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# Childhood Mental Health Diagnoses:

## Overview of Therapy Options

Presented at the
2018 Annual
KAAP Conference

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# Objectives

- Review criteria for evidence-based treatment (EBT) in pediatric psychology
- Overview of specific conditions and EBT
  - Anxiety
  - Disruptive behaviors
  - ADHD
  - Trauma
- Identify resources for continuing education, parent information

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## Evidence-Based Treatment in Pediatric Psychology

Value of Evidence-based treatment

Speed of knowledge

Society of Clinical Child and Adolescent Psychology (2014) created Evidence Based Update series

- Consensus of field around specific topics, diagnoses
- Available through Journal of Clinical Child and Adolescent Psychology (JCCAP) & division website: www.effectivechildtherapy.org
- Rate level of evidence from 1 (Well Established) to 5 (Treatments of Questionable Efficacy)

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## Levels of Evidence- Level 1 Well Established Treatments

Results of RCT trials show:

- Superior to pill, placebo, or another active treatment

*-or-*

- Equivalent to a well-established treatment

Independent research:

- Conducted in 2+ independent settings, by 2 independent teams

High quality **methods**:
Published articles include all 5 of the following:

- RCT design
- Treatment manual (or equivalent)
- Clearly identified population
- Reliable/valid outcome measures
- Adequate analyses and sample size

## Levels of Evidence- Level 2 Probably Efficacious Treatments

At least 2 good experiments show superior to waitlist

*-or-*

Almost well-established, but waiting for more studies (by independent teams, settings)

High quality **methods** (same as Level 1):
Published articles include all 5 of the following:

- RCT design
- Treatment manual (or equivalent)
- Clearly identified population
- Reliable/valid outcome measures
- Adequate analyses and sample size

## Levels of Evidence- Level 3 Possibly Efficacious Treatments

1) At least 1 RCT show superior to waitlist (using the five high quality methods criteria)
Published article includes all 5 of the following:

- RCT design
- Treatment manual (or equivalent)
- Clearly identified population
- Reliable/valid outcome measures
- Adequate analyses and sample size

**-or-**

2) 2+ clinical studies, but not RCTs
Published articles includes all 4 of the following:

- RCT design
- Treatment manual (or equivalent)
- Clearly identified population
- Reliable/valid outcome measures
- ~~Adequate analyses and sample size~~

## Levels of Evidence- Levels 4-5 Experimental Treatments

**Level 4: Experimental Treatments**

No RCTS
-or-
Tested in 1+ clinical studies

**Level 5: Treatments of Questionable Efficacy**

Tested in good group-design experiments and found to be ***inferior*** to other treatment group/waitlist

## Anxiety Case Example

A 10 year old boy comes to clinic with his mother and younger sister. He quietly watches you during the visit, and appears to understand the conversation. His mother mentions that he is extremely shy, is often tearful, and is afraid of spending the night away from home because he thinks something bad will happen to his family. He is afraid of being late, and will refuse to leave the house if he thinks he will be late to school in the morning. At school, he does well on classwork and homework, but often fails tests. He refuses to give presentations in class or raise his hand.

His mother would like to know what she can do to help him, and what to expect in therapy.

## Anxiety Evidence Based Update (2016)

**Conditions:** generalized anxiety, specific phobia, separation anxiety, social phobia
One of the most common reasons for referral
50% of referred youth have an anxiety disorder

**Level 1 Well Established**
Strongest support:
- ★ CBT (including exposure)
- ★ Exposure (without CBT)

Others:
- Modeling: others demonstrate nonfearful response to promote imitation
- CBT with parents: CBT + parent psychoeducation, individual therapy, parent training
- Education (for test anxiety, school phobia)
- CBT Plus Medication

Higa-McMillan et al., 2016

## Anxiety Evidence Based Update (2016)

**Level 2: Probably Efficacious**
- Family psychoeducation
- Relaxation
- Assertiveness Training
- Attention Control
- CBT for child and parent
- Cultural storytelling
- Hypnosis
- Stress inoculation

