The Child & Adolescent Anxiety SIG Newsletter

Advancing the Science and Practice of Youth Anxiety April 2011

Letter from the SIG Leader and Newsletter Editors

Dear Child & Adolescent Anxiety SIG Membership,

We hope that you all are enjoying the beginning of Spring! We are pleased to bring you our first CAASIG *Newsletter* of 2011, along with some important SIG-related news and updates. First and foremost, we would like to express our gratitude to Jon Comer, who will be stepping down as Newsletter Co-Editor due to his new fatherhood! A big thank you to Jon, from all of us, for his hard work, dedication, leadership, and creativity as co-editor for the past 2 terms! In this vein, we would like to announce a call for applications for the Newsletter Co-Editor position (see page 2 for details).

In addition, we are excited to provide a recap of CAASIG-related events from ABCT 2010 in San Francisco, including a list of our student poster presenters and research summaries from our student award winners, Andrea Letamendi (Student Travel Award Winner) and Valerie Noel (Student Poster Award Winner). Congratulations again to Andrea and Valerie, and to all of our student poster presenters!

Also in this edition, our terrific student representatives, Laura Skriner, Emily Bilek, and Shelly Gonzales, bring you a special *Student Corner* entitled "*The Quest for Funding*", featuring tips and resources for applying for external research funding, and an interview with Temple graduate student, Rinad Beidas. Finally, we have included some job postings/training opportunities from our child anxiety research colleagues at NYU and Penn. We encourage you all to check out these resources, updates, and more online at our website, **www.childanxietysig.com**.

As you read about the exciting changes and growth happening in our SIG, we hope you are all getting excited for this year's conference and CAASIG activities in Toronto! We encourage you to renew your membership by completing the Renewal Form on p. 14, including a convenient PayPal option, either online or by fax. Please contact Anthony Puliafico (puliafia@childpsych.columbia.edu) for changes of email address or membership-related issues, and Adam Weissman or Candice Alfano with any ideas or contributions to the newsletter. To post to the CAASIG listserv, simply send an email to **caasig@listserv.temple.edu**.

As always, thank you all for your continued support of our SIG and we look forward to seeing everyone in November!

Sincerely,

Muniya Khanna, Ph.D., SIG Leader (muniya@mail.med.upenn.edu)
Candice A. Alfano, Ph.D., Newsletter Co-Editor (calfano@cnmc.org)
Jonathan S. Comer, Ph.D., Newsletter Co-Editor (jcomer@bu.edu)
Adam S. Weissman, Ph.D., Newsletter Co-Editor (aweissman@jbcc.harvard.edu)

In this issue:

-- Published by the Child and Adolescent Anxiety SIG. The contents of this newsletter have not been reviewed, approved, or endorsed by the Association for the Advancement of Behavior and Cognitive Therapy.

SIG Elections

Call for Applications for Newsletter Co-Editor

If you are interested in applying, please submit a brief bio to muniya@mail.med.upenn.edu

Thank you, Jon Comer, for your dedication and leadership as Newsletter Co-Editor, and congratulations on your new baby girl!!!

SAN FRANCISCO 2010 ABCT CAASIG RECAP

Emily Bilek, B.A., Shelly Gonzales, M.S., & Laura Skriner, M.A.

Somehow it is already spring of 2011. 2010 has already come and gone, and with it, another wonderful ABCT, this year in San Francisco. In case you missed the festivities, we'll take a moment to recap the Child and Adolescent Anxiety SIG highlights.

This year, the SIG treated us to a fabulous full-day pre-conference entitled "*Recent Advances in Child Anxiety Treatment Dissemination and Implementation.*" The preconference kicked off with a dynamic keynote address from Dr. Bruce Chorpita about the importance of moving treatment research away from treatment development and toward knowledge management. He spoke of the profound evidence supporting cognitive behavioral treatments for anxiety, and emphasized that it is now time to unbundle and disseminate these skills in a way that will provide the most utility to community clinicians and providers. He discussed the problem of "information overload" faced by practitioners seeking guidance from the research literature for "How to decide what to do with a client?" He proposed the adoption of a "knowledge management" approach – defined in the communications field as a strategic and systematic approach to capitalize on what an organization knows – to move toward a unified and systematic method for turning knowledge gained through research into an accessible and usable form for the individuals who need it (i.e. practitioners) and can apply it to solving problems. As an example, Dr. Chorpita discussed his recent research applying the distillation and matching model (DMM; Chorpita, Daleiden, & Weisz, 2005) to create a map of evidence-based treatment practices with favorable outcome data for children and adolescents that can serve as a usable guidepost for practitioners to either select an evidence-based protocol or design an ad hoc treatment through a selection of practice elements. To paraphrase Dr. Chorpita's summary, we need to be in the business of building knowledge appliances, not just building knowledge.

This talk set the stage for a day of rousing and exciting talks on the subject of treatment dissemination. Among other topics, the day included talks about prevention, measurement development, and psychotropic practices. Additionally, members presented updates on ongoing projects. Overall, the preconference was a great success, and set a high bar for the rest of the conference!

