Chapter 11
Assessment of Anxiety Disorders, PTSD, OCD, and Depression in Young Children

Adrienne Garro

Abstract This chapter examines assessment of anxiety and related disorders in young children. It begins with description of risk factors for these disorders, including temperament characteristics and parent/family influences. Next, the chapter provides general background regarding anxiety and related problems in younger children. The author covers research literature and diagnostic and classification information for specific problems including fears/phobias, separation anxiety disorder/school refusal, selective mutism, PTSD, obsessive-compulsive disorder, and depression. In addition, specific measures/instruments for these problems are discussed. The chapter concludes with a discussion of implications for practitioners, including a summary of assessment principles and links to interventions.

Keywords Preschool anxiety, selective mutism · Separation anxiety disorder · Early childhood depression · Assessment of early childhood anxiety · Obsessive-compulsive disorder in young children · Posttraumatic stress disorder in young children · Fears and phobias in young children · Risk factors for anxiety in children

Introduction

As is the case with other psychological problems in young children, anxiety, depression, and related disorders are often difficult to assess. Accurate and valid assessment of these problems not only requires consideration of the rapid developmental changes during early childhood. It also calls for understanding of and

A. Garro (✉)
Department of Advanced Studies in Psychology, Kean University, Union, USA
e-mail: agarro@kean.edu

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sensitivity to the distinct ways they are manifested. Although researchers and clinicians continue to debate the validity and necessity of the internalizing versus externalizing distinction, it is clear that some psychological problems and disorders involve symptoms that are less visible and disruptive to other people (e.g., withdrawal, loneliness). Given the less advanced language abilities of young children, it is more difficult and, sometimes, impossible for them to verbally express these internal symptoms. At the same time, young children who are experiencing significant depression, anxiety, or trauma also exhibit outward changes in their behavior which may be mistaken for a "behavior problem" or a diagnosis that is more externalizing in nature (e.g., ADHD). Thus, these children often present with mixed combinations or heterogeneous profiles of symptoms which must be carefully evaluated in context to arrive at effective diagnosis and intervention planning. As an additional complication, there continues to be resistance among professionals, as well as the general public, about identifying young children with potentially stigmatizing diagnoses.

Despite the challenges in assessing emotional problems in young children, there is increasing interest, research, and advocacy in this area. This is related to the confluence of several factors. One primary factor is increasing recognition that emotional and behavioral problems in young children often show stability over time. Thus, affected children are at continued risk for a pattern of impairment that extends into later childhood and adolescence. In a study of children who were screened at kindergarten for behavioral and emotional problems and subsequently assessed in grades, 1, 3, and 5, Essex et al. (2009) found that children with recurrent comorbid symptoms had the highest levels of negative outcomes, including functional impairments in school, health problems, and service use. The researchers also concluded that there was solid support for accurately identifying at-risk children as early as first grade. The continuing trajectory from early history of behavioral and emotional problems to childhood disorders has not only informed the areas of diagnosis and identification, but also highlighted the importance of early intervention. The prospect for effective early intervention is even more pronounced when we consider brain plasticity in young children and the opportunities to shape major contexts of their development. A third factor contributing to the rising interest in early identification of internalizing problems is greater availability and feasibility of appropriate assessment procedures. As described in several chapters of this text, clinicians now have access to broadband and even some specific measures to assess emotional problems and clinical disorders in young children. In addition, since it is often difficult as well as developmentally inappropriate to apply many traditional diagnostic criteria to infants and young children, early childhood professionals also have the opportunity to apply adapted ones that are more suitable for this population.

Literature Review

Risk Factors

To begin, a discussion of risk factors related to anxiety, depression, and related disorders is pertinent to clinicians, especially from the standpoint of prevention and early intervention. One of the most substantial and well-studied risk factors is temperament. The research literature points to a distinct set of temperament traits that have been linked to psychological problems that are more internalizing in nature, even during the period of early childhood. Some recent research which has found connections between behavioral inhibition (BI) and anxiety symptoms or disorders in young children include the work of Pahl, Barrett, and Gullo (2012), Volbrecht and Goldsmith (2010) and Hudson, Dodd, Lyneham, and Bovopoulos (2011). Mian, Wainwright, Briggs-Gowan, and Carter (2011) examined an ecological risk model for early childhood anxiety and found that child temperament, including negative emotionality and BI, and early anxiety at age 3 were the strongest predictors of child anxiety at age 6 and 8.

In discussing temperament, it is clear that there is an interaction between this factor and environmental variables. For example, there is evidence that temperament interacts with parenting behaviors, such as maternal over-involvement, also known as intrusive parenting, to influence childhood anxiety. Hudson et al. (2011) studied BI and different aspects of family environment in children at age 4, and then again 2 years later. Their results indicated that BI, maternal anxiety, and maternal over-involvement at age 4 were significant risk factors for child anxiety at age 6. They also found that maternal over-involvement was significantly associated with BI at age 6. Feng, Shaw, and Silk (2008) looked at developmental trajectories for boys' anxiety symptoms across early and middle childhood and found that maternal overcontrol was associated with increasing levels of anxiety. The researchers posited that parental overcontrol contributes to increases in children's anxiety by "decreasing their sense of mastery over their environment and self-efficacy in coping with stressful and emotional situations."

Parent characteristics in their own right have direct connections to child anxiety and depression. For example, Meadows, McLanahan, and Brooks-Gunn (2007) found that maternal anxiety and/or depression was linked to higher likelihood of anxious or depressed behavior in a sample of 3-year-old children. Muris, van Brakel, Arntz, and Schouten (2011) found that maternal anxiety was associated with child anxiety over time. Bayer, Sanson, and Hemphill (2006a) found that combined parental anxiety/depression scores at age 2 significantly predicted early childhood internalizing difficulties at age 4, as did higher levels of over-involved/protective parenting and lower levels of warm/engaged parenting. In a meta-analytic review of research focusing on connections between parent and child anxiety and parental control, van der Bruggen, Stams, and Bogel (2008) found a significant association ($d = 0.58$) between child anxiety and parental control. Maternal depression has also been examined and found to be related to depression

symptoms and other internalizing problems in young children (Dawson et al., 2003; Garstein & Bateman, 2008; Trapolini, McMahon, & Ungerer, 2007). Although maternal psychopathology has been most widely studied, there is also evidence that depression in fathers can increase risk (Hanington, Ramchandani, & Stein, 2010).

