Anxiety Handouts

From: Handbook of Conceptualization and Treatment of Child Psychopathology, chps 8 & 10

pp. 155-157 specifics about creating graduated hierarchies for *in-vivo* exposure for SAD as well as useful information about the cognitive aspect)

p. 192 (Table 10.1) list of commonly feared situations for children and adolescents with social phobia

pp. 233-236 summary of session-by-session treatment goals for GAD

Cognitive Behavior Therapy for SAD

Cognitive behavior therapy (CBT) is one of the most common and effective treatments utilized for SAD. CBT for SAD consists of three main components: graduated exposure to feared or avoided situations, training in relaxation procedures, and instruction in rehearsal of coping self-statements. The aim of the graduated exposure approach is gradually to increase the child's or adolescent's independent activities, such as attending school or going to friends' homes without anxiety. Relaxation training is taught to help the child/adolescent cope with physiological aspects of anxiety, such as increased heart rate, shortness of breath, dizziness, or nausea, during exposure exercises and also to implement the lessons between sessions while in the real world. Cognitive rehearsal of coping statements also is used to facilitate the child's graduated approach to feared or avoided situations.

In-vivo Exposure

The first treatment component of CBT, graduated in-vivo exposure, involves having the child engage in activities previously avoided in a gradual or stepwise fashion. Initially, a Fear and Avoidance Hierarchy is developed using input from both the child and the parent(s). The hierarchy incorporates feared situations ranging from those that elicit mild levels of anxiety to those provoking extreme anxiety or panic. In instances in which the child both avoids school and other situations involving separation from the parent, two separate hierarchies are constructed. The treatment hierarchy typically consists of approximately ten items; each item explicitly states the activity to be practiced. The hierarchy is developed by including items that vary the feared/avoided situation based on dimensions of significance to the individual child, such as duration apart from the parent, distance from the caretaker, and presence (or absence) of other individuals. Items then are arranged in order from those eliciting minimal anxiety to those evoking maximal discomfort by having the parent and child rate each item on a Likert scale (e.g., 1-10) regarding the degree of anxiety or distress experienced in each situation.

The next step in the graduated exposure procedure is to implement the hierarchical exposure through use of homework assignments. Each homework assignment is negotiated among the child, parent(s), and therapist. It is important to note that the child needs to feel in control of the pace at which he or she progresses. Frequency of practice during the week is dependent on the nature of the particular item, but the child is encouraged to practice as often as possible (typically ranging from once a week to three times per week). The child keeps a record of the date of the practice and provides a Likert rating of anxiety experienced during the assigned exposure. Progression to the next hierarchy item occurs only after the child successfully approaches preceding items with little or no anxiety on at least two consecutive occasions and habituation has occurred.

Whereas the adult empirical literature has established efficacy of graduated

in-vivo exposure therapy in the treatment of agoraphobia and other specific phobias (Barlow & Beck, 1984), there has been less systematic evaluation of this behavioral procedure in alleviating fear associated with separation. Single-case studies (e.g., Ayllon, *et al.*, 1970; Kennedy, 1965) and several controlled investigations (Blagg & Yule, 1984; Hagopian & Slifer, 1993; Last, *et al.*, 1998) have provided preliminary evidence to support the effectiveness of in-vivo exposure to reduce separation anxiety symptoms or separation-related school refusal. In the first of these studies, Blagg & Yule (1984) demonstrated that prolonged in-vivo exposure (i.e., flooding) was superior to inpatient hospitalization and individual psychotherapy plus home tutoring in the treatment of school refusal. Hagopian & Slifer (1993) showed in a controlled case study that school avoidance in a six-year-old girl diagnosed with SAD could be treated successfully using graduated exposure combined with positive reinforcement for successive approximations of independent school attendance. In this latter study, the child received rewards for remaining in the classroom for gradually longer durations while fading the mother's proximity and time spent in the school. Interestingly, Last and colleagues (1998) found that graduated in-vivo exposure was equally effective at reducing school refusal in children with school phobia as an educational, supportive control condition. The authors concluded that psychosocial treatments are effective in returning children to school and alleviating anxiety regardless of whether children participated in a structured cognitive-behavioral treatment approach or a more traditional psychotherapeutic approach. Overall, these studies suggest that a graduated in-vivo treatment approach shows promise in treating separation anxiety symptoms, but more studies clearly are needed to establish its efficacy.

