - They give up: Make sure that they are convinced and committed to maintaining the process.
  - The children get bored with the reinforcers: Make small changes in the Menu on a regular basis (i.e. weekly).
  - Inconsistent application: Empathize with the parents, help them to become motivated again.

Behavior Modification

- One parent is sabotaging the process: This is a marital issue and has to be dealt with directly.
- If it's not working, there is always a way to troubleshoot it, because we know that properly managed, this system works.

- Check Patterson, G.R. (1975) *Families,* Second Edition. Champaign, IL: Research Press.

Positive Parenting

- Matthew Johnson's Positive Parenting or F.A.M.I.L.Y.
  - **F**ashion a list of family rules
  - **A**dd Good Habit Cards
  - **M**ix in Responsibility via Household Chores
  - **I**nstitute a List of Rewards
  - **L**ove and Encourage Your Children Daily
  - **Y**outh Residential Treatment if Needed (the Nuclear Option)

  - Johnson, M.A. (2001) *Positive Parenting with a Plan.* Anchorage Alaska.
    - drj@family-rules.com
    - www.family-rules.com

Depression, Assessment

- Half of all mood, anxiety, impulse control and substance abuse disorders start by age 14 (Kessler et al. 2005)
- This website has a list of many screening instruments along with links to all of them
  - http://www2.massgeneral.org/schoolpsychiatry/screeningtools_table.asp
- For younger children, the Pediatric Symptom Checklist (PSC) is well validated and very popular (range 4-16 yrs) or the Y-PSC
  - www.tn.gov/tenncare/tenndercare/psceng.pdf

Depression, Assessment, cont.

- For adolescents, you can use the Physical Health Questionnaire for Adolescents (PHQ-A) (range 13-17 yrs)
  - http://depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/
- Typical symptoms of depression may include irritability, and angry outbursts, but more often they resemble symptoms that are very similar to those of adults: Social withdrawal, problems concentrating, lack of energy, crying, feelings of worthlessness or of guilt, thoughts of death or suicide and physical complaints
- Therefore, it is important to also assess the risk of suicide

Depression, Assess, cont.

- Depression is often comorbid with other disorders
  - Anxiety
  - ADHD
  - Asperger's Syndrome

Depression, Advise and Agree

- Advise
  - Once you have arrived at a diagnosis of depression, you need to discuss this with the parents and the implications
  - Older children should be involved in the discussion
    - Parents often know that their child is depressed
    - As usual, there are often feelings of guilt involved
    - Explain the treatment plan
    - Be prepared to discuss expectations for the future
- Agree
  - Obtain agreement with the treatment plan on the part of all the parties involved

Depression, Assist

- Treatment approaches:
  - Antidepressants
    - Antidepressants increase the risk of suicide among teens
      - » Therefore, you want to make sure that if you recommend antidepressants, that regular monitoring is available
      - » Wellbutrin has been blackboxed for use with children and adolescents
      - » In general, the more sedating SSRIs are a better possibility
  - Exercise and other activities are very helpful
    - It is important to get the person to become activated
  - Cognitive Behavioral Treatment is a better choice, compared to other approaches
    - Well-documented as an effective method

CBT for children

- Older teenagers can be taught CBT using any of the traditional approaches
- Younger children, however, can do better with an approach developed for them
- I have used two:
  - One is very simple and was developed by Daniel Amen, M.D., a California neuropsychiatrist, as he likes to refer to himself
    - He is known for using SPECT scans to aid in the diagnosis and treatment of mental disorders
    - His approach follows Beck
  - The other represents an entire program that was developed by Martin Seligman, Ph.D., a research psychologist, who follows Ellis

Killing the ANTs

- I use a form that Amen handed out in one of his workshops
  - "KILLING THE ANTs EXERCISE (How to Gain Control Of Your Mind)"
  - The form explains that "KILLING THE ANTS EXERCISE is for whenever you need to be in control of your mind. It is for times when you feel anxious, nervous, depressed or frazzled. It is for times when you need to be your best. Do this exercise whenever you feel anxious, depressed, sad, angry or out of sorts."
  - There follows some space to write down the specific event
    - This is one of the areas that cause people problem
    - They need to be very specific about the event
  - Next is to write down the negative thoughts (2 or 3 will do) (typically on the first of 3 columns)
  - Next column is to identify the "Species" of ANTs (a standard list of distortions will do)

Killing the ANTs Exercise, cont.

