Welcome

Rogers treats children, adolescents and adults with:

- OCD and anxiety disorders
- Depression and mood disorders
- Eating disorders
- Posttraumatic Stress Disorder
- Addiction

800-767-4411
rogershospital.org

Understanding and Treating Childhood Anxiety Disorders

David M. Jacobi, Ph.D.
Behavior Specialist & Clinical Supervisor
Rogers Memorial Hospital
Oconomowoc, Wisconsin

Children Come First Conference
November 11, 2015

Goals

- What are the anxiety disorders?
- What is cognitive behavior therapy?
  - Thought challenging/cognitive skills
  - Exposure based interventions
- Anxiety at school
- Family Accommodation

What is an anxiety disorder?

- Generalized anxiety disorder (GAD)
- Separation anxiety disorder
- Social anxiety disorder
- Selective mutism
- Panic disorder
- Obsessive-compulsive disorder (OCD)
  - obsessive compulsive and related disorders (ex. BDD, Hair pulling disorder, Hoarding disorder)
- Posttraumatic stress disorder (PTSD)
  - trauma and stressor related disorders (ex. RAD, Disinhibited social engagement disorder, adjustment disorders)

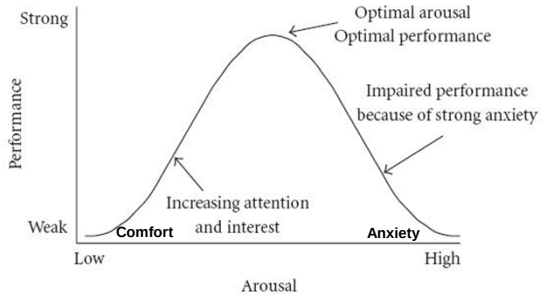
Anxiety vs. Fear

Anxiety: Apprehension about a future threat

Fear: Response to an immediate threat

- Both involve physiological arousal
- Both can be adaptive:
  - Fear triggers "fight or flight"
  - Anxiety can increase preparedness
  - Yerkes Dodson Curve (next slide)

Yerkes Dodson Curve



Epidemiology of Anxiety Disorders

- Most common emotional/behavioral disorder in childhood
- Incidence 10–15% of children and adolescents
- About 8% of teens ages 13–18 have an anxiety disorder, with symptoms commonly emerging around age 6.
  - However, of these teens, only 18% received mental health care
- Female-to-male ratio:
  - Equal in preadolescent children
  - Females are increasingly represented in adolescent years

Children with Anxiety Disorders

- Risk for developing other types of anxiety disorders/or psychiatric disorders
- Co-morbid psychiatric disorders
  - Other anxiety disorders
  - ADHD
  - PDD-Asperger's
  - Substance use in older teens
  - Depression (in kids: somatic complaints, acting out, aggression)
  - Learning disabilities
  - Eating disorders
  - Increased risk for adjustment difficulties in adulthood

Generalized Anxiety Disorder (GAD)

- Worry, worry, and more worry
  - About family, friends, health of others, natural disasters, school performance, etc.
- Somatic concerns
  - Headaches, feeling shaky, sweating
- Not easily reassured
- May throw tantrums related to anxiety
- Poor concentration and attention
  - May present similar to a child with ADHD

Separation Anxiety

- Excessive anxiety focused on separating from home or parent figure
- Most commonly diagnosed in pre-pubertal children
  - More common in 5-7 and 11-12 year olds with transition into elementary and middle school
- Typically occurs following a significant change or major life event
- Behaviors: Clinging/shadowing behavior, nightmares, fear of loss of loved ones, school refusal, somatic complaints

Social Anxiety Disorder

- Excessive fear in social situations where child is exposed to unfamiliar people/evaluation by others
- Tremendous concern about social failure, embarrassment and/or humiliation
- Fear is excessive and unreasonable
- Avoidance or endurance with extreme distress
- Interference in functioning

Selective Mutism

- Children either talk minimally or not at all in certain settings or situations that are part of their daily lives (e.g., school)
- Reflects underlying problems with anxiety
- Often inadvertently reinforced by other individuals (i.e., parents, friends) in the child's daily life (e.g., speaking for the child, permitting the use of nonverbal communication, etc.).
- Considered an extreme form of social phobia

Panic Attacks

- Sudden, discrete episodes of intense fear
- Intense desire to escape
- Feeling of doom
- Activation of autonomic nervous system
  - Fight or flight
- Duration: 15-30 minutes
- Common: 20-30% of adult population

Panic Disorder

- Recurrent panic attacks
- Inter-episode worry about having a panic attack
- Worry about implications and consequences
- Changes in behavior
- More common in adolescents

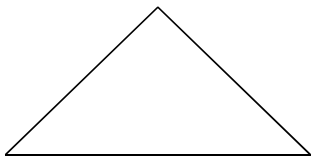
Posttraumatic Stress Disorder (PTSD)

- Exposure to an actual or threatened death, serious injury or sexual violence.
- Re-experiencing of the trauma (e.g., play echoing trauma theme, frightening dreams, reenactment of trauma in play)
- Avoidance of thoughts, feelings people, places that are associated with the trauma, anhedonia, feelings of detachment
- Negative changes to thoughts and mood (e.g. increased negative emotions such as fear guilt sadness; anhedonia; socially withdrawn; decreased expression of positive emotions)
- Arousal (e.g., irritability, hyper vigilance, exaggerated startle, poor concentration and sleep)

What is cognitive behavior therapy?