Relaxation Techniques

Relaxation techniques also are used to assist the child with SAD to cope with anxiety. The child is trained in deep muscle relaxation (Jacobsen, 1938), using a technique modified for children and adolescents (Ollendick & Cervy, 1981). Children learn a maximum of three muscle groups each session and practice these skills twice daily at home. Children also select a pleasant imagery scene, such as eating in ice cream or playing on the beach, to enhance relaxation (Graziano & Mooney, 1980). As with cognitive coping statements, relaxation procedures are utilized to facilitate approach behavior during homework assignments on the hierarchy; these relaxation skills can be used during imaginal exposure as well.

Cognitive Component

The second component, cognitive therapy approaches, also can be useful in the treatment of SAD. Using cognitive therapy procedures, the underlying assumption is that the child's maladaptive thoughts, beliefs, attitudes, and self-statements lead to or maintain anxiety-related behavior. The child's maladaptive self-statements,

displayed when anxious, are identified first. Subsequently, more adaptive coping statements are generated that can be used when anticipating or confronting anxiety provoking situations. Such statements for SAD children may include those that stress the child's capability of being independent (e.g., "I can do this on my own."), the fact that their parents will be safe while apart, and self praise (e.g., how brave the child is when he/she is alone). These cognitive self-statements are rehearsed within treatment sessions and then are practiced in the child's environment when confronted with anxiety provoking situations. In particular, these cognitive self-statements are used to assist the child when approaching items on the treatment hierarchy, thus reducing anticipatory anxiety or anxiety experienced during homework tasks.

Mansdorf & Lukens (1987) provided preliminary evidence for the efficacy of cognitive behavioral techniques in a study of two children presenting with school phobia (one also displayed SAD symptomatology). Through use of cognitive techniques, both children improved by the fourth weekly session of treatment. Follow-up assessments continued for three months after the children reached criterion, with no signs of relapse. Additionally, Ollendick, *et al.*, (1991) successfully eliminated nighttime fears and other SAD symptomatology in two children through the use of cognitive therapy combined with reinforcement. Interestingly, addition of reinforcement (e.g., earrings, trips to the mall, verbal praise) was a critical factor in treatment success; indeed, cognitive techniques in the absence of contingent reinforcement produced only slight improvement with one child and no improvement in the second child.

Table 10.1: Commonly Feared Situations for Children and Adolescents with Social Phobia.

Giving oral reports	Answering the telephone or doorbell
Taking exams or quizzes	Attending after-school activities
Calling a classmate for missed homework or assignments	Initiating or joining in conversations with peers
Asking the teacher for help	Situations requiring assertiveness, such as saying no to someone
Walking through the school hallways	Dating
Working on a group project	Having a picture taken
Performance-based activities such as gym class and music lessons	Ordering food in a restaurant
Speaking to persons in authority	Using public restrooms
Calling and inviting a friend to do something	Going to parties
	Writing on the blackboard

Adapted from Albano (1995) and Beidel and Turner (1998).

Table 11.1: Skills and Goals Emphasized in Cognitive-Behavioral Therapy (CBT) Sessions.