There are a number of potential mechanisms to explain the role of parent depression in children's internalizing difficulties. For example, mothers who are depressed might be less responsive to children's needs, contributing to the development of passive coping styles and/or learned helplessness (Downey & Coyne, 1990). Some have posited that parental depression contributes to a negative, critical interactional style which places children at greater risk for internalizing problems (Downey & Coyne; Murray & Cooper, 2003; Murray, Fiori-Cowley, & Hooper, 1996). Field, Hernandez-Reif, and Diego (2006) described two potential pathways, one of which involves withdrawn maternal behavior contributing to under-stimulation of infants, who are then less responsive to various environmental stimuli. The other involves greater maternal intrusion and over-stimulation, which, in turn, results in reduced opportunities for infants to acquire new skills and independence. Other studies have found more complex relationships between child temperament characteristics and parent depression (e.g., Olino, Klein, Dyson, Rose, & Durbin, 2010). Such research emphasizes the need to consider multiple aspects of temperament and to look beyond one-way influences in the development of childhood internalizing problems. In addition, the relationship between parent depression and child internalizing problems may also be partially explained by genetic factors, which contribute to a greater predisposition to psychopathology that is manifested in early temperament characteristics. Aside from parental psychopathology, research suggests that other family factors are associated, either directly and/or through mediating relationships, with child internalizing difficulties. These include harsh discipline and negative beliefs about parenting (Laskey & Cartwright-Hatton, 2009); life stress (Hopkins, Lavigne, Gouze, LeBailly, & Bryant, 2013); parenting stress (Anthony et al., 2005; Viaux-Savelon et al., 2010), and family violence or conflict (Viaux-Savelon; Roberts, Campbell, Ferguson, & Crusto, 2013). Conversely, some research suggests that positive parenting may serve as a protective factor against internalizing difficulties in young children (Bayer et al., 2006a; Koblinsky, Kuvalanka, & Randolph, 2006).

Anxiety and Related Disorders in Young Children: General Background

Although there has been sparse research focusing specifically on anxiety disorders in preschoolers, existing studies suggest that they are fairly prevalent. For example, in a community sample of 541 3-year old children, Dougherty et al. (2013) found that 19.6 % met criteria for at least one anxiety disorder based upon parent interview with the Preschool Age Psychiatric Assessment (PAPA). Specific DSM-IV

diagnoses included specific phobia (9.1 % of sample); separation anxiety disorder (SAD) (5.4 %); social phobia (4.4 %); GAD (3.9 %); agoraphobia (3.5 %); selective mutism (1.5 %); and panic disorder (0.2 %). Paulus, Backes, Sander, Weber, and Gontard (2015) conducted a population-based study with 1342 young children ages 4–7 years to examine prevalence of anxiety disorders and their association with BI. Using the DISYPS-II (Döpfner, Görtz-Dorten, & Lehmkuhl, 2008), a German parent questionnaire based upon ICD-10 and DSM-IV criteria, they found that the total prevalence of anxiety disorders was 22.2 %.

Aside from BI, other factors have been studied in connection with anxiety disorders. For example, research indicates that SAD, as an overall syndrome, is strongly heritable, but is also influenced by non-shared environmental factors (e.g., differences in parenting practices, experiences outside the home, etc.) (Bolton et al., 2006). With respect to fear and phobia symptoms, Lichtenstein and Annas (2000) found that genetic factors make a modest contribution to phobias and also contribute to the tendency to show specific fears. Their results also indicated that shared environmental influences contributed significantly to phobias and fears and to a general vulnerability to fearfulness, while non-shared environment also played a role. Other variables receiving some attention in the research literature are cognitive biases. These include attention bias, which is the tendency to focus more on threatening stimuli in the environment, and interpretation bias, which is the tendency to interpret neutral stimuli as harmful or threatening. In a prospective study beginning with children ages 3 to 4, Dodd, Hudson, Morris, and Wise (2012) found that there were significantly higher levels of interpretation bias in children who met criteria for an anxiety disorder versus those who did not. They also found that interpretation bias predicted anxiety symptoms at 1 year follow-up but not later follow-ups. Waters, Bradley, and Mogg (2014) looked at biased attention to threat as a potential mechanism to distinguish between children with diagnoses of principal fear disorders (i.e., specific phobia, social phobia, or SAD), those with a principal distress disorder (i.e., GAD), and those with no diagnosis. Consistent with their hypotheses, they found that, compared to the control group, the GAD group showed greater attention toward angry versus neutral faces; and the principal fear group demonstrated attention bias away from angry versus neutral faces.

Fears and Phobias

With respect to phobias, there is relatively little literature to guide assessment and diagnosis for younger children. This is due in part to the fact that fears are considered common and developmentally appropriate in young children, particularly preschoolers. For clinicians, it is extremely important to distinguish between fears in early childhood which are typical and generally transitory and those which require treatment. Some factors which can assist in this differentiation are the level of fear and/or anxiety expressed by the child and the degree of impairment generated by her or his symptoms. As an example, a 4 year old child who has been

bitten by a dog and, subsequently, screams when in close proximity to dogs but is able to walk on the other side of a street from them is not likely to meet criteria for a specific phobia. In contrast, a 5-year-old child whose fear of the dark is so intense that she insists on having multiple night lights, tantrums if the lights go off for brief periods of time, and repeatedly wakes her parents up is more likely to fit within the diagnostic parameters for a specific phobia. According to the DSM-5, two major elements should be examined when diagnosing specific phobia in children. One of these is explicitly stated in the criteria, namely that the fear or anxiety may be manifested as crying, clinging behavior, freezing up, or tantrums (American Psychiatric Association (APA), 2013a). Second, many children, particularly younger children, do not have the cognitive capacities to understand the concept of avoidance of a feared object or situation. Because of this factor, clinicians must be comprehensive in gathering information from parents, other family members, teachers, etc. who can shed light on the nature, degree, frequency and duration of the child's symptoms (APA).

In one of the few studies focusing on younger children (ages 1 to 7), Evans, Gray, and Leckman (1999) considered developmental factors related to fears and differentiated between those that are prepotent/early onset and those that were later onset. Prepotent fears are more likely to be dominant across all individuals and have a species-specific or evolutionary component, in that they help protect against general threats, unfamiliar stimuli, and other environmental harm. The results indicated that, in children younger than four, repetitive, compulsive-like behaviors were associated with overall levels of fearfulness and prepotent fears (e.g., fear of strangers). In contrast, children age four and older showed a wider range of fears that were more specific and contextual, (e.g., fears of contamination, death), and these were associated with "just right," compulsive-type behaviors, such as the need to have certain toys or activities arranged a certain way.

