

# S I G N e w s l e t t e r

Advancing the Science and Practice of Youth Anxiety

January 2016

Dear SIG members,

It was great to see many of you at the annual convention in Chicago this fall! We had another successful preconference this year with outstanding presentations from Drs. Marc Atkins and Susan Spence, and student travel award winner Jennifer Cowie. Thank you to the newsletter editors and student representatives for putting together a summary of their presentations in this edition of the newsletter.

We also had an excellent group of posters at the SIG poster expo this year. I am excited to announce that the poster award winner is **Aubrey Carpenter** for her poster entitled *Feasibility and Preliminary Efficacy of Internet-Delivered, Family-Based Cognitive Behavioral Therapy for Child Anxiety: A Multi-Site Pilot Study*, under the supervision of Drs. Donna Pincus and Jonathan Comer. Please see a summary of Aubrey's work in this edition. Our runner-up is **Amy Rapp** for her work, *Anxiety Moderates the Influence of Perceived Parental Criticism on Adolescent Depression Treatment Response*, in collaboration with Drs. Denise Chavira and Joan Asarnow. Thank you to everyone who contributed to SIG events throughout the conference.

Included in this newsletter is a list of newly elected members of the SIG executive committee who we are welcoming aboard as well as a list of our outgoing committee members. Our sincere thanks goes out to those who are stepping down from their SIG leadership roles, particularly Dr. Tony Puliafico for his exceptional service as SIG leader.

As we look to the year ahead, the executive committee is eager to develop new opportunities to foster collaboration and connectedness within the SIG. To this end, we are working to put together a video series that will enable us to stay up to date on the latest work from various groups, get feedback and fresh ideas from our colleagues, and help us put faces to names. We welcome suggestions for how to make this resource most useful to our members.

Looking forward to a productive and successful year for the CAASIG!

All the best,

Cara Settipani

SIG Leader

## Happy New Year!

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## **SIG Announcements**

We are extremely excited to announce the newest executive committee members of the Child & Adolescent Anxiety SIG. We look forward to collaborating closely with you!

### **Incoming SIG Executive Committee Members:**

Leader-Elect - Clark Goldstein, Ph.D.

Membership/Treasury Chair - Kendra Read, Ph.D.

Newsletter Co-Editor - Dana Galler-Hodkin, Psy.D.

Student Representatives - Michelle Clementi, Chris LaLima, Rachel Terry

*We would like to thank the executive committee members who are completing their terms with the SIG. We appreciate all of your dedication and service to the SIG. A special thanks to Dr. Anthony Puliafico for playing a significant role as SIG leader. We are also excited that although Dr. Clark Goldstein & Dr. Dana Galler-Hodkin will be leaving their respective positions of newsletter co-editor and student representative, they are moving on to other positions within the SIG!*

### **Outgoing SIG Executive Committee Members:**

Leader - Anthony Puliafico, Ph.D.

Membership - Courtney Weiner, Ph.D.

Newsletter - Clark Goldstein, Ph.D.

Student Representatives - Christine Cooper-Vince, Dana Galler-Hodkin, & Aubrey Carpenter



**Additionally, we would like to congratulate the winning research contributors. Please find the summaries of their work in this newsletter.**

**SIG Poster Expo Winner- Aubrey Carpenter**

Feasibility and Preliminary Efficacy of Internet-Delivered, Family-Based Cognitive Behavioral Therapy for Child Anxiety: A Multi-Site Pilot Study, *Aubrey L. Carpenter* and *Donna B. Pincus*, Boston University, and *Jonathan S. Comer*, Florida International University

**Student Travel Award- Jennifer Cowie**

Parental Involvement in Infant Sleep Routines Predicts Differential Sleep Patterns in Children with and without Anxiety Disorders, Jennifer Cowie, Cara A. Palmer, Ph.D., Hira Hussain, & Candice A. Alfano, Ph.D.: University of Houston, Houston, TX

**We would also like to acknowledge the SIG poster Expo Runner Up, Amy Rapp.**

Anxiety Moderates the Influence of Perceived Parental Criticism on Adolescent Depression Treatment Response, *Amy Rapp*, *Denise A. Chavira*, and *Joan R. Asarnow*, University of California, Los Angeles