Session number	Skill emphasized	Session goals
1	Introduce treatment program to child	1. Build rapport 2. Orientation to program 3. Encouragement of child participation and verbalizations in sessions
2	Identification and normalization of different feelings	1. Continue rapport building and review homework 2. Introduction of concept that different feelings have different physical expressions. 3. Normalization of fears and anxiety 4. Begin construction of a fear/anxiety-provoking situations hierarchy 5. Introduction of a journal to record child's experiences with anxiety
3	Recognition of somatic responses to anxiety	1. Review journal and homework assignments 2. Discuss specific somatic reactions to anxiety 3. Practice recognition of somatic responses to anxiety via modeling and role-play 4. Practice of somatic signal recognition in more stressful scenarios 5. Practice in using somatic responses as cues for increasing anxiety 6. Recording body reactions to anxiety in journal for one full day
Additional session with parents	Parental cooperation in treatment program	1. Provide parents with additional information about treatment plan 2. Give parents an opportunity to discuss concerns about child's behavior 3. Provide examples of situations in which child becomes anxious and his/her specific reactions to fear 4. Give parents specific ways to become involved in treatment
4	Introduction of relaxation as a method for reducing somatic responses to fear	1. Provide child with feedback regarding parent session 2. Review diary assignments 3. Discuss idea that somatic feelings are associated with muscle tension 4. Introduce idea of relaxation and specific relaxation therapy paradigm 5. Elicit suggestions about ways relaxation may be incorporate into daily life 6. Practice relaxation via modeling, role-play and *in vivo* participation 7. Reinforce need for daily relaxation exercise by assigning practice as homework assignment

Table 11.1: Skills and Goals Emphasized in Cognitive-Behavioral Therapy (CBT) Sessions (cont.).

Session number	Skill emphasized	Session goals
5	Recognition of the role self-talk plays in anxiety	1. Review relaxation practice from preceding week 2. Introduce concept of self-talk and relationship to anxiety 3. Detail role of self-talk in experiences specific to child 4. Rehearse self-talk skills via modeling, role-play and *in vivo* practice
6	Modification of anxious self-talk into coping self-talk	1. Review use of relaxation and self-talk 2. Introduce active modification of feelings and self-talk when anxious 3. Develop a problem-solving plan for intervening with anxious thoughts 4. Practice problem-solving under conditions of minimal anxiety 5. Continue practicing problem-solving in increasingly anxiety-provoking scenarios
7	Introduction of appropriate self-evaluation and reward for performance and coping skills	1. Review use of problem-solving and relaxation skills 2. Introduce concepts of self-rating and self-reward 3. Practice making self-ratings and self-rewarding when successful through use of imagined scenarios
8	To review the FEAR plan and practice its usage in non-stressful situations	1. Introduce FEAR acronym (*F*eeling frightened? *E*xpecting bad things to happen? *A*ttitudes and actions that will help? *R*esults and rewards?) 2. Encourage child to carry a wallet-sized copy of FEAR acronym with them to refer to when needed 3. Apply FEAR skills in non-stressful situations 4. Review all major concepts introduced in first 8 sessions 5. Post-session: Prepare several situations which may provoke mild anxiety in child, for use in sessions to assist in imaginary and *in vivo* practice
9	Practice FEAR plan in low anxiety scenarios	1. Utilize imaginary practice with mildly anxiety provoking situations 2. Begin in vivo practice in low anxiety situations 3. Practice relaxation exercises
10	Continue practice of coping skills via in- session practice	1. Discuss coping skills utilized during past week 2. Practice coping skills in session using imaginal exposure 3. Rehearse use of anxiety management through *in vivo* exercises 4. Post-session: prepare scenarios which may provoke moderate anxiety for practice in Session 11

Table 11.1: Skills and Goals Emphasized in Cognitive-Behavioral Therapy (CBT) Sessions (cont.).