**Level 3: Possibly Efficacious**
- Contingency Management
- Group therapy

**Level 4: Experimental**
- Biofeedback
- CBT with parents only

**Level 4…**
- Play therapy
- Psychodynamic
- Rational Emotive Therapy (RET)
- Social Skills

**Level 5: No support**
- Assessment/monitoring
- Attachment therapy
- Client centered therapy
- Eye movement desensitization and reprocessing (EMDR)
- Peer pairing
- Psychoeducation (general)
- Relationship counseling
- Teacher psychotherapy

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## Anxiety Evidence Based Update (2016)

**Common Elements in anxiety treatments:**
- Exposure:
  - Develop a fear hierarchy, fear ladder
  - Practice "facing your fears" until calm
- Cognitive:
  - Emotion identification
  - Feelings thermometer, 5 point scale, Subjective Units of Distress (SUDS)
  - Identify anxious thoughts (helpful, unhelpful thoughts)
- Relaxation skills:
  - Deep breathing, progressive muscle relaxation

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## Anxiety Evidence Based Update (2016)

**Role of medication:**

CBT + Sertraline performed better than monotherapies across diagnoses
Especially separation anxiety
Social phobia most difficult to treat
Children with lower severity responded best to treatment

Compton et al., 2014

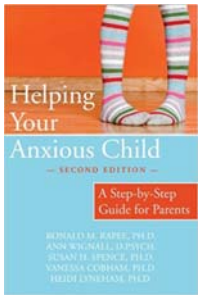
## Anxiety- Parent Resources

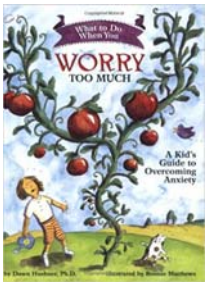
**Specific treatment manuals:**

- Coping Cat (Kendall et al)
- A Modular Approach to Childhood Anxiety (Chorpita)

**Parent resources:**

Helping Your Anxious Child: A step by step guide for parents- Ronald Rapee et al., 2008
What to Do When You Worry Too Much- Dawn Huebner



## Case Example- Disruptive Behavior

A 6 year old girl shares time between her mother and father's homes, as they are separated. Her father brings her in to clinic. She is observed to often interrupt, refuses to do what her father says, argues, and does annoying things (stick out tongue, throw toys, antagonizes siblings). She has meltdowns daily that involve aggression (hitting, biting), cursing, stomping, and screaming. Behaviors occur at both homes and school Her school has started sending home a note each day to track her compliance with completing assignments.

She's been working with a therapist for over a year, since her parents separated. Her father isn't sure what happens in therapy, since her grandmother often takes her.

He wants to know how to get her to stop having meltdowns.

## Disruptive Behavior Evidence Based Update (2017)

**Conditions:** oppositional defiant disorder, conduct disorder
Prevalence= 4.6% of cases based on parent-report of existing diagnosis

Trajectory:
30% of ODD develop CD
40% with CD develop antisocial personality disorder

Kaminski & Claussen 2017

## Disruptive Behavior Disorder- Evidence Based Update 2017

**Level 1 Well Established:**

Group Parent Behavior Therapy (BT)
Individual parent BT with child participation

Kaminski & Claussen 2017

## Disruptive Behavior Disorder- Evidence Based Update 2017

**Level 2 Probably Efficacious**

Group parent BT plus:
- Group child BT
- Child participation
- Family problem-solving training

Individual parent BT
Individual parent BT plus:
- Child participation + individual child therapy w/ parent participation

Self directed parent BT
Group parent-focused therapy
Group or individual child BT
Group or individual child-centered play therapy

Kaminski & Claussen 2017

## Disruptive Behavior Evidence Based Update (2017)

**Level 3 Possibly Efficacious**

Teacher training

Group parent BT plus:

- Teacher training
- Teacher training + group child BT
- Group parent focused therapy
- Individual child behavior therapy
- Individual parent BT with child participation + group child BT + individual child BT

Individual parent BT with child participation + address parent mental health

**Level 4 Experimental**

Family problem-solving training (Collaborative Problem Solving)

Kaminski & Claussen 2017

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## Disruptive Behavior Disorder- Evidence Based Update 2017

**Common elements of disruptive behavior treatments:**

Strengthen parent-child relationship

- Positive attention
- One on one time/special playtime/time-in
- Communication skills

