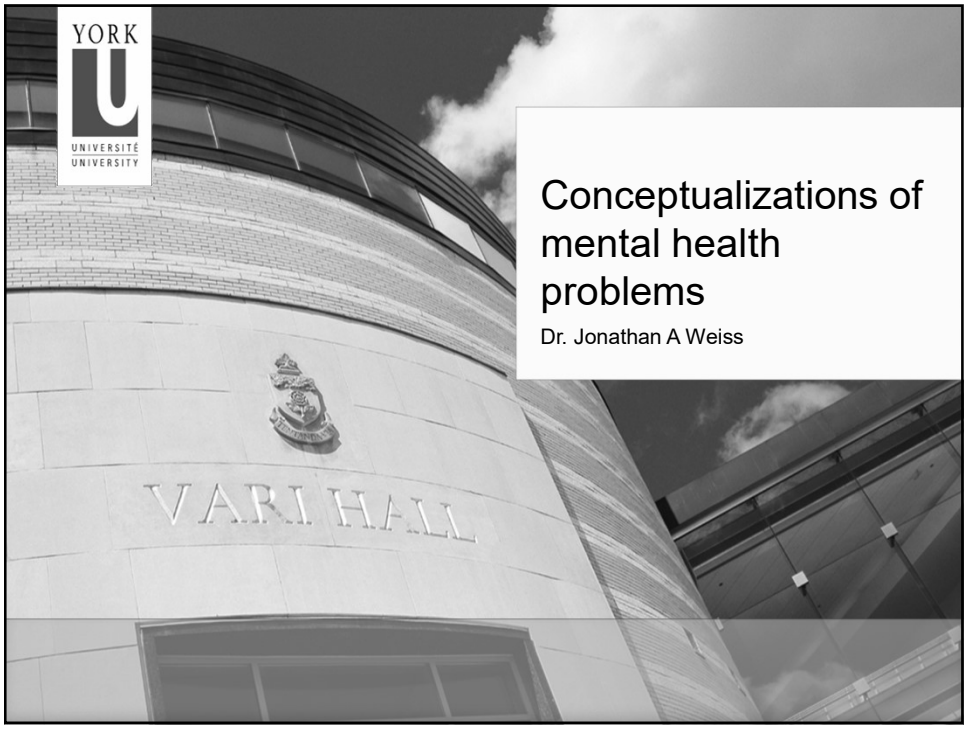

Conceptualizations of mental health problems

Dr. Jonathan A Weiss

This workshop is about

- Day 1) Understand the presentation of mental health difficulties in autism
  - Useful conceptualizations
  - Differentiating common mental health symptoms from ASD symptoms
- Day 2) Using CBT to address emotional problems
  - A focus on therapeutic adaptations
  - Example of our CBT intervention for emotion regulation

Case conceptualization

- The primary goal of case conceptualization is to infer a mechanism that accounts for the patient's symptoms and problems (Kendjelic et al. 2007)
- Can help clinicians organize and make sense of overwhelming details
- Predict client behaviours and responses to treatment
- Facilitates tailoring techniques to custom fit… establish a flexible framework
    - The bag of tricks comes afterward – this tells us when and how to use the tools
    - Revised as treatment continues
    - Keep it as simple as possible

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What are 'mental health problems' in the context of ASD?

- Emotional and behavioural problems that lead to significant impairment **above** the child's baseline level of impairment related to their symptoms of ASD

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In the context of ASD

- Are symptoms over and above what would be expected based on a child's developmental level and present challenges?
- Are THESE symptoms causes of significant impairment?
  - To social and academic functioning, family life, physical health, and general well-being, above what may be related to the child's ASD alone or impairments based on developmental level
- Distinguish symptoms from typical difficulties regulating emotional reactions or sensory sensitivities in the moment
- Are symptoms a *step beyond* what is characteristic of ASD?
  - Rule bound vs. anticipatory anxiety

(Kerns et al. 2016)

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Four generic case formulation components

- To conceptualization (Kendjelic et al. 2007):
  - symptoms and problems,
  - precipitating stressors,
  - predisposing events and conditions, and
  - an inferred explanatory mechanism accounting for the these three components

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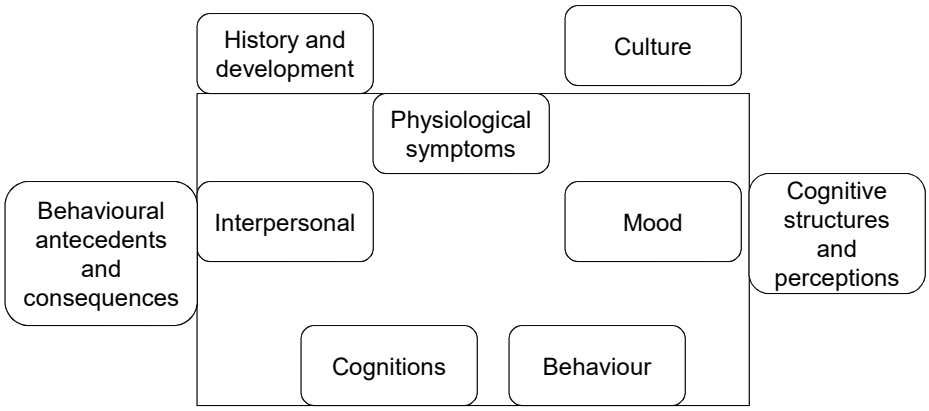
My CB orientation



*Friedberg & McClure (2002)

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The 4 P's

Domains	Biological	Psychological	Social-Relationship	Social-Environmental
Factors	Genetic, developmental, medical, toxicity, tempermental factors	Cognitive style, psychological conflicts, self-image, meaning, schema	Family, peers, others	Culture/ethnicity, social risk factors, systems issues
Predisposing (vulnerabilities)				
Precipitating (stressors)				
Perpetuating (maintaining)				
Protective (strengths)				

Winters, N. C., Hanson, G., & Stoyanova, V. (2007). The case formulation in child and adolescent psychiatry. *Child and Adolescent Psychiatric Clinics of North America, 16*, 111-132.