Cognitive Behavioral Model of Anxiety

Physical feelings/emotions
e.g., tummy ache, headache, racing heart



Behaviors
e.g., avoidance, clinging

Thoughts
e.g., I can't handle being away from Mommy

Cognitive errors-anxiety specific

- *Catastrophizing:* Making "a mountain out of a mole hill." You tell yourself that the very worst will happen without considering what is a more likely outcome.

  Example: If I touch that doorknob the germs will kill me!

- *Probability over-estimation:* Assuming that a dangerous event is more likely than it really is.

  Example: My heart is racing I must be having a heart attack!

Thought Challenging Process

1. *Identify your core fears*
   (ex. If I make a mistake during my presentation everyone will think I'm stupid and reject me)
2. *Identify the evidence you use in support of each fear*
   (ex. My teacher commented that my presentation could have been better organized)
3. *Logically and systematically examine each piece of evidence*
   (ex. Just because my teacher gave me feedback doesn't mean that she thinks I'm stupid. In fact, a couple of people said they liked my talk)

Thought Challenging Example

Fear: *"I am fat."*

Evidence:

- None of my jeans fit anymore
- When I look in the mirror my butt appears much larger to me now
- I am at the highest weight now that I have ever been

Thought Challenging Example, continued

Is the fact that _____ really evidence that ***I am fat***? Yes or no? Why or why not?

None of my jeans fit anymore. Now that I am eating a normal and healthy meal plan it is only natural that the jeans that I used to wear would no longer fit me.

When I look in the mirror my butt appears much larger to me now. I have a distorted perception of my body because my entire life I have been underweight. Once I am on a more regular exercise plan perhaps my muscles will tone up further and then weight will redistribute.

I am at the highest weight now that I have ever been. I am learning to eat an appropriate amount of food and am statistically in an appropriate weight bracket given my age, gender and height.

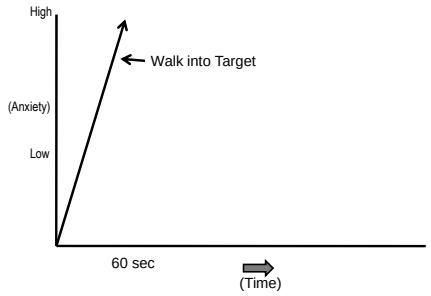
Challenging negative thoughts or self-talk:

anxietybc.com

- Am I falling into a thinking trap (e.g., *catastrophizing* or *overestimating danger*)?
- What is the evidence that this thought is true? What is the evidence that his thought is not true?
- What would I tell a friend if he/she had the same thought?
- Am I 100% sure that _____ will happen?
- How many times has _____ happened before?
- What is the worst that could happen?
- Is my judgment based on the way I feel instead of facts?
- Am I confusing "possibility" with "certainty"? It may be possible, but is it likely?

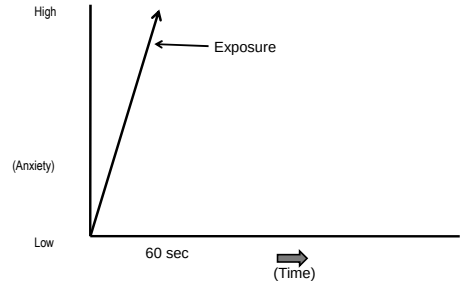
Exposure based interventions

Typical scenario

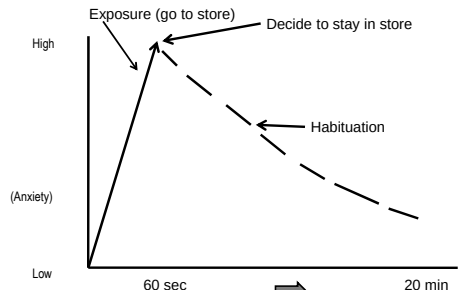


Typical scenario

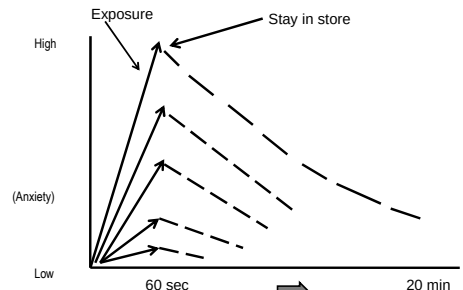
In Vivo Exposure



In Vivo Exposure



In Vivo Exposure



Exposure Examples

Social Anxiety: Exposures

- Call a business
- Ask classmates three questions
- Order food at a restaurant
- Ask for directions/information
- Mild criticism
- Answer a question in class
- Make a mistake in front of others