**Feasibility and Preliminary Efficacy of Internet-Delivered,  
Family-Based Cognitive Behavioral Therapy for Child Anxiety: A  
Multi-Site Pilot Study**

Carpenter, A.L.<sup>1</sup>, Furr, J.M.<sup>2</sup>, Pincus, D.B.<sup>1</sup>, & Comer, J.S.<sup>2</sup>

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<sup>2</sup>Mental Health Interventions and Technology (MINT) Program, Florida  
International University

Empirical support for the use of CBT to treat child anxiety has steadily grown (Silverman et al., 2008). However, few children with mental illness actually receive treatment (Comer & Barlow, 2014), and among those who do, few receive evidence-based treatment. Internet-delivered CBTs using videoconferencing can offer opportunities to bypass common treatment barriers and strengthen the ecological validity of care by providing real-time feedback in families' natural settings. To date, research supports the preliminary feasibility, acceptability, and efficacy of I-CBTs for child anxiety with minimal therapist contact (Donovan & March, 2014; Khanna & Kendall, 2010; Spence et al., 2011), but research is needed to examine the utility of videoconferencing methods for real-time treatment.

This poster presentation reported results from a recent multiple-baseline trial (N=5) examining preliminary outcomes from a feasibility trial of an Internet-delivered, well-supported CBT program for child anxiety (Kendall et al., 2008). Enrolled youth ages 8-10 years had a primary DSM-5 diagnosis of Social Anxiety Disorder (SOC), Separation Anxiety Disorder (SAD), or Generalized Anxiety Disorder (GAD). The sample was recruited from Boston, Massachusetts (n=3) and Miami, Florida (n=2), and was 60% female and 80% Caucasian non-Hispanic. This sample was also diagnostically diverse, with all participants meeting DSM-5

criteria for at least two disorders. At the initial evaluation, participating families came into the clinic and completed the Anxiety Disorders Interview Schedule (ADIS), Child and Parent versions, and several child- and parent-report measures of child and parent anxiety symptoms. If found to be eligible, families were randomized to a brief wait list of either two, three, or four weeks' duration before completing a second ADIS and the same measures to assess for stability of symptoms during the control phase. Following this second baseline evaluation, participants initiated the family-based CBT protocol, which was delivered once per week in real-time by the first author over videoconferencing software for four months. Following treatment, all participants completed another ADIS and the same measures (Post-treatment Assessment).

Eighty percent of participants completed treatment (n=3 Boston cases, n=1 Miami case) whereas one participant in Miami dropped out of treatment after ten sessions due to difficulties with engagement and parenting stress. Of the four cases that completed treatment, three (75%) were considered to be excellent responders (CGI improvement score of much improved or very much improved) whereas the remaining case (25%) was minimally improved. Symptom reductions were observed on a parent-report measure of anxiety (Multidimensional Scale for Anxiety in Children) and diagnostic improvements were observed following completion of both child-report and parent-report diagnostic interviews (ADIS) with an independent evaluator. Notably, the minimally improved case (BU site) and the case who prematurely dropped out of treatment (FIU site) both had secondary diagnoses of Attention Deficit Hyperactivity Disorder (ADHD) and parents of both cases cited inattentive symptoms as having a direct impact on treatment, whereas the other three completers did not hold an ADHD diagnosis. All parents of cases who completed treatment reported high satisfaction with the videoconferencing-based intervention, whereas the parent of the case who prematurely dropped out of treatment endorsed moderate satisfaction with the intervention. Preliminary results suggest that Internet-delivered CBT is both efficacious and satisfactory for families of children ages 8-10 with a primary diagnosis of SOC, SAD, or GAD, but that diagnostic comorbidities such as ADHD may be associated with poorer outcomes.