ABCT proper did not disappoint either. This year, the SIG had a strong presence, with at least thirty presentations relating to child or adolescent anxiety and covered a range of topics including, pediatric OCD, quality of life, as well as innovations in CBT. In a symposium entitled "*Innovative Formats of CBT for Child Anxiety: Efficacy, Feasibility, and Acceptability*," speakers presented research on: computer assisted treatment for child anxiety, treatment for individuals experiencing persistent medically unexplained symptoms, intensive treatment for youth with OCD, as well as a one week summer treatment for girls with separation anxiety disorder. These talks, along with the many other child and adolescent anxiety presentations at this year's ABCT underscored the cutting edge and exciting research being done in this field, and the importance of making dissemination a top priority of these efforts.

Congratulations Again to All of Our Student Poster Presenters!!!

1. Noel, V., Francis, S., *A Meta-analytic Review of the Role of Child Anxiety Sensitivity in Child Anxiety*

2. Regan, J., Ebesutani, C., Smith, A., Tung, I., Reise, S., Chorpita, B.F., Higa-McMillan, C., *Application of item response theory to the Positive and Negative Affect Schedule for Children, child and parent versions: A 5-item PA scale for efficient assessment of anxious and depressed youth*

3. Hitchcock, C.A., Chavira, D.A., Letamendi, A.M., Sung, S.C., Sullivan, S., Shipon-Blum, E., Stein, M.B., *Selective Mutism: Relationship with Sensory Integration Problems*

4. Waechtler,V.E., Miller, L.D., *Promoting Resiliency in Children by Fostering Emotional Intelligence*

5. Chan, P.T., Leyfer, O., Pincus, D.B., *Family and Clinical Characteristics of Children and Youth Diagnosed with Generalized Anxiety Disorder*

6. Hayes, L.P., Allen, L.B., Tsao, J.C.I., Zeltzer, L.K., *Correlates of Anxiety and Depression in a Pediatric Chronic Pain Sample*

7. Letamendi, A.M., Hitchcock, C.A., Ball, T.M., Chavira, D.A., Stein, M.B., *A Family Study of PTSD: Predictors of Anxiety in Children of OIF/OEF Soldiers with Posttraumatic Stress Disorder (Preliminary Findings)*

8. Sweeney, C., Ocner, E., Lerner, A.B., Reitman, E., Kim, R.E., Ludwig, K., Ryan, J.L., Masia Warner, C., *Effects of a Group CBT Intervention for Parents of Preschool-Aged Children with Anxiety: An Open Pilot of Strengthening Early Emotional Development (SEED)*

9. Rowley, A.M., Simpson, G.R., Laugeson E., Wood, J.J., Ehrenreich-May, J., *A Multiple Baseline, Pilot Study of a Cognitive Behavioral Treatment for Anxiety in Older Adolescents and Young Adults with High-Functioning Autism*

10. Dunbeck, K.M., Lewis, K.M., Ollendick, T.H., *Does Anxiety Sensitivity Moderate the Relationship Between Maternal Overprotection and Child Levels of Fear and Anxiety in Clinically Anxious Children?*

11. Madden, M.M., Lewis, K.M., Ollendick, T.H., *Do Parent-Child Interaction Styles affect Child Anxiety and Approach Behavior during the Behavioral Approach Task (BAT)?*

12. Ebesutani, C., Regan, J., Smith, A., Kim, H., Reise, S., Chorpita, B.F., Higa-McMillan, C., *Comparison of the Revised Child Anxiety and Depression Scale (RCADS) Anxiety Total scale and Generalized Anxiety scale in measuring the general factor of anxiety in youth: Are both scales really necessary?*

Visit our new website at www.childanxietysig.com to initiate or renew membership online!

CONGRATULATIONS

to the 2010 STUDENT POSTER AWARD Winner:

Valerie Noel

Memorial University of Newfoundland

A Meta-analytic Review of the Role of Child Anxiety Sensitivity in Child Anxiety (Noël & Francis, in press)

Anxiety sensitivity (AS) is the belief that anxious symptoms will have harmful physical, psychological, or social consequences for the individual (Reiss, Peterson, Gursky, & McNally, 1986). The *Childhood Anxiety Sensitivity Index* (CASI; Silverman et al., 1991) is the most frequently used measure of AS in children and adolescents. Two additional measures include the *Anxiety Sensitivity Index for Children* (ASIC; Laurent & Stark, 1993), and the *Childhood Anxiety Sensitivity Index-Revised* (CASI-R; Muris, 2002). Among adults, AS has been demonstrated to be a risk factor for anxiety disorders, particularly panic disorder and posttraumatic stress disorder (Olatunji and Wolitzky-Taylor, 2009); however, inconsistent results have been observed in the child literature. Drawing from Piaget's (1954) theory, children in the concrete operational period of cognitive development (ages of 6 and 11 years) might not have the capacity to associate present internal sensations with future-oriented consequences. Some studies have found predictive validity of AS above that accounted for by either fear or physiological anxiety symptoms in predicting trait anxiety in children (Weems, Hammond-Laurence, Silverman, & Ginsburg, 1998), whereas others have not (Chorpita, Albano, & Barlow, 1996). Evidence has also suggested that youth diagnosed with an anxiety disorder may have higher levels of AS than youth without a diagnosed anxiety disorder (e.g., Hensley & Varela, 2008). Additionally, AS could be a specific vulnerability factor for the development of panic disorder in youth (Kearney, Albano, Eisen, Allan, & Barlow, 1997).The central theme of the debate in the area of child AS and anxiety is at what age are children cognitively capable of experiencing AS and whether there are differences in the relationship between AS and anxiety in different child age groups. The purpose of the present study was to address three key questions that would assist in clarifying current knowledge of the role AS plays in child anxiety: (1) Does the relationship between anxiety and AS demonstrate a consistent pattern in both children (ages 6 to 11 years) and adolescents (ages 12 to 18 years)?; (2) Does AS distinguish anxiety disordered youth from non-clinical youth?; and (3) Does AS distinguish between the anxiety disorders, specifically panic disorder from the other anxiety disorders?

