Academic problems may be shown in difficulties with starting tasks, showing initiative, or sustaining effort.

Self-Study Activity #7

Make a chart with three separate columns labeled "Personal", "Social", and "Academic", and list areas or behaviors that can be affected by anxiety, based upon DSM-IV, research, or your knowledge and experience.

Analysis of the problems in this stage should be based upon five criteria: (a) the settings, events, or circumstances, (b) any precipitating conditions, (c) severity of the symptoms in terms of frequency, intensity, or duration, (d) the consequences of these symptoms, and (e) the child's demonstrated ability to cope with the situation. These criteria are particularly important to determine, because they will form the basis for evaluation of intervention effectiveness.

Prioritizing. After these criteria have been addressed, the clinician should, in collaboration with the child, parents, and/or teachers, come to agreement which behaviors or symptoms are of the most concern. Several behaviors may be identified, but it is unrealistic to address more than two or three simultaneously. As improvement occurs, the parties may review the priorities and make changes accordingly. Agreement should be based upon the consensus of the group, with particular attention given to the needs or concerns presented by the child.

Establish outcome goals. The persons involved should determine the desired outcome goals, which should be realistic and achievable. Because anxiety is a normally occurring experience, it is not realistic to set a goal to eliminate it; rather, the overall intervention goal(s) should be to help the child manage it at a comfortable level. For example, if a child is apprehensive about giving a speech in front of the class, it is not realistic that all anxiety can be removed. The overall treatment goal should be to help the child develop strategies to reduce the anxiety to a level where it can be effectively managed and not interfere significantly with performance. Kendall, et al., (1992) suggests that the goals should be to (a) help the child recognize and cope with anxiety, (b) reduce stress, and (c) to improve performance and enhance feelings of competence that situations can be managed.

Generating Possible Interventions

There are many techniques for intervening with anxiety problems, and the general approach to this stage of problem-solving is to generate as many ideas as possible without regard to their feasibility. It should be done in a collaborative mode with each suggestion being given equal consideration, and is often referred to as "brainstorming". This stage also presents an opportunity to consider novel and creative approaches toward intervention that are appropriate for the specific situation, such as the use of a particular reinforcement method. The most successful interventions tend to be of theree types: (a) cognitive-behavioral, where the emphasis is on changing beliefs, attributions, thoughts, or cognitive dysfunctions, (b) behavioral techniques, such as relaxation training, and (c) environmental or systems interventions, such as families or classrooms. In some rare cases, medications may be used, which is beyond the scope of this discussion.

Kendall, et al., (1992) describes several types of cognitive-behavioral/behavioral interventions that may be useful with children:

- relaxation therapy
- imagery techniques
- correcting maladaptive self-talk
- teaching problem-solving skills
- managing rewards
- using "Superhero" characters (e.g., "How would a famous comic strip characteristic handle this situation?")
- building a "coping template"
- modeling (symbolic, "live", and participant)
- rehearsal and role plays
- exposure to the anxiety-producing situation

Any of these techniques may be adapted to work with the individual child, but the goal is to generate a list of intervention strategies from which the most appropriate one(s) will be selected. Because many of these techniques would be known to a professional but not to a child or parent, it is important that the practitioner be able to discuss them as options. The techniques then could be adapted and modified in discussion with the child to determine specific methods of implementation. The reader is referred to Kendall, et al. (1992) and similar intervention-based materials for further suggestions.

Example

When children become anxious and engage in cognitive dysfunction, they may develop beliefs that are inconsistent with probable outcomes of their behavior. Therefore, they may convince themselves that they will most certainly fail at an impending task to be performed. Following is an example of how a therapist might work with a child who is concerned about giving a speech in class:

Child: I have to give this speech in class next week and I'm terrified about it.

>Therapist: What terrifies you about giving this speech?

Child: I just know that I'll get up there and stutter and make a fool of myself and everyone will laugh at me. The other kids will tease me later and be talking for weeks about how bad I did.

Therapist: It is normal for people to feel anxious when they have to perform before their friends like that. Even people who do that a lot sometimes get nervous in front of a group.

Child: Yeah, but they've done it before and they know how to handle it. I am such a total klutz in front of people.