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Mental health problems in youth with ASD

- 4-5x greater than youth in the general population (Totsika et al. 2011)
- 70% will meet criteria for at least one psychiatric disorder, and many meet criteria for multiple conditions (Simonoff et al., 2008)
  - Overall rates may be inflated due to miscoding ASD symptoms, but the same pattern emerges (Mazefsky et al, 2012)

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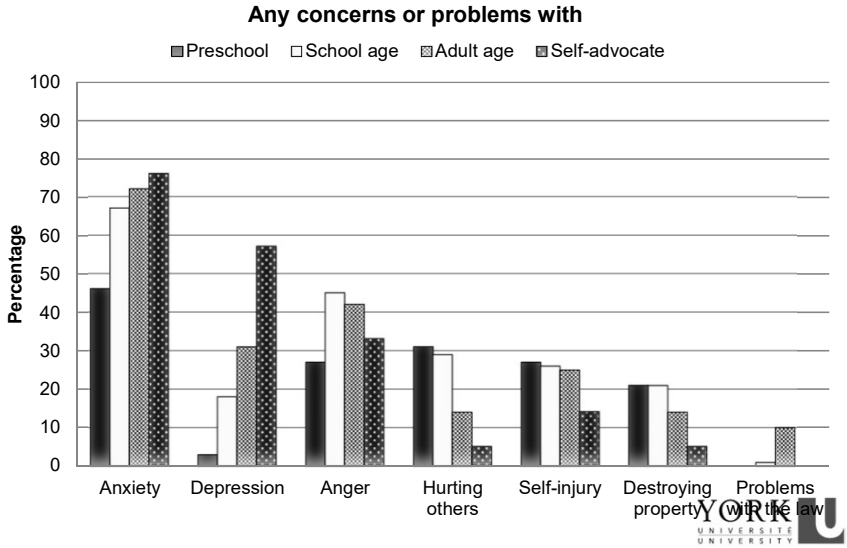
Autism in Canada: Concerns in BC



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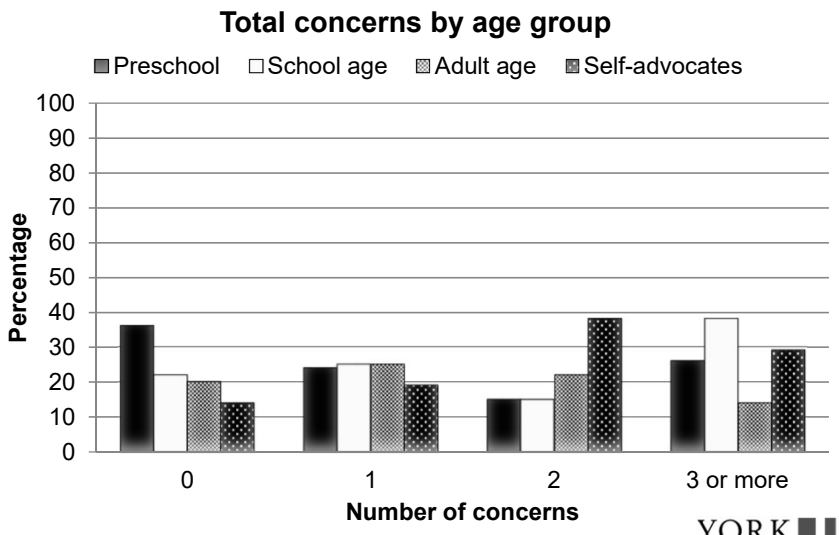
Autism in Canada: Concerns in BC



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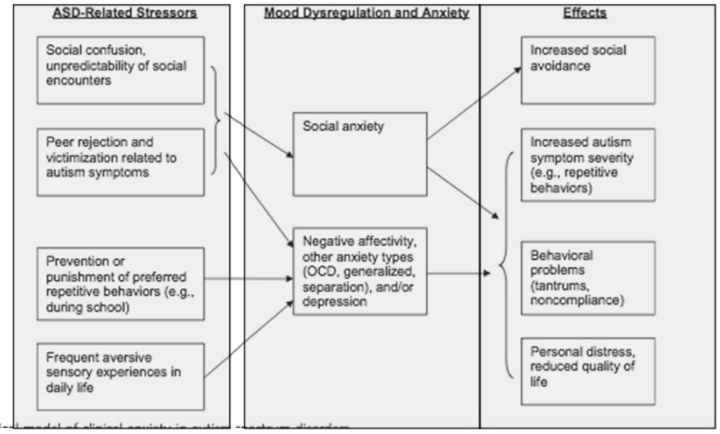
Relevant conceptualizations: Transactions (Wood & Gadow, 2010)



In Wood, J., & Gadow, K. (2010). Clinical Psychology: Science and Practice, 14, 281-291.