Separation Anxiety Disorder (SAD) and School Refusal

One of the biggest changes related to anxiety disorders in the DSM is that the age of onset for SAD is no longer confined to the period of childhood and adolescence. This change does not deflect from the fact that SAD continues to cause significant impairment in many children. As is the case with phobias, it is extremely important to assess SAD in a developmentally appropriate context when working with younger children. Stranger anxiety is expected and considered typical during infancy and toddlerhood and may continue into the early childhood years. Given that this behavior and a desire to be close to parents/caregivers when there is healthy attachment are expected and typical for young children, the earliest time-frame for diagnosis of SAD is generally not until preschool years. Even for preschoolers, diagnosis can be difficult and complicated by initial transition to preschool, a change which will naturally elicit some degree of anxiety in young children. There is little research focusing on SAD alone as a disorder. In one study

examining early predictors in German children, Lavalee et al. (2011) compared a sample of with SAD to a healthy sample and found that parents of the former group retrospectively reported a more intense period of stranger anxiety. The researchers also found that more intense stranger anxiety remained a significant predictor of SAD, even after controlling for maternal depression. This study and other research (e.g., Bron, Van Rijen, Van Abeelen, & Lambregtse-Van den berg, 2012) suggests that high levels of certain early behaviors in infancy are important to monitor as potential risk factors in the development of anxiety and other emotion regulation problems. In assessing for SAD, Pacholec et al. (2013) discussed the importance of looking at behavioral symptoms, including avoidance; emotional symptoms (e.g., irritability as well as worry), which can overlap with physical/bodily complaints; and cognitive symptoms (e.g., distortions, biases). The latter are more difficult to assess in younger children since they might not be able to fully or accurately express their thoughts and fears related to separation. SAD also needs to be assessed in light of a family's cultural background, since cultures vary with respect to their values and expectations regarding physical and emotional boundaries and interpersonal proximity within families (Pacholec).

SAD is significant not only as its own anxiety syndrome, but also due to its overlap with school refusal and school phobia. According to Heyne, King, and Tonge (2004), between 30 and 38 % of children who refuse to attend school met criteria for SAD, and Farris and Jouriles (1993) noted that 33–50 % of SAD cases were associated with school phobia. Although the terms school phobia and school refusal are sometimes used interchangeably, they are not the same. True school phobia involves intense fear of school, while school refusal might not involve fear. Kearney, Chapman, and Cook (2005) describe school refusal as a "child-motivated refusal to attend school and/or difficulty remaining in classes for an entire day." For younger children, school refusal may manifest when they attend daycare, preschool, kindergarten, or other structured environments outside of home. According to Kearney et al., it is important to consider the possible functions that might be served by school refusal behavior including: (a) pursuing attention from parents/significant others; (b) avoiding school-based events and other stimuli that trigger negative emotions; (c) pursuing tangible reinforcement outside of school (e.g., preferred activities at home); and (d) escaping difficult and unpleasant school-based social and/or evaluative situations (i.e., those that may be related to social anxieties.). When assessing school refusal behavior in young children, there are several factors and guidelines to consider. In line with Kearney et al.'s work, it is important to consider underlying function(s) served by the behavior, which requires interviews with parents, teachers and, perhaps, other central figures in the child's life to determine potential triggers and reactions/consequences. Family dynamics, such as enmeshment or low independence (Kearney et al.), might play an integral role in the development and maintenance of school refusal. Therefore, clinicians need to employ sensitive questioning to examine the potential role of these patterns. Kearney et al. also emphasized the need to assess attention-seeking, demanding, and oppositional behaviors since many children with school refusal demonstrate this conduct as a constellation of related symptoms. Among young children who are

transitioning to child care for the first time, it is imperative to look at potential precursors to full-blown school refusal; this might serve as a form of prevention. More specifically, for young children who already have risk factors related to temperament, existing anxiety, and/or family history of anxiety, variables in the child care or early school environment can make a difference in adjustment to these settings. Thus, clinicians or personnel in early child care environments can work with families to try to ensure good child/teacher fit and, if this is not possible, to monitor the child's status for early signs of refusal.

Selective Mutism

The update to DSM-5 resulted in selective mutism (SM) being classified as an anxiety disorder. The prevalence of SM is estimated to be less than 1 % (APA, 2013b). There has been no published research focusing exclusively on younger children (age 5 and under) with SM, but it is generally accepted that symptoms emerge during early childhood. According to Muris and Ollendick (2015), the mean age of onset is between 2 and 5 years. The new classification of SM as an anxiety disorder does have considerable research support. This includes research showing: (a) strong family history of anxiety-related problems/disorders in children with SM (e.g., Chavira, Shipon-Blum, Hitchcock, Cohan, & Stein, 2007; Cohan, Price, & Stein, 2006) and (b) presence of high level of anxiety symptoms, including social anxiety, in children with SM (e.g., Carbone et al., 2010; Levin-Decanini, Connolly, Simpson, Suarez, L., & Jacob, 2013). Muris and Ollendick (2015) noted that the etiology of SM is comparable to that of other child anxiety disorders in that, genetic factors, some environmental influences (e.g., high parental control) and temperament factors, such as high BI, are associated with the syndrome. However, more empirical evidence is needed to establish sound linkages and pathways between specific etiological factors and the development of SM.

As is the case with other anxiety disorders, when assessing SM in younger children, there are a number of unique considerations. First, while the research literature notes that diagnosis often does not take place until children are in school or even later, it is clear that signs often emerge before formal schooling. In addition to some of the risk factors described above, there is research suggesting that children with SM show lower social competencies in comparison to those without SM (e.g., Carbone et al., 2010; Cunningham, McHolm, & Boyle, 2006). Some research indicates that the prevalence of SM is higher in children from immigrant families (Elizur & Perednik, 2003; Manassis et al., 2007). This might be related to problems with language acquisition, cultural differences, in terms of social interaction, and/or processes of acculturation. However, more research is needed to determine reasons why immigrant children have higher rates of SM. Another developmental and risk consideration for younger children is the presence of communication problems. This can be a point of confusion due to the fact that, in order to receive a DSM-5 diagnosis of SM, the child's failure to speak in the

required situation(s) must not be **primarily** attributable to a lack of knowledge or comfort with the language being used. Because of this, clinicians might assume that a child cannot have communication deficits or delays and also be diagnosed with SM. However, this is not the case unless lack of language knowledge/skill is the primary reason for not speaking. In fact, several studies have documented the presence of language/communication problems in children with SM (e.g., Manassis et al., 2007; McInnes, Fung, Manassis, Fiksenbaum, & Tannock, 2004). Given the above factors, psychologists and other professionals should attend more closely to younger children who present with multiple risks and also educate personnel in early childhood environments with respect to best practices. In addition, teachers and, even physicians, might not recognize early signs of SM.