Therapist: So, you're convinced that this will go badly because you're a klutz and there's not much you can do about it. Do you think you're a total klutz or that it's just this speech that worries you?

Child: Well, I guess I'm not a total klutz, 'cause I'm a pretty good student. I just haven't done much speaking before.

Therapist: So, you're not a klutz, but you're worried about this speech. Do you know the material well?

Child: Oh, yeah. I know this stuff frontwards and backwards and I actually enjoyed learning about it, but I still am worried about giving the speech.

Therapist: You just said you are "worried" about this speech, while a few minutes ago, you said you were "terrified". What has changed here?

Child: Well, I guess I know the material well, and if I practice it a lot, I should feel better about it. I guess I'll still be nervous, but I'll figure a way to get through it. After all, I do pretty well otherwise.

Therapist: So, now you're not terrified, but worried. That seems normal. You think that you're just worried about this one thing, and that you know the material well. If you practice and rehearse, do you think it should go pretty well?

Child: Yeah, I guess so. I know I'll be a little nervous, but I know my stuff, so I think it will go O.K.

In this example, the therapist is successful in helping to change the child's distorted cognitions about his being a "total klutz", a self-attribution that is irrational, but is increasing his fear. By helping him to develop alternative cognitions and coping strategies, the anxiety is reduced to a lower level, rather than eliminating it totally. It would be unrealistic for the child to expect to be anxiety-free when giving the speech, but the goal should be to keep it at a manageable level(Huberty, 1997a)[1].

Selection of an Intervention

The final intervention that is selected should be drawn from the list of those generated during the brainstorming phase, and be discussed with the child, parents, teachers, and others. Although the choice is to be made in a collaborative manner, the clinician also should consider the following criteria: (a) evidence of empirical support and a reasonable likelihood of success, (b) appropriateness for the specific desired outcomes and treatment goals determined in the Problem Analysis stage, (c) availability of necessary resources and materials, (d) understanding by the parents and child specifically what is to be done, how long it may take, and the likelihood of success (or if experimental, that information is communicated, as well), and (e) acceptability to the child and others. A systematic approach to selecting an intervention reduces the possibility that the final choice will be imposed on the child or that it may be unintentionally subverted or be otherwise ineffective.

Implementation of the Intervention

Once the interventions have been identified, the process of designing a plan for implementation begins. The following are necessary components of an implementation procedure:

- What will be done
- Who will be responsible for which aspects
- When it will be done (e.g., time of day, when events occur, etc.)
- Where the interventions will occur (e.g., designated appointment times, etc.)
- What materials or services will be needed
- Training necessary for any participant
- How the intervention will be monitored
- How it will be determined when changes need to be made

Example of an Intervention Plan

Name:_____Referral
Questions:_____

Intervention:_____
Date:_____

Goal/Desired Outcome	What is to be Done

Evaluation and Revision of the Intervention Plan

A plan must be developed to systematically evaluate the intervention so that the therapist will know if progress is occurring or if changes to be made. After a pre-determined point in time, such as number of sessions, days, etc., evaluation should be conducted to ascertain if goals

have been accomplished or if changes need to be made. By using the assessment methods used in the Problem Identification stage, follow-up assessment should be conducted and compared to the initial data. If a goal has been met, then the intervention should be temporarily withdrawn to determine if the effects remain (i.e., "return to baseline"). If the improvement persists, then plans to fade the intervention should be made. If the goal has been achieved in part, then the parties must determine if the goal or the intervention methods are still appropriate and make necessary changes. It may also be determined that as much progress as possible has been made, and the intervention changed or discontinued. When it is determined that the intervention is no longer needed, the parties should develop a follow-up plan which should include: (a) post-treatment visits, and (b) on-going monitoring of behavior.

CASE EXAMPLE

Space limitations preclude a detailed example of applying this problem-solving process, but let us consider the case of nine-year old Eric, who is showing signs of "school refusal" , which is manifested as anxiety about going to school. There are no objective reasons at school why he should not attend (e.g., he is not being harassed by a "bully"). He is described as above average in ability and can do his work well. The therapist can implement the stages of the process, which is summarized here.

