Webinar Transcript: Managing Anxiety in Students with Learning Disabilities

Presented by: Dr. Marjory Phillips, C. Psych.

[SLIDE – WEBINAR: Managing Anxiety in Students with Learning Disabilities]
[*Text on slide:* MAY 8, 2018 3:45 – 4:45PM ET
Presented by: Dr. Marjory Phillips, C. Psych.
Director, Centre for Mental Health Research, University of Waterloo
Image of Twitter
@LDatSchool
#LDwebinar
Image of LD@school logo]

[Cindy Perras]: The LD@school team is very pleased to welcome our guest speaker today Dr. Marjory Phillips whose presentation is titled Managing Anxiety in Students with Learning Disabilities.

[SLIDE – Funding for the production of this webinar was provided by the Ministry of Education]
[Image of LD@school logo
Text on slide: Please note that the views expressed in this webinar are the views of the presenters and do not necessarily reflect those of the Ministry of Education or the Learning Disabilities Association of Ontario.]

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[SLIDE - Don't forget to use our social media hashtag!]
[Image of twitter bird holding megaphone and twitter bubbles coming out of megaphone
Text on slide:
#LDwebinar
@LDatSchool]

[Cindy Perras]: We will also be tweeting throughout the webinar, so if you would like to participate. You can send us a tweet by using our handle @LDatSchool or the hashtag: #LDwebinar.

[SLIDE – WELCOME]
[Image of Dr. Marjory Phillips
Text on slide:
Dr. Marjory Phillips, C. Psych.
Director, Centre for Mental Health Research, University of Waterloo]

[Cindy Perras]: And that takes care of our host for this afternoon. So let's get started. It is now my pleasure to introduce our speaker Dr. Marjory Phillips. Dr. Phillips is the director of the Centre for Mental Health Research at the University of Waterloo. From 2008 to 2017, Dr. Phillips's was the clinical director for the Integra program with the Child Development Institute. The only accredited children's mental health agency in Canada to specialize in providing mental health services to children, youth and families with learning disabilities. Dr. Phillips also worked as a clinical psychologist and a clinical director in a children's treatment rehabilitation centre in Kingston for 12 years. Welcome Dr. Phillips. The cyber floor is now yours.

[SLIDE – Managing Anxiety in Students with LDs]
[Image of University of Waterloo logo, and Centre for Mental Health Research Clinical Services, Training & Research logo.
Text on slide:
Dr. Marjory Phillips, C. Psych.]

[Dr. Marjory Phillips]: Wonderful thanks to everyone and I hope you can see my slides. I'd like to welcome everyone and thank you for attending this webinar on supporting students who have learning disabilities and anxiety. This is Mental Health Week so this is a really fitting topic and my hope today is to have more of an advance topic on anxiety exploring different types of anxiety disorders in order to help educators to understand the behaviors you may see in your students and have ideas for them to know how to help

[SLIDE – Learning Objectives]
[*Text on slide:*

1. To understand the relationships between anxiety and LDs
2. To learn about common Anxiety Disorders in Children and Youth
3. To understand the implications of Anxiety Disorders for students with LDs in the school setting
4. To gain practical strategies for supporting these students at school]

[Dr. Marjory Phillips]: The four objectives.
First is to understand the relationship. To understand the relationship between anxiety and learning disabilities.
Second to learn about common anxiety disorders in students.
To understand what that means for the classroom and school environment. And lastly, taking some practical strategies for how to help.

[SLIDE – What is Anxiety?]
[*Text on slide:*
Fear: emotional response to real or perceived imminent threat (DSM5)
Anxiety: anticipation of future threat

- Distress or uneasiness of mind

- Caused by fear of danger
- Basic human emotion
- Part of typical development

(Barlow, 2004)]

[Dr. Marjory Phillips]: And to understand anxiety let's start by looking at what is fear and what is anxiety. Fear is defined as an emotional response to real or perceived imminent threat. If I am alone in a house. And a person crashes through my window into my living room I experience fear. In contrast, anxiety is the anticipation of future threat. So after that incident of the crash. I may feel anxious every time I'm alone in my living room. Worried that someone may intrude. And Barlow defines this anxiety as distress. Or uneasiness of mind. And it really reflects a fear of danger. And as I'll explain anxiety is a basic human emotion that we all experience at some point and it's part of typical development.

[SLIDE – The Brain and Danger]

[*Text on slide:*

Short Term Stress Reaction:

- Lets you respond quickly
- Activation of sympathetic nervous system (SNS)
    - Fight
    - Flight
    - Freeze]

[Dr. Marjory Phillips]: Anxiety is a short-term stress reaction. That's part of our human experience. If you were a hunter facing a saber-toothed tiger. Your brain signals to you that you are in danger. Your sympathetic nervous system kicks in and you may experience symptoms such as: rapid breathing, sweaty palms, butterflies, in your stomach muscle tension. And our response to the perceived danger may be fight, flight or freeze. When you encountered that Tiger you may fight the tiger, you may run away or you may be frozen with fear. And the problem now is that the perceived danger may no longer be something like a tiger but more like a math test, or having to read in front of the class, or having to navigate a school cafeteria. The brain perceives these situations as dangerous just like a tiger and reacts with an activation of the sympathetic nervous system. And we may respond with fight, flight or freeze. Yet, this may not be adaptive for the situation.

[SLIDE – Adaptive Anxiety Reactions]

[Dr. Marjory Phillips]: As I said, anxiety is a basic human emotion. It's hard wired and adaptive. Anxiety cues us to be alert. It is necessary and can even be helpful. For example, anxiety activates our adrenaline. It helps us to be energized, aroused and that can be adaptive if you're running a race or giving a presentation or speech. Anxiety is also adaptive as an early warning signal for dangerous activities. You might get that adrenaline rush when you're skydiving or if you're walking near the edge of a cliff or on a high ropes course. And that may help you to be just a little bit more vigilant and alert.

[SLIDE – Maladaptive Anxiety Reactions]
[Dr. Marjory Phillips]: But there are times when it's not so helpful to have an anxiety response. Sometimes the perceived threat may be something like a spelling test or talking to a group of students, or even going to school. And the brain may respond as if we are in danger, activating all the nervous system arousal but that really isn't helpful for the situation.

[SLIDE – LDs and Anxiety Disorders]
[*Text on slide:*

- Children with LDs are 2 – 3 times more likely to experience mental health issues (Wilson et al, 2009)
- Students with LDs have higher rates of anxiety (Nelson & Harwood, 2010; Zakopoulou et al., 2014)
- 30% of children with LDs met criteria for an Anxiety Disorder (Magari et al., 2013)

Many (but not all) students with LDs have anxiety]

[Dr. Marjory Phillips]: So what do we know from the research about the relationship between learning disabilities and anxiety. We know that students without LDs have higher rates of anxiety. For example in one study 30 percent of children with diagnosed learning disabilities met criteria for an anxiety disorder. We'll talk about that in a minute. And it's common for students with LDs to have some level of anxiety. They may be feeling anxious at times or in response to specific situations, all the way up to meeting criteria for a disorder with more intense and impairing levels of anxiety. So if you work with students with LDs the odds are that they may experience some level of anxiety at some point. It's pretty common for this population.

[SLIDE – LDs and Anxiety Disorders]
[Image of pie chart representing Co-Occurring Anxiety Disorders in Children & Youth with LDs with the following proportions shown:

- GAD – 12%
- Specific Phobia – 15%
- Social Anxiety – 28%

Esmaili et al, 2016]

[Dr. Marjory Phillips]: These numbers are from a 2016 study of youth with learning disabilities who also met criteria for an Anxiety Disorder. And, just of note almost 30 percent of that sample met criteria for generalized anxiety disorder. I'll talk about what that means in a minute but it's also common to see students without these have social anxiety and specific phobias. There does not seem to be a gender difference. Both boys and girls with learning disabilities have anxiety at similar rates although, the presenting issues may look different and I'll demonstrate that with case examples.