Session number	Skill emphasized	Session goals
11	Utilize coping skills learned in situations which produce moderate anxiety	1. Reward appropriate coping skills demonstrated between sessions 2. Practice coping skills that cause moderate anxiety via imaginal exposure 3. Practice these same skills *in vivo*
12	Continue practice of FEAR skills in situations that produce moderate anxiety	1. Continue in vivo practice of FEAR plan in situations that evoke moderate anxiety 3. Ask child to create a poster or other reminder of FEAR plan to hang in child's room
13	Initiate use of coping skills in situations that provoke high levels of anxiety	1. Review self-monitoring of FEAR plan usage 2. Begin practice of coping skills, using imaginal exposure, in highly anxiety provoking situations
14	Begin *in vivo* practice of FEAR plan in high anxiety situations	1. Review journal entries detailing coping skills use 2. Practice use of FEAR plan *in vivo* with scenarios that evoke high levels of anxiety 3. Increase length of time between sessions to two weeks, to decrease dependence on therapy for anxiety management
15	Continue *in vivo* exposure to situations that produce high levels of anxiety	1. Review self-monitoring activities during two week interval between sessions 2. Rehearse *in vivo* exposure exercises in scenarios that produce high levels of anxiety 3. Continue two week interval between sessions
16	Review and summarize training program, emphasizing maintenance and generalization of new skills	1. Review self-monitoring activities during inter-session interval 2. Tape a video in which the child creates a narrative describing their progress and experiences in therapy 3. Schedule a follow-up session for child and parents to review assessment data and bring closure to the therapy process

Source: Kendall, *et al.*, 1992

Anxiety Handouts

From: Assessment and Treatment of Childhood Problems, Schroeder & Gordon, chp 8

pp. 265-266 (Table 8.1) list of normative worries and fears by age

p. 270 (Table 8.2) table for differential diagnosis

p. 276 (Table 8.4) conceptualization as a basis for treatment approach for school refusal behaviors

p. 280-281 eight-item list of anxiety features to distinguish clinically significant anxiety from normative, transient fears

pp. 292-293 thought stopping and how to involve parents/have parents respond to child's anxiety

p. 300 sample progress monitoring chart

TABLE 8.1. Sources of Fears and Worries at Different Age Levels

Age	Sources of fear or worry
0–6 months	Loud noises Loss of support Excessive sensory stimuli
6–9 months	Strangers Novel stimuli (masks) Heights Sudden or unexpected stimuli (e.g., noise, bright light)
1 year	Separation from caretakers Strangers Toilets
2 years	Auditory stimuli (e.g., trains and thunder) Imaginary creatures Darkness Separation from caretakers
3 years	Visual stimuli (e.g., masks) Animals Darkness Being alone Separation from caretakers
4 years	Auditory stimuli (e.g., fire engines, sirens, noises) Darkness Animals Parents leaving at night Imaginary creatures Burglars
5 years	Visual stimuli Concrete stimuli (e.g., injury, falling, dogs) "Bad" people Separation from caretakers Imaginary creatures Animals Personal harm or harm to others
6 years	Auditory stimuli (e.g., angry voices, thunder) Imaginary creatures Burglars Sleeping alone Personal harm or harm to others Natural disasters (e.g., fire, floods) Animals Dying or death of others
7–8 years	Imaginary creatures Staying alone Personal harm or harm to others Media exposure to extraordinary events (e.g., bombings, kidnappings) Failure and criticism Medical and dental procedures Dying or death of others Frightening dreams or movies Animals

(*cont.*)

TABLE 8.1. (cont.)

Age	Sources of fear or worry
9–12 years	Failure and criticism (e.g., school evaluation) Rejection Peer bullying or teasing Kidnapping Dying or death of others Personal harm or harm to others Illness
13–18 years	Social alienation Failure Embarrassment or humiliation Injury or serious illness Natural and human-made disasters (e.g., economic and political concerns) Death and danger

Note. The data are from Gullone (1999), Miller (1983), and Muris, Merckelbach, Gadet, and Moulaert (2000).