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A social-cognitive deficit

- Maladaptive processing of others
  - How we make sense of other people and ourselves in relation to others
  - **Analyze** the information from others correctly
    - generate **expectancies** about others
      - and draw **inferences** about how to respond in social situation
  - Requires ToM, use of social cues, and pragmatic language

Gaus, 2007

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A social-cognitive deficit

- Maladaptive processing of Self
  - Perceptions and regulation of arousal and sensory-motor
- Maladaptive processing about non-social environment
  - Cognitive control: "Ability to **flexibly** allocate mental resources to **guide thoughts and actions** in light of **internal goals**"
  - Planning & goal setting, organizing, flexibility (Ozonoff et al., 2005)
  - Seeing the forest, not the trees (Happe, 2005)

Gaus, 2007

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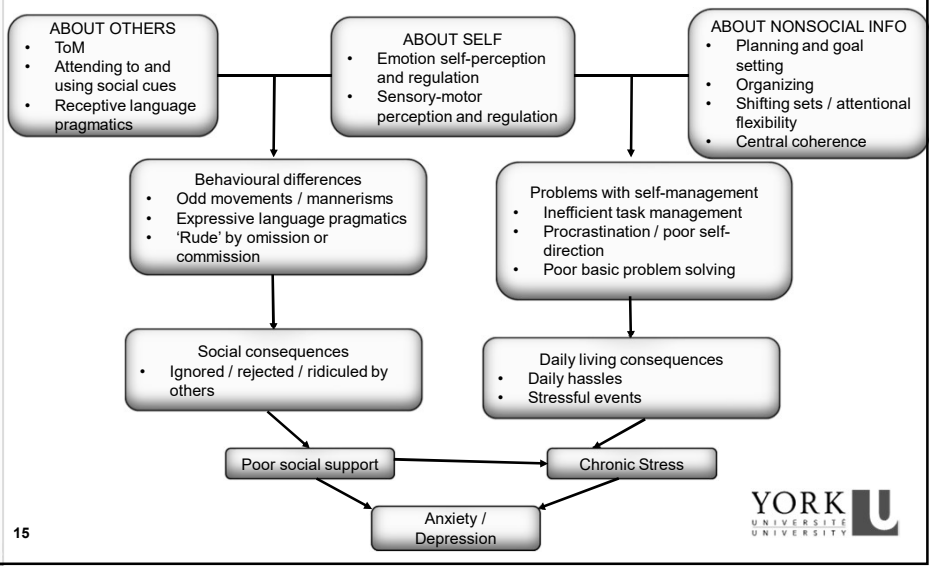
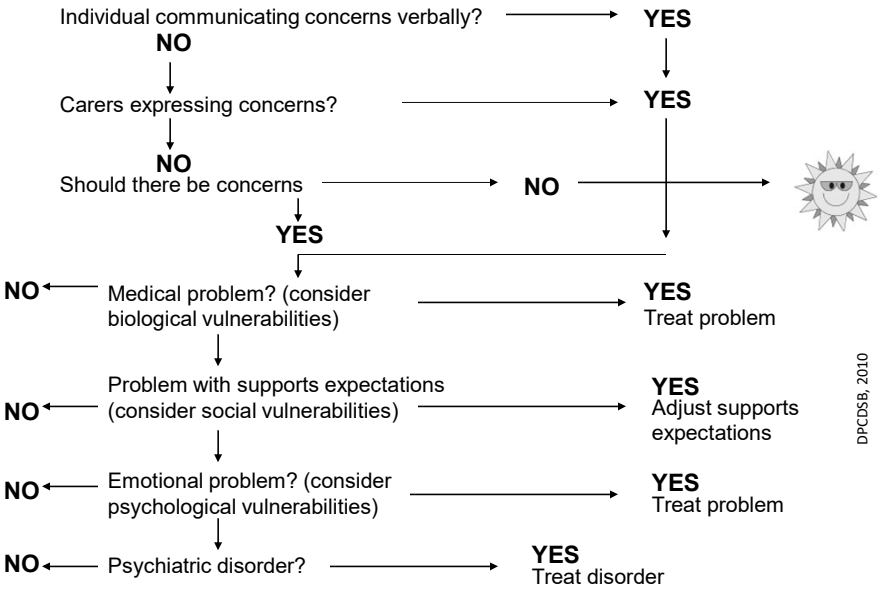
Relevant conceptualizations: Information processing focus (Gaus, 2007)



MENTAL HEALTH ASSESSMENT:DECISION TREE

Adapted from Bradley & Summers 1999, in Bradley & Burke, 2002



Diagnostic overshadowing

- Reduced accuracy or sensitivity in identifying mental health problem as a result of a person having ASD (Reiss & Szyszko, 1983)
  - a) the category / diagnosis reflecting psychopathology
  - b) the severity of the psychopathology
  - c) how the psychopathology should be treated

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Baseline exaggeration

- Behaviours signaling the development of a psychiatric condition reflect increase, or exacerbation, of long-standing difficulties

- Severity of challenging behaviours *may* be a communication of internal distress (agitation, depression, hypomania, anxiety)

Center for Autism and Related Disabilities, University of South Florida, Department of Child and Family Studies. Retrieved from http://card-usf.fmhi.usf.edu/docs/resources/CARD_ASDMH_Brochure092109.pdf

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Cognitive disintegration

- Challenges with coping with minor stressors become accentuated

- Existing impairments become more severe, leading to overall disorganization

- Behaviour may look 'psychotic'

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Differentiating mental health

- 1) Mental health problem as a separate co-occurring problem
  - Superimposed difficulties… implies similar treatment
- 2) Mental health problem as an aspect of ASD
  - The mental health symptoms may be driven by the ASD symptoms and vice versa… a manifestation of ASD
- 3) Mental health problem as separate but not independent of ASD
  - Predisposed, set up by, but still distinct
  - May be manifested by a range of maladaptive behaviors including tantrums, noncompliance, social avoidance, repetitive behaviors, aggression or self-injury.