Generalized Anxiety: Exposures

- Make a quick decision
- Cold all a friend
- Choose a restaurant
- Order something different without asking for input
- Choose movie for family to watch
- Worry exposure to worst case outcomes

Panic Disorder/Agoraphobia: Exposures

- Interoceptive exposure to bodily sensations
  (ex. Hyperventilate, spinning, stair steps, straw breathing)
- Enter a grocery store on a Tuesday evening after 8 p.m.
- Enter a grocery store with a trusted friend/parent during a busier time
- Go to a movie and sit in the back row near the exit
- Got to a movie and sit half way down three seats from the aisle

OCD: Exposures

- Touch contaminated surfaces
  (ex. Door knobs, hand rails, faucets, bathroom doors)
- Rearrange objects in your closet or drawers
- Walk away from the door without checking
- Think of a "bad" thought and don't retrace
- Write the word "hell", "devil" or numbers "666" or "13"
- Have the thought; "my parents will get in a car wreck" and don't undo

Separation Anxiety: Exposures

- Drive to school with Mom on a Saturday-walk the halls if possible
- Mom drives child to school and stays in school while child attends one class
- Mom drops off child at school and a trusted teacher/counselor meets child and child attends two classes and Mom picks up
- Child spends half day at school, etc

Anxiety at School

Anxiety at School

- Frequent self-doubt and criticism
- Seeking constant reassurance from the teacher
- Difficulty transitioning between home and school
- Avoidance of academic and peer activities
- Poor concentration

School-based Interventions

- Accommodate late arrivals
- Shorter school days to transition children with separation anxiety
- Allow extra time for transitions
- Have a "safe" place if child develops increased anxiety or panic attacks
- Have an anti-worry plan

Dealing with Back-to-School Anxiety

- The basics are important – sleep, diet, exercise, regular routines (including bedtime)
- Encourage child to share concerns and worries
- Avoid giving reassurance but instead encourage your child to problem solve situations
- Role-play challenging situations
- Focus on desirable aspects of school
- Model calmness and confidence for your child – if you are anxious your child will sense this.
- Praise your child for the behavior you want

Teaching a Child About Anxiety

- Anxiety is normal.
  - Everyone experiences anxiety at times. It's normal to feel anxiety before a big test or when trying a new activity.
- Anxiety is not dangerous.
  - Although anxiety may feel uncomfortable it does not last long and will eventually decrease.
- Anxiety is adaptive.
  - Anxiety helps us prepare for real danger. We perform our best at moderate levels of anxiety (Yerkes Dodson curve)
  - Advantages of the fight or flight response
- Anxiety can become a problem when our bodies react to normal situations as if they were real dangers

Coping Cards

- Reminder that physical symptoms of anxiety are normal
- Reminder that anxiety may feel dangerous but is not
- Identify a name your child can give anxiety (e.g., Mr. Meany, bully, monster)
- Realistic thought challenges (e.g., How many times have I worried about this and it has turned out fine?; what would I tell a friend to do in this exact situation?)
- Use of coping skills (e.g., respiratory control, deep muscle relaxation, reading, talking to a friend, etc)

Dealing with Physical Symptoms of Anxiety

- Respiratory Control: train children to breathe properly- demonstrate how breathing improperly can actually lead to additional physical sensations
- Deep Muscle Relaxation: progressively tense and release muscle groups
- Important that we not use these during an exposure trial

Family Accommodation

What is Family Accommodation?

Specific behaviors of family members to:

- Facilitate rituals
- Yield to the child's demands
- Provide reassurance to the child
- Assist with or complete tasks for the child
- Decrease the child's responsibility because OCD and anxiety symptoms interfere with daily life

Accommodation is common

AT LEAST

90%

of families accommodate!

Why some families accommodate:

- It's easier in the beginning
- You think it is helpful
- You fear your child will feel unloved if you don't accommodate
- You feel guilty or "mean" if you don't accommodate
- It's hard to tolerate your child's anxiety/distress
- You are scared of your child's behavioral response

Examples of Family Accommodation

- Talking for a socially anxious child
- Providing excuses to others as to why child isn't talking
- Providing frequent reassurance for a worried child
- Physically assisting your child to hand wash or complete shower rituals (OCD)
- Opening doors or turning on light switches (OCD)
- Avoidance - allowing your child to avoid certain activities, places, objects or persons because of anxiety

Impact on Family

- Linked to more family dysfunction and stress
  - Ends up consuming increasing amounts of time for the family
  - Leads to unintended changes in the family routine
- Accommodation impacts marriages
  - Increases conflict
  - Reduces time available for parents to spend time together
- Accommodation impacts siblings
  - Worse mental health outcomes
- Accommodation reduces self-care

What's the problem with accommodating?