[SLIDE – Continuum of Mental Health]
[Image of Integra mental health continuum illustrating the fluidity between the green, yellow and red zones. There is an arrow pointing at the yellow zone with the words *Stress and Distress Associated with LDs*, and an arrow pointing at the red zone with the words *Co-Occurring Mental Health Disorders (e.g., Anxiety or Depression*.
Image of Integra logo]

[Dr. Marjory Phillips]: One way to think about the relationship between anxiety and learning disabilities is to consider mental health on a continuum and this slide is credit to Integra conceptualization that was developed at the intake Tekere program at CDI where, as Cindy said it's a children's mental health agency that provides mental health services exclusively to children and youth with diagnosed LDs. It's an opportunity to really learn a lot about these kids. In this continuum many of us fall in the Green Zone. Meaning that we generally feel pretty good. Doesn't mean that we're happy all the time but we have social supports, or engaged, we have sufficient personal resources to cope with everyday life things. Most of us occasionally experience periods where we move into the yellow zone of feeling stressed. Could be changes! A new job, a lost, a family member who is struggling, changing schools, stress at work. The demands exceed our resources. And we may feel a bit stretched, we may have difficulty sleeping, we may feel tense, we may feel overwhelmed. For many of us the situation changes. Or we develop new coping strategies. And we move back into the Green Zone. And sort of go back and forth sometimes. For some of us the mental health issues are more serious and have a functional impairment. For example we may have significant low mood. And we have trouble getting out of bed in the morning. Or may not get to school. That might be the red zone. So again it's a continuum and with intervention, supports, sometimes medication, we may move out of the red zone back into the yellow zone or the Green Zone. And I worked with Integra for over a decade. And there we saw a number of students with LDs. Most being in the yellow zone as their baseline. As they're chronically stressed. School for kids with learning disabilities is often an ongoing stressor. By definition, it's hard to show what you know, school is a very social environment, we know that that's sometimes a challenge and so forth. But for a portion of these students with LDs, so as high as 30 percent or possibly 40 percent. These students move into the red zone of more serious mental health issues such as anxiety disorders. And at Integra, we called the subset of clients whose learning disabilities are complicated by mental health learning disability mental health or L.D.M.H.

[SLIDE – "Yellow Zone" Anxiety & LDs: Distress]
[*Text on slide:*
What situations have you noticed provoke anxiety for your students with LDs?]

[Dr. Marjory Phillips]: So if you think about the students with learning disabilities in your school, I'd like you to take a minute to consider the types of everyday situations that might provoke anxiety. Or that fight, flight or freeze response in your students. And just to reflect on what kinds of situations have you noticed that you can imagine would be anxiety provoking. If you had an LD.

[SLIDE – Sources of Increased Anxiety for Students with LDs]

[*Text on slide:*

In school:

- Reading aloud, writing on the board
- Answering questions

Socially:

- Navigating lunch hour
- Conversations

Daily Life:

- Going first with a new skill]

[Dr. Marjory Phillips]: So….I'm guessing that many of you thought of things like, like these. There can be a lot of things in a school setting depending on the student and depending on the nature of their learning disability. So for some it might be reading or writing in front of others, for others navigating a social situation with peers, like having lunch or recess, unstructured time or managing group work, figuring out how to hold conversations. For some it's learning a new skill in gym and then having to go first without enough time to really see how it's done. So lots of things I'm guessing that you, as you reflect, probably thought of other situations that you can think would be anxiety provoking

[SLIDE – Signs & Symptoms: Overlap Between LDs and Anxiety]

[*Table on slide:*

Sign/Symptom	Learning Disability	Anxiety Disorder
Difficulty Concentrating	Attention, Memory overload	Generalized Anxiety
Difficulty following instructions	Language, Processing Speed, Attention, Memory	Generalized Anxiety
Rigid decision making; Difficulty shifting ideas or problem solving	Executive Function: cognitive flexibility, impulse control, concrete reasoning	Obsessive Compulsive Disorder
Difficulty initiating social interactions; group work	Visual-perceptual problems ('reading' social cues), low Processing speed, Memory, Executive function	Social Anxiety

[Dr. Marjory Phillips]: When we consider the interconnected relationship between anxiety and learning disabilities, it can be tricky to know when to be concerned. So, that is when is anxiety a red zone problem or even a yellow zone problem that needs attention. One challenge is the overlap in symptoms between learning disability and anxiety disorders. For example, you might notice a student who has trouble concentrating and that could be related to the student's particular learning disability with attention difficulties or a weak working memory, or they could be distracted by internal thoughts or worries. Similarly, you may have a student who doesn't follow instructions. Are they having trouble understanding or remembering the instruction? Do they need more time to process what you said? Or did they missed instruction altogether because they were worrying about something else. For some rigid

decision-making and difficulty, shifting to a new point of view might reflect executive functioning problems. Or it could be because the student has OCD and has to complete a task three times before they can move on. And sorting out the relative contributions of social competence impairments related to the learning disability, in comparison to social anxiety can be particularly tricky.

[SLIDE – Anxiety & LDs: When Does it Become a Problem?]
[*Text on slide:*
Anxiety becomes a *disorder* when

- It interferes with normal functioning
- It is a "persistent and disabling pattern"
- It is out of proportion to the actual threat or danger
- Symptoms last at least 6 months]

[Dr. Marjory Phillips]: So if anxiety is typical, and we all have it, and kids with learning disabilities are really likely to experience some extra level of distress in certain circumstances. How do you know when it is a problem? Especially a problem for a student in your school, And a problem for which treatment will help. So the short answer is. When it seriously interferes with the child's ability to do the tasks of everyday life [Inaudible] could restrict their ability to go to school or to hang out with friends at the mall. Or it interferes with their concentration so much that they can't think about schoolwork or they can't sleep. When the anxiety is persistent. It's not just a period of time when a big change is happening. So for example, you may have a student who is not sleeping well and is distracted…in grade 8 because they're worrying about starting high school. But for it to be a disorder it needs to be persistent and last at least six months. Also when the intensity of the child's responses are outside the norm. That becomes a key factor. So for me as a psychologist when I'm doing an assessment and making a diagnosis, we try to get information about the child or adolescent from a variety of sources. The parents, the school, sometimes extended family, we watch the child in the assessment. And we find that often people will notice something that's just outside the norm with that child, or outside the usual.

[SLIDE – Prevalence Rates for Anxiety Disorders]
[*Text on slide:*
Lifetime Prevalence Rates (Stats Canada, 2006)

- Social Phobia – 8%
- Generalized Anxiety Disorder – 5%
- Panic Disorder – 3.7%
- Obsessive Compulsive Disorder – 2 %
- Agoraphobia – 1.5%

12% of children have Anxiety Disorder (Silverman & Field, 2011)]

[Dr. Marjory Phillips]: Anxiety disorders are relatively common. The Canadian statistics for lifetime prevalence rates are here on this slide. And so, all that means is that it's the percentage of the population who have an anxiety disorder at some point in their lifetime. And you'll see that the most

common are social anxiety or social phobia and generalized anxiety disorder. With 8 % t and 5 % respectively.
But most anxiety disorders start in children…childhood. And one prevalence study from the States suggests that 12 % of children meet criteria for an anxiety disorder. So again, it's fairly common among students in the school system.

[SLIDE – Who Diagnoses Anxiety Disorders?]
[Image of a three-circle sequential arrow process with *Educators flag concerns* in the top circle, *Consult with Parents, School Teams* in the middle circle, and *Mental Health expert (e.g. Psychologist)* in the bottom circle.

Text on slide:

- Educators may be the first to raise concerns about a student, or may support parents' concerns.
- Anxiety Disorders may be diagnosed by a qualified professional after a careful assessment.
- Diagnosis is a controlled act limited to professions including physicians & psychologists

Regulated Health Professions Act (RHPA) 1991]

[Dr. Marjory Phillips]: So who decides if an anxiety is a disorder… if the anxiety presentation is a disorder? Well, and what is the role of the educator with respect to identifying anxiety disorders. Educators are key because. They may be the first people to raise concerns about a student, or they may validate a parent's worry about their child. Educators have the opportunity to see a lot of children and adolescents of the same age. Unlike parents who may not have a comparison group.
But, as I've tried to point out with the overlapping symptoms, diagnosis of an anxiety disorder is a tricky thing, especially for students with learning disabilities or A.D.H.D and it requires careful assessment. Often the use of standardized tools and interviews and comprehensive knowledge. Diagnosis is a controlled act that can only be carried out by qualified professionals such as psychologists or physicians.