Method

PSYCInfo and SCOPUS were used to conduct the literature searches. Searches were conducted using the following key words in various combinations: *anxiety sensitivity, child, adolescent, panic disorder, generalized anxiety disorder, separation anxiety disorder, phobia, social phobia, posttraumatic stress disorder,* and *obsessive compulsive disorder*. The search yielded a total of 331 articles. Fifteen studies met the inclusion criteria listed below. Studies were included if (a) they were published in a peer-reviewed, English language journal, (b) the age of participants was between 6 and 18 years, (c) the AS outcome measure used was either the CASI, ASI, ASIC, or CASI-R, and (d) the informants were the child participants themselves. In calculating the weighted mean effect size addressing question 1 (does the relationship between anxiety and AS demonstrate a consistent pattern in both children and adolescents?), two weighted mean effect sizes were calculated: the first addressing the unique correlational relationship between AS and anxiety in children, and the second in adolescents. To test whether the difference in the magnitude of the correlations between AS and anxiety differed significantly between children and adolescents, the mean correlations were converted to *z*-scores using Fisher's *r* to *z* transformation (Cohen & Cohen, 1983). In calculating the weighted mean effect size for question 2 (does AS distinguish anxiety disordered youth from non-clinical youth?) and question 3 (does AS distinguish between the anxiety disorders, and specifically distinguish panic disorder from the other anxiety disorders?), Cohen's *d* was used as the unit of effect size. A FailSafe N (FSN) analysis was also conducted for each weighted mean effect size analysis to address publication bias.

Results

The overall weighted mean effect sizes calculated for the unique correlational relationship between AS and anxious symptoms in children revealed a robust small significant correlation indicating that higher anxious symptomatology is associated with higher levels of AS in children after controlling for other anxiety related variables (e.g., physiological arousal; $r = .26$, $p < .01$). With respect to adolescents a robust significant medium effect size was revealed for this correlation indicating that the presence of more anxious symptoms is associated with higher levels of AS after controlling for other anxiety related variables (such as, physiological arousal; $r = .36$, $p < .01$). Finally, a *z*-test was used to test whether the overall correlation between AS and anxiety in children differed significantly from the overall correlation found in adolescents. The correlation between AS and anxiety was significantly higher in adolescents compared to children, suggesting that the relationship between AS and anxiety increases with age ($z = -2.10$, $p = .04$). Anxiety sensitivity in youth diagnosed with an anxiety disorder was then compared to nonclinical youth. The analysis revealed a robust medium and significant effect size ($d = 0.64$, $p < .01$) for the difference, indicating that youth diagnosed with an anxiety disorder demonstrate higher AS than non-clinical youth. Two studies were used to calculate the weighted mean effect size for the difference in AS between panic disorder and the other anxiety disorders (i.e. generalized anxiety disorder, obsessive compulsive disorder, separation anxiety disorder, social phobia, specific phobia, and PTSD). A significant small effect size was observed ($d = 0.40$, $p < .01$) suggesting that youth diagnosed with panic disorder have higher levels of AS compared to children diagnosed with other anxiety disorders, however, a publication bias was probable.

Discussion

Central interest to the present study was whether the correlation between anxiety and AS is similar among children and adolescents in order to determine whether anxiety and AS are two different constructs amongst each of these two age groups. Twenty years of child research has culminated in demonstrating that AS can be experienced by children and adolescents and is a construct that is distinct from anxiety. Additionally, the present study provides evidence indicating that AS is elevated in youth diagnosed with an anxiety disorder compared to non-clinical youth. Furthermore, the present study provides tentative evidence to suggest that youth diagnosed with panic disorder may have greater AS compared to youth diagnosed with other anxiety disorders. These findings from the child literature provide a compelling rationale for future investigations examining hypotheses addressing whether, for example, (1) AS is a vulnerability factor for anxiety in children, (2) AS exacerbates symptoms of anxiety in children, and (3) AS is a maintenance factor for anxiety in children. Additionally, there does remain a dearth of research with regards to the development of AS itself, such as parental contributing factors to child AS (Francis & Noël, in press). However, the findings from this study provide some understanding of the changing nature of the AS-anxiety relationship across childhood and adolescence, which can augment current notions of the developmental trajectory of not only AS but childhood anxiety as well.