Problem Identification

1. Behavioral interviews with Eric and his parents and teacher(s), with emphasis on obtaining their perspectives about the behaviors

2. Observation of Eric when leaving home, getting on the bus, and when he arrives at school over several days to determine the nature of the antecedents and consequences of the behavior

3. Observation of Eric while at school across various activities and settings

4. Administration of the RCMAS and the Personality Inventory for Youth to Eric to gather more information about his anxiety and to help rule out other problems

5. Administration of behavior rating scales to the parents and teachers

6. Determine baselines of frequency of these behaviors over several days.

Problem Analysis

1. Rule out alternative explanations or the presence of co-existing problems of which school refusal is only a symptom, such as family difficulties. If other problems can be ruled out, then intervention for the refusal behaviors is indicated.

2. Determine if there are circumstances at home that precede the refusal behaviors, might occur during the trip to school, or are shown after Eric arrives

3. Determine the severity of the behaviors, such as frequency per week and amount of resistance encountered.

4. Determine the consequences of these behaviors, i.e., do they result in him being kept home

from school, arriving late, or being transported by parents.

5. Determine how Eric copes with being sent to school against his wishes, i.e., does his anxiety become greater, thereby creating more difficulties.

6. After these data have been obtained, the clinician should meet with the Eric and his parents and teachers to achieve consensus on the settings and circumstances where interventions should be focused. Outcome goals should be established, e.g., "Eric will get on the bus independently and go to school without resistance", and "Eric will remain in class for the entire day".

Generating Possible Interventions

1. Meet with Eric, his parents, and teachers to discuss ideas for how to address the refusal behaviors.

2. All persons generate possible approaches and solutions, including the clinician.

3. Consider all suggestions as possibilities.

Selection of an Intervention

Let us assume that an in vivo desensitization procedure has been selected as the intervention. These techniques have been shown to be effective in treating refusal behaviors, and are appropriate for Eric's age and the circumstances. It will be necessary to enlist the aid of the school and parents to implement such a strategy, because they will be directly involved in implementing and monitoring the intervention early in the school day until he goes home. Eric and his parents and teacherss are informed of the specific procedures to be followed, an anticipated time line, and some estimate of the likelihood of success. Agreement and acceptance of the specific intervention is obtained at this time.

Implementation of the Intervention

After the intervention is selected and agreed to, more specific information is given: what will be done, who is responsible for what components, what time the process will begin (e.g, when Eric wakes up), what will happen at school once he is on the bus, any materials or resources needed, parent or teacher training, who will monitor each step in the intervention, and how needed changes will be determined. Let us assume that the following plan has been devised:

9. Gets dressed in the morning and walks to the bus stop, but does not get on.

8. Gets dressed in the morning and walks to the bus stop, and gets on the bus.

7. Rides the bus to school, but then returns home.

6. Rides the bus to school, and gets off, but has instruction individually.

5. Rides the bus to school, goes to the door of the classroom, but has instruction individually.

4. Rides bus to school, and enters the classroom with an adult, who stays with him.

3. Enters the classroom with an adult, who stays for several minutes, and then leaves.

2 Enters the classroom with an adult, who leaves immediately.

1. Enters the classroom alone and remains to participate.

These steps could be changed to accommodate Eric's increased comfort with going to school and remaining in class. Changes would be based on the clinician's analysis of verbal reports from Eric, parents, and teachers, observations, anecdotal records, and ongoing data collection.

Evaluation and Revision of the Intervention Plan

As the desensitization program progresses, changes are made. At pre-determined points (e.g., after one week), the clinician meets with everyone involved to determine the progress made. At that time, any changes receive consensus from the group. If progress is seen, the program continues with any changes, and a time for a second review is established. This process continues until one of the following has occurred: (1) the treatment goalshave been achieved, or (2) as much progress has been made as possible. If success has not occurred, the group must decide the next steps. If goals have been met, then plans for follow-up and monitoring will be made.

Conclusion

Anxiety is a complex problem confronting children and adolescents that may require intervention from psychological and educational professionals. It is hoped that this self-study material will assist the reader to improve personal knowledge and skills and encourage further development and learning.

Documentation of Self-Study Activity Suggestion #1

Following is a form for developing a problem-solving approach to address an anxiety-related problem. Create a narrative example, complete each section of the form as to how you might complete each phase. Use extra sheets as necessary and include together as documentation.