TABLE 8.2. Symptoms Associated with DSM-IV Anxiety Disorders

Symptoms	GAD	SAD	OCD	PD	PH	PTSD
Worry						
• About work	×					
• About school performance	×					
• About relationships with others	×					
• About someone close to them being harmed or dying		×				
• About being separated from someone they are close to or a significant person		×				
Recurring experiences						
• Recurrent and persistent thoughts, impulses, images, or behaviors			×			
• Persistent reexperiencing of traumatic event						×
Actual or perceived physical symptoms						
• Restlessness	×					
• Being easily fatigued	×					
• Difficulty concentrating	×					
• Irritability	×					
• Muscle tension	×					
• Sleep disturbance—insomnia, too much sleep, or restless sleep	×					
• Pounding heart or accelerated heart rate				×		
• Sweating for no obvious reason				×		
• Trembling or shaking				×		
• Shortness of breath or feelings of smothering				×		
• Feeling of choking				×		
• Chest pain or discomfort				×		
• Nausea or abdominal distress		×		×		
• Feeling dizzy, lightheaded, or faint				×		
• Numbness or tingling sensations				×		
• Chills or hot flashes				×		
• Hypervigilance						×
• Sleep problems						×
• Irritability						×
• Exaggerated startle response						×
• Concentration problems						×
Fears and/or phobias						
• Fear of losing control				×		
• Fear of dying				×		
• Fear when separated or in anticipation of separation		×				
• Fear of being home alone without adults present		×				
• Fear of being in a social situation where there are unfamiliar people					×[1]	
• Fear related to an object or situation (e.g., heights, animals, flying, blood)					×[2]	
• Persistent avoidance of stimuli associated with trauma						×
Other symptoms						
• Refusal to go to school or to participate in outside activities because of separation		×				
• Nightmares about being separated from others		×				
• Refusal to sleep away from home or insistence on sleeping near someone they are close to		×				
• Feelings of unreality or being detached from themselves				×		
• Consistent failure to speak in social situations, despite speaking in other situations					×[3]	

Note. GAD, generalized anxiety disorder/overanxious disorder; SAD, separation anxiety disorder; OCD, obsessive-compulsive disorder; PD, panic disorder; PH[1], social phobia; PH[2], specific phobia; PH[3], selective mutism. Adapted from Laurent and Potter (1998). Copyright 1998 by Plenum Publishers. Adapted by permission.

TABLE 8.4. A Functional Model for Prescriptive Treatment of School Refusal

Reason for school refusal	Prescriptive treatment
To avoid stimuli that provoke negative affect (crying, stomachaches, distress)	Somatic control exercises and gradual reexposure to the school setting to reduce physical symptoms and anticipatory anxiety
To escape aversive social and evaluative situations	Role play and cognitive therapy to build social skills and reduce social anxiety
To get attention	Parent training in contingency management to establish clear parental commands, regular evening and morning routines, and consequences for compliance and noncompliance
For positive tangible reinforcement	Family contingency contracting to increase rewards for attending school and decrease rewards for missing school

Note. The data are from Kearney and Albano (2000) and Kearney and Silverman (1990).

ASSESSMENT OF FEARS AND ANXIETIES

Given the frequency of fears and anxieties in children, how does one distinguish a normal, developmental fear or anxiety from a clinically significant phobia or other anxiety disorder? Although DSM-IV (APA, 1994) provides criteria for each of the anxiety disorders experienced by children, it is also important to systematically evaluate the nature of the specific fear- or anxiety-based symptoms, including the intensity and frequency of the behavioral and physiological reactions, the content of the fear or anxiety, its persistence, its developmental timing, and the familial and environmental circumstances that could have precipitated and/or are maintaining it. Clinically significant anxiety disorders have some characteristics in these areas that make them distinguishable from more age-related, transient fears and anxieties (APA, 1994):

1. *Intensity.* The intensity of the child's reaction is out of proportion to the actual threat or demands of the situation. For example, a child who cries uncontrollably the entire time he

or she is in school, or starts vomiting every morning before school, should be assessed for a phobia or other anxiety disorder.

2. *Frequency*. The fear reaction or anxious symptoms occur with increased frequency and cannot be explained or reasoned away. No amount of reassurance seems to help, and reassurance often actually makes the situation worse.

3. *Content*. The child's fear or worry is usually focused on a nonthreatening situation or stimulus that is not likely to cause harm. This could include such things as the toilet, dogs, or thunder, and worries about vomiting or being separated from parents.

4. *Spontaneity*. The reaction appears spontaneous and beyond the voluntary control of the child. For example, a child becomes distraught at the news that a thunderstorm might occur that day.