        - These include: All or Nothing Thinking, Always Thinking, Focusing on the Negative, Fortune Telling, Mind Reading, Thinking with Feelings, Guilt Beatings, Labeling, Blame.
    - Finally, the KILL THE ANTs column: Write down a positive thought
        - The clue to a positive thought is the distortion
        - The positive thought is to counter or negate the distortion
- This approach is very simple and can be taught quickly
    - Then give the parent and child several blank sheets of paper to take with them
    - Assign it as homework

Seligman's approach

- Next is Seligman's approach which follows the Ellis method
- Start with a discussion of the Inner Dialog
  - Some children get this very readily, others don't
  - For those who don't:
    - Talk about how they may have a discussion in their heads about whether to do something or not, especially when something is not allowed (or the angel and the devil on their shoulders)

Seligman's Approach, cont.

- Then we move to teaching them about the ABCs
  - A stands for Adversity
  - B stands for Belief (or thought)
  - C stands for Consequence (behavior or emotion)
- Using examples, we discuss typical situations.
  - Try to draw from the child's experiences:
    - "Tell me about a time in the last few days when you got really mad at somebody"
    - That becomes the A
  - "And what did you think about that?"
    - That becomes the B
  - "And then what did you do?" or "How did you feel?"
    - That becomes the C

Seligman's Approach, cont.

- I often ask the parents for more examples that they can remember, and analyze several of them with the ABCs
- I also use the book liberally, which has many drawings, stories and examples
- Then, at some point, I start questioning the B:
  - "What if you found that this was the case, and not that?"
  - "Or what if you thought that…?"
  - "How would you feel then?"
- It's best to talk about D (disputation) and E (energization) after you've had a chance to bring up different alternatives to the B (belief or thought)
- Then you want to show them, that by changing the way they think (B), they can change the way the feel or behave (C)
  - That is the meaning of E (or energization)

Seligman's Approach, cont.

- You can use one of the forms from the book or draw your own:
  - Draw three columns
  - Label them A, B, C.
  - Ask them to do one or two situations for homework
  - When they come back, then work on D and E
- The book has several forms for this

- It's important that the parents learn to use the system in their own lives, as it makes it easier to teach them to the children

Typical Difficulties

- Not doing the homework
  - This happens rarely, but it happens
  - When it does, just practice in the office with other situations they can that happened recently
  - Explain to the parents that research shows that people who do homework in between office visits are more likely to improve
- Forgot to bring the homework
  - Reconstruct it as well as they can
- Not identifying a real event
  - Before you can proceed, you have to be able to identify a real event
  - It does not usually take long to do that, so keep asking what happened

Typical difficulties, cont.

- Can’t identify emotions or can’t identify thoughts
  - Usually, if you listen carefully to the thoughts or the emotions, you can deduce the other part of the equation and say what you think or give multiple choices
- Confusing thoughts and emotions
  - For many people, if you ask how did you feel, they will verbalize their thoughts
  - Paradoxically, if you ask what they think, sometimes they’ll tell you how they feel

Depression, Arrange

- Other services that may be very helpful
  - If medication is a choice, then a referral for a trial, either to the PCP or to a child psychiatrist, depending on the level of comfort of the PCP

References

- Amen, D.G. (no date). Healing ADD: How to recognize & treat six distinct types of attention deficit disorder. Workshop presented in Phoenix, AZ: Institute for the Advancement of Human Behavior.
- Amen, D.G. (1998). *A clinician's guide to understanding and treating Attention Deficit Disorder.* Fairfield, CA: MindWorks Press.
- Seligman, M.E.P. (1995). *The optimistic child.* Boston, MA: Houghton Mifflin Co.

Anxiety, Assess

- Assess:
  - The same instruments mentioned for depression can be used for assessing for anxiety
  - In addition there are two other instruments:
    - SCARED
      - 8 yrs. and older, 41 items measuring general anxiety, separation anxiety, social phobia, school phobia, and physical symptoms of anxiety
      - http://www.wpic.pitt.edu/research (look in Assessment Instruments listings)
  - More information later on the manifestations of anxiety throughout childhood and adolescence

Anxiety, Advise and Assist

- Advise
  - As before, give information about the level of anxiety and its relation to the developmental stages
  - Methods of treatment: The same approaches using CBT for children explained above are very helpful
  - Medications are rarely advised because of their side effects and the limited benefit
- Assist
  - More effective to discuss how to intervene based on the stages of development

Anxiety, Assist, cont.

- It is helpful to view presenting problems in the context of the patient's stage of development
  - Presenting problems are often manifested as deviations from the normal course of development
    - For example, encopresis or enuresis, speech problems
  - Sometimes, the stage of development may precipitate a psychological disorder in the case of a child who is vulnerable for other reasons
    - For example, panic disorders in a prepubescent child
  - At other times the stage of development may potentiate an individual tendency or problem
    - For example, the experience of trauma at a young age may cause a regression leading to secondary enuresis in a four-year old, which would be very unlikely in an eleven-year old.

Anxiety, Assist, cont.