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CONGRATULATIONS

to the 2010 STUDENT TRAVEL AWARD Winner:

Andrea M. Letamendi, M.S.
University of California at San Diego

A Family Study of PTSD: Occurrence and Correlates of Anxiety in Children of OIF/OEF Soldiers with Posttraumatic Stress Disorder

Posttraumatic Stress Disorder (PTSD) is a common, disabling anxiety disorder occurring in up to 8% of adults (Kessler et al., 1995; Breslau, 2001). PTSD causes significant psychological, social, occupational, and physical impairment in an individual (Keane, Marshall, & Taft, 2006). However, the impact of posttraumatic stress on parenting, family cohesiveness, and offspring functioning remains an understudied area. Seminal research on parenting and depression (Weissman, Pilowsky, Wickramaratne et al., 2006) has established plausible models on the intergenerational effects of psychopathology. However, only a modest number of studies have placed focus on intergenerational effects of PTSD. Furthermore, the extant literature surrounding PTSD in adult individuals suggests that specific features common to PTSD could potentially be responsible for disruptions in parent-child bonding; e.g., self-isolation, detachment, emotional numbing, dissociation, irritability and anger (King et al., 2006).

PTSD is nearly four times more common in soldiers than in the civilian population (Milliken Auchterloine, & Hoge, 2007; Keane, Marshall, & Taft, 2006). Repeated exposure to warzone stressors results in a constellation of chronic intrapersonal and interpersonal symptoms. The common psychological symptoms of PTSD stemming from combat exposure are shown in Table 1. These impairments raise critical questions about the functioning of interpersonal networks following exposure to such traumas. Of particular vulnerability to disruption of relational bonds is the parent-child dyad, as this relationship constitutes a seminal role in the psychological development of youths. Furthermore, the high incidence of PTSD among soldiers returning from U.S. Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) presents an imminent need for a more advanced understanding of the mental health risks for children in these families. This study examined the relationship between diagnostic data on fathers who were deployed during OIF/OEF and the psychological symptoms in their offspring. Early detection of children at risk for internalizing disorders is important, especially because treatment of these symptoms during mild or prodromal stages may avert the development of full-blown psychiatric disorders in adulthood (Kessler & Wang, 2008).

Methods

Families were recruited via referral from the VA San Diego Medical Center, flyer postings in local military communities, and web advertising. Fathers who had been deployed at least once to either Iraq or Afghanistan during OIF/OEF conflicts with at least one child living at home were eligible. Fathers with PTSD as well as fathers with exposure to combat trauma but no endorsement of PTSD symptoms (i.e., resilient fathers) were recruited. Children ages 6 – 17 with no history of medical or developmental disorders were considered eligible. Fathers and children were provided separate in-person clinical interviews at the UCSD Anxiety and Traumatic Stress Disorders Research Center. Fathers received the Mini International Neuropsychiatric Interview (M.I.N.I.) in addition to self-report measures examining combat trauma exposure, posttraumatic stress symptomatology, depression, substance use, and predeployment functioning. Fathers also completed the Child Behavior Checklist 6-18 (CBCL). Youths were given a clinical interview using the UCLA PTSD Index for DSM-IV (UPID), as well as a brief battery of self-report forms including the Multidimensional Anxiety Scale for Children (MASC) and the Child Depresion Index (CDI). In addition, fathers and youths at least 10 years of age reported on family functioning using the Family Assessment Measure (BFAM) and the Family Adaptability and Cohesion Evaluation Scales (FACES). Families were compensated for their interviews and received referral for individual or family services if indicated.

Results

A total of 21 families are included in the preliminary analyses. The average age of fathers was 35.2 years. Their average number of deployments to Iraq and/or Afghanistan was 3.1. Their average time of OIF/OEF deployment was 9.2 months. The majority of fathers met current diagnostic criteria for PTSD from military trauma (n=15). Using the PTSD Checklist for the Military (PCL-M), their average PCL-M score was 51.5. PCL-M scores for resilient fathers were significantly lower at 27.7. The most common comorbid disorder among soldiers with PTSD was Generalized Anxiety Disorder (GAD) followed by depression. The average age of youth participants was 9.8 years. Girls outnumbered boys at a ratio of 1.57:1.

MASC Total Scores were higher among children of fathers with PTSD (55.2 [19.9]) compared to children of resilient fathers (45.6 [18.5]). The MASC Total Scores mean difference approached but did not reach statistical significance ($t(19)=-1.57$; $p=.14$). Table 2 lists mean comparisons of offspring anxiety and depression between families of fathers with PTSD and those with resilient fathers. One mean difference reached statistical significance: The CBCL Anxious/Depressed Subscale was higher among children of fathers with PTSD (56.9 [7.2]) compared to children of resilient fathers (51 [1.7]) at $p=.0006$. In addition, although only one youth participant met clinical cutoff for PTSD, total UPID scores of children of fathers with PTSD were higher (4.8[15.2]) than those of children of resilient fathers (3.0[2.3]). These indices, however, were not statistically different.

Examination of family functioning data revealed that families of fathers with PTSD scored higher on chaotic structure, rigidity, enmeshment, and disengagement, and lower on flexibility, communication, cohesion, and family satisfaction compared to families of resilient dads (see Table 3). Narratives were recorded during 25-minute unstructured play to capture the perspectives of youth who endorsed anxious or PTSD symptoms. Descriptions of fears, worries, and somatic symptoms were recorded. A six-year old boy stated, "I'm scared at night and have nightmares that my dad might eat me." A thirteen-year old girl stated, "I'm scared of my dad. He changes from happy to angry very fast." An eleven-year old girl reported difficulty sleeping and recurrent nightmares about her father dying.