Effective behavior management techniques

- Attention for positive behaviors
- Planned ignoring, time out
- Setting appropriate limits
- Consistent consequences
- Preventing behavior problems

Kaminski & Claussen 2017

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## Disruptive Behavior Disorder- Evidence Based Update 2017

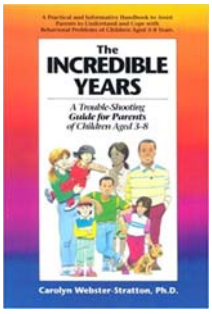
**Specific Treatment Programs/Manuals**

Individual parent training with child participation:

- Parent Child Interaction Therapy/PCIT***
- Helping the Noncompliant Child
- Triple P
- Defiant Child
- Parent Management Training- Oregon (PMTO)

Groups:

- Incredible Years




**Books for parents:**

The Incredible Years (dense!)- Webster-Stratton
1-2-3 Magic! (easy read)- Phelan
Parenting the Strong Willed Child- Forehand & Long

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## Case Example ADHD

A 7 year old boy presents to clinic with concerns of numerous behavioral problems at school and home. He won't sit still, refuses to do work, disrupts and interrupts the other children, constantly loses things, talks loudly and quickly, and is impulsive. He has trouble falling asleep at night. There is a family history of ADHD.

Results of Vanderbilt scales confirm the presence of ADHD Combined Type.

His parents are divorced and one parent is in favor of medication, the other is reluctant to pursue medication.

What do you recommend?

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## ADHD- Evidence Based Update 2014

**ADHD Prevalence: 9% (2016)**

**Level 1: Well Established**

★ Behavioral Parent Training

Behavioral Classroom Management
Behavioral Peer Intervention
Combined Behavior Management Interventions

Organization Training

Evans, Owens, and Bunford (2014)

## ADHD Evidence Based Update 2014

**Level 2: Probably Efficacious**

Combined Training Interventions (school based organization, academic skills, social skills)

**Level 3: Possibly Efficacious**

Neurofeedback Training

**Level 4: Experimental**

Cognitive Training (CogMed)

**Level 5: Questionable Efficacy**

Social Skills training

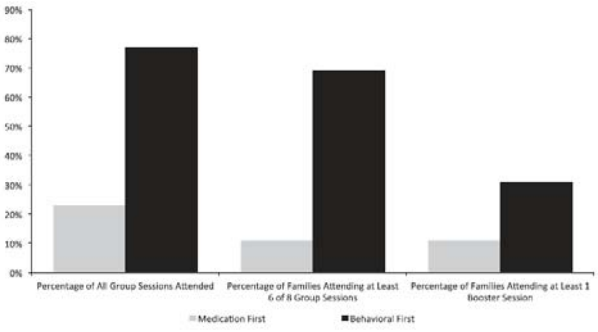
Evans, Owens, & Bunford 2014

## Other ADHD Behavior Tips

**American Academy of Pediatrics:**
**Treatment Recommendations for ADHD**

| Age 4-5 years | Age 6 and up |
|---|---|
| Behavior therapy first, before trying medication | Behavior therapy and medication, preferably together |

Sequencing of Treatment (Pelham et al., 2016)




Children started on a low dose of behavior therapy, followed by adding medication do best

Therapy attendance improves when medication offered second

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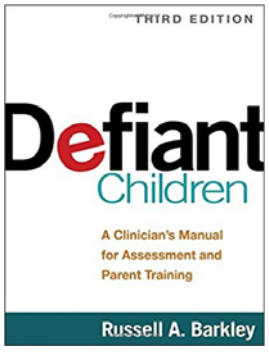
## Other ADHD Behavior Tips

Common therapy elements:
- Daily Report Card
- Teaching parents & teachers elements of BT tailored to impulsivity, inattention, hyperactivity
- Tangible rewards and praise, regularly track progress
- Organization skills, checklists
- Promoting appropriate peer interactions

Specific Treatment Programs/Manualized Interventions:
- **Defiant Child- Russell Barkley**
- Incredible Years
- Parent Child Interaction Therapy (PCIT)
- New Forest Parenting Programme
- Triple P