[SLIDE – Why Diagnose?]
[*Text on slide:*
Anxiety Disorders can be effectively treated
Image of a radial cluster with the acronym *CBT* in the centre surrounded by three individual circles with text – thought, behavior, and feeling.]

[Dr. Marjory Phillips]: So why does it matter whether a child is diagnosed with an anxiety disorder? Most likely because diagnosis can inform treatment. There are effective medications and evidence based therapies, such as cognitive behavioural therapy, that can be quite helpful.

[SLIDE – Types of Anxiety Disorders (DSM–5)]
[*Text on slide:*

- Anxiety Disorders
    - **Generalized Anxiety Disorder (GAD)**
    - Separation Anxiety Disorder
    - **Selective Mutism**

    - **Social Anxiety Disorder**
    - Panic Disorder
    - Specific Phobia
- Obsessive Compulsive Disorders
    - **OCD**
    - Trichotillomania (hair pulling)
- Trauma & Stressor Related]

[Dr. Marjory Phillips]: Ok so let's turn over to the types of anxiety disorders. The *Diagnostic and Statistical Manual* version number five (DSM 5) is a system of classifying diagnoses and it organizes anxiety disorders into three broad categories: anxiety disorders, obsessive-compulsive disorders and trauma and stress related disorders such as PTSD.
For this webinar, we 'll focus on just a few of these disorders. The ones I bolded, so generalized anxiety disorder, selective mutism, social anxiety disorder and obsessive compulsive disorder. Humm, because these are the ones that I think you may see in students you teach. And they're also the ones that are sort of tricky for the LDMH Group, the students with anxiety and learning disabilities.

[SLIDE – Anxiety Disorders in Students with LDs]

[Dr. Marjory Phillips]: So for this next section I'll present one disorder at a time, identifying the key features, the consideration for the overlap between the particular anxiety disorder and the learning disability. I'll give you a case example and then some specific strategies to consider.

[SLIDE – Generalized Anxiety Disorder (GAD)]
[*Text on slide:*
- Excessive, unrealistic, and pervasive worrying for more than 6 months
- Feelings of distress and worry much of the time
- Individual finds it hard to control the worry
- Worrying gets in the way of daily life
- Key difference across ages is the content of the worry (often age appropriate)]

[Dr. Marjory Phillips]: We'll start with the generalized anxiety disorder or GAD. Students with GAD are the general worriers. They have excessive unrealistic worries that persist, are distracting, and they interfere with everyday life. So these students for example might hear about what's happening in Syria or a bombing in a subway in London or about the Zika virus and are really worried about their safety here in Ontario. Or they may have fears about something bad happening to a family member. They may not be sleeping because of a worry that someone could break in or be kidnapped. Erm...or they may have worries about their future, you know feeling like I'm going to fail this course, I'm going to drop out of school, I'm going to never get a job. The future is bleak. The nature of these worries, varies across individuals. But the concept is that the worry is generalized, vague, and often hard to contain.

[SLIDE – LDs Complicate GAD]

[Image of iceberg in the water with a line drawn dividing the small piece of iceberg that appears on top of the water, and the larger piece that is under the water with a sailboat steering towards the iceberg. There are bullet points of text above the water line, which read:

- Inattentive, distracted
- Does not follow instructions
- Fidgety, restless
- Misses class and school

There are bullet points of text below the water line, which read:

- ADHD or difficulties with executive functioning
- Language processing difficulties
- Memory
- Anxiety (worries)
- Somatic symptoms
- Experiential avoidance]

[Dr. Marjory Phillips]: I'll use this familiar metaphor of an iceberg. And the tip of the iceberg represents the behaviours you may see in school. For example, a student with both Generalized Anxiety Disorder and learning disabilities. They may look inattentive and distracted. They may not follow instructions. They may be restless. Or you may never see them in your class because they miss class, they're sick, they don't have their work done. So those are pretty common kinds of symptoms that could be reflecting a lot of different things. And there are a number of possible contributing factors below the surface. So those, some of those or any of those behaviours could reflect attention deficit hyperactivity disorder or difficulties processing language, tracking or remembering what you say. Or it could be the student who's distracted by worries or have somatic symptoms, or avoiding situations that make them feel bad or stupid.

And often you have all of those or a combination of those. It's hard to know for sure what you're seeing what the surface level behaviors really reflect. But an approach is to be curious and ask yourself 'what might be going on with the students? At the least, it gives you more options of things to try.

[SLIDE – Case Study: LD + GAD]

[*Text on slide:*

"Trevor" is an articulate 16 year old

- Struggles with writing and math
- Argumentative, challenges teachers
- Asks questions persistently (e.g., timing of pop quizzes, plans for substitute teachers)
- Seems easily distracted, inattentive
- Frequently fidgets, seems uncomfortable in his skin
- Often cuts class]

[Dr. Marjory Phillips]: Let's put a face on this kind of LD and GAD presentation. Trevor is in secondary school, Grade 11. He seems very bright and articulate. He loves to argue his points in class. He often challenges his teachers on certain topics and he points out situations he perceives to be unfair. He constantly asks questions and pass around deadlines and upcoming schoolwork as well as any changes in class schedule. Trevor seems easily distracted and inattentive. He frequently fidgets and seems uncomfortable in his skin. He often gets activated by his worries about schoolwork and change. Attendance is also an issue for Trevor as he often cuts classes. And the tricky thing about GAD and many anxiety disorders is that they are internalizing disorders. You don't always see the inner dialogue. You may not see Trevor's worries about something bad happening to his family or worrying about where he'll end up in life or that he'll be mocked or attacked.

[SLIDE – GAD: What might this look like at school?]

[*Text on slide:*

Worries may sound like they are challenging or questioning authority.

- Surface: "Y*ou didn't tell us about this quiz. How am I expected to know this?*"
- Underlying Core Belief:
    - What if I fail this class?
    - My parents, teachers will be so disappointed in me
    - Everyone will think I am stupid
    - I am stupid]

[Dr. Marjory Phillips]: What you might see for example with a student like Trevor is that he appears oppositional and stubborn. He may sound like he's challenging authority. For example, when presented with a pop quiz, Trevor might go into fight mode, and argue. "*You didn't tell us about this quiz! How am I supposed to know this*?"

What you don't see and what Trevor may not even be able to articulate in his internal worries. "*What if I fail this class? My parents and my teachers will be so disappointed in me". "Everyone will think I'm stupid. I am stupid !*". And that's a core thought, common to kids with learning disabilities that can really drive distressing feelings and can lead to avoidant behaviors.

[SLIDE – GAD: What might this look like in school?]

[*Text on slide:*

- School avoidance or school refusal
- Missing classes
- Illness (headaches, stomach aches)
- Irritability
- Fatigue (may look tired in class)
- Inattention, difficulties concentrating
- Perfectionistic

Image of three boxers – the first one is green and has the word S*uccess* in it, the second is a yellow box and has the word *Good enough* in it crossed out with the word F*ailure* written overtop, and the third is a green box with the word *Failure* in it.]

[Dr. Marjory Phillips]: And these are just some of the behaviors you may see in a student with GAD. So school avoidance, illness, irritability, fatigue, inattention, perfectionism. You know, not handing things in because it's just not good enough. But again, every student is different.

[SLIDE – Specific Strategies for GAD at School]
[*Text on slide:*

- Increase structure and Predictability
- Practice patience and empathy
    - Recognize that the questions, need for advance notice of changes in plans, the meltdowns may reflect the student's anxiety
- Support universal practices in mindfulness, breathing, stress management
    - Without centering out the anxious student, encourage everyone to take short breaks to re-focus attention or to manage stress]

[Dr. Marjory Phillips]: What can you do to support a student like Trevor with generalized anxiety disorder and learning disabilities at school. We'll talk a lot at the end about some general strategies that are helpful for all types of anxiety. But, you know related to GAD in particular we know that structure and predictability is often helpful. As well as being empathic and patient. Recognizing that the questions are coming from a place of anxiety and not belligerence. Understanding that advance notice might help. Sort of figuring out what are the triggers that might really get these kids anxiety flaring. And is there anything you can do to mitigate that.
So for *Generalized Anxiety Disorder* the universal practices for stress management such as mindfulness and breathing that can be helpful for everyone but especially for the student with GAD and LDs.