(Lecavalier et al. 2014)

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- Is anxiety good or bad?
- What do you VALUE?

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Anxiety

- Grandin (1992)
  - *"The feeling [of anxiety] was like a constant feeling of stage fright all the time. I had a pounding heart, sweaty palms, and restless movements (…) For weeks I had horrible bouts of colitis. (…) I started waking up in the middle of the night with my heart pounding."*
- Idiosyncratic anxiety symptoms
  - Unusual specific phobias (e.g., vacuum cleaners, toilets) and fears of change/novelty
  - Unclear whether such symptoms are manifestations of anxiety or reflect aspects core ASD symptoms

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Phenomenology

- Anxiety can be less noticeable because of clinical variability in ASD
  - Any atypical behavior in this population can be mistakenly interpreted as being a consequence of having ASD (e.g., diagnostic overshadowing)
  - We can miss the obvious

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In general population

- Anxious symptoms is tied to normative developmental periods (Warren and Sroufe 2004)
  - separation anxiety and phobias of animals are predominant at 6–9 years
  - generalized anxiety symptoms and phobias about danger and death at 10–13 years
  - social anxiety at 14–17 years

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Separation anxiety

- Developmentally inappropriate and excessive anxiety about separation from attachment figures
- *Persistent* concerns about harm on attachment figures and about events that could result in separation from attachment figures (e.g., getting lost, being kidnapped)
  - Reluctance or refusal to separate from attachment figures (e.g., going to school)
  - Nightmares involving the theme of separation
  - Physical symptoms of distress (e.g., headaches, stomachaches) when separation occurs or is anticipated
  - Present for at least 4 weeks

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Separation anxiety

- *Anxiety vs. rigidity*
  - Some symptoms of separation anxiety may be better explained by ASD
    - "refusing to leave home because of excessive resistance to change" (APA, 2013 , p. 191)
  - Should clarify that the individual's anxiety is due to attachment-related aspects of separation and NOT a change in routine
    - Can the person be apart from his or her attachment figure without signs of distress?

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Separation anxiety

- Gather information about whether
  - the individual frequently wants to know the whereabouts of his attachment figures
  - has difficulty staying in a room of the house alone
  - has fears of potentially dangerous situations to themselves or family members

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Separation anxiety

- *Reality basis of fear*
  - An individual with ASD may be highly dependent on parent or caregiver for daily functioning needs
    - Anxiety related to separation may not be “developmentally inappropriate”
- *Precipitating events*
  - Separation anxiety often develops after a life stress,
    - loss, change in schools, parental divorce, or move to a new house

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Specific phobia

- Markedly intense and excessive fear or anxiety about a specific object or situation, leading to active avoidance or distress when the object or situation is endured
  - At least 6 months
- 5 types
  - animal type (e.g., spiders, insects, dogs),
  - natural environment type (e.g., heights, storms water),
  - blood-injection-injury type (e.g., needles)
  - situational type (e.g., airplanes, elevators)
  - other type (e.g., choking, vomiting, loud sounds)
- Most common co-occurring disorder (e.g., Leyfer et al., 2006; van Steensel et al. 2011)

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Specific phobia

- *Physiological reactions*
  - Particularly prevalent in specific phobias, both in anticipation of, or during, exposure
  - Animal, natural environment, and situational specific phobia types: sympathetic nervous system arousal (e.g., increased heart rate)
  - Blood-injection-injury type: vasovagal syncope (fainting) or near-fainting response because a drastic drop in heart rate and blood pressure

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Specific phobia

- *Unusual fears*
  - Ensure open ended questions
- *General hypersensitivity*
  - A specific phobia diagnosis may not be warranted if the fear is part of a generalized sensitivity
    - Hypersensitivity to most noises may show distress at the sound of a specific tone, but this distress is better accounted for by ASD

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Specific phobia

- *Restricted interests*
  - Is a restricted interest related causing fear?
    - Is there negative affect about future exposure and avoidance?
- *Stability*
  - Cannot be transient fear following a frightening experience
  - Individuals with ASD can perseverate on a negative event for longer than expected, but still transient

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Social anxiety disorder

- Excessive and persistent fear of social scrutiny that typically lasts at least 6 months

- Social anxiety must occur with peers
  - Fear of embarrassment or negative evaluation by others in social or performance situations
    - Incl. concerns about rejection, ridicule, or offending others

- Careful of "doublecounting" symptoms that overlap (e.g., poor eye contact, social avoidance)
  - Need to look for more subtle symptoms of social anxiety (e.g., diverting attention to others)

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Social anxiety disorder

- *Bidirectional relationship of social anxiety and social skill impairment*

  - Increased anxiety can lead to
    - inaccurate processing and interpretation of social cues
    - avoidance of social encounters
    - fewer opportunities to acquire new learning or practice social skills

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Social anxiety disorder

- *Social motivation and theory of mind capabilities*
  - Aware of their social difficulties
  - Care about peer approval and desire social interactions and friendships
  - Experience isolation and loneliness
    - If *limited social motivation*, need to evaluate whether this represents a change from baseline
      - Could be a coping mechanism to rejection

