

# Identifying, Managing, and Supporting Children with Anxiety Disorders

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# What is Evidence-Based Treatment?

**EBT consists of three components:**

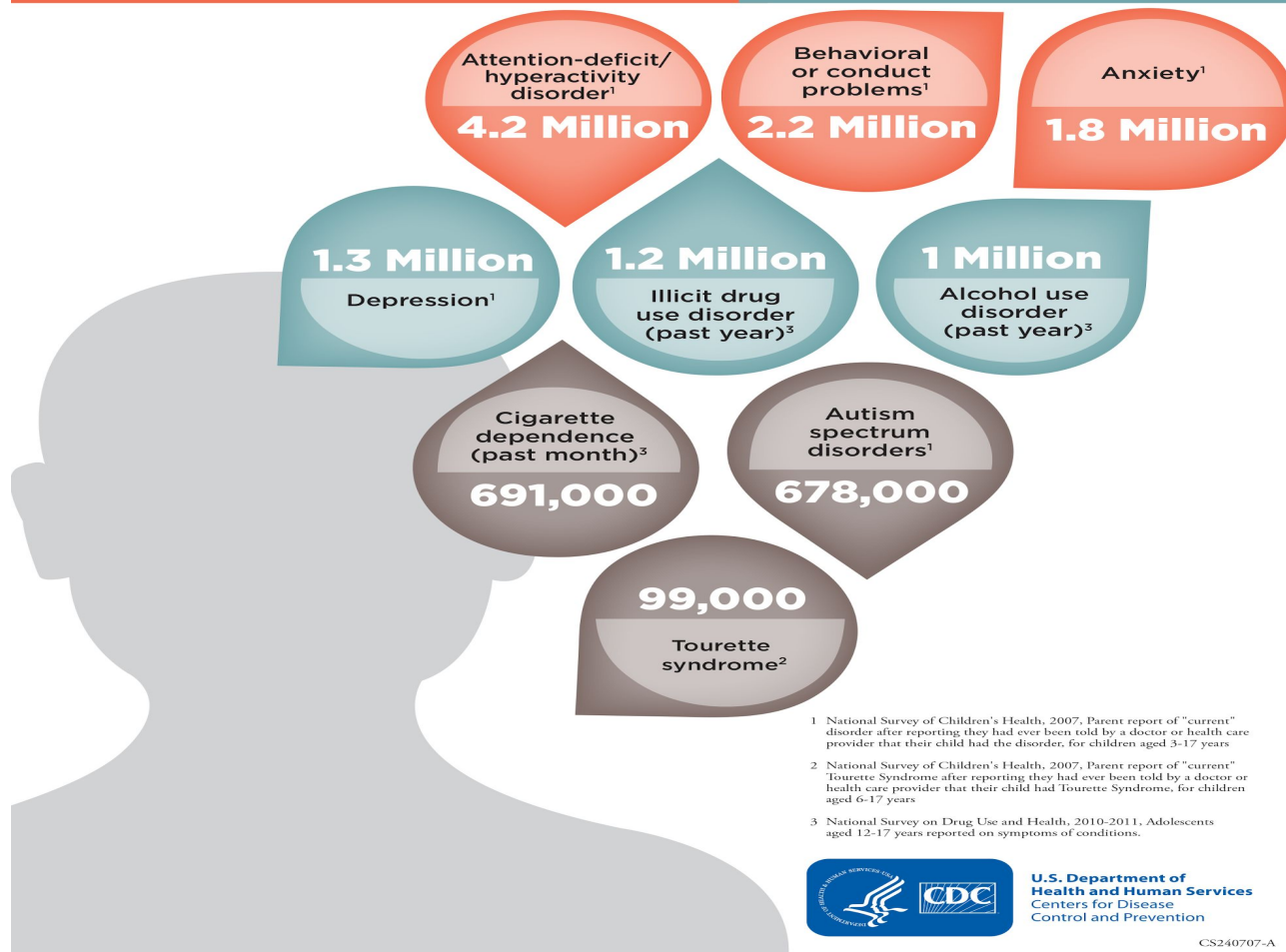
- **It is practice guided by the best available research evidence**
  - Not all mental health treatments are equally effective
- **Takes into consideration patient's values and preferences**
  - Psychological treatment should be a collaborative process that respects your own experiences, needs, and values.
- **It is conducted by someone with the appropriate clinical expertise**
  - It is your therapist's job to interpret the best evidence from systematic clinical research (the first leg) in light of your preferences, values, culture, and daily life realities. Therapists rely on their own clinical expertise in figuring out how to integrate these different pieces of information to formulate your individual treatment plan.