Discussion

PTSD from combat trauma is extremely common among OIF/OEF servicemen with school-age children. The current study found that self-report anxiety symptoms were more prevalent among youths of fathers with PTSD than those of resilient fathers. Parent-report on youth functioning also demonstrated increased anxious/depressed symptoms among offspring of fathers with PTSD compared to those of resilient fathers. Taken together, scores across externalizing and internalizing subscales trended such that offspring of fathers with Combat PTSD had lower functioning in these areas; however, averages remained below clinical cutoff. The relationship between paternal PTSD and child anxiety/depression may be mediated by attributes in family functioning such as high chaos, rigidity, and disengagement in families of fathers with PTSD. These trends and potential mediators need to be examined further with larger samples of families headed by returning veterans from Iraq and Afghanistan with varying levels of posttraumatic stress symptoms. Identifying at-risk groups in this population addresses a national mental health need, bridges a gap in the trauma literature, and elucidates potential sensitive developmental periods along mental health trajectories.

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Table 1: Common Manifestations of PTSD from Combat in Iraq and Afghanistan

- **Hyper-vigilance**
- **Elevated startle response**
- **Increased irritability/agitation**
- **Sleep disturbances (insomnia, nightmares)**
- **Avoidance of family/friends**
- **Misinterpretation of emotional cues**
- **Depressed mood**
- **Substance Abuse**
- **Impulsivity**
- **Inappropriate social decision making**

Table 2: Youth Anxiety and Depression by Diagnosis of Father

Measure	**PTSD Father**	**Resilient Father**
CDI	9.9 (5.9)	6.0 (6.0)
MASC	55.2 (19.9)	45.6 (18.5)
Physical Symptoms	12.4 (7.3)	7.8 (8.6)
Social Anxiety	12.9 (6.0)	8.0 (5.8)
Harm Avoidance	19.2 (4.7)	18.6 (2.6)
Separation/Panic	10.8 (6.1)	11 (6.5)
Anxious/Depressed T-Score (CBCL)	**56.9 (7.2)***	51 (1.7)

CDI = Child Depression Index; MASC = Multidimensional Anxiety Scale for Children; CBCL = Child Behavior Checklist
* p=0.006

Table 3: Family Functioning by Diagnosis of Father

Measure	**PTSD Father**	**Resilient Father**
BFAM-G T-Scores	60.31 (15.9)	48.7 (17.5)
BFAM-D T-Scores	54.31 (13.5)	45 (9.7)
FACES: *Satisfaction*	23.5 (17.1)	46.5 (28.9)
Communication	41.9 (30.9)	58.3 (33.9)
Flexibility	45.4 (30.9)	60.2 (24.9)
Cohesion	40.9 (32.0)	62.8 (30.9)
Chaotic	36.6 (15.9)	34.2 (15.4)
Rigid	**39.3 (15.9)***	32.0 (9.2)
Enmeshed	27.8 (8.9)	24.5 (7.9)
Disengaged	37 (17.2)	25.8 (14)

BFAM = Brief Family Assessment Measure; FACES = Family Adaptability and Cohesion Evaluation Scales
*p=0.031

Toronto: A Sports City?

For all you CAASIG sports fans, did you know that Toronto has a storied sports history, boasting seven professional sports franchises and many more semi-professional and university athletic teams? Here are some interesting facts about the establishment, history, and championship impact of Toronto's premier professional sports teams!

HOCKEY:

It's no secret that hockey is the apple of Canada's eye, and it comes as no surprise that the **Toronto Maple Leafs** are the pride of Toronto! The organization, one of the "Original Six" members of the NHL, is officially known as the "Toronto Maple Leaf Hockey Club". The Leafs are well known for their long and bitter rivalries with the Montreal Canadiens and the Ottawa Senators. The franchise's 13 championships are second only to the Canadiens, who have 24. However, the Leafs have not won the Stanley Cup since 1967, giving them the longest-active Cup drought in the NHL. At $505 million US (in 2010), the Leafs are the most valuable team in the NHL, followed by the New York Rangers and the Montreal Canadiens.

BASEBALL:

The **Toronto Blue Jays** are an expansion franchise founded in 1977. As just the second MLB team based outside the United States, they became the first and only team outside the U.S. both to appear in and to win a World Series. They also became the fastest American League expansion franchise to win a World Series (winning in their 16th year). Since their fellow Canadian franchise, the Montreal Expos, relocated to Washington, D.C. after the 2004 season (becoming the Washington Nationals), the Blue Jays are currently the only MLB team outside the United States.

BASKETBALL:

The **Toronto Raptors** organization was established in 1995, along with the Vancouver Grizzlies, as part of the NBA's expansion into Canada. When the Grizzlies relocated to Memphis, Tennessee in 2001, the Raptors became the only Canadian team in the NBA. Like most expansion teams, the Raptors struggled in their early years; but after the acquisition of Vince Carter through a draft day trade in 1998, the team set league attendance records and made the NBA Playoffs in 2000, 2001, and 2002. Carter was instrumental in leading the team to their first playoff series win in 2001, where they advanced to the Eastern Conference Semifinals. The Raptors captured their first division title in 2007 under the leadership of Chris Bosh, who left Toronto in 2010 to sign with the Miami Heat, ushering in a new era for the franchise.