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Social anxiety disorder

- *Atypical manifestations of social anxiety*
  - Excessive relative to actual social difficulties
  - Potential to lack *excessive* fear of negative evaluation
  - Worries related to ToM, and not knowing what to do or expect in social situations, due to social deficits

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Social anxiety disorder

- *Reasons behind avoidance of social situations*
  - Avoidance of social situations must be related to social aspects of the situation, not
    - a lack of interest in situation
    - sensory overarousal or environmental stimulation
    - general disinterest in social engagement
    - distress about uncertainty
    - dislikes about change in routine

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Social anxiety disorder

- *Fear of negative evaluation*
  - Important to explore cognitive component
    - Direct questions about feared consequences
- *Fear of positive evaluation*
  - Information conveying social approval (e.g., a smile or verbal praise) conveys threat
    - by making a socially anxious person feel observed or self-conscious

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Panic disorder

- Recurrent, unexpected panic attacks
  - *Sudden* surges of intense fear or discomfort
    - Peaks in intensity within minutes
    - at least four physical (e.g., heart palpitations, sweating) and cognitive (fear of losing control, fear of dying) symptoms
  - Persistent concern (at least 1 month) about having more panic attacks or consequences

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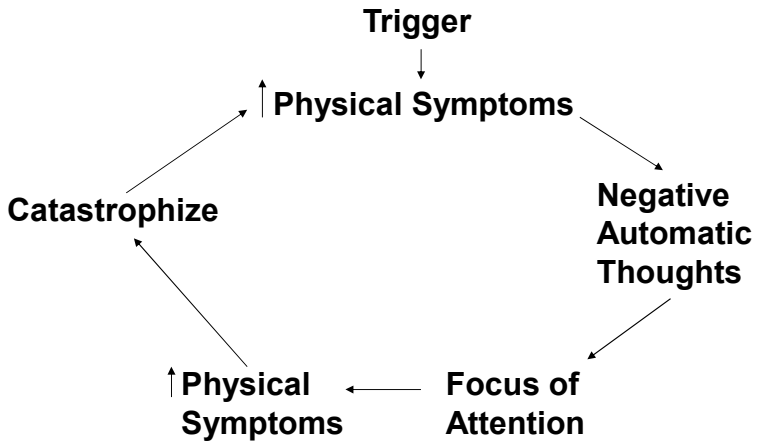
CB Model of Panic Disorder



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Panic disorder

- *Unexpected vs. expected panic attacks*
  - At least some of the panic attacks are to be unexpected
  - In individuals with ASD, a surge of panic-like symptoms may be situationally bound or triggered by specific triggers
- *Other reasons for (or indications of) somatic symptoms*
  - Going to the doctor often?

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Agoraphobia

- Marked fear and anxiety about two or more of the following situations
  - Using public transportation, being in open spaces, being in enclosed spaces, standing in line or being in a crowd, or being outside of the home alone
- Fear that escape might be difficult or help might not be available during panic or other incapacitating or embarrassing symptoms (e.g., falling, incontinence, vomiting)
  - For at least 6 months
- Can result in being homebound

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Agoraphobia

- *Reasons behind avoidance*
  - Cannot be a result of
    - restricted interests at home
    - overwhelming sensory input outside of home
    - rigid routines at home
- *Nature of fear*
  - May be agoraphobia if with a companion, can cope

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Generalized anxiety disorder

- Excessive anxiety and worry (i.e., apprehensive expectation) about a number of events or activities, such as work and school performance, family affairs, and health
  - Difficult to control
  - Occurs more days than not for at least 6 months
  - Regularly accompanied by some of the following physical symptoms:
    - Restlessness or feeling keyed up or on edge, fatigue, difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbance
  - "Worriers" / Excessive "planners"
- *Focus of worry*
  - Typically about forthcoming problems or future events
  - Worry must be generalized and not restricted to one area, or about limited access to restricted interest
- *Perseverative style*
  - Is the perseveration associated with worry and physical signs of distress?

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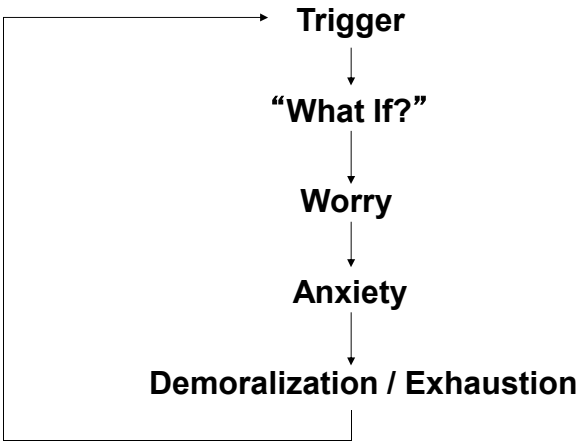
CB Model of GAD



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Generalized anxiety disorder

- *Need for reassurance*
  - Family members and friends often spend excessive amounts of time reassuring, without much relief
  - It feels impossible to go for long periods of time without feeling worried, despite reassurance
- Atypical worries in ASD
  - Excessive worries about novelty and change
  - Worries related to circumscribed interests, but not other more generalized concerns
  - Worries about insistence on sameness, or intolerance of uncertainty

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Challenges with understanding generalized anxiety

- Challenges with gauging degree of excessive worry in GAD in children with communication difficulties
- Emotionality vs. Anxiety disorder
- Can also be expressed as aggression
  - Mood disorders are often under-represented in developmental disabilities, while psychotic disorders are overly-diagnosed (Lunsky et al. 2006)

