

Pediatric Weight Management

Weight gain and obesity are increasingly common in people of all ages, and have received a great deal of media attention as serious risks to the health of children and adults alike. While most people are actively aware of the health risks of extra weight, many feel at a loss for how to control their weight. Dr. Panzer (2006) describes several ways professionals can help children and families develop safe and effective weight loss plans.

Dr. Panzer strongly suggests that families turn to a team of professionals in setting up their weight management plan, with a "mental health professional serving as primary clinician within a collaborative effort, (p 532)" He sees therapists as particularly important as they have more experience than other health professionals in managing the emotional and social difficulties around changing behaviors, and are frequently trained to work with professionals from several disciplines. Dr. Panzer also recommends that families consult professional nutritionists, exercise physiologists and school personnel whenever possible.

Dr. Panzer suggests that weight management needs to consist of several areas. First and foremost is education on topics such as hunger, what it feels like to be "full", appropriate meal sizes, non-food rewards, emotional aspects of eating, and appropriate amounts and kinds of physical activity. Professionals then help the family make choices based on this information, track their progress, maintain effort and motivation, and manage the emotions that make change difficult. Dr. Panzer encourages parents to keep most of their child's favorite foods on the family menu; if they are not optimally healthy, serve them in smaller amounts or less frequently. He also recommends families find other kinds of rewards and means of physical comfort to replace food. Families may be asked to keep a food diary, to accurately track their old and new habits and to track their progress towards goals. Overall, Panzer emphasizes that weight can successfully be managed with a combination of accurate facts, reasonable plans and emotional support.

Panzer, B. (2006). Integrating pediatric obesity treatment into clinical practice. *American Journal of Orthopsychiatry*, 76(4), 531-544

Improving Social Skills in ADHD

Children with Attention Deficit/Hyperactivity Disorder (ADHD) frequently struggle socially as well as academically. Some act impulsively around peers, accidentally insulting peers and overreacting to the critical statements of peers. Others just have trouble attending to the words and actions of friends, and often feel left out of things. While most treatment for ADHD focuses on improving learning and behavior, a growing body of research focuses on helping kids with ADHD increase their social success. De Boo and Prins (2007) reviewed this research, looking for the key aspects of treatment to help children with ADHD make and keep friends.

Overall, de Boo and Prins found social skills training to be effective in improving relationships of children with ADHD. Treatments included activities such as practicing conversation skills, listening skills, giving and receiving both compliments and complaints, problem solving, and recognizing the emotions of others. Many treatments also included emotional control skills, such as anger management, improving self esteem, relaxation training and recognizing emotional thinking. Two studies included use of stimulant medication. In both of these studies, medication alone was as effective as medication plus social skills training, indicating that if medication manages symptoms of inattention and hyperactivity, children with ADHD are often able to effectively manage social situations without additional therapy.

De Boo and Prins (2007) emphasize that children with ADHD typically do not struggle socially due to lack of knowledge of social interactions. First, children with ADHD often have trouble attending to and accurately reading social cues. They may miss subtle signals such as tone of voice or facial expressions, and may therefore not know when to start, stop or adjust their way of interacting. Second, children with hyperactive symptoms may have additional difficulties controlling aggressive impulses even when they know it is inappropriate. De Boo and Prins suggest that the best social treatments for ADHD would address these 2 areas of difficulty, rather than teaching other skills children cannot apply due to inattention and impulsivity.

De Boo, G. M. & Prins, P. J. M. (2007). Social incompetence in children with ADHD: Possible moderators and mediators in social-skills training. *Clinical Psychology Review*, 27, 78-97.

Social Anxiety and Perception in Teens

Social anxiety is a difficulty faced by many teens, interfering with their ability to feel comfortable in school and in the community. Therapists need to know more about how teens actually treat each other in order to help anxious teens overcome their social fears. Blöte and Westenberg questioned nearly 1000 teens about how they think others act towards themselves, and how other teens would act towards a fictional person. Overall, they showed that most teens tend to treat socially awkward and anxious teens differently, with more criticism and less tolerance for mistakes. This indicates that socially anxious teens are accurate in their belief that they are treated more harshly. They may need skills to change their actions in social settings rather than cognitive therapy aimed at changing how they believe they are treated.

Blöte, A. W. & Westenberg, P. M. (2007). Socially anxious adolescents' perception of treatment by classmates. *Behavior Research and Therapy*, 45, 189-198.

ADHD and Working Memory

Researchers believe ADHD to be related to neurological deficits in executive functions, and think that children with ADHD may have difficulty with working memory. Wu, Anderson and Castiello (2006) explored this using a procedure in which children had to divide attention and switch between two related but different tasks. They found that, compared to children without ADHD, ADHD children had no significant problems in working memory itself. If working memory were the problem, children with ADHD would be expected to work slower than children without ADHD. Instead, they continued working rapidly when the task became more difficult, and consequently made more errors. Wu et al concluded that a fundamental difference between children with and without ADHD is that children with ADHD are not able to monitor the demands of a task and change their effort accordingly.

Wu, K. K., Anderson, V. & Castiello, U. (2006). Attention Deficit/Hyperactivity Disorder and working memory: A task switching paradigm. *Journal of Clinical and Experimental Neuropsychology*, 28, 1288-1306.