FOOTBALL:

Founded in 1873, the **Toronto Argonauts**, a professional football team in the Canadian Football League, are one of the oldest existing professional sports teams in North America—after the Chicago Cubs (1870) and the Atlanta Braves (1871) of Major League Baseball. The Argonauts have won the Grey Cup championship a record fifteen times, most recently in 2004. Having appeared in the Grey Cup a record 21 times, the Argonauts also hold the record for the best winning percentage in the championship game at 71.4%. Additionally, the franchise has the longest current win streak in the Grey Cup, winning their last four appearances (1991, 1996, 1997, & 2004).

SOCCER:

Toronto FC (TFC) is a professional soccer club in the MLS (Major League Soccer), the top professional soccer league in the U.S. and Canada. Toronto became MLS's thirteenth team, and first Canadian team, upon their expansion into the league in 2007. TFC fans have helped make the club one of the MLS' most successful franchises off the pitch, having been profitable since its first year with regular sellouts and sold-out season tickets. The club is the reigning Canadian champion, after winning the 2010 Nutrilite Canadian Championship.

LACROSSE:

The **Toronto Rock**, a lacrosse team in the National Lacrosse League (NLL), was a dynasty in the late 1990s /early 2000s winning five championships in seven years. From 1999 to 2003, the Rock appeared in an NLL-record five straight championship games. In ten seasons, they have an 11-4 record in the playoffs. The Rock play their home games at the Air Canada Centre, which they currently share with the Toronto Maple Leafs of the NHL and the Toronto Raptors of the NBA.

Student Corner

The Quest for Funding

Emily Bilek, B.A., Shelly Gonzales, M.S., & Laura Skriner, M.A.

As if fulfilling the requirements of grad school wasn't stressful enough, more and more students are feeling pressure to obtain their own funding and awards. While the thought of applying may be stressful, there are a variety of fellowship and funding sources available through many different agencies, and there are several potential advantages to obtaining your own funding. Attainment of an award or fellowship can support training opportunities that may otherwise be difficult to complete (e.g., collecting independent data, attending conferences and workshops), and if you're interested in an academic or research career, it can demonstrate your potential for applying for and obtaining a grant (and looks great on your CV!). Funding can come in many shapes and sizes, from a smaller monetary award, to a larger fellowship with full graduate tuition plus a stipend. Individual training fellowships, such as an NRSA, are a great option for students wishing to pursue an academic or research career. However, the NRSA application process can be an intense, time-consuming, and very involved grant-writing experience, which may not be necessary depending on your training and career goals. There are many additional funding opportunities and other types of awards available for more specific purposes. For example, many universities offer student travel awards to attend conferences, and some organizations (e.g., APA) offer dissertation awards to aid students in the completion of an independent project. Finding the right funding mechanism is important, and increasing your knowledge about various funding opportunities is an important first step. Below is some information about different sources of funding, some tips for students seeking to apply, resources to learn about funding opportunities, and a brief interview with a student who was successful in securing her own funding.

We had a chance to speak with Rinad Beidas, a doctoral student at Temple University (currently on internship at University of Illiniois, Chicago), and learn about her experience and success in securing funding from NIH:

Title of Grant: A Comparison of Training Methods for Dissemination (F31 MH083333)
Funding Institute: National Institutes of Mental Health
Faculty Sponsor: Philip C. Kendall, Ph.D., ABPP

1. Can you give us a quick summary of the aims and design of your funded project?

Evidence-based training (EBT) is needed to effectively disseminate evidence-based interventions. This study investigated therapist training and consultation in cognitive-behavioral therapy (CBT) for youth anxiety.

Participants were 115 therapists (age *M* = 35.93; 90.4% female) and identified as Caucasian (67.0%), African-American (13.0%), Hispanic/Latino (5.2%), Asian (4.3%), Native American/Alaskan (.9%), and Other (5.2%). Training content and delivery included: (a) routine training: a workshop that covered a specific treatment program delivered through passive learning, (b) computer training: computer training on a specific treatment program delivered through active learning, and (c) augmented training: a workshop that covered core CBT competencies delivered through active learning. Training success was operationalized as: (a) adherence, (b) skill (both independently rated using the Adherence and Skill Checklist; Beidas, Barmish, & Kendall, 2009), (c) knowledge (Knowledge Test; Beidas et al., 2009), (d) and satisfaction (Training Satisfaction Scale; Tello, Moscoso, Garcia, & Chaves, 2006). The

study also investigated the degree to which consultation following training impacted therapist adherence and skill.

All three training conditions were effective in improving therapist adherence, skill, and knowledge; no significant differences were identified between conditions. Participants were significantly most satisfied with in-person training compared to computer training. Higher consultation attendance significantly predicted higher therapist adherence and skill. The findings underscore the importance of consultation in EBT.

2. How did you decide to apply for an NRSA grant, and did you consider any other funding options?

My mentor, Dr. Kendall, encouraged me to apply for an NRSA grant given my interest in a career in clinical research. I did not consider other funding options.