Problem-Solving Plan

Referral Question/Concern:_____

_____

Goals/Desired Outcomes:_____

_____

Problem Identification	

Problem Analysis	
Possible Interventions	
Select Intervention	
Implementation	
Evaluation/Revision	

Documentation of Self-Study Activity Suggestion #2

Create a case study of a child with an anxiety problem, specify goals/desired outcomes, and develop an intervention plan using the following form. Use extra sheets as necessary. Submit all materials as documentation.

Name:_____Referral Questions:_____

Intervention:_____
Date:_____

Goal/Desired Outcome	What is to be Done

Suggestions for Further Reading

Huberty, T. J. (1997). Anxiety. In G. G. Bear, K. M. Minke, & A. Thomas (Eds.), Children's needs II: Development, problems, and alternatives (2nd ed.), (pp. 305-314). Bethesda, MD: National Association of School Psychologists. This book chapter discusses anxiety from clinical and school perspectives, and includes content on the normal and atypical aspects.

Comorbidity, the relationship of anxiety to depression, assessment, and interventions are some of the topics presented.

Kendall, P. C., Kane, M., Howard, B., & Siqueland, L. (1990). Cognitive-behavioral treatment of anxious children: Treatment manual. [Available from Philip C. Kendall, Department of Psychology, Temple University, Philadelphia, PA 19122.] This publication offers specific suggestions and guidelines to develop intervention programs for anxiety-related problems, and includes materials to assist in treatment planning.

March, J. S. (Ed.). (1995). Anxiety disorders in children and adolescents. New York: Guilford Press. This excellent book discusses anxiety problems in terms of basic concepts and foundations, assessment, and intervention approaches. Material on the neuropsychology of anxiety and comorbidity are included.>

Ollendick, T. H., & King, N. J. (1994). Diagnosis, assessment, and treatment of internalizing problems in children: The role of longitudinal data. Journal of Consulting and Clinical Psychology, 62, 918-927. This article provides an overview of major issues in childhood internalizing problems, including anxiety, and discusses comorbidity, longitudinal findings, and results of selected outcome studies. The article will provide the practitioner with a firm background in the conceptual and practical aspects of internalizing problems of childhood.

Ollendick, T. H., King, N. J., & Yule, W. (Eds.). (1994). International handbook of phobic and anxiety disorders in children and adolescents. New York: Plenum Press. This book provides a comprehensive overview of anxiety disorders in childhood, and is comprised of four sections: current issues, specific phobic and anxiety disorders, assessment techniques, and intervention and prevention strategies.

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The Child Anxiety NETWORK

Anxiety disorders are one of the primary mental health problems affecting children and adolescents today. Given the wide range of stressors associated with growing up, it is important that our children have appropriate skills for coping with anxiety and other difficult emotions.

The Child Anxiety Network is designed to provide thorough, user-friendly information about child anxiety. It is also designed to provide direction for those who are not sure where to turn when they think their child or a child they know may need professional help to cope with anxiety.

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I Can Relax! Relaxation CD for Children

The "I Can Relax!" CD will help your child develop the skills they need to learn to relax during stressful times. Could your child use some help...

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- before stressful medical procedures

Give your children the skills they need to learn to relax.
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Learn about anxiety & depression from the experts

Successful Strategies for Test Anxiety

We all experience some level of anxiety before a test. A little nervousness can actually help motivate us to perform our best. Too much anxiety can become a problem if it interferes with your performance on tests. Some strategies for dealing with test anxiety:

Before the test, take good care of yourself:

? **Be prepared.** *Study the material in advance; do not leave cramming for the day before your test. Do not do a last minute review.*
? **Get plenty of sleep,** *it is hard to function at your best when overtired.*
? **Avoid any use of drugs and alcohol,** *they can interfere with your mental ability.*
? **Exercise** *may increase your alertness and sharpen your mind.*
? **Have a moderate breakfast,** *fresh fruits and vegetables help reduce stress; avoid caffeine, sugar and junk foods.*
? **Allow yourself plenty of time;** *arrive at the test location early.*
? **Choose a seat** *where you will not be easily distracted.*
? **Use abdominal breathing** *to help reduce anxiety. Place one hand on your abdomen, right beneath your rib cage. Inhale through your nose and feel your abdomen fill like a balloon?count to three on your inhalation and then slowly exhale counting to four, feeling your abdomen contracting with the exhalation.*
? **Do a reality check,** *how important is this exam in the grand scheme of things? Put it in perspective.*
? **Use positive affirmations,** *say a phrase to help keep things in perspective, ?I?ve done this before, I can do it again.? or ?I have all the knowledge I need to get this done.?*