**Children's Mental Health Matters!**

# ESTIMATES OF U.S. CHILDREN

with Mental Disorders



<sup>1</sup> National Survey of Children's Health, 2007, Parent report of "current" disorder after reporting they had ever been told by a doctor or health care provider that their child had the disorder, for children aged 3-17 years

<sup>2</sup> National Survey of Children's Health, 2007, Parent report of "current" Tourette Syndrome after reporting they had ever been told by a doctor or health care provider that their child had Tourette Syndrome, for children aged 6-17 years

<sup>3</sup> National Survey on Drug Use and Health, 2010-2011. Adolescents aged 12-17 years reported on symptoms of conditions.



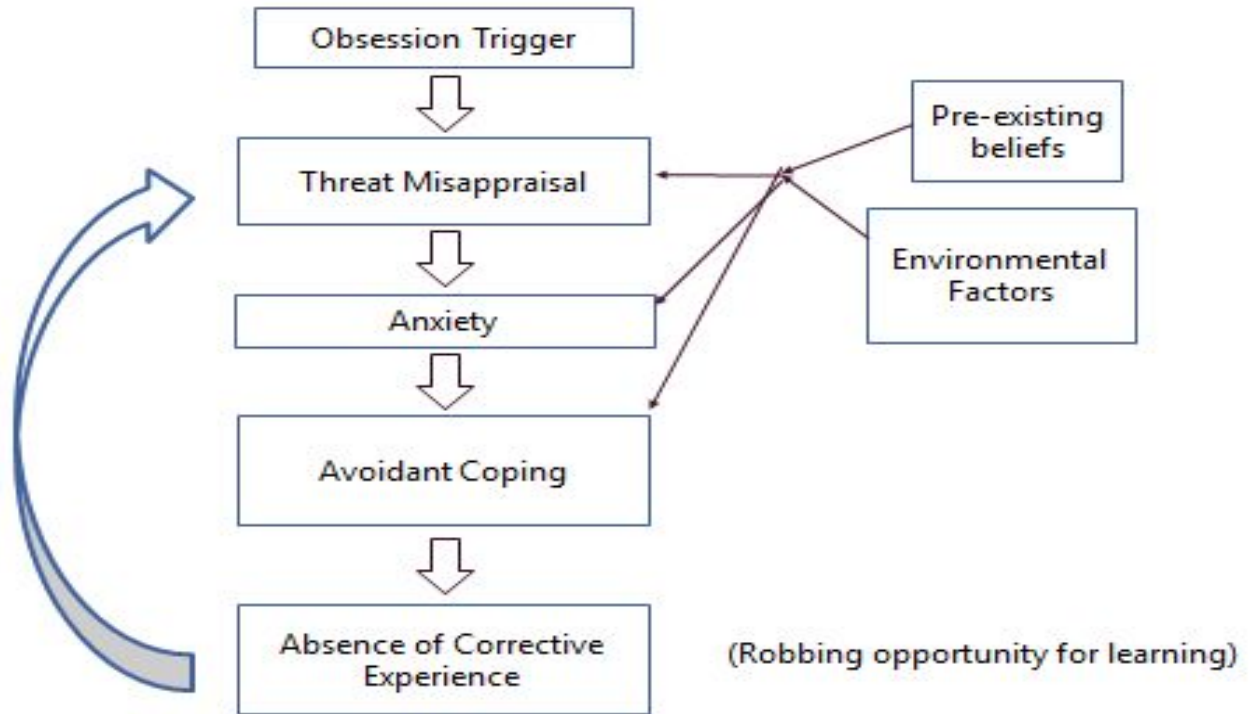
**U.S. Department of  
Health and Human Services**  
Centers for Disease  
Control and Prevention

