Collaboration Needed to Help Anxious Children

BY BRUCE K. DIXON
Chicago Bureau

ST. LOUIS — In the 1946 movie "It's a Wonderful Life," a highly stressed George Bailey berates his sick daughter's teacher for sending the tyke home without her overcoat on when, in fact, the teacher was blameless.

Bailey's erroneous assumption serves as an object lesson for therapists dealing with children who have obsessive-compulsive disorder and separation anxiety disorder, clinical psychologist Anna K. Boller, Psy.D., said at the annual conference of the Anxiety Disorders Association of America.

"Therapists too often get sucked into the blame game between parents and teachers because they don't take the time to get both sides of the story," she said.

"It's one thing to be the child's advocate, and it's quite another to think that you know the whole world view based on what an 8-year-old is telling his parents. So talking to the teacher is critical," said Dr. Boller, a school counselor at the Waterford School in Sandy, Utah.

Such communication forms the foundation of a collaborative relationship with key adults—including the teacher and parents—in the anxious child's life, said Dr. Boller, who has taught communication courses at the University of Michigan, Ann Arbor, and the University of Illinois at Chicago.

Obsessive-compulsive disorder and separation anxiety disorder are painful for children, and both research-based therapy and a bit of imaginative thinking must be brought to bear, she said.

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DR. BOLLER

"Children with anxiety disorders have functional impairment at both home and school, which is a two-edged sword. The good news is, slight changes in the child's environment, such as seating location and placement in line or timing of daily events, can make a tremendous difference," Dr. Boller said, adding that nothing can be accomplished without forming a collaborative relationship.

"The information you get from talking to the teacher just one time at the beginning of treatment will tell you something you didn't know that's going to be salient to therapy," she said.

Dr. Boller borrows liberally from two books she urges every therapist to own: "Anxiety Disorders in Children and Adolescents, Second Edition," edited by Tracy L. Morris and John S. March (New York: Guilford Press, 2004), and "Talking Back to OCD" by John S. March (New York: Guilford Press, 2006).

Dr. Boller conceded that making contact with angry parents who blame the teacher for their child's problems at school can be intimidating. Once all parties have become involved, it is important to avoid the blame game by maintaining focus on observable behaviors without using or trying to interpret value-laden statements, she said.

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George Bailey (James Stewart) hugs his daughter Zuzu (Karolyn Grimes) before yelling at her teacher in "It's a Wonderful Life."

"The parent may say, 'Joey goes to the restroom frequently to wash his hands because the classroom is such a mess, and everybody's sick because the school makes no effort to maintain hygiene!' Assumptions and blame destroy efforts to help the anxious child," Dr. Boller said.

In addition, the therapist should seek information before giving information. "Don't call the school and say, 'You have a student in your classroom named Mark who has obsessive-compulsive disorder.' Ask questions first and make it clear to the parents that it's important that you be given clearance to talk to the teacher," she explained.

After the initial discussion, the therapist and teacher can track the child's progress by exchanging e-mails. The teacher's role in noticing the child's anxiety triggers cannot be underestimated, she said.

"That initial phone call to the teacher and those follow-up e-mails are going to make all the difference for treatment. It's going to lead to relief of suffering at a more effective rate and empower an increasingly self-confident child," Dr. Boller said. ■

Two ADHD Drugs Continue To Show Benefit in Trials

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN DIEGO — Lisdexamfetamine, the recently approved once-daily medication for attention-deficit/hyperactivity disorder that appears to have low abuse potential, was safe and effective when given for a full year, and guanfacine, an investigational alpha-2A–adrenoreceptor, produced substantial improvement in a phase III trial, according to studies presented at the annual meeting of the American Psychiatric Association.

These studies were among several presented at the meeting on new ADHD medications and formulations expected to greatly broaden the number of treatments for ADHD.

Lisdexamfetamine is a prodrug of dextroamphetamine that is thought to have less abuse potential because the central nervous system is not rapidly exposed to high levels.

In the study, of 272 individuals aged 6-12 years who had been treated in previous short-term trials were followed for up to 1 year. The subjects had a mean improvement of 63% from their baseline ADHD Rating Scale score, and 95% were judged by their treating physicians to be much improved or very much improved, Dr. Ann C. Childress, a psychiatrist from Las Vegas, said in a poster presentation.

The most frequently reported adverse events in the trial were decreased appetite, headache, decreased weight, and insomnia. The study was supported by New River Pharmaceuticals Inc., Radford, Va., which is collaborating with Shire Development, and by funding from Shire.

Guanfacine, in an extended-release, once-daily–dosing formulation, was shown in a phase III clinical trial to improve all the core symptoms of ADHD, including inattention.

In the trial, 322 subjects (aged 6-17 years) with ADHD received one of four doses, ranging from 1 to 4 mg/day, or placebo, Dr. Floyd R. Sallee said in a poster presentation.

After 6 weeks, the mean reduction in the ADHD Rating Scale score for those who got active drug was 19.6 points, from a baseline of about 40 points, compared with a mean reduction of 12.2 points for the placebo group, also from a baseline of about 40 points, reported Dr. Sallee, professor of psychiatry and pediatrics at the University of Cincinnati.

In addition, investigators rated about half of patients as much improved or very much improved, compared with only about 30% of patients who got placebo.

The least-square mean improvements in the inattentive subscale, compared with placebo, ranged from 2.96 points in the 2-mg–dose group to 4.16 points for the 1-mg–dose group. ■

Recurrent Abdominal Pain May Indicate Anxiety Disorder

BY CHRISTINE KILGORE
Contributing Writer

BETHESDA, MD. — Recurrent abdominal pain appears to be part of a larger syndrome of somatization and anxiety, Lynette Dufton reported at a meeting sponsored by the National Institutes of Health Pain Consortium.

Physiologic factors may contribute to pain episodes in children with recurrent abdominal pain, "but I think anxiety is a key part of this," said Ms. Dufton of Vanderbilt University in Nashville, Tenn.

"Providers should assess comorbid psychological symptoms in these children, and maybe refer them for [therapies such as] cognitive-behavioral therapy," she said in an interview at her poster presentation on the study.

Using various parent and child reports of somatization and anxiety, different measures of stress reactivity, and the "cold pressor" test of pain tolerance and sensitivity, Ms. Dufton compared 21 children with recurrent abdominal pain (9 boys) with 21 children with a diagnosed anxiety disorder (11 boys) and 21 children who were well (9 boys). The children in each group had a mean age of either 11 or 12 years.

A total of 67% of the children with recurrent abdominal pain—a problem experienced by 8%-25% of school-aged children—met criteria for an anxiety disorder, compared with 100% of the children with anxiety and 6% of the well children.

On parent and self-reports of somatization and anxiety, such as the Child Behavior Checklist for Ages 6-18 (CBCL/6-18) and the Youth Self-Report, children with recurrent abdominal pain rated significantly higher on internalizing symptoms, such as anxiety and somatic complaints, than did well children.

They did not differ from children with anxiety disorders on the CBCL's measures of anxiety, but they did report significantly more somatic complaints, Ms. Dufton said.

Children with recurrent abdominal pain also reported different levels of stress reactivity on various measures from those reported by well children. On one self-reported measure—the "Responses to Stress Questionnaire"—those children exhibited higher levels of stress reactivity than both well and anxious children.

The cold pressor test measures the length of time one can keep one's hand and arm in ice-cold water (pain tolerance) and rates pain at 40 seconds using a visual analog scale (pain sensitivity). Unexpectedly, there were no differences in pain tolerance among the groups of children, Ms. Dufton said. ■