

Anxiety Does Not Interfere With Phobia Treatment

BY ROXANNE NELSON

Contributing Writer

SEATTLE — The presence of a comorbid anxiety disorder in children with phobias does not interfere with the child's ability to respond to cognitive-behavioral treatment.

The children who responded to cognitive-behavioral treatment (CBT) were also able to reduce the symptoms of their comorbid disorder, according to data presented by Thomas H. Ollendick, Ph.D., at the annual meeting of the Anxiety Disorders Association of America.

"The presence of a comorbid anxiety disorder made no difference and did not interfere with the ability to treat," reported Dr. Ollendick, in a poster presentation. "There was no difference as to the type of comorbidity, although we did exclude comorbid disorders such as autism and schizophrenia, which generally cause more severe impairment."

The rates of comorbidity in children with anxiety are significant. But the impact of comorbidity on treatment efficacy is relatively unknown, and this area has not been well studied, said Dr. Ollendick, professor of psychology and director of the Child Study Center at Virginia Polytechnic Institute and State University in Blacksburg. In fact, no studies have been undertaken looking at the in-

fluence of specific treatments on nontargeted comorbid conditions.

The investigators evaluated treatment efficacy in 105 children aged 7-16 years, who met the DSM-IV criteria for a specific phobia based on a pretreatment structured interview.

Within the group, 22.8% had a specific phobia (SP) only, 42.8% had an SP as their primary diagnosis and another untreated SP as a secondary diagnosis, 29.5% had a generalized anxiety disorder as a secondary diagnosis, 17.1% were diagnosed with comorbid separation anxiety disorder, 17.1% had comorbid social anxiety disorder, and 12.4% had comorbid attention-deficit hyperactivity disorder, Dr. Ollendick reported.

The primary diagnosis was determined as the one causing the greatest interference and distress for the child, based on the Anxiety Disorders Interview Schedule for Children and Parent (ADIS-C/P).

Treatment was an intensive CBT for specific phobias called "One Session Treatment," which was implemented in a single session and involved several CBT techniques, including in vivo exposure, participant mod-

eling, social reinforcement, and cognitive restructuring.

Another therapy, known as Educational Supportive Treatment (EST), served as a control and did not provide exposure to fear-producing stimuli or modeling of contact with the phobic object.

The study is still in progress, Dr. Ollendick said, but based on the data found so far, the numbers are robust.

Children with a specific phobia had a 62.5% response rate to CBT, compared with 53.8% of those with an accompanying comorbid anxiety disorder.

Response rates to EST were much lower, compared with intensive CBT. But no significant difference

was found between subjects with and without a comorbid condition.

Another finding was that treating for a specific phobia also had an impact on the comorbid disorder. Before receiving therapy, 77% of the children had at least one additional diagnosis, but at posttreatment, that percentage had declined to 48.6%.

"It is very important to know that treatment can work with children who are more complex, and we found that it worked very well," Dr. Ollendick said. ■

Treatment was an extensive CBT for specific phobias called 'One Session Treatment,' which included in vivo exposure and participant modeling.

Persistent Asthma Associated With Behavior Problems

BY KERRI WACHTER

Senior Writer

WASHINGTON — Inner-city children with persistent asthma appear to have more problems with negative social skills, anxiety, and shyness than children without asthma, according to data presented at the annual meeting of the Pediatric Academic Societies.

"Children with persistent asthma symptoms had significantly more behavior problems across several domains, compared to children with no asthma symptoms," said Jill S. Halterman, M.D., of the University of Rochester in New York.

Dr. Halterman and her colleagues looked at the relationship between asthma and behavior in all kindergarten children in the city of Rochester school district in 2003. At the beginning of that school year, parents of kindergarten children completed a detailed health and development survey assessing the child's background, behavioral functioning, and medical history—with specific questions about asthma symptoms.

Children were included if they were older than 4 years but younger than 6 years at the time of the survey, making a total of 1,619. Black children accounted for 60% of the survey population; Hispanic children accounted for 22%. A majority of the children (59%) received Medicaid insurance.