[SLIDE – Social Anxiety Disorder (Social Phobia)]
[*Text on slide:*

- **Marked fear or anxiety about one or more social situations with peers in which there is possible exposure to scrutiny by others**
    - Examples: meeting new people, conversation, eating in a public place, performing before others (presentation, sports event, music/drama)
- **Student worries that she/he will do something that will be negatively evaluated by others**
    - Examples: will be humiliated or embarrassed, or rejected

(DSM-5)]

[Dr. Marjory Phillips]: Okay, so we'll talk next about social anxiety disorder. It's also called social phobia. You'll see the words used interchangeably. Social anxiety is a common and complicated problem for students with learning disabilities. According to the DSM 5, this reflects a marked intense fear of social situations. And for children and teens. The social anxiety has to pretend peers. It can't just be a fear of strange adult. So could be meeting new people or having a conversation. Eating in a public place like a cafeteria. And performing before others. So it could be, in a presentation like giving a speech or in a

musical event, a choir or a band or sports team, like an athlete. And typically. The key thing is that the student may have significant worries about what others will think. Or they worry that they will feel humiliated or rejected.

[SLIDE – Social Anxiety Disorder (Social Phobia)]
[*Text on slide:*

- Student avoids social situations
  OR
- Endures social situations with intense fear / anxiety that is out of proportion to the actual threat
- Symptoms are persistent (>6 months) & cause significant impairment]

[Dr. Marjory Phillips]: The other criteria for social anxiety disorder is that the person either avoid social situations or they endure them but they experience significant anxiety that is out of proportion to the situation. And these symptoms have to have lasted for at least six months and [inaudible] significant impairment. And it's not always obvious. I've worked with a teenager who had significant social anxiety disorder. He was a star athlete who had anxiety about his performance that got worse such as his athletic skills improved, and he rose up the ranks to becoming a quite a high level performer where the anxiety got really debilitating but people the coaches didn't see it initially.

[SLIDE – Social Anxiety Disorder: Safety Behaviours]
[*Text on slide:*

- Sitting in the back of the room
- Eating lunch in a classroom rather than the cafeteria
- Avoiding eye contact to avoid being noticed by others
- Offering to take on roles in a social situation that minimize social contact (e.g. taking pictures, operating the slides)
- Wearing clothing that does not call attention
- Daydreaming / self-focused attention

(Kley, Tuschen-Caffier & Heinrichs, 2012)]

[Dr. Marjory Phillips]: Individuals with social anxiety disorder usually engage in what are called safety behaviors. Safety behaviours are defined as cognitive and behavioural strategies used by socially anxious individuals to reduce the risk of negative evaluation by others! By Clark McManus.
And we know we know from the research that highly socially anxious children use safety behaviours more frequently than non socially anxious people. The tricky part is safety behaviours look like a lot of other behaviours. So you might see them in your classroom. They're common and can mean a lot of things. For example students who don't make eye contact or who wear hoodies or have long bangs that hide their eyes or they may be students who are really trying to avoid calling attention to themselves by how they sit, how they look, what they wear. They might be the students who offered to help out at a function by taking tickets at the door because they don't really want to be involved in the performance. Or they may be the types that are sort of daydreaming or look like they're zoning out.

[SLIDE – LDs Complicate Social Anxiety]
[Image of iceberg in the water with a line drawn dividing the small piece of iceberg that appears on top of the water, and the larger piece that is under the water with a sailboat steering towards the iceberg. There are bullet points of text above the water line, which read:

- Not initiating social interactions
- Withdrawn, isolates self from peers
- Quiet, does not participate in group discussions
- Misses school

There are bullet points of text below the water line, which read:

- Lagging social competence
    - 'reading' non verbal cues
    - Understanding nuanced language
- Executive functioning
    - Gets stuck, rigid problem-solving
    - Impulsive, dysregulated
- Social anxiety
    - Freezes, avoidant, not a risk taker
    - Somatic symptoms]

[Dr. Marjory Phillips]: The overlap between learning disabilities and social anxiety is particularly tricky. 75 % of students with learning disabilities have difficulty in social situations. But often, that reflects the impairment in social competence. It could be misperceiving social cues or misunderstanding intentions related to their LD. Then the outcomes with the student with LD is that the social interactions don't always go well. So as a result, the students may begin to feel anxious. Erm…they may feel that they are not very popular or they're seen as an outsider or that nobody wants to be in a group with them. And that all may be related to the learning disability. And still valid and important to us to support. But different. So it can be tricky to figure out if there's an additional social anxiety disorder on top of the LD anxiety. Erm and important to do so because in order to treat the disorder we want to take into account both social competence and anxiety together and the intervention. A social skills group that doesn't [inaudible] alone, that doesn't attend to the social anxiety it may not be so successful. And conversely a social anxiety group may really not give the kid enough skills and practical queuing for navigating a social relationship.

[SLIDE – Case Study: LD + Social Anxiety]
[*Text on slide:*
"Jenny" is a 12 year old, grade seven student

- Struggles with reading, writing, math
- Slow processing of information

- Has difficulty ‘reading’ social cues and misperceives interactions (thinks others are mad at her, don’t like her)
- Makes little eye contact, quiet in group work and in class
- Avoids the cafeteria, eats at home
- Misses school frequently due to illness]

[Dr. Marjory Phillips]: So let's consider Jenny. Jenny is a 12 year old student in grade 7 who has both LDs and social anxiety disorder. She's always had trouble making and keeping friends and she finds it hard to follow a group conversation. Jenny perceives that other students don't like her and are mad at her. She experiences tremendous anxiety even thinking about going to school every morning. She makes little eye contact, doesn't contribute to group work, avoids the cafeteria and stays away from school on days when there are assemblies. She feels lonely and like an outsider, but doesn't know how to change things.

[SLIDE – Specific Strategies for Social Anxiety]
[*Text on slide:*

- Group work
    - Plan carefully: Assign students deliberately
    - Limit the size of the group
    - Pair with the right fit of student
- School events: Assemblies
    - Give advance notice
    - Allow the student to enter the gym early
- Recess / unstructured time
    - Foster structure (e.g., ‘kindergarten monitor’)
    - Pair appropriately]

[Dr. Marjory Phillips]: So what might you do as an educator to help someone like Jenny, besides accommodating for the learning disability and referring her to your Student Support Team or mental health professionals, that's sort of a given. You can be thoughtful when you're implementing group work. So instead of allowing students to pick their own partners. Assign carefully. And pair Jenny perhaps with a kind, socially skilled student who will be patient. You could talk to a student like Jenny about a plan for crowded events, such as assemblies and, if possible, helping a student like Jenny to find a role and structure for unstructured time such as recess. For example, there may be an opportunity for the student with social anxiety to help with the kindergarten class. But pairing them with another student from her grade for example so that it's destigmatizing, it's sort of a normative thing it gives her a chance to have small group interaction that would be an example.

[SLIDE – Selective Mutism]
[*Text on slide:*

- Consistent failure to speak in specific social situations in which there is an expectation for speaking
- Student is able to speak in other situations, and failure to speak is not due to language difficulties or a communication disorder
- Persistent (behaviors present for at least one month)
- Behaviors cause significant impairment]

[Dr. Marjory Phillips]: OK let's switch to selective mutism selective. Mutism is a relatively rare disorder, occurring in less than 1 percent of children and it is more commonly seen in young children, in comparison to adolescence. Usually starts before the age of five years. But often, the behaviors become a significant impairment when they start school, such as in kindergarten. Students with selective mutism can speak. However, they're usually silent in situations when speech is called for. Such as in the classroom. And for a diagnosis, the behaviors have persisted for at least a month to meet diagnostic criteria and they have to be impairing.

[SLIDE – Selective Mutism]
[Image of a directional cycle with a continual arrow that links all of the blocks together in a reoccurring cycle, and has the word *Behavioural Conceptualization* in the centre. The first block in the cycle is *Child is asked a question and prompted to engage*, then *Child feels very anxious*, then *Child avoids*, then *Adult rescues*, then *Everyone feels better: child and adults anxiety are lowered*, then *Negative reinforcement*.]