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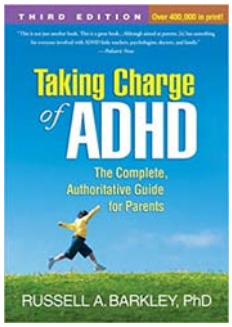
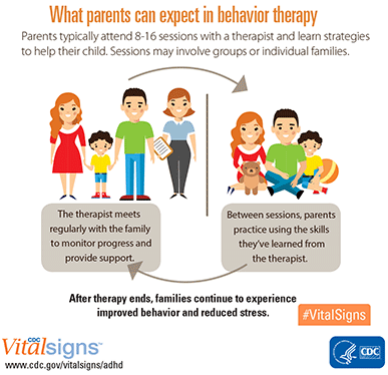
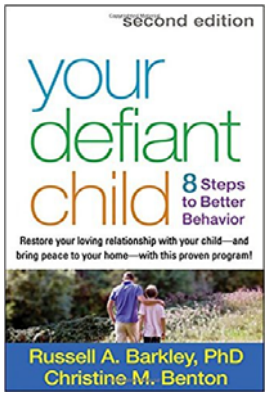
## ADHD- Parent Resources

Parent Resources:

- CDC Handouts:
  - https://www.cdc.gov/ncbddd/adhd/documents/adhd-behavior-therapy-overview-all-ages.pdf
- Your Defiant Child
- Taking Charge of ADHD: The Complete, Authoritative Guide for Parents
- www.chadd.org

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## Trauma Case Example

A 12 year old girl attends clinic with her aunt, who has recently been named as guardian. She was recently placed in foster care due to ongoing neglect and physical abuse in her biological parents' home. She has history of outbursts and disruptive behaviors at school and home, and often engages in work refusal. Additionally, she is extremely shy with new adults. Sleep is a concern, as she has frequent nightmares.

Her aunt is interested in finding a therapist for her, but doesn't know where to go or how to choose a therapist. The girl is reluctant to go to therapy, and wants to know what to expect.

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## Psychosocial Treatments for Trauma- Evidence Based Update 2017

**Conditions**: PTSD, Post Traumatic Stress Symptoms

Prevalence:
- 2/3 children experience a traumatic event
- PTSD: 7% of girls, 3-4% of boys

Traumatic exposure increases risk for other mental health problems:
- Behavior problems: 19%
- Depression: 12%
- Anxiety: 10%

Significant impairment:
Single traumatic event: 22% report impairment
Multiple traumatic events: 50% report impairment

Dorsey et al., 2017

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## Psychosocial Treatments for Trauma- Evidence Based Update 2017

**Level 1: Well Established**

★ Individual CBT with parent involvement
Individual CBT

Group CBT in school, with individual exposure sessions

Dorsey et al., 2017

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## Psychosocial Treatments for Trauma- Evidence Based Update 2017

**Level 2: Probably Efficacious**
Group CBT with parent involvement
Eye movement desensitization and reprocessing (EMDR)

**Level 3: Possibly Efficacious**
Individual Integrated Therapy for Complex Trauma
Group Mind-Body Skills

**Level 4: Experimental**
Individual Client-Centered Play Therapy
Individual Mind-Body Skills
Individual Psychoanalysis

**Level 5: Questionable Efficacy**
Group creative expressive + CBT

Dorsey et al., 2017

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## Psychosocial Treatments for Trauma- Evidence Based Update 2017

**Common Elements of Trauma Therapy:**
- Psychoeducation about trauma prevalence, impact
- Emotion identification
- Cognitive coping (helpful, unhelpful thoughts)
- Relaxation
- Imaginal and/or in vivo exposure
- Cognitive processing
- Problem solving

**Specific Treatment Manual/Manualized Interventions:**
- Trauma Focused CBT (TF-CBT)
  - Includes all common elements above
  - Parent involvement for some parts of CBT
  - Parent behavior management tips