# Common Anxiety Disorders Seen in Children, Adolescents, and Young Adults

- Anxiety
- Social Anxiety
- School Refusal
- Performance Anxiety (sports, presentations)
- OCD
- Body-Focused Repetitive Behaviors (BFRBs)



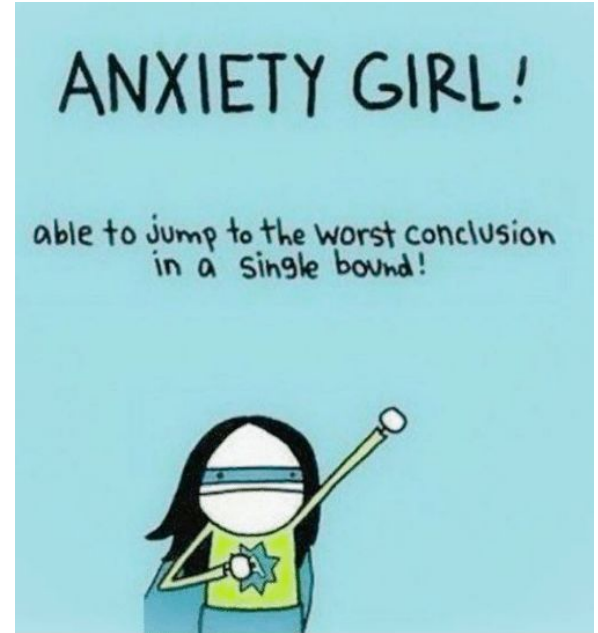
# But how does anxiety develop?!



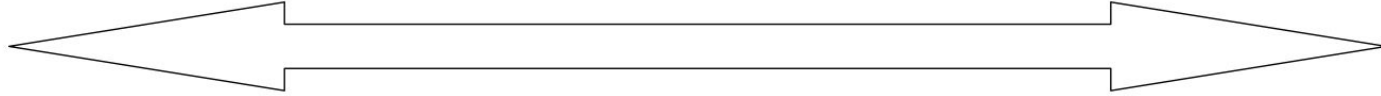
# EBT: Cognitive- Behavioral Therapy

Elements of CBT used when treating anxiety-based disorders

- Thought records
- Behavioral activation/Opposite Action
- Fear hierarchy
- Exposure & Response Prevention
- SCAMP (sensory, cognitive, affective, motor, place)
- Habit reversal



# **ANXIETY RATING SCALE**



0	1	2	3	4	5	6	7
<b>HAVE TO RESIST</b>				<b>TRY AS HARD AS POSSIBLE TO RESIST</b>			
<i>LOW ANXIETY &amp; URGE TO RITUALIZE</i>				<i>MEDIUM ANXIETY &amp; URGE TO RITUALIZE</i>		<i>HIGH ANXIETY &amp; URGE TO RITUALIZE</i>	
<b>CALM NO ANXIETY NO URGES TO RITUALIZE AT ALL</b>	<p><b>"It bothers me"</b></p> <p><b>"Don't want to do it but know it will be easier than I think."</b></p> <p><b>A few urges to use safety behaviors.</b></p>	<p><b>Anxiety is bothersome, yet manageable.</b></p> <p><b>A little bit harder to resist urges but can still do it.</b></p>	<p><b>Difficult to resist urges.</b></p> <p><b>"Wish I didn't have to do it, but can do it. Glad when it's over!"</b></p> <p><b>Come close to safety behaviors but can still resist.</b></p>	<p><b>Challenging</b></p> <p><b>Unsure if able to resist ritualizing.</b></p> <p><b>Very hard to resist urges to use safety behaviors.</b></p>	<p><b>Challenging</b></p> <p><b>Extremely hard to resist urges to use safety behaviors.</b></p> <p><b>Start feeling symptoms of panic.</b></p>	<p><b>Near panic</b></p>	<p><b>Panicking</b></p> <p><b>Fear of dying.</b></p>
<b>EXAMPLE:  GOING TO THE DENTIST</b>	A few weeks before appointment. Think about not wanting to go, but no worries, really.	Dreading going. Really don't want to, but know it will be ok if I go.	Think about 'faking being sick.' Trying to make excuses. Go to it, but glad when it's over.	Can't imagine making it through the appointment. Think about leaving in the middle of the appointment. Strong relief when I make it.	Don't know if I can make it. Feel some panic symptoms starting.	Refuse to go. Feeling panicky.	PANIC Fear of dying if I go.