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Obsessive Compulsive Disorder

- Recurrent obsessions and/or compulsions that cause marked distress and/or functional interference
  - (1) obsessions: intrusive, recurrent, and persistent thoughts, images, or impulses;
  - (2) compulsions: repetitive, purposeful behaviours or mental acts performed in response to an obsession, often according to certain rules or in a stereotyped fashion
- Obsessions have dysphoric affect, such as fear, disgust, doubt, or a feeling of incompleteness, and are distressing to individual
  - Compulsions, which can be observable repetitive behaviours (e.g., washing), or covert mental acts (e.g., counting), serve to neutralize or alleviate obsessions and accompanying dysphoric affect

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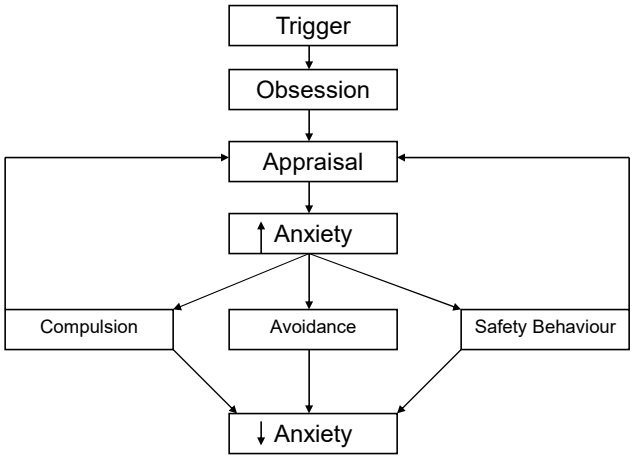
Example of CB Model of OCD



Behaviours reinforce appraisals, which then increase the likelihood that behaviours will be repeated.

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Obsessive Compulsive Disorder

- Functional link between obsessions and compulsions is important to determine if repetitive thoughts or behaviour are OCD
- Do topics of obsessions cause anxiety, or is it only the *absence* of the topic that causes anxiety?
  - Egodystonic vs. syntonic
- *Restricted interests vs. obsessions*
  - obsessions in OCD give rise to distress
  - restricted interests usually satisfy a need
  - do the obsessions bother the person?
    - Anxiety around getting sick as a result of germs vs. sensory interest in washing

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Obsessive Compulsive Disorder

- "*Not Just Right" OCD vs. behavioural rigidity*
  - Subgroup in OCD with low insight, discomfort is neurtralized by compulsion
  - In ASD, though may also occur, often because of a deviation in routine or need for assurance on sameness

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Obsessive Compulsive Disorder

- *Repetitive behaviours vs. compulsions*
  - Compulsions are defined in relation to obsessions: Obsessions give rise to anxiety or some other form of distress and are typically experienced as intrusive
    - Compulsions are typically reported to be intentional and reduce obsessional distress
  - Stereotypies in ASD can serve a calming function or stimulatory function, but not associated with a distressing compulsion

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Measuring anxiety and OCD

- Pediatric Anxiety Rating Scale combines child and parent reports with clinical judgment
  - panic, phobias, separation, social, and generalized anxiety disorders in youth ages 6–17 years
- Multidimensional Anxiety Scale for Children (MASC; March, 1998)
  - physical symptoms, social anxiety, harm avoidance, and separation/panic\
- The Spence Children's Anxiety Scale (SCAS; Spence, 1998)
  - physical injury fears, panic, obsessive compulsive, separation, social, and generalized anxiety symptoms

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Measuring anxiety and OCD

- The Screen for Anxiety and Related Emotional Disorders (SCARED; Birmaher et al., 1999)
  - panic, generalized, social, and separation anxiety symptoms
- Yale-Brown Obsessive Compulsive Scale (Y-BOCS; Goodman et al., 1989) and Children's Yale-Brown Obsessive Compulsive Scale (CY-BOCS; Scahill et al., 1997)
  - Clinician-administered interviews to measure symptom severity of obsessions and compulsions in adolescents/ adults (age 14+ years) and children (age 6–14 years)

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Common assessment tools

- How is the youth different from typically developing peers and others with ASD of the same age? Examples:
  - Child Symptom Inventory-4 (CSI-4; Gadow & Sprafkin, 2002)
  - PDD Behaviour Inventory
  - Developmental Behaviour Checklist
  - Nisonger Child Behavior Rating Form (Aman et al. 1996)
  - Common adaptive and maladaptive behaviour scales (especially if a baseline is already available)
  - Problem specific scales (e.g., SCARED)
  - Behavioral Assessment System for Children — Second Edition (BASC-2; Reynolds & Kamphaus, 2004)
  - Child Behavior Checklist (CBCL; Achenbach, 1991) and related Teacher's Report Form (TRF; Achenbach, 1991)
  - Anxiety Disorders Interview Schedule-Child/Parent Versions (ADIS-C/P; Silverman & Albano, 1996)

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Functional assessment

- Critical in the presence of 'challenging behaviour' where a person cannot communicate their internal experience
- Particularly because topographically similar examples could have very different functions
- Can be maintained by positive, negative or automatic reinforcement
  - Attention
  - Access to tangible
  - Escape