Dorsey et al., 2017

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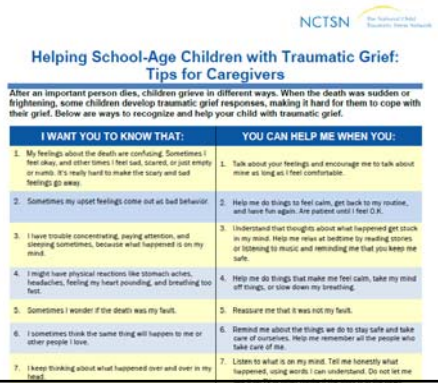
## Psychosocial Treatments for Trauma

**Parent Resources**

National Child Traumatic Stress Network (NCTSN.org)

- Informational pages on types of trauma
- Effective treatments
- Handouts for families, child welfare, justice system, schools, healthcare providers, youth, policy makers
- School advocacy

Dorsey et al., 2017



NCTSN

**Helping School-Age Children with Traumatic Grief: Tips for Caregivers**

After an important person dies, children grieve in different ways. When the death was sudden or frightening, some children develop traumatic grief responses, making it hard for them to cope with their grief. Below are ways to recognize and help your child with traumatic grief.

| I WANT YOU TO KNOW THAT: | YOU CAN HELP ME WHEN YOU: |
|---|---|
| 1. My feelings about the death are confusing. Sometimes I feel okay, and other times I feel sad, scared, or just empty or numb. It's really hard to make the scary and sad feelings go away. | 1. Talk about your feelings and encourage me to talk about mine as long as I feel comfortable. |
| 2. Sometimes my upset feelings come out as bad behavior. | 2. Help me do things to feel calm, get back to my routine, and have fun again. Are patient until I feel O.K. |
| 3. I have trouble concentrating, paying attention, and sleeping sometimes, because what happened is on my mind. | 3. Understand that thoughts about what happened get stuck in my mind. Help me relax at bedtime by reading stories or listening to music and reminding me that you keep me safe. |
| 4. I might have physical reactions like stomach aches, headaches, feeling my heart pounding, and breathing too fast. | 4. Help me do things that make me feel calm, take my mind off things, or slow down my breathing. |
| 5. Sometimes I wonder if the death was my fault. | 5. Reassure me that it was not my fault. |
| 6. I sometimes think the same thing will happen to me or other people I love. | 6. Remind me about the things we do to stay safe and take care of ourselves. Help me remember all the people who take care of me. |
| 7. I keep thinking about what happened over and over in my head. | 7. Listen to what is on my mind. Tell me honestly what happened, using words I can understand. Do not let me |

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## Psychosocial Treatments for Trauma- Evidence Based Update 2017

**Level 2: Probably Efficacious**

Group CBT with parent involvement

Eye movement desensitization and reprocessing (EMDR)

**Level 3: Possibly Efficacious**

Individual Integrated Therapy for Complex Trauma

Group Mind-Body Skills

**Level 4: Experimental**

Individual Client-Centered Play Therapy

Individual Mind-Body Skills

Individual Psychoanalysis

**Level 5: Questionable Efficacy**

Group creative expressive + CBT

Dorsey et al., 2017

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## Additional Evidence Based Updates- J. Clin Child & Adolescent Psychology

- Early Interventions (<5 years) Autism Spectrum Disorder
- *Adolescent* Disruptive Behavior Disorders (presented on childhood DBDs today)
- Child and Adolescent Depression
- Child and Adolescent Bipolar Spectrum Disorders
- Self-injurious thoughts and behaviors
- Pediatric Elimination Disorders (enuresis, encopresis)
- Overweight and Obesity
- Pediatric OCD
- Pediatric Body-Focused Repetitive Behavior Disorders (hair pulling, thumb sucking)
- Adolescent Substance Use
- Child and Adolescent Eating Disorders
- Illegal Sexual Behaviors

## Source for Evidence Based Treatments

Effectivechildtherapy.org

## Source for Evidence Based Treatments

| Tested Therapies for Adolescents | |
|---|---|
| Level One: Works Well | • Overall CBT<br>• Individual CBT<br>• Group CBT<br>• Overall IPT<br>• Individual IPT |
| Level Two: Works | • Group IPT |
| Level Three: Might Work | • Bibliotherapy CBT<br>• Family-based intervention |
| Level Four: Experimental | • Technology-assisted CBT |
| Level Five: Unknown/Untested | • N/A |

To find out more about how these treatment levels are defined, click here.