## **Parental Involvement in Infant Sleep Routines Predicts Differential Sleep Patterns in Children with and without Anxiety Disorders**

Jennifer Cowie, M.A.,<sup>1</sup> Cara A. Palmer, Ph.D.,<sup>1</sup> Hira Hussain, B.S.,<sup>1</sup> & Candice A. Alfano, Ph.D.<sup>1</sup>

<sup>1</sup>Sleep and Anxiety Center of Houston (SACH), Department of Psychology, University of Houston, Houston, TX

### **Introduction**

Many children with generalized anxiety disorder (GAD) report significant sleep-related difficulties, which correspond with greater anxiety symptom severity and impairment (Alfano, Ginsburg, & Kingery, 2007). Early sleep problems also robustly predict later anxiety symptoms and disorders (Gregory et al., 2005); however, few studies have explored the origins and development of sleep problems in clinically-anxious children.

Parental over-involvement in infant sleep routines such as feeding, cuddling, and rocking ranks as one of the most robust predictors of early sleep problems, promoting a pathway for later problems, theoretically by undermining infant self-regulation (Simard, Nielsen, Tremblay, Boivin, & Montplaisir, 2008). Parental over-involvement more generally limits a child's sense of self-efficacy and autonomy and is implicated in etiological models of childhood anxiety (Rapee, 2001). Alternatively, lax disciplinary practices regarding sleep, such as allowing children to sleep in the parents' bed, are frequently endorsed by parents of anxious children (Thompson-Hollands, Kerns, Pincus, & Comer, 2014). Consistent rules and firm disciplinary practices are nonetheless essential for ensuring adequate sleep throughout development.

Examination of parent-child sleep-related interactions in infancy may explicate developmental risk factors for anxiety and pinpoint specific entry points for intervention. Therefore, the first aim of this study was to compare infant settling strategies between parents of children with GAD and typically-developing control children. We hypothesized that parents of

children with GAD would report higher levels of involvement in infant sleep routines compared to typically-developing children, even when controlling for parental anxiety symptoms. The next aim was to examine relationships between infant settling strategies and sleep patterns (actigraphy-based and self-reported) during childhood within both groups, accounting for current disciplinary practices. Based on developmental models of both sleep-wake regulation and anxiety, we hypothesized that greater involvement in infant settling for sleep would be associated with more actigraphy-based sleep problems during childhood. Finally, because research shows low correspondence between objective and subjective sleep data among anxious youth (Alfano, Patriquin, & De Los Reyes, 2015), we explored relationships between parent settling strategies in infancy and children's subjective reports of current sleep problems.

### **Method**

N=84 children with a primary diagnosis of GAD ( $n = 44$ ) and healthy controls ( $n = 40$ ) participated. Children were ages 7-11 years ( $M = 8.80$ ,  $SD = 1.40$ ), roughly half female (52.4%), and mostly Caucasian (59.5%). Most participating parents were biological mothers. Most caregivers were married (84.52%) and had a college (39.29%) or advanced degree (40.48%). About half the sample (54.8%) reported a household income above \$100,000. Consenting families underwent a comprehensive diagnostic evaluation and completed questionnaires. Children then wore wrist actigraphs 24-hours a day and kept a sleep log for 7 days. The Institutional Review Board approved the study protocol and families were paid for their participation.

### **Child-based Measures**

Final diagnoses were determined using the Anxiety Disorders Interview Schedule for DSM-IV- Child and Parent versions (ADIS-C/P; Silverman & Albano, 1996). Objective sleep patterns were assessed via actigraphy, a small accelerometer-based activity monitor that records movement. Variables derived were sleep onset latency (SOL), total sleep time (TST), and wake after sleep onset (WASO). Children also completed the Sleep Self Report (SSR; Owens, Maxim, Nobile, McGuinn, & Msall, 2000), a 26-item questionnaire assessing sleep during the past week. Children rated current parental behavior using the Lax Discipline subscale of the Children's Report of Parental Behavior Inventory (CRPBI; Schaefer,



1965). This subscale indicates parents' lack of engagement (higher scores = more lax discipline).

### **Parent-based Measures**

Parents completed the Sleep History Questionnaire (SHQ), a measure developed for the current study to assess bedtime/sleep routines during the first six months of the child's life. Parents were asked how often they: 1) rocked the infant to sleep before bed; 2) put the infant to bed already asleep; 3) nurse/fed the infant before sleep; and 4) slept in the same bed with the infant, from 1 = "always" to 5 = "never". The SHQ also assesses for the presence of health issues that may disrupt infant sleep or influence proclivity of parental involvement in sleep routines (e.g., sleep apnea, reflux, colic). Parents reported on their own anxiety using the Anxiety Subscale of the Brief Symptom Inventory (BSI; Derogatis & Spencer, 1993).