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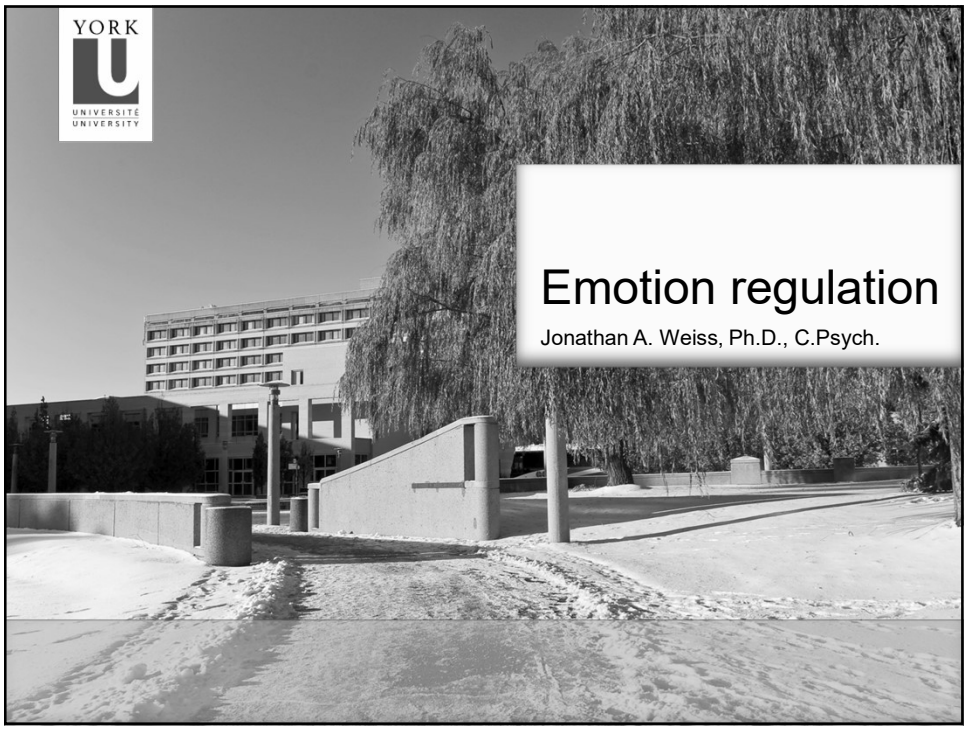
Dealing with multiple issues

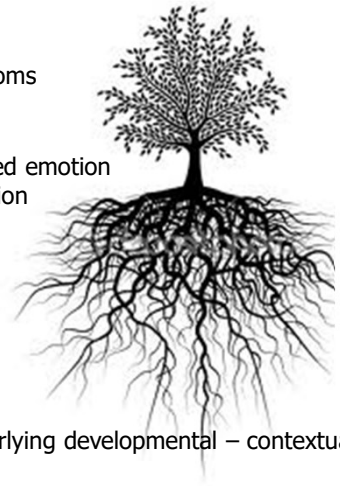
- Anxiety is the tip of the iceberg
- Many psychiatric diagnoses at the same time
- Depression, anger and anxiety often go hand in hand



Emotion regulation skills

Symptoms

Impaired emotion regulation



CLINICAL PSYCHOLOGY
SCIENCE AND PRACTICE

Transdiagnostic Case Conceptualization of Emotional Problems in Youth with ASD: An Emotion Regulation Approach

Jonathan A. Weiss, York University

Youth with autism spectrum disorder often struggle to cope with co-occurring anxiety, depression, or anger, and having both internalizing and externalizing symptoms is a common clinical presentation. A number of authors have designed cognitive-behavioral interventions to address transdiagnostic factors related to multiple emotional problems, although none have applied this focus to youth with ASD. The current review article describes how a transdiagnostic emotion regulation framework may inform cognitive-behavioral interventions for youth with ASD, which until now have focused almost exclusively on anxiety. Research is needed to empirically test how a transdiagnostic intervention can address the processes of emotion regulation and assist youth with ASD to cope with their emotional disorders.

Key words: **autism spectrum disorder, cognitive behavior therapy, emotion regulation, transdiagnostic.**

(Clin Psychol Sci Prac 21:331–350, 2014)

review, I view emotional and behavioral problems as symptoms that lead to significant impairment above the individual's baseline level of impairment related to his or her symptoms of ASD (i.e., above the impairment associated with the core social, communication, and repetitive features of ASD; as in Leyfer et al., 2006). Distinguishing core symptoms of ASD from comorbid internalizing and externalizing symptoms is particularly challenging, and a number of authors suggest that while some symptoms may reflect distinct disorders with unique etiologies, other symptoms are likely "co-occurring" issues, related to the etiology of the ASD or associated with symptoms of ASD (see also the commentaries by Folstein & Carbajal, 2012; Kerns & Kendall, 2012; Ollendick & White, 2012; Scahill, 2012; Wood & Gadow, 2010).

Rates of emotional and behavioral problems are high in youth with ASD, either when viewed as co-morbid or as co-occurring. Using a population-based cohort, Totsika, Hastings, Emerson, Berridge, and

Underlying developmental – contextual variables

Weiss, J. A. (2014). Transdiagnostic case conceptualization of emotional problems in youth with ASD: An emotion regulation approach. *Clinical Psychology: Science and Practice, 21(4),* 331–350.