Affect Dysregulation and Bipolar Disorder

Rich et al (2007) conducted a study in attempt to clarify appropriate diagnostic criteria for bipolar disorder in children. Their study included 3 groups of children: children with classical, episodic bipolar disorder, children with atypical bipolar disorder consisting of constant, severely dysregulated moods, and children with no bipolar symptoms. The researchers found that each group had a different EEG responses to frustration. The children with classical bipolar disorder showed lower levels of activity at the P3 area of the brain (executive attention) compared to both other groups, whereas the children with dysregulated moods showed lower levels of activity in the P1 and N1 areas of the brain (initiating early attention) compared to both other groups. Authors conclude that severe mood dysregulation is a different condition than bipolar disorder as it involves different areas of the brain. [Rich, B., Schmajuk, M., Perez-Edgar, K., Fox, N., Pine, D., & Leibenluft, E. (2007). Differential psychophysiological and behavioral responses elicited by frustration in pediatric bipolar disorder and severe mood dysregulation. *The American Journal of Psychiatry*, 164(2), 309-317.]

Stability of Childhood Depression

Tram and Cole examined the stability of children's depression symptoms over the transition from grade school to middle school. They postulated that if environmental changes and "growing up" could change depression symptoms in children, the physical, academic and social changes at this age would be most likely to cause this. They followed a group of students from 5th grade to 8th grade, and found depression symptoms were remarkably consistent over this time, with most stability estimates in the .90's. Even over the summer between grade and middle school, 71% of depression scores were stable. They concluded that depression in children is highly consistent over time in the absence of treatment. Depressed children have a need for timely and effective treatment – unfortunately we cannot hope they will just grow out of it. [Tram, J. M & Cole, D. A. (2006). A multimethod examination of the stability of depressive symptoms in childhood and adolescence. *Journal of Abnormal Psychology*, 115(4), 674-686.]

Benefits of Parental Involvement in Schools

Parent involvement has long been known to increase children's performance at school. Dr. Stone (2006) looked at changes in involvement and performance as teens move from middle school to high school. She found that parents tend to talk less with their children and with teachers about school activities in high school, but continue to monitor their children's work. When parents communicated less with children and school professionals, students GPA's tended to also drop. Two factors helped parents maintain communication about school – volunteering time at the child's school, and school sponsored activities to ease the transition from middle to high school. Both of these factors lead to increased parent-child and parent-teacher communication, and to higher student GPA's. [Stone, S. (2006). Correlates of change in student reported parent involvement in schooling: A new look at the National Educational Longitudinal Study of 1988. *American Journal of Orthopsychiatry*, 76(4), 518-530.]



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Child Precursors of Adult Bipolar Disorder

Another path to clarifying appropriate childhood criteria for bipolar disorder is to learn what childhood symptoms are associated with adult bipolar disorder. Henin et al compared the childhood difficulties of 83 adults with bipolar disorder to the childhood difficulties of 308 adults with no mood disorder diagnosis. 64% of the adults with bipolar disorder reported a history of childhood difficulties, compared to only 15% of comparison adults. Of the adults with bipolar, 45% had a childhood history of anxiety disorders, 30% had a history of disruptive behaviors, and 22.5% had a history of ADHD. Most participants had adult onset of bipolar disorder, although those with childhood behavioral difficulties or ADHD were diagnosed as Bipolar earlier. Results of this study would suggest that dysregulated mood and behavior are important childhood precursors of adult bipolar disorder.

Heinin, A., Biederman, J., Mick, E., Hirshfeld-Becker, D., Sachs, G., Wu, Y, Yan, L., Ogutha, J., & Nierenberg, A., (2007). Childhood antecedent disorders to bipolar disorder in adults: A controlled study.

Managing Aggression in Children and Teens

Peer aggression is a significant problem that is receiving growing attention from parents, schools and communities. Searching for causes of increasing childhood aggression, Duman and Margolin (2007) examined several family factors that may contribute to children's aggression. They found that parents reports of physical marital aggression correlated with children choosing aggressive responses to peers. In particular, girls chose aggressive responses more when parents reported mother-to-father aggression, and boys chose aggressive responses when parents reported father-to-mother aggression. However, all children were equally able to describe appropriate, assertive responses. This study supports social learning theories, that children who witness aggression are more likely to chose aggressive actions even when they are aware of other alternatives.

Brookmeyer, Fanti and Henrich (2006) also explore youth aggression, looking at factors that reduce violence by middle and high school students. They found several factors that are associated with lower teen violence. Similar to Duman and Margolin (2007), Brookmeyer et al found that teens who had witnessed peer violence or been victims of violence were much more likely to engage in violence themselves. A few factors served to buffer these effects. Teens who felt a sense of connection with their parents and with their school (both teachers and peers) were less likely to report engaging in violent behaviors. Also, teens attending larger schools and schools rated as having a better climate engaged in slightly less violence.

Koblinsky, Kovalanka and Randolph (2006), conducted an early intervention study to identify the most important things families can do to help very young children develop the social skills and behavioral control needed to manage relationships without aggression. They found that positive parenting (managing behaviors through consistent and emotionally sensitive means) and having consistent family routines (activities that occur at the same time daily or weekly) help children develop more positive relationships with peers. They also found that positive parenting and lower levels of family conflict were linked with fewer problem behaviors. Consistency and routine were key elements of families of successful preschoolers.

Brookmeyer, K. A, Fanti, K. A & Henrich, C. C. (2006). Schools, parents, and youth violence: A multilevel, ecological analysis. *Journal of Child and Adolescent Psychology*, 35(4), 504-514.

Duman, S. & Margolin, G. (2007). Parents' aggressive influences and children's aggressive problem solutions with peers. *Journal of Child and Adolescent Psychology*, 36(1), 42-55.

Koblinsky, S., Kovalanka, K. & Randolph, S. (2006). Social skills and behavior problems of urban, African-American preschoolers: Role of parenting practices, family conflict, and maternal depression. *American Journal of Orthopsychiatry*, 76(4), 554-563.