### **Results**

Preliminary analyses revealed significant group differences in maternal education, parental anxiety, and child preterm birth. These variables were therefore entered as covariates in subsequent analyses. Correlation coefficients indicated parental anxiety was associated with co-sleeping with infants in both the control,  $r = .64, p < .001$ , and GAD groups,  $r = .38, p = .01$ .

Mothers of children with GAD rocked their infant to sleep,  $F(1, 77) = 4.75, p = .032$ , and had infants already asleep when put down to sleep,  $F(1, 77) = 4.02, p = .049$ , significantly more often than controls. Among controls, being rocked to sleep was positively related to WASO and SOL, and co-sleeping was negatively related to TST in childhood. In the GAD group, current lax discipline was positively related to SOL and being rocked to sleep as an infant was positively associated with TST in childhood.

Hierarchical linear regression models were conducted separately by group to examine whether infant settling strategies predicted childhood sleep patterns beyond the influence of current parental disciplinary practices. Among control children, being rocked before sleep significantly predicted greater WASO and co-sleeping predicted lower TST. For children with GAD, being rocked before sleep significantly predicted greater TST and lower WASO after current parental disciplinary practices were entered into



the model. No significant associations emerged between child-reported sleep problems and infant settling strategies.

### Discussion

The current study is the first investigation we are aware of to retrospectively examine parent sleep practices during infancy among clinically-anxious and non-anxious children. As hypothesized, parents of children with GAD reported rocking their infants to sleep and putting them down when already asleep significantly more often than control parents. These group differences may be attributed to a number of factors including intrinsic factors in infants that elicit greater parental intervention for nighttime self-soothing (e.g., difficult temperament), parental factors such as cognitions regarding sleep, and/or their interaction. Interestingly, higher levels of involvement in infant sleep routines predicted better objective sleep patterns during childhood for children with GAD but worse sleep for controls. Although preliminary, these findings suggest that higher levels of parental sleep involvement occurring early in life (i.e., infancy) may exert a positive influence on later sleep outcomes among children prone to anxiety, possibly by facilitating early self-regulatory abilities. An association was also found between prolonged SOL and current lax discipline among children with GAD, highlighting the potential benefit of targeting parent limit-setting, broadly, in families of anxious children.

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**“Future Directions for Dissemination and Implementation Science: Aligning Ecological Theory and Public Health to Close the Research to Practice Gap”**

Marc Atkins, Ph.D.

University of Illinois, Chicago

*\* As summarized by Aubrey Carpenter, M.A., Student Representative & edited by Dr. Marc Atkins*

The Child and Adolescent Anxiety SIG members were fortunate to hear an innovative and compelling presentation by Dr. Marc Atkins based on a recent paper from his group on future directions for dissemination and implementation science (Atkins, Rusch, Mehta, & Lakind, 2015). Dr. Atkins first discussed a call to merge basic research and applied research in an effort to promote science that will influence changes at the community level and therefore produce more impactful outcomes. He raised the point that large-scale efficacy trials are actually directly affecting a very small number of youth, but efforts to change community-based attitudes towards pursuing mental healthcare are likely to influence a larger population of individuals in need of such services. Dr. Atkins raised many issues related to problems with the way treatments are disseminated, particularly emphasizing that there are too many different treatments for consumers to choose from. As a comparison, he described how the World Health Organization responded to the H1N1 virus through a three-tier public health approach to effectively reduce the risk of spread of the virus, prioritize vaccination to the most vulnerable populations, and to promote a public health campaign to reduce the risk of infection. Dr. Atkins noted that in behavioral health, dissemination and implementation research should follow a similar public health approach for mental health promotion to most effectively reach the most in need and reduce the burden of mental health (Atkins & Frazier, 2011).