Posttraumatic Stress Disorder

In DSM-5, PTSD is now housed under the umbrella of trauma- and stressor-related disorders instead of being classified as an anxiety disorder. While anxiety symptoms might be seen in PTSD, the new diagnostic criteria recognize that affected individuals can show a range of reactions to traumatic stressors, and some people do not show "intense fear, helplessness, or horror," as was specified in the DSM-IV (APA, 2013c). The most significant DSM-5 change is the inclusion of the subtype: Posttraumatic Stress Disorder for Children 6 Years and Younger, which takes into account differences in how younger children might manifest symptoms and is also developmentally sensitive to their feeling states and cognitions. The new subtype recognizes that types of traumatic events in younger children might be different from those experienced by older children and adults. This means that witnessing events experienced by others can qualify as trauma. For example, witnessing violence against primary caregivers might be uniquely distressing for young children because of their greater dependence on them. Other events which might be more likely to trigger traumatic reactions in younger children include invasive medical procedures, which can be experienced as out of the child's control, and dog or other animal attacks (APA, 2013c).

The new PTSD subtype also references potential changes in play activities as distinctive symptoms in children under 6. For example, spontaneous and/or intrusive memories might be expressed as play; dissociative reactions and/or trauma-specific reenactment might manifest in play; and restriction of play might signify symptoms related to "negative alterations in cognition" (APA, 2013c). With respect to intrusion symptoms, children under 6 might not be distressed by intrusive memories of the trauma, and, if they have dreams that are upsetting, it might be difficult to make the cognitive connection between the content of these dreams and the trauma they have experienced. Another difference seen in the younger subtype involves the criterion of alterations in arousal and reactivity. More specifically, the younger subtype notes that children under 6 might show extreme temper tantrums as a sign of irritability or anger (APA, 2013c).

Since the relatively recent publication of the DSM-5, data is still being gathered regarding the validity of the new preschool subtype. In a 2015 study, Gigengack, van Meijel, Alisic, Lindauer looked at diagnostic outcomes in a sample of almost 100 children ages 0–7 years who suffered accidental injuries using: (a) the new DSM-5 PTSD Preschool subtype; (b) Scheeringa's (2002) alternative algorithm for PTSD in young children (PTSD-AA), which helped inform changes for the DSM; and (c) the DSM-IV PTSD criteria. Their results suggested that the DSM-5 subtype and Scheeringa's algorithm were more suitable than the older DSM-IV criteria in identifying posttraumatic stress symptoms in this sample. Similarly, in earlier studies, Scheeringa, Myers, Putnam, and Zeanah (2012) and De Young, Kinardy, and Cobham (2011) found empirical support for developmentally sensitive PTSD criteria, which contributed to the new preschool subtype in DSM-5. From a practical standpoint, clinicians assessing for potential PTSD in younger children should become knowledgeable regarding the range of symptoms that might be manifested, including: (a) more subtle avoidance behaviors (e.g., looking away from trauma reminders); (b) changes in cognition (e.g., withdrawal from social interactions, constriction of play) that are not easily apparent, especially since younger children have less sophisticated language skills; and (c) changes in arousal/reactivity (e.g., irritability, outbursts, poor concentration), which are sometimes mistaken for other disorders (De Young et al.). In addition, De Young et al. and Scheeringa et al. note that younger children might manifest other features of trauma: increased clinginess or separation anxiety, regression in development, new fears, or new onset of aggression. Based upon the above, it is important for clinicians to adopt a more comprehensive framework in assessing PTSD and trauma symptoms in younger children. Questionnaires should be supplemented with interviews and observations as much as possible. In addition, clinicians need to monitor young children who have been exposed to traumatic events, do not meet full criteria for PTSD, but demonstrate subthreshold levels of symptoms.

Obsessive-Compulsive Disorder

In the DSM-5, Obsessive-Compulsive Disorder (OCD) is no longer in the same chapter as anxiety disorders, though clinicians and researchers still acknowledge overlap between the two. While most research related to pediatric OCD has been conducted with children ages 8 and up, there is a small, but growing body of literature focusing on younger children. According to Garcia et al. (2009), OCD has been documented in children as young as 2–3 years old. "Early childhood OCD" is often used to refer to OCD with onset of symptoms before age 8. In a study of 58 children with early childhood OCD, Garcia et al. found that the mean age of onset was 4.95 years. Seventy-five percent of the sample reported multiple obsessions, with the most common being contamination, followed by themes related to aggression or catastrophe, religious or moral obsessions (also known as scrupulosity), and somatic obsessions. Ninety-six percent of the sample reported multiple

compulsions, with the most common being checking, washing, rituals involving other people, and repeating in some form. In this same study, the researchers found that 20 % of the children had a first degree relative with OCD and 32 % had such a relative with some other type of anxiety disorder. Garcia et al. noted that their sample showed lower rates of depression in comparison to older children with OCD. However, a key similarity is that the young sample showed full-blown symptoms, not just beginning stages or partial symptoms. Other research has also found that early childhood OCD is associated with family history and is characterized by significant impairment (Coscun, Zoroglu, & Ozturk, 2012; Nakatani et al., 2011). Some research has noted that OCD in younger children may, in fact, be more impairing due to longer illness duration, higher levels of comorbid tics, and greater psychosocial difficulties (Nakatani et al., 2011). In addition, child-onset OCD in general may be more impairing than later onset OCD, since it can interfere with the attainment of major developmental tasks (Valderhaug & Ivarsson, 2005).

When it comes to assessment for early childhood OCD, there are some unique developmental considerations. One of these is that children may have difficulty talking about or even recognizing cognitions that are repetitive, unusual, etc. since metacognitive skills are less developed in this age range. If children are unable to identify or express their obsessions to others, compulsions are more likely to be prominent as symptoms to parents, teachers, and others. However, at the same time, these behaviors may not be well understood if the child cannot explain them. Even as children become aware of obsessive thoughts, they may not be able to distinguish them from other types of recurring thoughts or images or to make the connection between their obsessions and their compulsive behaviors (Choate-Summers et al., 2008). Choate-Summers also described difficulties discriminating between compulsive behavior and tics or other repetitive behaviors. This might be related to young children having a hard time describing the fear behind their compulsions, which contributes to the impression that they are more automatic behaviors. Also, young children's compulsions might involve the need to touch or tap items until certain sensations are attained. Given this sensory aspect, such compulsions are often difficult to differentiate from tic behaviors. In addition, it is vital to discern OCD symptoms from ritualized behaviors that have been incorporated into a young child's routine. Parents and families are encouraged to establish routines early in children's lives to establish a sense of stability and organization. However, some routines might become overly rigid due to child temperament, parent personality, or variables in the home/family environment. To distinguish between more typical developmental routines and OCD, Choate-Summers et al. recommend that clinicians examine duration of behaviors, the roles/functions they serve in the child's life, and the degree of interference and distress they generate. Families might reinforce or otherwise contribute to OCD in young children through unhealthy problem solving or coping techniques, exemplifying anxious ways of thinking about or interpreting situations, and accommodating to OCD symptoms. There are no specific measures for assessing OCD in younger children. However, Freeman, Flessner, and Garcia (2011) and Cook, Freeman Garcia, Sapyta, and Franklin (2015) examined use of the Children's Yale-Brown Obsessive Compulsive Scale

(CY-BOCS; Scahill et al., 1997) with 5–8 year old children instead of older children. Results indicated good internal consistency and test-retest reliability for the total scale. However, there was poor internal consistency for the Obsessions subscale and the Compulsions subscale has received mixed empirical support. Both of the above studies found solid evidence for the convergent validity of the total CY-BOCS score, but there were mixed results for discriminant validity.