3. Can you explain a little about the process of applying for this grant?

I began conducting programmatic research in my area of interest during my first year of graduate school. My master's thesis was a pilot study for my dissertation. In my second year of graduate school (2006-2007), I began designing the dissertation study that I applied for NRSA funding with. I submitted the study in August, 2007 for the first time. I ended up submitting it 3 times, and it was funded on the 3rd submission (no longer applicable as submissions are now capped at 2 cycles). I conducted the study and was funded my 5th year of graduate school. The study is now under review at a journal.

4. What was the best advice (if any) you received when starting this process?

To engage in programmatic research so that I could show a history of interest in the area of research I am interested in pursuing.

5. What was the biggest challenge you faced when applying? Any unforeseen obstacles?

The biggest challenge for me was the uncertainty about what score would be funded and the length of the process. It was difficult to apply for something in 2007 and not get funding for it until 2009 although that is the reality of applying for grants. Now that I've gone through this process, I am more prepared for this experience – an advantage to getting acclimated to applying for grants in graduate school.

6. How early before the deadline did you begin the application process?

I began designing the study in my 2nd year of graduate school with my mentor, Dr. Kendall. We submitted the summer after my 2nd year. I did the majority of the writing from May-July of 2007.

7.What is one thing that you wish you had known before applying?

Dr. Kendall provides mentorship in grantsmanship from the beginning of graduate school so I felt prepared for the application process and was not surprised by my experience.

8. When do you think is the ideal time in a graduate career to apply for this type of grant?

It really depends on how long you are applying for funding. It is possible to be funded for more than one year. I was interested in funding for my last (5th) year of graduate school and I applied when there were 3 submissions possible. Given that there are now 2 opportunities for submission, the best time to apply would have been the summer after my 3rd year (I applied summer after my 2nd year). But this would also depend on how many years you plan to stay in graduate school (e.g., 4 vs. 5) and how many years of funding are requested.

9. What's next for you?

I am currently on internship at the University of Illinois at Chicago. The next step is to continue conducting research in dissemination and implementation science.

10. What would you tell other CAA SIG students who are interested in applying for this award?

Engage in programmatic research in your area of interest so that you have a track record of interest. Also, it is never too early to start thinking about applying for an NRSA.

Some additional tips for those beginning the funding search and application process:

1. **Start early** → most applications are not awarded on the first round, so leaving yourself time to re-apply or re-submit is wise and leaves the option of pursuing additional funding mechanisms if one does not work out. Certain fellowships and awards may be a better fit for you depending on where you are in your training. Some fellowships and grants require applicants to have a well-formulated research plan and project, which may be difficult for students in their first year of graduate training, but more feasible for students who are close to writing a dissertation prospectus. Dissertation awards often require applicants to have defended their proposal; and some fellowships are awarded to students who show high academic achievement and a dedication to teaching and conducting research.

2. **Search far and wide, but start by looking around you** → Talk to the Training Director at your grad program to see if there are certain funding mechanisms with which students in your program have had great success. In some programs, NRSAs are common, while in others, students have had better luck with obtaining fellowships though APA, APF, or NSF. We have provided a list of resources to learn about funding opportunities. We also highly recommend visiting your Institution's office of graduate studies or financial aid office in order to learn about opportunities available at your institution. Also, many professional organizations offer dissertation awards or student awards (e.g., ADAA, SRCD). Check out what organizations in your area and in related areas have to offer.

3. **Find a good fit** → For certain types of fellowships, it is important to make sure that your particular project and training goals are in line with the mission of the organization. For example, if you apply for an NRSA, make sure you apply to the appropriate NIH Institute. Let's say you are interested in a proposing a project examining the effects of substance use on the mental health trajectories of youths with anxiety. While applying to NIMH seems like an obvious choice, it would be useful to speak with a Program Officer from NIDA as well, in order to see whether your project might be a good fit with their current funding priorities, and/or how your proposal might need to be modified in order to match their priorities (e.g., would it be an option to collect genetic samples in your protocol?).

4. **Ask for feedback** → In addition to your own faculty mentor, ask other faculty members, post-docs, or more senior graduate students to review your application materials or proposal. Remember that obtaining awards not only makes you look good, but it makes your institution and department look good, so don't feel bad about asking your Training Director or other in your department for feedback on your application.

5. **Keep trying** → if you are unable to secure your first fellowship/award of choice, try again! While it may be disheartening, there are a variety of reasons why some applications are not funded, and if you keep looking, you are more likely to find a funding opportunity that is right for you.

Some helpful websites/resources:

Grants writing tips sheet:
http://grants.nih.gov/grants/grant_tips.htm

NIH resources for grant applicants:
http://cms.csr.nih.gov/ResourcesforApplicants/

F-Kiosk on NIH website:
http://grants.nih.gov/training/F_files_nrsa.htm

Siegle, G.J., Johnson, S.L., Everhart, D.E., Newton, T. (Winter, 2010). Tips on writing national research service award predoctoral fellowship proposals from real NRSA reviewers. The Behavior Therapist.