[Dr. Marjory Phillips]: Typically a vicious cycle occurs in which. The child is asked a question or encouraged to verbally participate. The child with a selective mutism may respond with, will respond with anxiety and they often freeze and say nothing. Perhaps may gesture or shrug. And the caring adult sees the child in distress and comes to their aid and answers for them. And often, especially with young kids, other children in the class will do this too and sort of say 'oh Johnny doesn't talk' and so they'll talk for them. And that works in the short term. The anxiety levels decrease for the child with selective mutism, all the adults and caring people around feel like they're helping. And yet. The child with selective mutism doesn't really get to override that danger signal to learn that it is safe to speak. And thus they negatively reinforced the safety behaviour of silence.

[SLIDE – LDs Complicate Selective Mutism]
[Image of iceberg in the water with a line drawn dividing the small piece of iceberg that appears on top of the water, and the larger piece that is under the water with a sailboat steering towards the iceberg. There are bullet points of text above the water line, which read:

- Not initiating social interactions
- Withdrawn, isolates self from peers
- Quiet, does not participate in group discussions
- Misses school

There are bullet points of text below the water line, which read:

- Lagging social competence
    - ‘reading’ non verbal cues
    - Understanding nuanced language
- Executive functioning
    - Gets stuck, rigid problem-solving
    - Impulsive, dysregulated
- Social anxiety
    - Freezes, avoidant, not a risk taker
    - Somatic symptoms]

[Dr. Marjory Phillips]: So much like social anxiety. There's a lot of overlap with students with LDs and selective mutism. Although, it's a little less common to see. Often, kids may not be identified with an LD until they're a little older but it's the same kind of social peace not initiating interactions being withdrawn or quiet and figuring out what's a language impairment, what's lacking social competence, what's anxiety. It's important!

[SLIDE – Case Study: LD + Selective Mutism]
[*Text on slide:*
“Naomi” is a quiet 6 year old

- In grade one, Naomi cannot print her name and still struggles with her letters
- Rarely speaks in class, or speaks in a whisper
- Freezes when she is asked a question
- Does not speak during story time
- Seems to daydream and not pay attention at times
- Parents are frustrated because Naomi is a chatterbox at home]

[Dr. Marjory Phillips]: Consider Naomi. Naomi is a shy and quiet Grade 1 student. Her classroom teacher has never heard her regular speaking voice. It has taken until Christmas for Naomi to whisper to her teacher. The other children in the class assume that Naomi doesn't speak. And they'll answer for her. Naomi often looks at the window and appears distracted. Her parents are frustrated because at home with her 4-year-old sister and her parents Naomi is a chatterbox.

[SLIDE – Specific Strategies for Selective Mutism]
[*Text on slide:*

- Consult with the student’s mental health professional(s)
- Adjust expectations, work gradually, and notice positive efforts
- Begin with creating a safe environment, with reduced pressure for the student to speak in public. Continue to speak to the student without expecting a response.
- Set up opportunities for the student to respond to you in private in which the student has to give an answer (avoid yes/no questions)
- Repeat what the student has whispered so others can hear

- Pair the student thoughtfully in any group work]

[Dr. Marjory Phillips]: So as with the other anxiety disorders it's really important to flag concerns and to ask about a referral. If you think your student may have this problem. But, you know, once that's been sorted out, what can you do in the classroom? You can create a safe environment and gradually support the student to voice his or her ideas to you and then eventually to the class. So initially for example, it could be helpful to express ideas and observations to the student so they feel part of the class without the pressure to respond. You might start with questions where the student cannot yes or no. Like, if you're working with a grade one kid, you know, "Do you think the girl will find her necklace in the story?" So that the student is still part of the class. Then over time, asking questions that require a verbal response. "Would you like this or that?" And if you have a student who whispers then simply repeating what the student said to the class. As always, pairing thoughtfully for any group work can be helpful.

[SLIDE – Obsessive Compulsive Disorder (OCD)]
[*Text on slide:*

- Obsessions: recurrent & persistent intrusive unwanted thoughts, images or urges
- Compulsions: repeated behaviors aimed at preventing or reducing anxiety / distress
- Thoughts and behaviors are time consuming or cause significant distress or impairment
- Can be tricky to diagnose in children, especially those with ASD]

[Dr. Marjory Phillips]: The last disorder that we'll talk about is obsessive-compulsive disorder or OCD. OCD is commonly not diagnosed until late adolescence or early adulthood. However, 25 % of adult males with OCD report their first symptoms started by the age of 10 years. The disorder is characterized by obsessions, or recurrent and persistent intrusive unwanted thoughts, images or urges. The key feature here is unwanted thoughts. Often youth with OCD are aware that their worries are rational. They may feel a sense of shame and want to hide what's happening. Compulsions are behaviors that are aimed at reducing the anxiety associated with the unwanted thought. They are often excessive, such as hand-washing frequently, showering for hours, or counting items repeatedly.

[SLIDE – Obsessive Compulsive Disorder (OCD)]
[*Table on slide:*

Obsessions	Compulsions
Contamination →	Handwashing, cleaning, aversion to touching objects
Safety/Harm →	Checking, counting

[Dr. Marjory Phillips]: Of note, Children or students may not be able to explain why they do the behaviors. They know the behaviors don't make sense but they feel compelled to do them to feel safe. Common examples are worries about being contaminated by germs or disease. Then developing cleaning and avoidance behaviors to feel safe. Similarly, students may have worries about safety or

harm. And may engage in what seems like superstitious behaviors counting or repeating something three times or checking and rechecking locks, for example.

[SLIDE – LDs Complicate OCD]
[Image of iceberg in the water with a line drawn dividing the small piece of iceberg that appears on top of the water, and the larger piece that is under the water with a sailboat steering towards the iceberg. There are bullet points of text above the water line, which read:

- Rigid thinking, stubborn
- Difficulties in problem solving
- Distracted, inattentive
- Oppositional, unwilling to transition
- Argumentative

There are bullet points of text below the water line, which read:

- Executive functioning
    - Cognitive inflexibility
    - Difficulties in shifting set
- ASD
    - Repetitive behaviors
- Anxiety
    - Recurrent worries
    - Rituals, odd behaviors
    - Avoidance]

[Dr. Marjory Phillips]: Students who have LDs and OCD can be challenging particularly if they're also on the autism spectrum. So for example, rigidity and repetitive behaviors may be part of ASD: Autism Spectrum Disorder. They may be part of OCD. They may be rigid, coping and executive functioning related to LDs, or all three. And sometimes, it's tricky to know what to make of it. It can be helpful to know whether the behaviors are welcome for the child or not. So are they egosintonic or egodistonic. For example, if the student is aware that this way of thinking isn't logical, if they feel embarrassed or shamed by needing to complete rituals it may be more anxiety and OCD, but a professional assessment and intervention is really important.

[SLIDE – Case Study: LD + OCD]
[*Text on slide:*
"James" is a 15 year old grade 10 student

- Strengths: likes mechanics and design
- Has difficulty with reading and writing
- Frequently late to school
- Appears distracted with poor concentration
- Skips gym class (won't touch soccer or basketball)

- Frequently in bathroom, washing hands
- Avoids sharing pencils, won't write on board]

[Dr. Marjory Phillips]: So consider James. James is a 15-year-old student in grade 10. Academically, James has always found school difficult, particularly reading and writing. He's really good with mechanical things and with his hands but this year he seems preoccupied and disengaged. He liked gym in Grade 9 and was a good athlete but this year he started to avoid touching sports equipment like soccer balls and basketball. Things became awkward during a class presentation when another student hinted him a dry erase marker to write on a whiteboard and James left the classroom. And as his teacher you've noticed that James won't touch something after someone else has touched it. But he doesn't say anything.

[SLIDE – Specific Strategies for OCD]
[*Text on slide:*

- Consult / collaborate with mental health professional(s)
- Support a treatment plan of exposure & response prevention
- Create a safe environment, avoiding publicly embarrassing or shaming the student
- Where possible, support the student (e.g. computer instead of writing if erases compulsively; give notice about changes; more time if needed)]

[Dr. Marjory Phillips]: So the recurrent theme for all of these anxiety disorders is consult with the family professionals who are treating the student to know what to do for that particular child or youth. For OCD, we know that the treatment of choice is cognitive behavioral therapy that includes exposure and response prevention or ERP.
But I think from an educators perspective creating a safe environment and avoiding publicly embarrassing or shaming the student. Erm…Just really knowing that the student is not doing just to get attention, they're often embarrassed. And if you know the nature of the compulsions there may be a way to support the student working with their treatment team like giving them a computer instead of writing or giving more time because you might have a kid who has compulsions around tapping at the end of each math problem and needs more time on a test, for example.