Depression in Young Children

While there have been recent advances in assessment of depression in young children, the field is emerging and complex. In addition, controversy still exists regarding time of diagnosis. When focusing on infancy, there are no standardized instruments for assessing depression. If clinicians do suspect depression in an infant, they are typically relying on information gathered through observation and parent/caregiver report. Several studies suggest that symptoms related to depression can be identified as early as 2–3 years of age (Garstein & Bateman, 2008; Luby, Si, Belden, Tandon, & Spitznagel, 2009). Luby et al. examined a sample of children ages 3 to 6 years (including subsamples of healthy, disruptive, and depressed children) and interviewed their parents. Their results indicated that significant symptoms of depression may develop as early as age 24 months, and aspects of negative self-concept in toddlers were the strongest predictors of preschool depression.

As noted above, temperament factors are strongly emphasized when considering a young child's general risk for psychopathology, and this applies to depression itself. As the construct of emotion regulation (ER) has gained greater recognition, both clinically and empirically, it is clear that it plays a role in many psychological disorders, including early depression. Bron et al. (2012) looked at young children who were classified with an ER difficulty between birth and 3 years of age. They found that 39–69 % of them had scores above the clinical cutoff range for internalizing, externalizing, and total problems as measured by the CBCL in comparison to 16 % of children without some form of ER difficulty. In a research review, Eisenberg, Sprinrad, and Eggum (2010) indicated that a range of studies (e.g., Dennis, Brotman, Huang, & Gouley, 2007; Feldman, 2009) found significant inverse relationships between various aspects of ER (e.g., effortful control, attentional control, positive reward anticipation) and internalizing difficulties in young children. Given the empirically supported link between low ER in young children and internalizing difficulties, the assessment of ER early in a child's life, even during infancy, is an important step. Such assessment most typically involves structured observations and tasks.

Beyond infancy, during the preschool years, as children's behavioral and emotional patterns become more visible and they develop greater language skills, assessment of depression is more feasible. In line with these changes, some

researchers have developed more structured techniques and models of assessment. For example, both Luby et al. (2002) and Scheeringa et al. (2002) proposed modifications to the DSM-IV that were focused on making the criteria for diagnosis of depression more developmentally appropriate and valid in younger children. Luby placed an emphasis on the symptoms of sad OR irritable mood, anhedonia, eating and/or sleeping difficulties, low energy, and low self-esteem. Both Luby and Scheeringa proposed changes in the duration requirement for Major Depressive Disorder (MDD) diagnosis in children, such that symptoms of depressed or irritable mood did not have to be continuously present for a two-week period. Thirdly, both Luby and Scheeringa indicated that preoccupation with death can be conceptualized as a symptom of depression in young children, but suggested that it might not be expressed verbally. Instead, young children's play should be examined for potential signs, which may include themes of characters, dolls, etc. being seriously hurt, injured, or dying. Studies by Luby and colleagues (e.g., Luby et al., 2002, 2003) provide some support for the concurrent and predictive validity of Scheeringa's RDC-PA for diagnosing MDD in children ages 3 to 5.

Instruments/Measures

Several standardized tools have gained prominence in assessing psychological problems in younger problem. This section will be devoted to measures that are most applicable to children below age 7.

The Children's Moods, Fears, and Worries Questionnaire (CMFWQ; Bayer, Sanson, & Hemphill, 2006b) is a parent-report questionnaire designed to assess internalizing difficulties in toddlers and preschoolers. The original sample included 112 parents of 2-year-olds drawn from an Australian community who were followed until the children were 4 years old. Bayer et al. noted that most parents were Anglo-Australian but showed a mix of cultural, educational, and employment backgrounds. After pilot testing and further revision, the current version consists of 35 items for 2-year-olds; 38 items for 4-year-olds and 34 items for 7-year olds. Items are answered on a five-point frequency scale ranging from 1 = Almost never to 5 = Almost always. For a sample ages 18 months–7 years, Andrijic, Bayer, and Bretherton (2013) found that a cutoff score of 2.87 was useful in delineating true positives and negatives for children with anxiety diagnoses. Early factor analyses of the CMFWQ generated two main factors: (a) internalizing difficulties, consisting of items tapping anxiety, depression and BI and (b) solitary play with peers. However, Broeren and Muris (2008) examined a 60-item version of the CMFWQ which yielded three factors, including fear and anxiety problems, inhibition/solitary play, and mood problems. Both Broeren and Muris and Bayer et al. (2006b) found high internal consistencies for the total scale, with Cronbach's alphas over 0.90. Broeren and Muris also found strong internal consistencies for the three subscales they generated, with Cronbach's alphas ranging from 0.88 to 0.92. Test-retest reliability over a 2-year period was strong (r = 0.56).

The Preschool Anxiety Scale-Revised (PAS-R; Edwards, Rapee, Kennedy, & Spence, 2010) is a parent-report measure specifically devoted to the assessment of a range of anxiety symptoms in young children. The original PAS was developed using a large community sample of young children ages 2½–6½ in Australia. The PAS-R consists of 30 items rated on a five-point scale from 0 (not at all true) to 4 (very often true). Based upon the revised items, the authors derived four factors: generalized anxiety, social anxiety, separation anxiety, and specific fears. Internal consistency was solid, with an alpha of 0.92 for the total scale and alphas ranging from 0.72 to 0.89 for the component scales. In addition, Edwards et al. reported good stability over 1 year, with test-retest reliabilities ranging from 0.60 to 0.75; moderate to high agreement between mother versus father informants; and moderate to high correlations with other measures/indicators of anxiety.