5. *Avoidance*. The fear reaction leads to the avoidance of or escape from the feared stimuli. A child who refuses to leave the house if there is a chance of rain, or a child shadowing a parent all day so as not to be separated or refusing to go to school, are examples.

6. *Stage of development*. The fear or worry is not specific to a child's age or stage of development. For example, an adolescent may refuse to spend the night away from home, or a school-age child may refuse to use public toilets.

7. *Nonadaptive and persistent nature*. The reaction of the child is not adaptive and is persistent; thus the child does not learn more effective ways to deal with the situation or feared stimuli. For example, the child's clinging to the parent does not allow the child to learn to gain control over his or her anxiety and adapt to the environment.

8. *Interference*. The degree to which the child's reaction interferes with the child's or family's functioning is an important criteria for making a DSM-IV diagnosis and determining the family's motivation for treatment. Clinical levels of anxiety or fear reactions can interfere with social relationships and activities, academic performance, and family functioning.

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Thought Stopping

Thought stopping is a self-management technque developed by Wolpe (1958), and although it has little or no empirical support, clinical reports indicate its potential effectiveness. A case report by Campbell (1973) demonstrates the technique as well as its potential power with children. Campbell treated a 12-year-old boy who was experiencing distressing and persistent negative thoughts related to the violent death of a younger sister 1 year earlier. The child spent so much time ruminating about the experience that he stopped eating and sleeping, and performed poorly in school. Campbell trained the boy to evoke a negative thought and then to stop the thought pattern by counting backward from 10 to 1 as rapidly as possible. After counting, the child was to imagine a preselected pleasant scene. The boy was then instructed to use this technique (including a subvocal "No!") every time he began to think of the negative experience, and to practice it every night before he went to bed. Within 4 weeks the boy was free of the negative thoughts; he was also able to talk about his sister without undue distress.

We have found thought stopping to be very effective for children who engage in excessive fantasy about a situation that is out of their control (e.g., wishing divorced parents would reunite or wishing they could move back to an old neighborhood), or who ruminate about a past event to such an extent that it interferes with effective coping (e.g., worrying about an upsetting interaction with a teacher or peer). Some children indicate that they like to think about a particular event or situation to some extent, but they find it difficult to stop these thoughts. Others are afraid that if they stop worrying, the feared event will occur. We have successfully

decreased the intrusive nature of the worry or unproductive thoughts by having a child worry for a set period of time each day. The child is told, for example, "After school you are to go to your room and think about your parents' remarrying for 30 minutes." A timer is used, and the child is told not to engage in any other activity until it rings. If something interferes with doing this (e.g., a Scout meeting), then the child must wait until the next day for the worry time. During the day, children are to observe when they worry, and immediately say "No!" and count backward from 10 to 1. They are to remind themselves that they will have time to worry later and there is no use upsetting themselves now. Furthermore, they are to focus their attention on whatever they are currently doing. We have found that children are soon calling the therapist to ask whether the timer can be set for shorter periods of time! The punishment (i.e., counting backward) appears to decrease the negative thoughts, which then allows more appropriate thoughts to increase. Thought stopping obviously requires high levels of motivation and cooperation on a child's part.

Intervention with the Parents

Parents play an important role in the treatment of a child with an anxiety disorder, since they are usually in the best position to teach and reinforce more adaptive responses on the child's part. Often parents can effect changes in the child's behavior simply through gaining a better understanding of the child's anxious or fearful behavior and learning effective ways to help the child learn to cope with the feared situation. Other parents may actually be contributing to the anxious behavior by reinforcing or punishing it, or having expectations for the child that are too high or too low. Thus their behavior management techniques or parent–child interactions may be the focus for treatment. The parents' own problems (e.g., depression, anxiety) can also interfere with the child's treatment, as noted earlier. Any such issues must be identified, and the parents must be helped to deal with them. If there is marital/couple or family conflict, these problems need to be targeted for treatment before the child's symptoms will improve. Books written for parents of anxious children include *Keys to Parenting Your Anxious Child* (Manassis, 1996) and *SOS! Help for Emotions: Managing Anxiety, Anger, and Depression* (Clark, 1996). National resources include the Anxiety Disorders Association of America, 11900 Parklawn Drive, Suite 100, Rockville, MD 20852, 301-231-9350, http://www.adaa.org; and the Obsessive Compulsive Foundation, P.O. Box 70, Milford, CT 06460, 203-878-5669, http://pages.prodigy.com/a/willen/ocf.htm/.