The Grant Application Writers Workbook:
http://www.grantcentral.com/

APA Scholarships, grants, and awards:
http://www.apa.org/about/awards/index.aspx

CHILD AND ADOLESCENT ANXIETY SIG

Membership/Renewal Form

Name: _____
Title: _____ Degree _____
Address: _____
_____
_____
_____
Phone: _____
Fax: _____
Email: _____
Web Page: _____

Membership Status (check one):

Professional _____	Student _____
$10 (US funds)	$5 (US funds)
for one year	for one year

Are you an AABT member or student member?
YES ____ Note: You must be an ABCT member to join the Child and Adolescent Anxiety SIG.
NO ____

Would you like to join the Child and Adolescent Anxiety SIG Listserve?
YES ____ (make sure email address is included above)
NO ____

<u>To initiate your membership:</u>
Please fax membership form to: Anthony Puliafico, Ph.D. at: 212-246-5792. Then send a check or money order (in US funds), payable to Child and Adolescent Anxiety SIG, to Anthony C. Puliafico, Ph.D., 3 Columbus Circle Suite 601, New York, NY 10019

OR

Use Paypal in 5 easy steps:
1. Go to www.paypal.com. To complete the following steps, you must be a registered PayPal member. If you aren't registered already, follow their directions to "Sign Up," then continue with the following steps:
2. Login to your account.
3. Click on the "Send Money" tab.
4. Enter childanxietysig@yahoo.com as the recipient's e-mail address.
5. Enter the amount and currency type, then hit "Continue."
2. 6. Enter credit card information, review, and hit "Send Money."

ANNOUNCEMENTS

DR. MARTIN FRANKLIN AND COLLEAGUES IN THE

CHILD/ADOLESCENT OCD, TICS, TRICHOTILLOMANIA AND ANXIETY GROUP (THE COTTAGE) OF THE UNIVERSITY OF PENNSYLVANIA

WOULD LIKE TO ANNOUNCE:

MASTER CLINICIAN WORKSHOP:

COGNITIVE-BEHAVIORAL TREATMENT OF PEDIATRIC OCD

JUNE 6 – 7, 2011

AGENDA:

Objective #1: To gain fluency in the diagnosis of pediatric obsessive compulsive disorder (OCD), including the use of evidence-based diagnostic interviews and questionnaires, and to develop a strong understanding of considerations needed for differential diagnosis and comorbid diagnoses.

Objective #2: To briefly review the current empirical evidence on the treatment of pediatric OCD.

Objective #3: To gain in-depth knowledge of the principles and session-by-session content of Cognitive-Behavioral Therapy (CBT) with Exposure and Response Prevention (EX/RP) for OCD.

Objective #4: To refine fundamental CBT skills with an emphasis on successful hierarchy development and implementation of exposure & response prevention techniques.

ATTENDEES: 25 person limit

REGISTRATION: Please call Aubrey Edson or Kristin Benavides at 215-746-3327 to reserve your place in the workshop. You may then fax or mail in a completed registration form and send your payment to the address below, with attention to Dr. Muniya Khanna or complete payment with credit card by phone with Aubrey or Kristin at 215-746-3327.

TIME: 9:00 am to 5:00 pm (8:30 am for check-in and continental breakfast)

COST: $500 (14 contact hours)/$450 for PBTA and NJASP members/$100 for graduate students. Fee covers cost of workshop, handouts and supporting materials, and refreshments during breaks.

CONTINUING EDUCATION CREDIT: This workshop will be co-sponsored by the Philadelphia Behavior Therapy Association (PBTA). PBTA is approved by the American Psychological Association to sponsor continuing education for psychologists. PBTA maintains responsibility for this program and its content. PBTA is also an authorized provider for Continuing Education credits for Professional Counselors, Marriage and Family Therapists and Clinical Social Workers licensed in the state of Pennsylvania. This program provides fourteen (14) hours of CE credits. ***A separate check for $60 must be given to PBTA associate at time of workshop to receive CE Credits***

LOCATION:

This workshop will take place at the University of Pennsylvania in Philadelphia, PA in the **3535 Market Street building on the 4th floor, in Room #4123.**

New York University
School of Medicine
Department of Child and
Adolescent Psychiatry

Paid Clinical Research Position at the Institute for Anxiety and Mood Disorders at the NYU Child Study Center

One paid clinical research position is available beginning July 2011 at the Institute for Anxiety and Mood Disorders at the New York University Child Study Center. This position is available to advanced clinical psychology doctoral students (4-5th year) with a background in CBT and flexible hours for scheduling. The project assistant will be fully integrated into our project, which involves conducting a federally-funded R01 to train school counselors in the treatment of anxiety disorders in schools.

Main responsibilities include conducting semi-structured diagnostic interviews (ADIS) and delivering school-based treatment groups for approximately 16-20 hours per week. Access to a car is necessary, as study sites are located in New Jersey (Union and Morris Counties). Reimbursement for travel to conduct diagnostic interviews will be available. This position also includes opportunities for writing and presenting scholarly work.

Please send a letter of interest, curriculum vitae and two letters of recommendation by March 15, 2011 to:

Carrie Masia Warner, Ph.D.
Associate Professor of Child and Adolescent Psychiatry and Pediatrics
Associate Director of the Anita Saltz Institute for Anxiety and Mood Disorders
NYU Langone Medical Center, Child Study Center
215 Lexington Avenue, 13th floor
New York, NY, 10016
Ph: (212) 263-8919
Email: carrie.masia@nyumc.org

SEE YOU IN NOVEMBER!

ABCT ASSOCIATION FOR BEHAVIORAL AND COGNITIVE THERAPIES