The Picture Anxiety Test (PAT; Dubi & Schneider, 2009) was developed on a Swiss sample to measure anxiety symptoms in children ages 4–8 years. It obtains information from the child's perspective and was developed to be aligned with the cognitive and verbal skills of younger children. The PAT includes 17 items, each of which consists of two color illustrations, portraying two different reactions of a child in a potentially fearful or anxiety-provoking situation. The examinee is asked to pick which picture would most closely correspond to him or her. The examiner also asks the child to indicate his/her degree of both fear and avoidance for each illustration, and these reactions are assessed on a five-point-scale ranging from "not at all" (0) to "very much" (3). The examiner can adjust these ratings based upon clinical judgment. The PAT provides a total anxiety score, a total avoidance score, and a composite score (anxiety + avoidance). The PAT also assesses symptoms related to separation anxiety disorder, generalized anxiety disorder, and social phobia. Dubi, Lavalee, and Schneider (2012) examined psychometric properties of the PAT in a community sample and found strong internal consistency for the three main scores, with Cronbach's alphas ranging from 0.77 to 0.88 and adequate test-retest reliability over a 4–6 week period with r values ranging from 0.65 to 0.71. For inter-rater reliability, there was strong agreement between raters, with Cohen's Kappas ranging from 0.83 to 1.0 for anxiety ratings and 0.79 to 1.0 for avoidance ratings. Evidence for the convergent validity of the PAT has been mixed (Dubi, Lavelle & Schneider; Dubi & Schneider).

The Preschool Feelings Checklist is a 16 item checklist, answered by parents in a "yes"/"no" format, that is used to screen for depression in young children (PFC; Luby, Heffelfinger, Mrakotsky, & Hildebrand, 1999). The PFC is available online as a PDF: http://www2.tulane.edu/som/tecc/upload/Preschool-feelings-checklist.pdf and takes 2–3 min to complete. It was developed using a sample of 174 children ages 3–0 through 5–6 recruited from community pediatric settings (77 % of sample) and young child mental health clinics (23 % of sample). Internal consistency for the PFC was fairly strong with a Cronbach's alpha of 0.76. The sensitivity and sensitivity of the PFC were assessed by Luby, Heffelfinger, Koenig-McNaught, Brown, and Spitznagel (2004), who concluded that a total PFC cutoff score of 3 provided maximal ability to correctly differentiate youngsters with depression from those without (sensitivity) and to not incorrectly identify children who did not have

a psychiatric disorder (specificity). The greatest limitation of the PFC is the small sample used to examine its psychometric properties. There has been additional research using the PFC. Luby, Si, Belden, Tandon, and Spitznagel (2009) used it to screen a sample of approximately 300 children ages 3 to 6 years and concluded that clinical-level symptoms of depression arise as early as 24 months for some children. Fuhrmann, Equit, Schmidt, and von Gontard (2014) studied a sample of 653 children in Germany at school entry, with a mean age of 6.2 years. Using the cutoff score of three or higher, they found that 5.7 % of the sample had depression symptoms "of clinical relevance."

When it comes to assessment of trauma in young children, one of the most widely used instruments is the Trauma Symptom Checklist for Young Children (TSCYC; Briere, 1999), which is a parent-report questionnaire containing 90 items that is intended for children ages 3–12 years. The most common application of the TSCYC is with abused and traumatized children as a measure assessing overall trauma reaction, including trauma symptomatology and comorbid conditions. The TSCYC includes eight clinical scales: (a) posttraumatic stress (PTS)-Intrusion, which reflects distress related to intrusive thoughts, memories, etc.; (b) PTS-Avoidance, which reflects behaviors/symptoms related to escaping from or trying to get away from stimuli associated with the trauma; (c) PTS-Arousal, which reflects symptoms related to reactivity and sensitivity; (d) Sexual Concerns, which reflects sexual distress and preoccupation; (e) Anxiety, which encompasses general aspects of anxiety and worry as well as specific fears; (f) Depression, which captures depressive feelings and thoughts and related symptoms; (g) Dissociation, which reflects degree of detachment from the environment; and (h) Anger/Aggression. It also includes two validity scales: (a) Response Level, which assesses the general tendency to deny typical, minor behavior problems in one's child and is, thus, related to under-reporting of symptoms and (b) Atypical Response, which assesses the parent's tendency to endorse a set of very unusual and unrelated behaviors (Briere, 1999).

The TSCYC was normed on 750 children matched to the U.S. Census with 42.3 % having experienced a highly upsetting or traumatic event. According to Briere et al. (2001), the TSCYC shows solid internal reliability, with an overall alpha of 0.94, and the clinical scales demonstrate good internal reliability, with coefficient alphas ranging from 0.73 to 0.91. There is some evidence for the construct validity of the TSCYC, and several studies have demonstrated the instrument's convergent validity specifically (Gilbert, 2004; Wherry, Graves, & King, 2008). Wherry, Corson, and Hunsaker (2013) developed a short form of the TSCYC consisting of 32 items loading onto the eight factors described above. Though additional research is warranted, this short form showed evidence of good convergent validity when compared to other measures. Although the TSCYC does have a self-report counterpart, the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) the minimum age range for the TSCC is 8 years, making it inappropriate for preschoolers. Despite this, it is valuable to gain input of preschoolers through other means such as observations. Clinicians also need to make distinctions in the type of assessment that is warranted. For example, in some cases it may be unclear if a young child was exposed to a traumatic event and this warrants careful investigation.

For these situations, parent- and/or child-report measures, such as the Trauma Exposure Symptom Inventory-Parent Report Revised (TESI- PRR; Ghosh-Ippen et al., 2002), the Violence Exposure Scale for Children-Preschool Version (VEX-PV; Fox & Leavitt, 1995), etc. are warranted. If a child has been exposed, it is imperative to understand the nature, degree and impact of their symptoms. Young children who have been exposed to traumatic events might or might not meet criteria for a PTSD diagnosis, but still need intervention for subthreshold symptoms.

When it comes to broadband instruments, the parent and teacher/caregiver rating scales of the BASC-3 (PRS and TRS) (Reynolds & Kamphaus, 2015) and the ASEBA (Achenbach & Rescorla, 2000) have early childhood versions. The PRS and TRS of the BASC-3 cover ages 2-5 years, with specific norms for this age group, and it generates an Internalizing Problems composite score that is relevant to many of the concerns discussed in this chapter. These BASC rating scales also produce Clinical Scale scores for Anxiety and Depression and Content Scale scores for several areas related to internalizing type problems (e.g., Emotional Self-Control and Negative Emotionality). Given the recent release of the BASC-3, there has not yet been any published research focusing on its use with preschool populations. The preschool version of the ASEBA covers ages 1 ½-5 years using the Child Behavior Checklist (CBCL) and the Caregiver-Teacher Report Form (C-TRF). These measures yield an Internalizing problems score as well as scores for Syndrome scales (e.g., Anxious/Depressed and Emotionally Reactive). There is some research to support the validity of these Syndrome scales (e.g., Ivanova et al., 2010, 2011). Some research has examined the score profiles and/or factor structure of the CBCL for 1½–5 year olds across different race or ethnicity groups and income levels. For example, Gross et al. (2006) concluded that the CBCL is appropriate to use with parents of low-income children from African American and Latino backgrounds but also found that there were differences in some Internalizing Scale scores based upon income and parent race/ethnicity, suggesting the need to interpret these scores with caution.