[SLIDE – What can you do to help anxious students with LDs?]

[Dr. Marjory Phillips]: Okay, so we've talked about some strategies that might be helpful for the particular anxiety disorders and in the last segment of the webinar we'll just review some general strategies that are helpful for students with learning disabilities and anxiety who are in either the yellow or red zone. And there's resources at the end including the supporting mind reference and handbook on learning disabilities mental health by Integra, that's helpful.

[SLIDE – Determine the Problem]
[*Text on slide:*

- Do others have concerns about the student?
    - Within the school
    - Parents or guardians
- Refer to the School Support Team (or equivalent), or ask for a school meeting
- Consult and/or ask team including caregivers about whether an assessment might be appropriate]

[Dr. Marjory Phillips]: So as I said the first step is to recognize and identify signs of potential mental health problems. If you are concerned then it's important to share your observations with others who can help develop a plan to support the student. And often, mental health issues are complex and require a careful assessment. So talking just to see where that might happen or if anybody else has concerns is a good first step.

[SLIDE – Collaboration is Key!]
[Image of a radial cluster with the word *student* in the centre with arrows pointing outward to three boxes: *parents, educators, other professionals*. There are double-sided arrows connecting all boxes.

Text on slide:

- Regular communication between the home and school leads to better outcomes
- Teamwork takes the onus off each individual member]

[Dr. Marjory Phillips]: A team approach with caregivers, school staff, and other professionals is really important for mental health challenges. It can be hard to communicate with each other. It can also be hard to access resources and I know that often there are not enough mental health resources in the community for these. But at least playing together with the resources that you've got to have a team is an important start. And each school board will have some procedures but all boards usually have a process that educators can use to raise concerns about students that are experiencing mental health challenges.

[SLIDE – Preventative Strategies]
[*Text on slide:*

- Get to know your students
    - Understand their strengths and weaknesses
    - Learn what helps and what hinders
- Educate your students on anxiety
    - Normalize and generalize experiences of anxiety
    - Highlight fictional characters or real role models who have struggled with anxiety and talk about how they coped]

[Dr. Marjory Phillips]: So these are strategies that are really good for supporting mental wellbeing, good for everyone kind of in any zone. One is to get to know your student can know their strengths and

weaknesses, knowing what situations they can handle and how to respond when they can't cope to that to the extent that you can. Where it's appropriate, normalizing, or educating your students on anxiety and helping them to understand what's, by role modeling or highlighting fictional characters just how it's fairly typical to have anxiety.

[SLIDE – Preventative Strategies Cont'd]
[*Text on slide:*

- Provide predictable schedules and routines in the classroom
    - Have a daily or weekly schedule on the board
    - Provide clear warnings when transitioning subjects or activities (e.g., "You have 5 minutes before we move on to the next activity")
- Provide advanced warning for any changes in routines
    - Send a note home indicating a change in routine (e.g., a change in the classroom, a substitute teacher)]

[Dr. Marjory Phillips]: Changes of any sort may be very stressful for students with learning disabilities. So predictable schedules and routines, warnings when transitioning, as well as clear expectations can help students predict how the day will go and that may help to decrease opportunities for emotions to build up. And also give the student time to process information and ask questions if they need to**.**

[SLIDE – Preventative Strategies Cont'd]
[*Text on slide:*

- Have a quiet and safe place where the student can go for a few minutes if they are feeling overwhelmed
- Manage the demands of the environment
    - Consider seating arrangements in the classroom
    - Plan ahead for assemblies and large group activities
    - Assign groups instead of letting students pick their own groups
    - Adjust or reduce schoolwork and/or homework based on information from parents and the school team on how much stress the student can handle]

[Dr. Marjory Phillips]: Having a quiet and safe place for your student can go for a few minutes to calm down. Like resource room or library, that you workout with the student ahead of time can be helpful. And knowing, also knowing the individual student you may seat the child in the classroom deliberately near the front where it's quiet and less distracting or you may choose by the door so that the student can feel they can escape and leave when they need to. If you have a student who is overwhelmed by sudden changes or large crowds as I suggested before planning in advance for assemblies or large group activity, it might mean sitting on the end of a row or arriving early or late. It all depends on what makes sense for the student and what makes the student most comfortable. And again, group work is really important. Instead of letting students pick their own groups erm…because students tend to gravitate towards the peers they know and are familiar with and they often leave out students who may not have

a close relationship with their peers. So, and if you're the student with anxiety picking your own group can be really anxiety provoking especially if you have few friends. And lastly, if you have a student who's spending unreasonable amounts of time on homework or they're simply worrying about completing an assignment properly. Then again, working with your team adjusting or reducing the amount of work focusing on effort not outcome may help.

[SLIDE – Preventative Strategies Cont'd]
[*Text on slide:*

- Model self-regulation
    - Understanding and acceptance of feelings, emotion regulation, problem solving
- Use positive self-talk
    - "I need a break"
    - "This is hard, but I can handle it"]

[Dr. Marjory Phillips]: Children and Youth often lack of self-regulation skills by observing others. So modeling optimism: positive behavior understanding, accepting feelings, emotion regulation, and positive self-talk. All of those things can be helpful.

[SLIDE – Preventative Strategies Cont'd]
[*Text on slide:*

- Create a learning environment where mistakes are viewed as a natural part of the learning process

Image of typography with the words *We all make mistakes. It's how we come back from the mistakes that matters.*]

[Dr. Marjory Phillips]: And creating a learning environment where mistakes are viewed as a natural part of the learning process. So providing students with reassurance after a mistake is made, "everyone makes mistakes" "no one is perfect" or it's how we come back from the mistakes that matter.

[SLIDE – Preventative Strategies Cont'd]
[*Text on slide:*

- Teach mindfulness or relaxation skills to the class
- Calm breathing, muscle relaxation, movement breaks]

[Dr. Marjory Phillips]: More and more when we're learning about the benefits of mindfulness. And so teaching mindfulness to class, to the classes again are good for all sort of strategy or practicing relaxation skills throughout the day. Breathing having mini breaks. We know that that's really good, for good mental illness.

[SLIDE – Preventative Strategies Cont'd]

[*Text on slide:*

- Offer praise when a student is able to calm their emotions
    - Authentic and genuine praise will bring attention to helpful coping strategies
- Recognize, praise and reinforce efforts not just results]

[Dr. Marjory Phillips]: And praise is important but for students with learning disabilities are often really aware of their academic or social difficulties. So ensuring that your praises genuine and meaningful. And praise, again, praise, reinforce efforts not just results, is important.

[SLIDE – In the Moment Strategies]

[*Text on slide:*

Use **Empathy**

1. **Observe and listen** to the student
2. **Reflect and label** the feeling (e.g., "I noticed you are asking a lot of questions about the upcoming field trip. Are you worried about how it will go?")
3. **Validate** the feeling (e.g., "Lots of students feel tense when they have pop quizzes")
4. **Support** the students strengths (e.g., "You have worked hard and put a lot of effort into studying")]

[Dr. Marjory Phillips]: For the student with anxiety. Empathy is often the best place to start. It may start with noticing a student who's struggling. And in a tactful manner finding an opportunity to pull the student aside and listen to their concerns or just check in. You might, help to reflect and label the feeling. So for example saying to a student, "I notice you're asking a lot of questions about the upcoming field trip, are you a little worried about how it will go?" You can also validate their feeling by understanding and not judging why a student might feel that way. So you might say, for example, "lots people feel sort of nervous when they have pop quizzes." And then, lastly supporting a student's strengths. So again, not giving false reassurance, but really a genuine acknowledgement of effort saying to the student "you've worked hard, you've put a lot of effort in, you're ready" but you don't say "you're going to ace the test" especially with kids with LDs because you just don't know that.

[SLIDE – In the Moment Strategies Cont'd]

[*Text on slide:*

- Encourage slow, deep breathing when a student appears stressed
    - Stay calm and patient
- Have a cool down pass or an agreed upon signal where the student is show they need to take a break (e.g., go for a quick walk, get a drink of water)
    - An agreed upon signal or a colour-coded card allows the student to ask for support without being placed in the spotlight]

[Dr. Marjory Phillips]: And as an educator and as caring adults we need to stay calm, ourselves. When the students are anxious and develop some strategies that might be a cool down path or signal when they need a break.

