BRIEF INTERVENTIONS: ANXIETY (Non Pharmacologic Approaches)

BI-PED PROJECT (BRIEF INTERVENTIONS: PEDIATRICS)
Emotional Health Committee Maryland Chapter American Academy of Pediatrics

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The diagnosis of an anxiety disorder requires a careful history (see Behavioral Interview module) that may be supplemented with the use of standardized anxiety questionnaires.

Ideally it is best to intervene with an anxious child before symptoms have reached the level to qualify for the diagnosis of an anxiety disorder. A key factor in making the diagnosis of an anxiety disorder is the degree to which the symptoms cause *impairment in functioning*. However, even without significant impairment in functioning, anxiety, symptoms can be distressing for both the child and his family.

When symptoms do interfere with functioning, the clinician should determine whether symptoms are specific (such as with a specific phobia), pertain only to certain situations (such as with separation anxiety disorder), are routed in a specific cause (such as with post traumatic stress disorder), or are more diffuse (such as with a generalized anxiety disorder).

Anxiety symptoms may present as worrying and nervousness, difficulty with separation, fears, trouble concentrating, trouble sleeping at night, somatic complaints such as abdominal pain, and/or frequent visits to the physician or school nurse.

Anxiety symptoms may also coexist with other disorders such as obsessive compulsive disorder, depression, autism spectrum disorders, or ADHD.

Pediatric clinicians can be helpful in identifying the type of anxiety the child is experiencing and providing education to families about why the child has symptoms and what interventions might be helpful. Primary care interventions are best implemented when the symptoms are bothering the child but not yet causing substantial interference with functioning.

In most cases, anxiety problems stem from a combination of:

- **the child's temperament and a genetic risk for anxiety**
- **parental anxiety (both because of the role model the parents set and because of the restrictions they impose on the child out of their own worry)**
- **how parents and adults respond to the child's worries or expressions of anxiety**

- **the child's previous experiences with stressful events such as abuse, witnessing violence, illness, environmental disasters, etc.**

There are a number of effective first line interventions available to the pediatric clinician when addressing the needs of a child or adolescent with mild anxiety. Some interventions apply to all types of anxiety problems while others work best with specific types of problems.

In *all* cases, the following principles apply:

1. The discomfort of the child's anxiety should be acknowledged and the child should never be ridiculed for their fears or pushed to "just cope."

2. The child should <u>not</u> be advised to avoid anything that makes them anxious as this likely will lead to a withdrawal from many activities outside the secure, immediate family household. Instead point out that some anxiety helps us to both perform at our best and experience new things.

3. The child should be supported in developing a plan that allows them to master the areas that provoke anxiety in incremental steps that are at or just beyond his comfort zone. They should be given an appropriate level of support to help them succeed and should be given messages that they are competent to handle the new challenges they will face at each step of their development.

4. Encourage proper sleep, nutrition and exercise to help reduce anxiety symptoms.

5. The child can be given tools to help him handle their anxious feelings including positive self- talk, visual imagery, progressive relaxation and deep breathing. (see Anxiety Appendix)

6. There are several anxiety questionnaires that are available for screening such as the SCARED and the GAD-7.

<u>Separation Anxiety</u>

The child with separation anxiety is afraid to be away from their parent(s). Usually this is the product of both the child's temperament and the parent's anxiety. These children often are more cautious and have more difficulty with changes in their usual routine. Parental anxiety is often a combination of fearfulness about dangers in the world and fears that the child is not yet ready to handle the common tasks which involve separation from parents such as going to childcare, attending school, riding the bus to school, visiting

friends at their homes, spending overnight at a friend's house, etc. Parents who have experienced the loss of a child or a child with chronic illness may be particularly anxious.

Children who are already tend to be anxious, respond to their parent's verbal and nonverbal messages by becoming increasingly fearful of the separation involved. Often, when the child and parent are separated, the child does very well although sometimes the child continues to be very anxious during the entire period of separation. <u>Suggestions for management</u>:

1. Consistent routines and preparing the child for new experiences make a difference. If the child knows what to expect, they are likely to do better when the parent leaves. Often it helps to visit a new setting ahead of time. For instance, visiting a new school to meet the teacher and see what the room looks like before the start of the school year can be quite helpful.