During the test take a few minutes to:

? **Review the entire test.** *Read the directions carefully.*
? **Work on the easiest portions of the test first.**
? **Pace yourself.** *Do not rush through the test.*
? **If you go blank,** *skip the question and go on.*
? **Multiple choice questions,** *read all the options first, eliminate the most obvious.*
? **Essay questions,** *make a short outline. Begin and end with a summary sentence.*
? **Take short breaks,** *tense and relax your muscles throughout your body.*
? **Pause,** *do a few abdominal breaths, say your affirmation.*
? **Stay in the present moment.**
? **There is no reward for being the first done.**

After the test, reward yourself:

? **Try not to dwell on your mistakes.**
? **Indulge in something relaxing for awhile.**

IF TEST TAKING ANXIETY STRATEGIES DO NOT WORK FOR YOU,

VISIT YOUR SCHOOL COUNSELOR OR OTHER HEALTH CARE PROFESSIONAL.

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Learn about anxiety & depression from the experts

Reducing The Stress in Your Life

What is Stress?

Stress is the way that we respond to change in our lives. It is the way our bodies react physically, emotionally, cognitively, behaviorally to any change in the status quo. These changes do not have to be only negative things; positive change can also be stressful. Even imagined change can cause stress.

Stress is highly individual. A situation that one person may find stressful may not bother another person. Stress occurs when something happens that we feel imposes a demand on us. When we perceive that we cannot cope or feel inadequate to meet the demand we begin to feel stress.

Stress is not all bad. We need a certain amount of stress in our lives because it is stimulating and motivating. It gives us the energy to try harder and keeps us alert. When we find ourselves in situations that challenge us too much we react with the ?fight or flight? stress response. Stress actually begins in our brains and it is expressed in our body. Once w perceive a stress our body sends our chemical messengers in the form of stress hormones to help our bodies handle the stress.

Chronic Stress

Stress hormones are important to help us meet the demands of stress occasionally but if they are repeatedly triggered disease will occur. Our body does signal us when we are we are experiencing the effects of chronic stress.

Physical Symptoms

headaches
Tension
Fatigue
Insomnia
Muscle aches
Digestive upset
Restlessness
Appetite change
Alcohol, tobacco, drug use

Mental Symptoms

Forgetfulness
Low productivity
Confusion
Poor concentration
Lethargy
Negativity
Busy mind

Emotional Symptoms

Anxiety
Mood swings
Irritability
Depression
Worrying
Little Joy
Anger
Resentment
Impatience

Social Symptoms

Lashing out
Decrease sex drive
Lack of intimacy
Isolation
Intolerance
Loneliness
Decrease in social activities
Desire to run away

Spiritual Symptoms

Apathy
Loss of direction
Emptiness
Loss of life?s meaning
Cynicism
Unforgiving
Feeling s of martyrdom

Managing Stress

Being able to manage stress is important in order to live healthy, happy and productive lives.

Negative Coping

Ignoring the problem, Withdrawal, Procrastination, Alcohol/drug use, Smoking, Overeating, Inactivity, Over committed, Buying things

Positive Coping

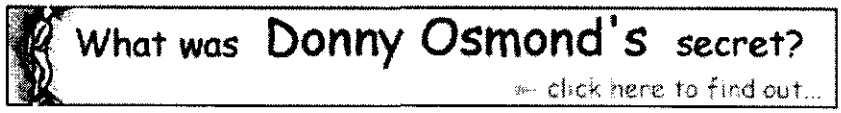
Become aware of your reactions, Maintain a healthy balanced diet, Exercise regularly, Balance work and play, Practice relaxation techniques, Meditate Develop a support system, Pace yourself, Simplify your life

Self-Care Techniques

Daily choices to care for oneself helps one?s feelings of worth, and increases a sense of well-being.