Dr. Atkins also provided very useful commentary on how he and his colleagues have addressed systemic and political barriers to dissemination by partnering with local schools and agencies to train key informants, such as teachers and other school staff, at the community level. Dr. Atkins emphasized that key informants elicit change by shifting attitudes of their

social networks, rather than the behaviors themselves. He argued that schools are an optimal setting to focus on, given that the majority of mental healthcare occurs or is at least initiated in the school setting. Dr. Atkins argued that these key informants will need our professional help in determining *how* to change those attitudes, as raising awareness and education about particular mental health topics is likely not enough. Instead, Dr. Atkins proposed a collective effort to train school-based and community-based key informants as agents of change in promoting preventative and intervention services for youth. Only then, he argued, will we see influential changes on a large-scale level (Atkins & Lakind, 2013; Atkins, Shernoff et al. 2015).

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## **The Use of Internet-Based and Mobile Tools in the Treatment of Anxiety in Young People – Where to Next?**

Susan Spence, Ph.D.  
Griffith University

*\*Presentation summarized by Monica Wu, M.A. and edited by Dr. Susan Spence*

With the advent of technology, there has been a rise in the incorporation of electronic mediums in the administration of psychotherapies. Varied terms have been used to describe this integrative approach, such as “e-mental health” and “e-therapies.” Diverse modes of intervention have been rapidly developing, and they often vary in the level of interactivity. For instance, individuals can interact via text messages, online counseling, online communities, and virtual reality modalities, and the involvement can range from self-help interventions to fully integrated mediums.

As many individuals don't receive the necessary interventions, electronic mediums of receiving treatment may help facilitate dissemination. Indeed, young people have easy access to the internet and are technologically proficient. Anonymity is often a desired outcome of these methods as well, with many of these individuals preferring an online/phone interaction versus a face-to-face meeting. Furthermore, the large majority of these individuals seek information online in response to a mental health issue, serving as a primary source of information (e.g., insight into others' experiences, types of treatments available). Despite the increased popularity in these modalities, there has been limited uptake by clinicians. There are myriad reasons for this hesitance, with many clinicians having concerns about the perceived lack of skills/training, security, effectiveness, risk of self-harm, low rate of compliance, and drop-out rates. However, recent developments within the world of cognitive-behavioral therapy (CBT) have been emerging, with various randomized controlled trials (RCTs) supporting their effectiveness.

Collectively, CBT tools and apps for child and youth mental health can target general emotional wellbeing or specific mental health problems. It follows that these applications can also range in the content (specific skills/therapy component versus multiple therapy elements) and method of administration (e.g., mobile apps versus website) as well. The BRAVE-

online program, in particular, is an exemplar for mitigating anxiety in children and youths. Specifically, it is an online CBT program based in Australia that is packaged into different versions (e.g., self-help and therapist versions, age-specific versions) and typically entails approximately 10 weekly sessions with some parent sessions built in. The content includes traditional CBT concepts, such as psychoeducation, recognition of somatic responses to anxiety, and exposures. To capture the interest of the user, a “brave trainer” is used and presented through interactive games, colorful graphics, automated e-mails, and quizzes to consolidate learning. Results from 4 RCTs were reviewed, with the final takeaways as follows: (1) individuals seemed interested in these modalities of treatment, (2) there was a strong interest from schools, (3) compliance is generally low for the self-help program, as is the case for many self-help interventions, but good if there is brief therapist support, and (4) if participants completed 4-7 sessions, significant treatment gains and reductions in anxiety were observed, of moderate effect size.

Looking forward, there are still gaps in the extant literature that need to be filled to help augment the efficacy of online/electronic modalities of administering treatments to these children and youths. It is imperative to devise ways to increase compliance with self-help methods of treatment and also discern what factors may impact motivation. Breakdowns of which elements of treatment are most effective need to be conducted and program designs should be evaluated. Additionally, to help facilitate the dissemination of treatment, it would be important to determine the types of personnel that are able to facilitate these programs (e.g., teachers in the schools). Ultimately, it is evident that the field of internet-based and mobile tools for the treatment of anxiety is rapidly growing and will benefit from further development.

# **SAVE THE DATE!**

## **ABCT 2016 Convention**



**October 27th-October 30th**

**New York City**