2. Help parents understand the role their fears and anxieties might be playing in the symptoms the child is having. Good role modeling by parents can teach children how to handle stress and anxiety provoking situations. It is important to advise that parents keep their own fears in check so they can encourage the child to try new things and convey confidence that the child can handle the separation.

3. Encourage parents to evaluate the situation in which the symptoms are occurring. Help parents to set age appropriate expectations. If the situation is one that can easily be deferred until the child is older, that may be a reasonable option. An example of this would be a three year old going to a birthday party without the parent staying. On the other hand, if the child is 5 or 6, they should be encouraged to attend, especially if they will have a friend there with him. When dealing with age appropriate activities such as attending elementary school, parents need to concentrate on giving messages to the child that school is where they *should be* and that they are *ready* for school.

4. How parents separate from their child and the manner in which they return are both important. A parent should help their child get settled for a short period of time (e.g. 2-5 minutes), then should say goodbye to the child with a short ritual, and leave (even if the child seems upset). The vast majority of children will settle down within a few minutes of the parent leaving. If the parent "sneaks out", the child will learn that they need to be vigilant so they will know when the parent is leaving. This will interfere with the child settling in to the new setting. It is better to have the brief distress at leaving than to have the child fearful about the parent sneaking away. Similarly, the parent should return at the expected time. Children who are anxious should not be the last ones to be picked up since that will increase their fears that the parent is not coming back. When parents leave and then return on time, the message is reinforced that the child can handle separations and that they also can count on their parents.

5. In some cases, one parent is particularly over protective. In these situations, it may be helpful for the less anxious parent to take the child to activities that require separation.

<u>Specific Fears or Phobias</u>

Specific fears or phobias may be age appropriate – especially when the child is between 3 and 8 years of age. In order for a fear to be considered a disorder at these ages, it would have to be very extreme and cause major interference with functioning. Childhood fears that are poorly handled can lead to ongoing fears as the child gets older. Childhood fears that are properly handled can provide the child with tools to handle fears that may arise in the future.

Mild to moderate fears or phobias can often be handled with some minimal counseling. Key steps to handling them include the following:

1. Clarify the fear/phobia including exact details about the fear, how often it occurs, how the child and their family usually respond, and how much it is interfering with the child's functioning.

2. Determine if there is any previous experience that led to this fear. For instance, a child who was bitten by a dog is likely to have a persistent fear of dogs, especially in situations similar to the one that led to the bite.

3. Ask the child if they have any ideas about what would make it easier to cope. Reasonable ideas should be implemented. Less reasonable ideas can be modified and implemented but still give the child credit for the idea. An example of an easily implemented intervention is leaving on a light in the hall and the door cracked open for a child who is afraid of the dark. A less reasonable idea is having an older child who is afraid of the dark propose to sleep in their parents' bed. A reasonable modification would be to let them sleep in a sleeping bag on the floor of their parents' room or have the doors to both rooms remain open.

4. Teach the child more about the object of their fears. This may help them narrow their anxiety to only a subset of the objects he fears. For example, children who are afraid of bugs often benefit from learning more about different kinds of insects and learning which bite or sting and which do not. Quickly it becomes apparent that most bugs are not going to hurt. One can also teach a child how to appropriately interact with the object they fear. For example, a child who is afraid of dogs may benefit from learning to ask owners about

whether the dog is friendly before touching the dog, learning how to determine if a dog is angry or is feeling threatened, and learning how to gently approach a dog (e.g. let the dog sniff the child's hand).

5. *Desensitization* interventions provide experiences in *gradual* steps that help the child master their fears with appropriate support from key adults. (see AnxietyAppendix on desensitization) For example, a child who is afraid of dogs may learn to pet a friendly dog while the parent makes sure the dog does not jump on the child and scare them again. Another example would be to meet a child at their bus stop when they get off the bus for the first week, wait half a block away so they can see the parent when they gets off the bus during the second week, and then move to a full block away the third week, etc. Provide the child with positive feedback for the steps they take to handle stressful situations.

6. A young child can be encouraged to gain control over the object of their fears by drawing a picture of the thing they fear or drawing a "fear monster" and then drawing themselves doing something to "tame" the monster. The young child can also carry props like a protective stone that will make them feel more confident in an anxious situation.

When fears or phobias cause major disruption in the child's or the family's life, it may be appropriate to make a referral for more extensive counseling and/or medication support to address the specific fears.

Generalized Anxiety

Generalized anxiety is usually the product of complex interactions between the biologic/temperamental risk factors in the child, parental responses to the child's anxiety, and the child's previous experiences coping with stressful situations.