The importance of planned, systematic involvement of parents in treatment is demonstrated in a number of studies using CBT for children with anxiety. Barrett, Dadds, and Rapee (1996), for example, described the addition of a family component to a 12-week CBT program for children. The family component emphasized methods for empowering parents and children by forming an "expert team" with them, whereby the parents were trained to reward courageous behavior (verbal praise, privileges, and tangible rewards) and to extinguish excessive anxiety in children (parents listened to initial complaints and then encouraged coping strategies, with no further response to complaints). Parents were also taught to deal with their own emotional upsets, to gain awareness of their own anxiety responses in stressful situations, and to model problem-solving responses to feared situations. At the end of treatment, 84% of the children in the CBT-plus-family-intervention group no longer met criteria for an anxiety disorder, compared to 57% of the children in the CBT-only treatment. Both groups improved further at 6- and 12-month follow-ups, with CBT plus family intervention still superior to the CBT-alone condition (95.6% vs. 71.4%)!

Going Back to School Chart

Behavior	Pts.	Monday	Tuesday	Wednesday	Thursday	Friday	Sun. Nite
Getting up in the morning when called without fuss	1						
Eating breakfast and being ready for the bus on time	1						
No crying or fussing when leaving for school	2						
Staying in school all day	1						
Happy day report from teachers	1						
Report on two good things that happened in school	1 1						
No tears or fussing at bedtime	1						
BONUS	1						

Total points 10
Possible points per week 50

1st Prize 85% (43–50) _____ (Dinner out, friends spend the night, or go to movie with friends)
2nd Prize 75% (38–42) _____ (Rent video)
3rd Prize 65% (33–37) _____ (Trip to frozen yogurt shop)

FIGURE 8.1. A record chart for a reward system in the treatment of school refusal. From *Assessment and Treatment of Childhood Problems* (2nd ed.) by Carolyn S. Schroeder and Betty N. Gordon. Copyright 2002 by The Guilford Press. Permission to photocopy this figure is granted to purchasers of this book for personal use only (see copyright page for details).

Anxiety Handouts

From: Treatments that Work with Children, Christophersen & Mortweet, chp 8
p. 210 (Exhibit 8.3) reducing anxiety related to pill-taking by shaping

EXHIBIT 8.3
Pill-Swallowing Handout for Parents

1. Model for your child the steps in swallowing a pill:
   A. Place pill on the back of your tongue.
   B. Keep the tongue flat.
   C. Take liquid in the mouth.
   D. Tilt the head backward slightly.
   E. Swallow.
2. Gradually increase the size of the pill in the following order:
   A. Oblong, multicolored sprinkle used for cake decoration.
   B. Spherical, silver cake decoration.
   C. Round, multicolored candy (0.3–0.7 cm diameter).
   D. Red licorice whip cut to 1-cm length.
   E. Capsule-shaped candy, multicolored, sold as "Tic Tacs" or "Dynamints."
   F. Normal-sized capsule: the child's actual pill.

Have your child practice swallowing each size piece of sprinkle or candy as many times as it takes for him or her to get accustomed to it. These procedures usually take about 45 minutes to 1 hour but may take you a little longer.

Note. From "A Brief, Effective Method for Teaching Children to Swallow Pills," by R. L. Blount, L. M. Dahlquist, R. A. Baer, and D. Wouri, 1984, *Behavior Therapy, 15,* p. 383. Copyright 1984 by Association for Advancement of Behavior Therapy. Adapted with permission of the publisher.