# General, Social, Performance, & School Refusal Anxieties

- Cognitive Restructuring/Reframing
- Increasing effective engagement with triggers causing distress
- Tolerating Distress
- Using ERP:
  - Prolonged and repeated exposures to distressing situations
  - Preventing habitual responses that actually increase distress



### **AUTOMATIC THOUGHT RECORD**

When you notice your mood getting worse, ask yourself, "What's going through my mind right now?" As soon as possible, fill in the table below.

<b>Date, Time</b>	<b>Situation</b>	<b>Automatic Thoughts (ATs)</b>	<b>Emotion/s</b>	<b>Adaptive Response</b>	<b>Outcome</b>
	<ul style="list-style-type: none"><li>• What led to the unpleasant emotion?</li><li>• What distressing physical sensations did you have?</li></ul>	<ul style="list-style-type: none"><li>• What thought/s or image/s went through your mind?</li><li>• How much did you believe the thought at the time (0-100%)?</li></ul>	<ul style="list-style-type: none"><li>• What emotion/s did you feel at the time?</li><li>• How intense was the emotion (0-100%)?</li></ul>	<ul style="list-style-type: none"><li>• Which thinking styles did you engage in?</li><li>• Use questions below to respond to the automatic thoughts/s.</li><li>• How much do you believe each response (0-100%)?</li></ul>	<ul style="list-style-type: none"><li>• How much do you now believe your ATs (0-100%)?</li><li>• What emotion/s do you now feel? At what intensity?</li></ul>

**Questions to compose an Adaptive Response:** (1) What is the evidence that the automatic thought is true? Not true? (2) Is there an alternative explanation? (3) What's the worst that could happen? What's the best that could happen? What's the most realistic outcome? (4) If a friend were in this situation and had this thought, what would I tell him/her?

# OCD: Exposure & Response Prevention (ERP)

- Exposure and Response Prevention
  - Is used for increasing tolerance to anxiety-based triggers (obsessions) and interrupting ritualized behaviors (compulsions)
  - Prolonged, graduated, repetitive, and consistent exposure to situations and thoughts that provoke anxiety and distress
    - Situational/In vivo exposure
    - Imaginal exposure
  - Exposures are considered challenges by choice
  - Hierarchies are developed with clients using a Likert scale rating subjective units of distress



# BFRBs: The SCAMP Model & Habit Reversal Training

BFRBs are based in anxiety and can usually be attributed to being over-stimulated or under-stimulated

- S: sensory
  - Reinforcement comes from sensory experiences from pulling, picking, or biting (e.g., feels satisfying to feel the “pop”, tingling when pulled, rubbing the hair follicle, etc)
- C: cognitive
  - Reinforcement is received from thoughts pre-, during-, and post- pulling/pick/bite behaviors (e.g., “You won’t be able to relax until you get that ONE hair”, “Ah, whew, now you can relax”)
- A: affective
  - Reinforcement if felt through emotional satisfaction of following through with the urge to pull, pick, or bite
- M: motor
  - BFRBs can also be dictated by repetitive motor behaviors that create a vulnerability to follow through with pulling, picking, or biting (e.g., twirling hair, cleaning under nails, rubbing fingers over eyelashes)
- P: place
  - At times, certain locations can also be triggers for engagement in BFRBs (e.g., sitting in the car, looking in the mirror, sitting in class)

# How to find the best fit clinician for your child...

- Assess willingness
- Assess severity of symptoms
- Interview several providers for “goodness of fit”
- Internet search for “evidence based treatment for....”
- Word of mouth referrals
- Early intervention is best!

# What can you do at home?

- Validation
- Distress Tolerance
- Mindfulness
- Checking the Facts



# If your child is in treatment, what questions should you ask your child's therapist?

## **At the initial session:**

- What is the diagnosis and treatment choice?
- What is the “order of operations” for each of the presenting problems
- Do you use manualized treatment or “informed”, “integrated” or “eclectic” approaches?
- Are parents/family involved in your treatment approach?
- How severe are the concerns we are addressing?