**Therapies and Terms Defined:**

- CBT: cognitive behavioral therapy
- IPT: individual interpersonal psychotherapy

| Tested Therapies for Children | |
|---|---|
| Level One: Works Well | • N/A |
| Level Two: Works | • N/A |
| Level Three: Might Work | • CBT<br>  • Comprehensive<br>  • Group<br>  • Technology-assisted<br>• Behavior therapy |
| Level Four: Experimental | • Individual CBT<br>• Psychodynamic therapy<br>• Family-based intervention |
| Level Five: Unknown/Untested | • N/A |

To find out more about how these treatment levels are defined, click here.

***Source(s):*** *V. Robin Weersing, Megan Jeffreys, Minh-Chau T. Do, Karen T. G. Schwartz, and Carl Bolano. Evidence Base Update of Psychosocial Treatments for Child and Adolescent Depression. Journal of Clinical Child and Adolescent Psychology. (2016)* http://dx.doi.org/10.1080/15374416.2016.1220310

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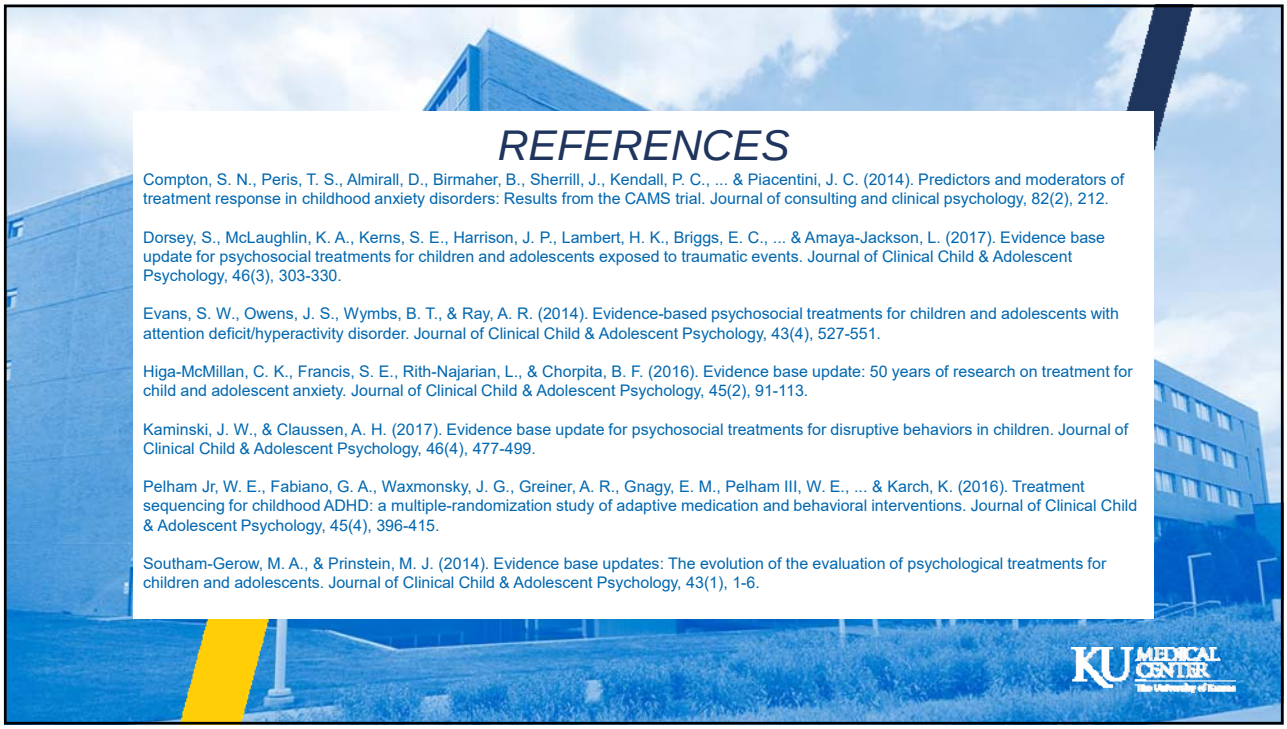

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