The Diagnostic and Infant Preschool Assessment (DIPA; Scheeringa, 2004) is a diagnostic interview for parents/caregivers of children who are six and younger. It incorporates both structured aspects (i.e., initial probe questions are detailed and should be read exactly as they are) and unstructured aspects (i.e., the interviewer follows scripted probes with questions to obtain examples). Each disorder of the DIPA has its own set of questions (module), corresponding to a symptom from the DSM-5. Each module can be administered individually. The DIPA was updated in February 2014 to align with the DSM-5. The DIPA and its manual can be accessed online: http://www.infantinstitute.org/measures-manuals/. According to Scheeringa, the DIPA can be used with parents/caregivers of infants up to age 6 years. The DIPA operates under the assumption that interviewees have some frame of reference of what is normal and abnormal. This represents a potential limitation since parents might not feel knowledgeable about this, especially if the target child is a first and/or only child. Follow-up questions for each DIPA module involve assessment of onset, frequency, and duration of symptoms and functional impairment. According to Scheeringa and Haslett (2010), the original DIPA showed good test-retest reliability and concurrent validity; psychometric properties of the updated DIPA were not yet available at the time of this writing.

The Preschool Age Psychiatric Assessment (PAPA; Egger & Angold, 2004) is a structured interview for diagnosing psychiatric disorders in children ages 2–5. The PAPA is administered to parents/caregivers and focuses on problems and symptoms that have occurred within the 3 months prior to the interview. The PAPA includes modules related to a variety of syndromes including, but not limited to, depression, separation anxiety, anxious affect, and posttraumatic stress syndrome. The interview also assesses disability resulting from symptoms, family environment and relationships, family psychosocial problems, and life events. As described by Egger et al. (2006), the PAPA involves a highly structured protocol with mandatory questions and probes. Interviewers must be knowledgeable when it comes to ensuring that interviewees understand the questions and when providing examples about behaviors and feelings that relate to symptoms. It also requires interviewers to document frequency, duration, onset, setting and context of symptoms. In a study of the reliability and utility of the PAPA, Egger et al. noted that it showed diagnostic utilities comparable to those of interviews for older children and adolescents. In addition, reliability did not differ significantly based upon gender, age, or race of the child (African–American vs. non-African–American). The PAPA has been effectively used to assess depression as well as anxiety in young children (Bufferd, Dougherty, Carlson, & Klein, 2011; Wichstrøm, 2012).

Historically, the assessment of psychopathology in younger children has involved adult informants based upon the assumption that children under age 6 cannot serve as reliable informants of their own symptoms due to limitations in cognitive and linguistic skills. However, research has found significant differences in parent and child reports of emotional and behavioral problems (Kolko & Kazdin, 1993; Wu et al., 1999), and there is also increasing evidence that young children can provide valid self-assessments of their symptoms, especially when it comes to more internalizing types of difficulties which might not be accurately detected by adults (Luby, Belden, Sullivan, & Spitznagel, 2007).

One of the more well-studied instruments for young children's self-reports of anxiety and depression is the Berkeley Puppet Interview (BPI; Measelle, Ablow, Cowan, & Cowan, 1998; Morris et al., 2002). The BPI is an interactive technique, which involves engaging the child in conversation by having two puppets make opposing statements (e.g., "I am a sad child" and "I am not a sad child") and then asking the child "What about you?" The BPI can be used with children ages 4–6 years through 8 years and taps children's self-perceptions across academic, social, and emotional domains (Measelle et al., 1998). The BPI allows children to respond with full or partial verbal statements or nonverbally. Children's responses are coded on a 7-point scale, with a seven representing the greatest absence of problems and a one representing a strong presence of a problem (Stone et al., 2014).

The BPI consists of more than 25 scales, and interviewers can choose the scales they want to administer. Eight of these are Symptomology Scales (BPI-S) (Ringroot et al., 2013). Three of these eight (depression, anxiety, and separation anxiety) contribute to the overall Internalizing scale, and three contribute to the overall Externalizing scale. The two additional symptomology scales—acceptance and rejection by peers and being bullied—are considered part of the Peer Relations

scale. The psychometric properties of the BPI have been examined in several studies. For example, Stone et al. (2014) found evidence of congruent and concurrent validity and satisfactory inter-rater reliability for the instrument. Ablow et al. (1999) found that test-retest reliability for the overall BPI was 0.60 with an interval of 7–10 days. This study also provided some support for the construct validity of the internalizing and externalizing dimensions and for the discriminant validity of the instrument since clinic-referred children scored in the expected directions as compared to a community sample. Luby et al. (2007) focused specifically on the utility and validity of BPI depression and anxiety items. Their results indicated that self-reports of basic BPI depression and anxiety symptoms significantly correlated with other measures concurrently and at 6 month follow-up. However, the researchers found that symptoms that were more complex or abstract for young children were less likely to be significantly associated with data from parent measures. Ringroot et al. (2013) conducted confirmatory factor analysis of the BPI in a large community sample of Dutch children (n = 6375). They found adequate internal consistencies for the three problem domains of internalizing, externalizing, and peer relations, with Cronbach's alphas of 0.72, 0.79 and 0.68, respectively, but not all of the individual scales. Ringroot et al. also reported that higher scores on many of the BPI scales were linked to non-Western ethnicity and lower maternal education and family income. Thus, ethnicity and SES factors might influence children's responses to the BPI and warrant further exploration.

Implications for Practice

The following is a summary of guidelines and key points for practitioners who are assessing young children for possible anxiety or other clinical diagnoses described above. They are intended not only to provide a framework for conducting evaluations with these children and their families, but also to serve as a meaningful link to effective intervention strategies. As a general guideline, clinicians should be mindful that prevention of clinically significant anxiety and other psychological problems has multiple levels. Selective prevention for young children with known risk factors and indicated prevention for those with early signs/symptoms of disorders are most applicable in early childhood settings. In these contexts, psychologists can collaborate with families and other care providers to reduce risks and use evidence-based strategies to optimize child and family functioning.