[SLIDE]

[*Table on slide:*

Cool Down Strategies	Calming Strategies
• Take a drawing break • Take a reading break • Run an errand for the teacher • Listen to music • Work on the computer • Your choice	• Take a break • Get a drink • Go for a walk • Count to 10 • Take a deep breath

[Dr. Marjory Phillips]: There are some visual aids for Elementary school kids that can be helpful some that you can post in your classroom. Those cool down strategies.

[SLIDE – In the Moment Strategies Cont'd]

[*Text on slide:*

- Do not teach in a crisis moment
    - Contain, debrief, problem-solve and teach when calm
- Offer to help problem solve a better way to deal with the emotion once calm
- Resist asking too many 'why' questions]

[Dr. Marjory Phillips]: And lastly just reminding us all that it's less effective to have a teachable moment when a student is fully dysregulated or if they're really anxious. Their brain is offline. They are not able to concentrate and really process what you're saying when that sympathetic nervous system is fully aroused. So finding a time to debrief or problem solved. When the student is calm. When you are calm it's really important. And I'll leave you with the tip that I think is the hardest, it's to avoid or resist asking too many "why" questions. Especially for students with anxiety they may not know why or they may not be able to articulate why they feel overwhelmed, anxious, especially in the moment. What's really helpful is just validating and helping them to regulate and find their way back to calm.

[SLIDE – For More Information]

[*Text on slide:*

Dr. Marjory Phillips, C.Psych.
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[Image of University of Waterloo logo, and Centre for Mental Health Research Clinical Services, Training & Research logo.]

[Dr. Marjory Phillips]: So as you'll see in the sides, that will be sent out to you. There are good resources. I'm now at the University of Waterloo. But I want to put a plug in for my colleague, Hayley Stinson who is a social worker with the Community Education and Engagement program at Integra, Child Development Institute and Haley is an Integra folks that can come out to your school, to places, to give workshops to staff, to students, to parents on a variety of topics related to LDMH, or there are some workshops in Toronto that you can look at.

[SLIDE – Resources]
[*Text on slide:*

- School Mental Health ASSIST (www.smh-assist.ca)
- Supporting Minds: An Educator's Guide to Promoting Students' Mental Health and Well-Being (www.edu.gov.on.ca)
- Children's Mental Health Ontario (http://cmho.org/
- Integra Program, CDI http://www.childdevelop.ca/programs/integra-program]

[SLIDE – Resources: Educators]
[*Text on slide:*

- SMH-ASSIST Anxiety Information Sheet https://smh-assist.ca/wp-content/uploads/Info-Sheets-Supporting-Minds-Anxiety.pdf
- Learning Disabilities and Mental Health Article
- https://www.ldatschool.ca/learning-disabilities-and-mental-health/
- The ABC's of Mental Health: Teacher Resource
- http://www.hincksdellcrest.org/ABC/Teacher-Resource/Welcome
    - Developmental Stages
    - Levels of concern (green, yellow, red light)
- Ontario Teacher's Federation – Teacher's Gateway to Special Education
- http://www.teachspeced.ca
    - Effective strategies and resources for teaching kids with special needs]

[SLIDE – Resources: Websites (Mental Health)]
[*Text on slide:*

- **The ABCs of Mental Health**
    - http://www.hincksdellcrest.org/ABC

- **Sick Kids Hospital**
  - www.aboutkidshealth.ca
- **Worrywisekids**
  - http://www.worrywisekids.org/node/40
- **Children's Mental Health Ontario – CMHO**
  - www.kidsmentalhealth.ca]

[SLIDE – Resources: Websites (LD/ADHD)]

[*Text on slide:*

- Learning Disability Association of Ontario-LDAO
  - www.ldao.ca
- LD@school
  - https://www.ldatschool.ca/
- National Centre for Learning Disabilities – NCLD
  - www.ncld.org
- Smart Kids with LDs
  - http://www.smartkidswithld.org/
- Teach ADHD –Sick Kids
  - http://research.aboutkidshealth.ca/teachadhd/
- Children and Adults with ADHD (CHADD)
  - http://www.chadd.org/]

[Dr. Marjory Phillips]: Then we also have good information on the website. That may be of use to you so as you will see in these sources *Supporting Minds* is a fantastic document from the Ministry School Mental Health assist you are probably aware of Children's Mental Health Ontario has list of agencies, children's mental health agencies that are in your region. And Integra has some information.
And then again lots of great resources that you'll see for educators. And I will leave it there and pass it back to you, Cindy.

[SLIDE – Q&A]

[Cindy Perras]: Thank you very much Dr. Philips. That was a fabulous presentation. We're so appreciative that you've taken the time today to share your knowledge and your expertise and for providing our webinar participants with incredibly in-depth practical suggestions and strategies to manage anxiety in students with LDs.

OK! So let's move on now to the Q & A part of today's webinar! If anyone has questions please type your question into the chat box on our go to webinars dashboard and I will read your question to Dr. Phillips. First question and this is actually a two part question. Part 1, is it common for students with learning disabilities to experience multiple mental health concerns?

[Dr. Marjory Phillips]: Can I answer the parts one at a time.

[Cindy Perras]: Yes.

[Dr. Marjory Phillips]: Yes, so, yes comorbidity is really common with LDs. I think we're we're just learning really about these, we call them LDMH but a common thread seems to be emotion regulation challenges and executive functioning difficulties. But, it's quite common that you'll see anxiety plus depression, plus ADHD, plus LDs, plus sometimes ASD. Comorbidity is really quite common.

[Cindy Perras]: Okay thank you. Part two of this question. How then can teachers support students with learning disabilities who have complex mental health needs.

[Dr. Marjory Phillips]: Well I think I feel first for educators because I think all of us are trying, these students need all of us to work together but we're really set up and different, you know, our services are not always accessible easily. So, I think the biggest thing that educators can do is to really help to say, you know, “I'm worried about this students” and just to pull in here at your school board level to flag to say “I'm worried. I think he, you know, this student is acting really defiant” or “I never see him. I don't even know what he looks like, he never comes to class”.

And just to pull the alarm bells off, there are waitlists everywhere, but more and more in Ontario we have drop-In clinics we have services and then I think the school mental health and other leaders are really trying to beef up resources. So for the educators, it's not feeling like it's your job to do the intervention. You have a fantastic job to flag concerns and raise alarms and then support in this kind of generic universal strategy kind of ways.

[Cindy Perras]: Thank you.

Next question, can a student displays signs of obsessive thinking without manifesting compulsive-like behaviours?

[Dr. Marjory Phillips]: Yes absolutely. Yeah. OCD isn't only defined if you, you don't have to have compulsion. Not necessarily. It's just fairly common. One of the tricky parts and diagnosis of obsessional thoughts is just how much is it really Obsessive Compulsive Disorder and how much is a generalized anxiety disorder. So you can have students where they have worries and they're vague and they're intrusive and they just can't let them go. But they're not obsessions. And it's, you know, a nuanced point in some ways it doesn't matter so much because either way if the thoughts are intrusive and they're concerning to the student then working with someone to help them figure out what those thoughts are and how to change their thinking is important.

And the last comment I'll make about that is that sometimes the compulsion might be not noticeable you might you know that impulse… there may be a compulsive piece that you don't see because it's the students counting in their head. You know, [inaudible]. So sometimes, there are compulsions that are invisible.

[Cindy Perras]: Great, thank you. Next question.

How would you handle the situation where a student has a diagnosis of ADHD? Experiences significant anxiety and the learning gap is increasing, but parents are not in favor of medication to help manage ADHD.

[Dr. Marjory Phillips]: Right.

Yeah I think that's such a big piece. It can be you know with or without anxiety. That's a big piece.

I think in our experience, my experience from working with families a long time as it helps to give the family some time and having a relationship with someone to really understand what their concerns are about medication. So it's tough again. I feel for educators because you know you might see you… get to see a whole classroom and you can see my gosh if that kid had something to take you know to help bring them their focus up or bring the anxiety down they they could really attend better or it would be so much better. But you know it's respecting the family values that it's helping the family to start to see somebody where they can really take over their worries with more time and get to know what their concerns are. It's often not just a simple you should do it. You know, you have to understand.