- Associated with poorer treatment outcomes in children and adults with OCD
  - Reduces effectiveness of CBT and long-term outcomes
- Accommodation conflicts with goals of CBT
  - Prevents habituation
    - Habituation – the body's way of adapting to new situations (i.e. night vision, cold water, wool sweater)
  - Limits opportunities for child to learn that feared consequences don't happen
  - Reduces child's motivation to change

Reassurance: A form of accommodation

- Reassurance seeking involves:
  - Your child asking you lots questions
  - Asking the same question over and over in order to hear from you that things will be "okay"
- Information seeking vs. reassurance seeking
  - We are always suspicious of reassurance at CHC

Information Seeking	Reassurance Seeking
Asks a question once	Repeatedly asks the same question
Asks a question to be informed	Asks questions to feel less anxious
Accepts the answer provided	Responds to the answer by challenging the answerer, arguing, or insisting the answer be repeated or rephrased
Asks people who are qualified to answer the question	Often asks people who are unqualified to answer the question
Asks questions that are unanswerable	Often asks questions that are unanswerable
Seeks the truth	Seeks a desired answer
Accepts relative, qualified or uncertain answers when appropriate	Insists on absolute, definitive answers whether appropriate or not
Pursues only the information necessary to form a conclusion or make a decision	Indefinitely pursues information without ever forming a conclusion or making a decision

Developed at the Anxiety Disorders Center, St. Louis Behavioral Medicine Institute

Examples of Reassurance Seeking

- Requests for Reassurance
  - "Are you sure you locked all the doors?"
  - "Tell me that I'm a good girl!"
  - "Daddy will be alright, won't he?"
  - "Do you love me?"
  - "I did a bad job."
  - Calling mom or dad repeatedly from school to make sure they are "okay".

What's the problem with giving reassurance?

- It's a bottomless pit because you can NEVER provide enough reassurance.
- It's a never ending cycle – the more you give reassurance, the more the child wants
- It feeds the anxiety monster; thus, keeping the anxiety monster alive
- It undermines CBT work because it provides the child with the message that there is actual danger
- IT'S EXHAUSTING!!!

How To Reduce Reassurance

1) Give your child the opportunity to answer the question themselves: } *What do you think?*
2) Limit the number of worry questions per day (per hour): } *One Worry Question / Hour*
3) Insert a predetermined length of time before answering questions to increase tolerance for uncertainty: } *Delay Reassurance* (ask child to rate their fear)
4) Use rewards to increase motivation to tolerate anxiety: } *Coins in the Pocket to Use for Reassurance*
5) With compliancy issues, perform a cost-benefit analysis to increase insight : } *Long-term vs. Short-term gain*
6) Practice responding to reassurance questions in session: } *Role Model Responses*

Helping a child "boss back" their anxiety

Mentally Prepare Yourself

- Your child will NOT thank you for removing accommodations
- He or she will initially get worse when you withdraw accommodations
- Anger will be expressed from your child that you are not accommodating them
  - Mom, you don't love me anymore!
  - You're the meanest parent in the world!
- You have to remain consistent!

Tolerating Your Child's Anxiety

- Put on your poker face!
- Be aware of your body language and tone of voice when your child is anxious
- You can be empathetic without being accommodating
- Have age-appropriate expectations
- Thought challenge: Anxiety is NOT dangerous.
- This is harder when you struggle with anxiety
  - Seek professional help if you feel the need to rescue your child every time

Reducing Accommodations

- Will need to occur gradually
- You should prepare your child for accommodation reduction through good communication
  - Accommodation is allowing OCD monster to "win"
  - Separate OCD behaviors from child
- Needs to be in concert with the treatment team and the CBT goals
  - Important that your child knows we are working together and are in agreement

Resistance to Accommodation Reduction

- Prepare yourself for negative behaviors when accommodation is reduced/stopped
- Anger/rage/frustration from your child is understandable but NOT acceptable
  - Violating others rights is not acceptable in society so you should not allow them to violate your rights in your home
- Spell out the rules for safety and respect in your household
- Do NOT over talk when your child is going into meltdown mode

Resources

Anxiety Disorders Association of British Columbia
www.anxietybc.com

Anxiety and Depression Association of America
www.adaa.org

International OCD Foundation
www.IOCDF.org

Thank you

David M. Jacobi, Ph.D.
djacobi@rogershospital.org

800-767-4411
rogershospital.org