- Early identification and intervention have potential to prevent internalizing problems in early childhood. Clinically significant anxiety and depression can occur in children as young as two or three.
- Temperament characteristics are reliable indicators of risk for anxiety in early childhood, particularly high BI and negative affectivity and low effortful control.

- Some research indicates that speech/language and motor problems are risk factors for early childhood depression, suggesting the need for increased monitoring in this population.
- Parental depression and anxiety show clear evidence as risk factors for early childhood internalizing problems. Parenting behaviors, most notably, overprotection and harsh discipline, are also risk factors. All of the above should be considered when assessing social-emotional functioning in young children.
- Assessment with families is crucial. Interviews provide information regarding symptoms and context and also enable clinicians to gather family history. Based upon the above risk factors, clinicians need to examine specific temperament characteristics and parenting practices.
- A number of standardized tools are available to assess depression, anxiety and related problems in young children. Many measures are parent-report, but input from affected children should also be incorporated into assessment protocols. Structured observation tasks are also useful to gather information regarding young children's reactions, responses and temperament. For a review of preschool narrative tools, meaning those that are intended to elicit verbal accounts from young children about their feelings, thoughts, etc., the reader is directed to Bettman and Lundahl (2007).

The following list summarizes information related to treatment:

- Given the connections between parents' and young children's anxiety, treatment of this condition in parents might be beneficial in addressing child symptoms. There is some evidence that parental anxiety management is helpful in treating young children's anxiety (Cobham, Dadds, Spence, & McDermott, 2010).
- Preventive interventions show positive effects for young children at risk for clinical anxiety. *Cool Little Kids* is a prevention-based program focusing on child inhibition and overprotective parenting (Kennedy, Rapee, & Edwards, 2009). This intervention has the most empirical support as a form of early intervention.
- Modified cognitive-behavioral therapy, involving parents/families and using cartoons, drawings, etc., shows promise in treating PTSD & anxiety disorders in younger children (Hirshfeld-Becker, Micco, Mizursky, Bruette, & Henin, 2011). Modified Parent–Child Interaction Therapy (PCIT; Bell & Eyberg, 2002) also has some research support in treating anxiety and depression in this age group. For a more extensive review, readers are referred to the work of Luby (2013).
- When selective mutism is suspected, functional behavioral observation (FBO) is recommended as a form of assessment (Shriver, Segool, & Gortmaker, 2011). This includes examination of the child's quality of communication, setting events, and environmental variables (including people the child does and does not communicate with), and antecedents and consequences. FBO can be used to inform interventions including contingency management to reinforce speaking, shaping techniques, and stimulus procedures (e.g., prompting, introducing, and then fading new conversants into child's environment).

- In young children, selective mutism is most likely to be effectively addressed through a team approach which incorporates behavior principles, such as contingency management (e.g., rewarding verbalizations/speaking), stimulus fading, systematic desensitization, modeling, and shaping (Ponzurick, 2012; Viana, Beidel, & Rabian, 2009). With greater age and cognitive abilities, children with selective mutism may also benefit from cognitive-behavioral interventions, such as role playing, guided imagery, relaxation techniques, and graduated exposure to real situations.
- There is little data regarding effective treatment for OCD in young children. However, Lewin et al. (2014) found positive effects for family-based exposure and response-prevention therapy, as compared to a control group, in a small sample of young children. This therapy involved psychoeducation for parents and children; use of behavioral principles such as development of appropriate rewards, differential reinforcement, extinction of OCD behaviors, and modeling; and exposure to cues/stimuli that trigger OCD with associated prevention of OCD symptoms.
- Similarly, there is little information related to evidence-based treatment of school refusal in young children. Kearney et al. have noted that parent-based treatments are often indicated due to separation anxiety, attention-seeking, and other family factors that contribute to symptoms.

Case Study—Anxiety in a Young Child

Emma is an almost 5 year old girl who lives at home with both parents, Mr. and Mrs. Mason, who work full-time outside the home. She was born full-term and reached early language and motor milestones within normal limits. Emma is described by her parents and preschool teacher as reserved, but not excessively shy. She has several friends in her classroom. However, it does take her a long time to get used to new situations or environments. For example, Emma has been attending the same small child care facility since infancy, and, whenever she has transitioned up to an older classroom, she becomes extremely upset and throws tantrums. Since she was a baby, Emma has shown difficulty when it comes to trying new activities. Mr. and Mrs. Mason have tried to get her involved in dance and swimming lessons. Emma initially expressed interest in doing these activities. However, when her parents brought her to them, she was clingy, withdrew from the other children, and did not want to participate. Mr. and Mrs. Mason have tried to talk to Emma and coax her into participating. They have also stayed with her during new activities to try to get her comfortable with them. This has not worked, and Emma's parents note that she only winds up crying and refusing to leave their side. Emma is about to enter kindergarten, and her district holds a special event for prospective students to come to the elementary school, meet their teacher, and ride the school bus; parents are also expected to attend. Mrs. Mason took time off and accompanied

Emma. Prior to the "move-up" day, Emma expressed resistance about going, but her mother was able to convince her. Throughout the move-up activities, Emma cried and clung to her mother. When Mrs. Mason tried to leave briefly to take a tour of the school with the other parents while the children stayed with their prospective teachers, Emma threw a tantrum involving screaming, crying and some physical aggression.

Following this incident, Mr. and Mrs. Mason spoke to their pediatrician who recommended that they have a mental health consultation. The Mason's, with Emma, go to see a psychologist, Dr. Anderson, who specializes in emotional/behavioral difficulties in younger children. Through parental interview, Dr. Anderson finds that both parents have a history of anxiety problems; Mrs. Mason also has a history of depression. The Mason's responses to questions about parenting strategies indicate they often give Emma a lot of attention when she cries or expresses frustration because they have difficulty tolerating these emotions. Dr. Anderson spends time alone with Emma and finds that she is initially shy about playing without her parents present. Dr. Anderson is able to engage Emma in pretend play which reveals frequent themes of dolls being afraid to do different activities. Dr. Anderson administers the CMFWQ to Emma's parents. Mrs. Mason's total score for Emma was 18, while Mr. Mason's score was 16. Both of these scores exceed the suggested clinical cut-off score of 2.87. Both parents rated Emma higher for the Internalizing Difficulties subscale, which captures a variety of symptoms related to anxiety, withdrawal, depression, etc., than the Solitary Play subscale.

Discussion Questions

1. Describe additional assessment information that Dr. Anderson should gather.
2. What are specific anxiety disorders/diagnoses that might apply to Emma?
3. Based upon the information provided in the scenario, what might be considered the best strategies and targets for treatment for Emma's anxiety problems?
4. In considering treatment, in what ways should home and Emma's future school be specifically involved?

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