So in the meantime I think for educators it's managing what you can do with the student you've got and doing environmental changes to the extent that you can like seating and queuing, that sort thing.

[Cindy Perras]: The next question, is cognitive behavioral therapy, CBT? Possible with a youth who has had a diagnosis of selective mutism for five years and is completely non-verbal outside the home. This particular youth is now 18 and became non-verbal at age 13.

[Dr. Marjory Phillips]: Oh wow. So and so I don't know enough about the specifics but I would be really curious about, that's not a common trajectory for selective mutism. It may reflect some complexity related to a trauma or something having changed for that individual. So that's, yes, I'm guessing, often for complex pictures that are outside the typical presentation like having selective mutism at 18 with an onset at 13.

And you know the typical treatment as usual often is less effective and it may take a combination of a lot of things including, really like medication and careful therapy. It depends on the students' willingness to engage. There may be other factors. I would certainly want to be sure that there was a really good assessment being done to make sure there isn't something like a brewing schizophrenia or autism or something that could also account for a change in that kind of you know reduction in talking or without loss of function in that way. That's just atypical.

[Cindy Perras]: OK. We have so many questions here. I know we're not going to get to all of them in the time that we have but I will read or read a couple more and give people a heads up when we're at at the last question.

Elopement, leaving school and running home. Are there specific strategies that we can use?

[Dr. Marjory Phillips]: Yeah. Wow that's such a tough one. It often depends on the age of the child. So you know safety is paramount. If you have an elopement in a 6 year old that's different than elopement and a 15 year old which, probably wouldn't even call it elopements.

So I think one of the. So again putting together a team trying to understand what are the situations that we think back to that very basic fight flight or freeze. That's a classic flight literally flight. The child is running away from school to get to the safety of home. So what is it about that school environment that's really flaring up that anxiety. Is there a way to work with the student and the staff and the family to change the contingency is you know maybe as a particular teaching style or maybe it's a class or maybe it's a time of day or maybe it's just that it's just too much. They can get to school but they just

can't. You know, they worry all day and by the time they hit 11 o'clock, they're done and so changing their length of day till you work backup. You know, sometimes can be things like this child can be attention seeking but often they're some kind of distress that starts it off you know. And understanding, but you know in terms of strategy that also depends on the specific skill location and you know whether or not you need to, because you're worried about the child running into traffic and have an adult at side, or everything is, it's all quite specific that.

[Cindy Perras]: Yes! I know there are a lot of variables that have to be factored into any sort of an intervention plan that is put into place. What happens is when anxiety and learning disabilities are diagnosed later rather than earlier and oppositional behaviors seem to be out of control?

[Dr. Marjory Phillips]: Well I think, again, sometimes that the you know a good diagnosis of some of these things can be tricky so it can be the case that the student had learning disabilities along but they kind of grew into their areas of impairment and they become more evident. It may be that you can develop, anxiety disorders can emerge. They don't all start at a young age. So those can emerge.

And oppositional behavior, I think is often one way to look at when a student is just refusing to do what they need to do. And so that diagnosis can be helpful but oftentimes it's just more of a descriptor of, description of what's going on. Why is the student digging in their heels. Is it anxiety based, is it competency based because they don't, they need more supports think they know. And unfortunately the later the diagnosis especially for something like LDs than it can you can get pretty entrenched behaviors in the student they can feel like giving up. Or that, what's the point? Every time I do something it just does the outcomes not, doesn't it's not worth the effort I put in. So why bother? And so then that it just gets harder, harder to manage as you get older. But again the principles would be a good diagnosis and putting a team together and looking at what are the situations where a student can experience success and trying to build on the successes bit by bit.

[Cindy Perras]: Our next question here.

And I think we will have time for about another three. Just so you're aware as well Dr. Phillips. [Inaudible] issues with learning disabilities and mental health.

[Dr. Marjory Phillips]: Sorry, I only heard the learning disabilities and mental health, you cut out.

[Cindy Perras]: OK. Not a problem. I'll repeat the question.

What are your thoughts around evidence based social skills training for students with LD and MH?

[Dr. Marjory Phillips]: Well and I'm a biased, I'll state my biased right at the top at Integra we developed a social competence intervention that we're evaluating, that's really promising. It's not an evidence-based intervention as yet.

But having read a lot in the field I think it needs, the interventions need to be multifaceted and that's the, if people are interested after are they can contact me I have some good resources and articles and so forth. But the key thing is that to consider social skills and self-regulation and social awareness as all different components of social competence and that students with LDs, we need to take their learning into account when understanding that and then adding in anxiety if that fits. So we know from the research that social skills alone don't always generalize but if kids learn by doing they learn from each other. And if we can provide in the moment coaching and we match kids that they're learning from the

right other kids, you know, they learn from each other and we set the contingencies effectively and we're targeting the skills that they need to learn. Like conversation or turn taking or awareness, that those skills seem to be generalizing much better.

[Cindy Perras]: Ok thank you!

Second last question now. Is there any research showing a connection between the non-treatment/diagnosis of learning disability and anxiety disorders?

[Dr. Marjory Phillips]: Sorry. So research showing the non-treatment diagnosis.

[Cindy Perras]: That's the question here so I'm wondering if this research has groups [inaudible] so that there would be students who don't receive specific interventions or support with LDs and anxiety.

[Dr. Marjory Phillips]: Right, meaning like a control group. I'm guessing that's the question is: have there been controlled studies of intervention in anxiety?

[Cindy Perras]: That's how I will interpret those yes. OK.

[Dr. Marjory Phillips]: So the literature in this field is really sparse. I think there is one of the challenges is just, even internationally, is our definitions of learning disabilities and how that's defined in different studies. And so, but in terms of controlled studies I don't, what hasn't been there is people really tailoring interventions in a controlled way to look at you know what difference, how the tailoring works, or whether students with LDs have been compared to non LDs for intervention but certainly for diagnosis and prevalence we know that, that that's compared to control samples. You know if you have students with, how many kids with anxiety versus how many students with LDs and anxiety there.

But I think more controlled studies are needed. And there's, even at Integra I think that's been our aim when I was there as I was trying to conduct controlled studies and compare. But we were comparing students with LDs who weren't in treatment to students without these who were in treatment as the control group.

[Cindy Perras]: OK. Yeah, and I think that answers the intent of the question and this is our final question then for the afternoon. My goodness there are so many great ones here. Actually, the question that I went to pose to you has come up a couple of times in what our webinar our participants submitted. If anyone participating today has a student-specific question for you, would they be able to contact you directly?

[Dr. Marjory Phillips]: Oh that's a good question. So because I'm in my old role Yes absolutely. In my new role, yes. Yes I'll answer, I'd be happy to. I'm now at the University of Waterloo in a different kind of position but this still is a passion area. I also think the Integra community engagement, Community Education and Engagement program is really, that program, that's my old program is to facilitate knowledge transfer and support. So yes to both! My contact information's there I'd be happy to chat.

[SLIDE – Other questions?]
[*Text on slide:*
EMAIL: info@LDatSchool.ca

TWITTER: #LDwebinar]

[Cindy Perras]: Alright, wonderful thank you very much**.**

Alright, wonderful thank you very much. That's all the time we have for today. And we're going to end our question and answer session at this time. Should you have any further questions please either email us at info@ldatschool.ca or use our hashtag on Twitter #LDwebinar and we will ensure your questions get answered.

[SLIDE – Educators' Institute]
[*Text on slide:*
August 21st & 22nd, 2018
Hilton Mississauga/Meadowvale
SAVE THE DATE!]

[Cindy Perras]: Please mark your calendar and saved a date to join us at LD@school's 5th annual Educators Institute which will be held on August 21st and 22nd in Mississauga. Public registration opens on May 14. Please check the LD@school website for information on the program, registration and hotel accommodation.

[SLIDE – THANK YOU!]
[Cindy Perras]: And on behalf of the LD at school team, I would once again like to thank Dr. Phillips for her presentation and thank you to all of our participants for joining us.
Please remember that we will be sending out presentations slides and a short survey following today's webinars. The feedback we receive through this survey provides us with important information for producing future webinars and as a final reminder, we will be sending out a link to this recorded webinars in approximately three weeks. Thank you again for participating and enjoy the rest of your day!