Deep slow diaphragmatic breathing
Listen to relaxation tapes
Avoid caffeine
Use positive affirmations
Do something you love
Allow extra time for projects
Leave work at the office
Do not ruminate over the past
Try to live in the present
Take brisk walks
Listen to your body?s signals
Finish what you start

Do less, enjoy more



Helping Children Handle Disaster-Related Anxiety

Children sense the anxiety and tension in adults around them. And, like adults, children experience the same feelings of helplessness and lack of control that disaster-related stress can bring about.

Unlike adults, however, children have little experience to help them place their current situation into perspective.

Each child responds differently to disasters, depending on his or her understanding and maturity, but it's easy to see how an event like this can create a great deal of anxiety in children of all ages because they will interpret the disaster as a personal danger to themselves and those they care about.

Whatever the child's age or relationship to the damage caused by disaster, it's important that you be open about the consequences for your family, and that you encourage him or her to talk about it.

Quick Tips for Parents

- Children need comforting and frequent reassurance that they're safe make sure they get it.
- Be honest and open about the disaster.
- Encourage children to express their feelings through talking, drawing or playing.
- Try to maintain your daily routines as much as possible.
- For more information call the National Mental Health Association 1-800-969-NMHA (6642)

Pre-School Age Children

Behavior such as bed-wetting, thumb sucking, baby talk, or a fear of sleeping alone may intensify in some younger children, or reappear in children who had previously outgrown them. They may complain of very real stomach cramps or headaches, and be reluctant to go to school. It's important to remember that these children are not "being bad" --they're afraid. Here are some suggestions to help them cope with their fears:

- **Reassure young children that they're safe.** Provide extra comfort and contact by discussing the child's fears at night, by telephoning during the day and with extra physical comforting.

- **Get a better understanding of a child's feelings about the disaster.** Discuss the disaster with them and find out each child's particular fears and concerns. Answer all questions they may ask and provide them loving comfort and care. You can work to structure children's play so that it remains constructive, serving as an outlet for them to express fear or anger.

Grade-School Age Children

Children this age may ask many questions about the disaster, and it's important that you try to answer them in clear and simple language.

If a child is concerned about a parent who is distressed, don't tell a child not to worry--doing so will just make him or her worry more.

Here are several important things to remember with school-age children:

- **False reassurance does not help this age group.** Don't say disasters will never affect your family again; children will know this isn't true. Instead, say "You're safe now and I'll always try to protect you,-- or--Adults are working very hard to make things safe." Remind children that disasters are very rare. Children's fears often get worse around bedtime, so you might want to stick around until the child falls asleep in order to make him or her feel protected.

- **Monitor children's media viewing.** Images of the disaster and the damage are extremely frightening to children, so consider limiting the amount of media coverage they see. A good way to do this without calling attention to your own concern is to regularly schedule an activity--story reading, drawing, movies, or letter writing, for example--during news shows.

- **Allow them to express themselves through play or drawing.** As with younger children, school-age children sometimes find comfort in expressing themselves through playing games or drawing scenes of the disaster. Allowing them to do so, and then talking about it, gives you the chance to "re-tell" the ending of the game or the story they have expressed in pictures with an emphasis on personal safety.

- **Don't be afraid to say "I don't know."** Part of keeping discussion of the disaster open and honest is not being afraid to say you don't know how to answer a child's question. When such an occasion arises, explain to your child that disasters are extremely rare, and they cause feelings that even adults have trouble dealing with. Temper this by explaining that, even so, adults will always work very hard to keep children safe and secure.

Adolescents

Encourage these youth to work out their concerns about the disaster. Adolescents may try to down-play their worries. It is generally a good idea to talk about these issues, keeping the lines of communication open and remaining honest about the

financial, physical and emotional impact of the disaster on your family. When adolescents are frightened, they may express their fear through acting out or regressing to younger habits.

- Children with existing emotional problems such as depression may require careful supervision and additional support.
- Monitor their media exposure to the event and information they receive on the Internet.
- Adolescents may turn to their friends for support. Encourage friends and families to get together and discuss the event to allay fears.

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Treating Anxiety in Children and Adolescents

What is Anxiety?