Helpful interventions include:

1. *Regular routines* that result in generally predictable days.

2. *Sufficient sleep* at night so the child is not stressed by fatigue in addition to whatever is making him anxious. Recommended average sleep times are as follows:

- **Toddlers – 12 hours within 24 hours, part as naps and part at night**
- **Preschoolers (ages 3-5) - 11-12 hours**
- **School age (ages 6-12) – 10-11 hours**
- **Adolescents (ages 12-18) –8- 9 hours**

3. *Preparing* the child *for changes* in routines and transitions.

4. Helping the child *plan for routine situations that might go array*. For instance, the parent of an anxious child might wish to discuss what the child would do if their parent did not meet the bus at the usual time. This discussion should include some consideration of the most common reasons this might happen (e.g. boss kept mom late at work, mom got a flat tire or tied up in traffic on the way home, but mom getting injured in a car accident would be a much less likely reason). The child can be asked how they might manage in the situation and parents can provide feedback to help shape the plan. Another example is discussing what an anxious child would do if they got separated from their parents in an unfamiliar place such as an amusement park. Such a discussion can make both the parents and the child feel more comfortable.

5. *Avoid letting parental anxiety overwhelm* the child. Parents may need to put their own fears in perspective. For instance, only a miniscule number of children are actually kidnapped each year by strangers. Anxious and over protective parents may need help in allowing/encouraging their children to do normal child things, even if it makes the parents anxious. Examples of this include using the climbing equipment on the playground, visiting other children's homes, and trying out for a school play or a sport.

6. Parents should be careful not to belittle their child's fears but rather help them think ahead and *plan what he could do to be more comfortable* in a stressful situation.

7. Parents should be advised *not to set excessive goals* that may drive children to over accomplishment or perfectionism placing undue pressures on the child to achieve.

8. Parents should be counseled that the goal of parenting is <u>not</u> to help their child have a "stress free childhood" but rather to help their child learn how to cope with and experience the ups and downs of life. Some parents are overly protective and are averse to allowing their children to experience discomfort and frustration. Such children may not develop the requisite skills to cope with challenging situations. Parents can be guided to allow children to learn to "self soothe" beginning at very young ages. Infants need to learn how to settle to sleep and toddlers need to learn how to deal with frustration when trying new tasks. Helping children develop problem solving and coping skills is one of the best gifts that can be given to children.

9. Children can be encouraged to use positive self talk, visual imagery, and deep breathing strategies to manage times when they are feeling anxious. Provide instruction and make sure the child is encouraged to practice these coping skills. (see Anxiety Appendix)

10. Help the patient to identify and address *cognitive distortions.* (see Anxiety Appendix on catastrophic thinking) People with anxiety often fear that "anything that can go wrong, will go wrong". They may also be preoccupied with thoughts such as "something bad will happen", "I will fail", "I need to be perfect", "I need to be in control". Sometimes these cognitive distortions can become magnified and take on catastrophic proportions for the anxious person. The clinician can help decrease this distortion in thinking by asking questions such as "what is the worst thing that could happen?", or "what is the likelihood that this will happen?' and "what would you do if this did happen?"

Summary:

First line interventions that can be implemented by a primary care pediatric practitioner for the child or adolescent with mild anxiety include:

- **Educating parents about the variety of symptoms of anxiety**
- **Encouraging appropriate sleep, nutrition and exercise**
- **Establishing consistent routines and discussing how the child will handle unexpected situations**
- **Using visual imagery, progressive relaxation, deep breathing and positive talk techniques**
- **Using desensitization approaches to assist with fears**
- **Using some simple cognitive behavioral techniques such as having children think through "worst scenario" concerns and prepare themselves for how they will handle them**
- **Encouraging parents to let children at young ages experience some discomfort and frustration in order to develop coping skills**
- **Discouraging parents from pushing excessive agendas of over achievement and perfectionism**

Mental health referrals for children with anxiety are appropriate if:

- **the patient has moderate to severe anxiety that is interfering with function,**
- **the parents are displaying significant marital discord or psychopathology,**
- **the practitioner is not comfortable managing the patient,**
- **the patient or family request a referral,**
- **the patient is not responding to brief primary care interventions.**

Reference:

Lester T et al. Anxiety and Depression Treatment in Primary Care Pediatrics.
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