- Transition from one stage of development to another can always be a source of anxiety
- If trauma occurs during a time of transition from one stage to another, anxiety may develop and manifest in different ways
- During times of transition, a transitional object is very helpful
  - For example, a blanket, during the transition from infancy to early childhood (separation)
  - Or a romantic, idealized and unattainable love object (esp. for girls)
- We will consider these following the stages of development

Infancy

- The major developmental task during infancy, in terms of anxiety, is separation
  - This can be a problem when young children are taken to daycare or other places when they are going to be separated from their parents
  - The most effective method is extinction
  - The parent(s) have to drop the child off and leave immediately, completely ignoring any reaction by the child

Infancy, cont.

- The new surrogate should also ignore the child's reaction
  - Often trying to console them is to no avail, as the child is very angry and will not want any substitution
  - Eventually, they will calm down and then may be ready to be soothed
    - It usually takes between 45-90 min.
    - If repeated daily, the time decreases dramatically over the next few days and lasts about a week
    - There is an instance of spontaneous regression, usually 3-5 days later, which is much milder than in the beginning
  - Stopping the process while the child is still crying only creates an intermittent reinforcement schedule, which is very difficult to extinguish

Early/Middle Childhood

- Young children typically have a period of increased anxiety between the ages of 4 to 6
  - This is the transition from early childhood to middle childhood
  - It may also coincide with starting school
  - This is interpreted as a time when they become aware of the world as a dangerous place
  - This is a time when some parents often threaten kids with the “boogey man”
  - If a traumatic event happens at this time, the child will often develop a phobia, may regress, and may develop secondary enuresis or encopresis and/or PTSD

Early/Middle Childhood, cont.

- Treatment approaches:
  - If a behavioral problem develops, treat it as you would any other
  - Phobias should be treated with Systematic Desensitization
    - With the child absent prepare a hierarchy of most-anxiety-producing to least-anxiety-producing steps
    - Teach the parents how to do the desensitization
    - At the point of stopping, it is crucial to return to an earlier point where there was not anxiety
  - Play therapy may be helpful
    - Especially in the cases of truncated grief
    - Or of disasters

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School Refusal

- A common situation that develops is for children who have not been attending day care or preschool
  - School refusal (or school phobia) may manifest at other stages also
  - At this stage, the fear of going to school is also related to separation anxiety
  - Very often it is a “symbiotic” relationship in which the parenting figure (usually the mother) is also experiencing anxiety about the separation
    - The only effective treatment is extinction, as described earlier
    - But mothers are often very reluctant to do this also because of their own anxiety
    - The school also has to be cooperative, and sometimes, it is not

Prepubescent

- There is a period right as puberty is beginning or right before it begins when children are more susceptible to anxiety attacks
  - It is often difficult to find a trigger
  - The hypothesis is that the person is sensing the changes in the body that are ushering a new stage of development
  - They seem to be mostly males
  - The complaint is usually panic attacks
  - Often there is a family history of anxiety or panic attacks

Prepubescence, cont.

- These can be helped by the usual methods:
  - Education: Once it starts, the attack can't be stopped. It must be allowed to run its course.
  - Mindfulness: Observe the thoughts without trying to change them
  - Periods of diaphragmatic breathing combined with mindfulness meditation throughout the day to reduce autonomic system arousal
- It is very helpful to find a transitional object for them:
  - Most of these children want an animal: a kitten or a puppy
  - A grown animal won't do

Early to Middle Adolescence

- School phobias may develop at this time also
- The approach is the same as with a child who is entering school
- Often there are several secondary gains
- Practical problems sometimes develop, such as making sure that the child gets to school
  - These have to be solved usually requiring the cooperation of the school

Late Adolescence

- Romance and romantic involvement
  - This is a time of significant turmoil
  - Transitional objects now take the form of an unattainable love object
    - For girls it is often a celebrity, but it can also be a teacher or coach or friend of the family
      - The romance is usually totally secret
      - But this is a mechanism that predators often exploit to take advantage of minors
  - Anxiety at this time can be related to facing emancipation and leaving home
  - Treatment would be specific to the presentation, with the knowledge of the background, which may be helpful if shared or discussed

Anxiety Summary

- In the case of children it is always helpful to consider the developmental stage of the person as the backdrop of the presenting problem
- Depending on the age and presentation different methods may be useful

Summary

- We reviewed a method of treating children in Primary Care Settings, the Biodyne Model
- We discussed the role of the BCP
- We added applying the 5 As to this method in order to create a structure for services
- We discussed the culture of medical settings and helpful suggestions for adapting to the setting

Summary, cont.

- We reviewed screening scales that are available at no cost from various Internet sites
- We also discussed clinical applications in the treatment of ADHD, ODD, with behavioral interventions
- Next, we covered how to treat depression using two forms of CBT
- And finally, we discussed how anxiety manifests throughout the developmental periods and specific adaptations of CBT for each stage of development

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