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Emotion Regulation

- "the extrinsic and intrinsic **processes** responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish one's goals" (Thompson, 1994, pp. 27–28)

- It can be adaptive or maladaptive: successful in achieving the appropriate affect and which do not have negative long-term costs
- We all do it and are always doing it
- We depend on our environment for it
- It is developmental and relational

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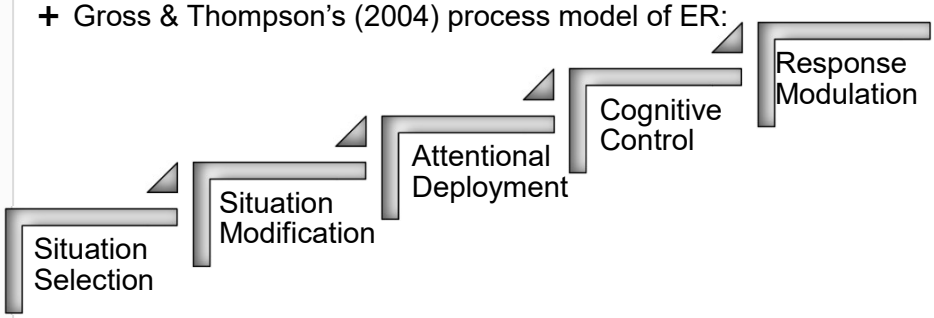
A transdiagnostic issue of emotion regulation

+ Gross & Thompson's (2004) process model of ER:



Unified Protocol for the Treatment of Emotional Disorders (Barlow et al., 2011)
*Unified Protocol for Youth (*Ehrenreich-May et al., 2009)

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A transdiagnostic issue of emotion regulation

1. Situation Selection

The control we exert over the situations we choose to go into

- Maladaptive
  - Unrealistic expectations of situations
  - Avoidance of situations
  - Adherence to 'safe' situations

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Situation selection

- What is it about the situation they struggle with or fail to understand?
- What do they avoid / escape from?
- What situations do they adhere too?

↓

- Increase understanding of target situations
- Enhance exposure to situations that elicit mild distress
- Expand situational exposure to neutral situations
- Reduce avoidance through parent/teacher involvement

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2. Situation Modification

Altering situations to address emotional responses

- Maladaptive
  - Shape environment for escape purposes
  - Rely in 'safety signals'
  - Keep environment in highly structured and controlled manner

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Situation modification

- Do they adhere to rituals that serve to keep them calm?
- How do they shape their environments?

↓

- As tolerance to distressing emotions increases (situation selection), aim to fade safety behaviours
- Enhance problem solving: Adaptive scripts for specific situations
- Assertiveness skills

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3. Attentional Deployment

How we choose to focus or distance our attention on the emotional aspects of a situation

- Maladaptive
  - Perseveration on topics
  - Rumination/overattention on distressing experience

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Attentional deployment

Are they aware of emotional cues?

Where do they focus their attention?

Do they ruminate?

↓

Enhance emotional understanding (of self and others) through picture vocabulary

Practice shifting and distractions

Use 'chunking' of activities

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4. Cognitive Control

Our thoughts about the situation and ability to handle it

- Maladaptive
  - Rigid, concrete, and thinking in absolutes
  - Tendency for mood congruent thinking

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Cognitive control

What are their self-statements like?

What are their views of others like?
Safe/dangerous?

What are their views of the contexts like?

↓

Teaching of gradients
Coping self-statements
Collecting positive evidence

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5. Response Modulation

Physiological and behavioural ways of regulating emotion once the emotion is felt

- Maladaptive
  - Inability to express affect in appropriate ways; to tolerate negative affect
  - Fixed response patterns and poor problem solving skill
  - Higher resting state arousal to begin with
  - Lack of social filter

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Response modulation

Assess for self-soothing ability and history of over-arousal / lability

Are they aware of social context?

Build in relaxation activities to be employed **regularly** and **prior** to emotional distress

Develop alternatives behaviours to EDR

What are the pro's of their reactions? And what are the cons?

Naturalistic consequences

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Where's the evidence for CBT?

- Overall effectiveness of CBT
  - Recent systematic review and meta analysis (Weston, Hodgekins & Langdon, 2016)
    - 48 studies met inclusion criteria
    - High risk of bias
    - 24 studies addressed affective problems
      - 17 were < 18 years
      - 15 group based
      - 19 targeted anxiety
      - 14 were RCTs
      - *Small to medium* effect sizes, when using informant report or clinician ratings

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So what is the use of CBT for ASD?

- Sukhodolsky et al. 2013
  - 8 studies (469 participants)
  - Parental ratings: d = 1.19
    - Removing one study with d = 4.34 reduced this to d = .57
  - Clinician ratings: d = 1.21
    - Removing one study with d = 2.53 reduced this to d = .89
  - Child ratings: d = .68
    - Removing one study with d = 2.69 reduced this to d = .17

76 Sukhodolsky, D. G., Bloch, M. H., Panza, K. E., & Reichow, B. (2013). Cognitive-behavioral therapy for anxiety in children with high-functioning autism: a meta-analysis. Pediatrics, 132(5), e1341–50. http://doi.org/10.1542/peds.2013-1193

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Conclusions

- CBT for mental health in ASD has a small to medium effect size, but not for self-report measures, when heterogeneity considered
- Small samples - masquerading as trials. Proper pilot or feasibility trials often had larger samples
- Need more data on
  - engagement and fidelity
  - allocation concealment
  - 10 studies not randomised
  - treatment description

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Published manuals

- *Facing Your Fears* (Reaven, et al., 2011). Paul Brookes.
- *Child anxiety disorders: A family-based treatment manual for practitioners* (Wood, et al., 2008). WW Norton & Co.
- *Exploring Feelings* (anger / anxiety) Attwood, 2004). Future Horizons.
- *Coping Cat* (Kendall & Hedtke, 2006). Workbook Pub.

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