# What other questions should you ask?

## After each session:

- What is the homework?
- Should we/child be tracking any symptoms?

## After 6-8 sessions/weeks of working together:

- Did my child complete an outcome measure?
- Do we see an improvement in symptoms?

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"Sure, there's traditional therapy, Mr. Wayne, but how about this? You get a costume, some gadgets, maybe a sidekick, and you fight crime. See how that works."



# When psychopharmacology should be considered...

- Medication is an evidence based treatment:
  - Anxiety
  - OCD
- Many disorders can be treated without the help of medication
- Assess your personal beliefs about medication use and identify pros and cons
- Consider medications as short terms aids to treatment
- Check the facts by asking a medical professional

# Medication can help when...

- Your child and family have been attending regular and frequent therapy for long enough to see improvements
- Instructions between therapy sessions have been fully followed
- Healthy behaviors in addition to therapy such as nutrition, movement, sleep hygiene, recreational and social self care don't seem like enough
- You and your child's therapist seem stuck
- Another healthcare professional has suggested thinking about medication
- Your child responded well to medication before, maybe it's time to think about restarting

# The first visit for medication evaluation

Think of it as an information session!

- Talking to a doctor does NOT obligate your child to take any medications
- It's OK to leave the first visit undecided about medication
- It's OK to decide against medication after you've had an informed discussion with your child's doctor
- Your child's doctor may decide medication is not the best option for them at this time
- You can change your mind about medication at any time later
- Your child is not going to be medicated against your will

# What to expect from medication

- Medications will not change your child's personality
- Antidepressants and mood stabilizers are not addictive
- Your child should still have emotional responses
- If your child experiences globally dulled emotions (“blunting”) speak with their doctor about this *side effect*
- The goal of medication is *not* to make your child a “zombie”
- Antidepressants and mood stabilizers are not intoxicating

# What about risks?

- No treatment is risk free, but *not taking medication* can be risky
- Ask your child's psychiatrist to discuss pros and cons with you of
  - Taking Medication
  - Not Taking Medication
- Also ask what can be done to reduce risks as much as possible
- Tell your child's psychiatrist if there are specific risks you want to discuss (abuse potential, overdose, etc.)

# What about that “Black Box Warning” ?

- The warning is intended to encourage patients to ask questions and encourage doctors to review risks and benefits
- It does NOT mean young people should never take medications

“The rate of suicidal thinking or suicidal behavior was 4% among patients assigned to receive an antidepressant, as compared with 2% among those assigned to receive placebo, although none of the suicide attempts documented in the trials were fatal.”

<https://www.nejm.org/doi/full/10.1056/NEJMp1408480>

- **The risk is NOT 0% when medication is NOT taken**
- **Statistics may not reflect the risks of the individual**

# How long does a child need to take medication?

- Many children do NOT need long term medication
- Some children will if they have a chronic or recurring condition
- That's what follow up is for!
- This may not be a one time discussion
- Weigh pros and cons with your child's doctor of *continuing* medication
- "In how long should we discuss staying on meds again?"

# Should I stay or should I go?

- Many EBTs are manualized and require a 12-week commitment
- Attendance at therapy should be routine (weekly at minimum)
- Assess your own willingness to engage in treatment (changing behavior is hard work!)
- Assess your relationship and trust with the provider
- Assess if your relationship is leading you to stay with the provider even if changes/improvements aren't observable
- Have an open discussion with your provider about the effectiveness of treatment. Setting this precedent early allows for easier transition or termination of treatment



# Referral Links:

Anxiety:

<http://www.abct.org/Home/>

BFRBs:

<http://www.bfrb.org/>

OCD:

<http://iocdf.org/>



For any further question, comments, or concerns, please do not hesitate to reach out to your LCPS student services contacts or feel free to contact us at:

Potomac Behavioral Solutions

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(571) 257-3378





Information about medications was prepared by Aileen Kim, MD. Dr. Kim has no financial disclosures related to the content presented. Questions? Please feel free to contact her at:

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