Asthma status—no asthma, intermittent asthma, or persistent asthma—was determined from parent responses to three questions about asthma symptoms. The criteria for these three categories were based on the National Heart, Lung, and Blood Institute's guidelines for defining asthma severity. Seven percent of the

children had intermittent asthma, and 8% had persistent asthma.

Using 12 items on the survey, a child's behavioral functioning was assessed using a 1-4 scale in four areas—positive and negative peer social skills, task orientation, and shyness/anxiety.

There was no difference between the three asthma groups for average positive peer social skills scores, but children with persistent asthma had worse scores for negative peer social skills than children with intermittent asthma or no asthma. Children with persistent asthma also had worse scores than the other two groups for task orientation skills and had higher scores for shyness/anxiety.

More than 20% of children in the persistent asthma group had worse scores (one standard deviation or greater) on two or more behavior measures, compared with 16% of those with intermittent asthma and 10% of those with no symptoms. Children with persistent symptoms were two times more likely than those without symptoms to score more than one standard deviation worse on two or more of the scales.

Multivariate regression analysis was used to evaluate the independent relationships between asthma status and the behaviors. There was no significant association among children with intermittent asthma and negative behaviors.

"For children with persistent asthma, a significant association was shown for negative peer and shy/anxious scores," said Dr. Halterman, speaking at the meeting also sponsored by the American Pediatric Society, the Society for Pediatric Research, the Ambulatory Pediatric Association, and the American Academy of Pediatrics. ■

Behavioral Issues More Common In First-Time Seizure Patients

BY KERRI WACHTER

Senior Writer

WASHINGTON — Children with new-onset epileptic seizures appear to have more behavior problems than do those without the disorder, David W. Dunn, M.D., said at the annual meeting of the American Academy of Child and Adolescent Psychiatry.

"We know that kids with new-onset seizures have more problems at baseline than siblings. This suggests to us that there's got to be something going on already before" children have a first seizure, said Dr. Dunn of Indiana University in Indianapolis.

The researchers enrolled 356 children aged 6-14 years who had their first recognized seizure within the past 3 months.

Their siblings, also aged 6-14 years (205), were recruited as controls. The Child Behavior Checklist (CBCL) was used to measure behavior problems. The genders were roughly equal in the group of children with seizures, and the group was largely white (83%).

"We found that it was the children with prior unrecognized seizures who had the higher scores," Dr. Dunn said. With the CBCL, a higher score provides greater evidence of behavior problems. Children with prior unrecognized seizures had a mean CBCL total score of 57, while those with true first seizures had a mean score of 54 and siblings had a mean score of 50.

About a third of the children who have prior unrecognized seizures already measured in the clinical range of the CBCL for behavior problems.

Just over 20% of the children with

true first seizures measured in the clinical range, as did 16% of the siblings.

When the researchers looked at CBCL syndrome scores, they found "the highest mean syndrome scores were in attention problems," he said.

In fact, 15% of children with prior unrecognized seizures and 9% of children with true first seizures were in the clinical range for attention problems.

Children with prior unrecognized seizures also had significantly higher rates of aggressive behavior and anxiety/depression, as well as higher withdrawal syndrome scores, than did children with true first seizures.

Dr. Dunn theorized that this might be a problem with children having some underlying central nervous system discharge that doesn't appear on an EEG.

"We are saying that there is probably some kind of underlying central nervous system dysfunction that causes both seizures and behavior problems," he suggested.

These findings come from a baseline analysis that is part of a larger study, which will follow the children for several years.

"Our thought was that if behavior problems were due to recurrent seizures, medication effect, or the patient's reaction to illness, we wouldn't see very many behavior problems right at the very beginning of the epilepsy but these would build up over time.

"But if the behavior problems were due to some underlying central nervous system problem, then the behavior problems should be present at the beginning of the seizures and should persist," Dr. Dunn said. ■