Anxiety is worry, apprehension or concern about something unknown in the future. It is often a normal, healthy reaction to life experiences. However, these worries can become excessive causing physical symptoms, school problems, and at times may interfere with functioning.

Some common signs of anxiety in childhood and adolescence include:

- feeling nervous
- feeling frightened for no reason
- difficulty concentrating or the mind going blank
- irritability, tension, sleep problems, and nightmares
- worrying excessively
- feeling scared at times of separation
- shyness

Course of Treatment

Following a brief screening to determine eligibility to participate, parents will be interviewed and children will receive a comprehensive psychiatric evaluation. Treatment with medications is recognized as being beneficial in the treatment of adults with anxiety. Although medications are now widely used in children and adolescents, we would like to know the benefits of these medications in the treatment of anxious children ages 7 to 18 years.

Persons consenting will enter a study in which the child, parent, and research clinician is unaware if the medication they are receiving is an approved medication or placebo (inactive substance). For a period of 12 weeks the child or adolescent will be seen twice per month to monitor for symptoms of anxiety and side effects. Treatment provided during the course of the study is free of charge.

Qualifications of Investigators

Boris Birmaher, M.D., Associate Professor of Psychiatry

Duncan Clark, M.D., Associate Professor of Psychiatry

James Perel, Ph.D., Professor of Psychiatry and Pharmacology

For more information or referral please contact Catherine Kalas, RN and Kelly Monk, RN, tel: 624-1238

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November 2002 **contents**

Anxiety Disorders: Treatments Work

by Harrison Wein, Ph.D.

Anxiety disorders like panic disorder and post-traumatic stress disorder are more common than most people realize. Over 19 million adults in America suffer from these chronic conditions, which can seriously interfere with work and personal relationships.

Dr. Dennis Charney, director of the Mood and Anxiety Disorders Program at the National Institute of Mental Health (NIMH) of the National Institutes of Health (NIH) wants you to know that there are effective ways to treat these conditions. "Treatment works as well as, if not better than, most treatments for other serious medical disorders," he says.

Types of Anxiety Disorders

Anxiety disorders can become very serious if left untreated. It's important to realize that they can also be accompanied by depression, eating disorders, substance abuse or another anxiety disorder, compounding the problem. There are several types of anxiety disorders. They include:

Social Anxiety Disorder (SAD). SAD is the most common of the anxiety disorders, with 15 percent of the American population afflicted by it. It is characterized by a persistent fear of social or performance situations.

A Word to the Wise...

How to Get Help for Anxiety Disorders

If you, or someone you know, has symptoms of anxiety, a visit to the family physician is usually the best place to start. A physician can help determine whether the symptoms are due to an anxiety disorder, some other medical condition, or both. Frequently, the next step in getting treatment for an anxiety disorder is referral to a mental health professional.

Among the professionals who can help are psychiatrists, psychologists, social workers, and counselors. For some people, group therapy is a helpful part of treatment. It's important that you feel comfortable with the therapy that the mental health professional suggests. If this is not the case, seek help elsewhere. However, if you've been taking a

"In social situations," Dr. Charney explains, "people with SAD become very nervous. They feel that people are looking at them, that they're not saying the right things, that they don't look right." These people can become very shy and begin to avoid social situations. As a result, they don't have as many friends as they could. It also affects their ability to perform at work because many jobs involve speaking in front of other people and being in group meetings where you are expected to make a contribution. So SAD can have a very broad effect on your life.

"This should be separated from shyness," Dr. Charney stresses. "Shyness is a temperament. Some people are more shy than others. SAD produces impairment."

Post-traumatic stress disorder (PTSD). PTSD is a reaction to a terrifying event that keeps returning in frightening, intrusive memories. The traumatic event could be something you see or something that happens to you directly.

"PTSD produces an intense fear and a sense of helplessness," Dr. Charney says. People with this disorder can become detached and emotionally numb. They may feel guilt for surviving. "The survivors wonder, why me?" he says. They also often have problems sleeping.

PTSD is fairly common. At some point in their lives, 40 to 80 percent of people are exposed to a very serious, traumatic event. At any given time, eight percent of the people in the U.S. have PTSD.

Generalized anxiety disorder (GAD). Everyday events and decisions cause exaggerated worry and tension in people with GAD. "Patients with GAD are worrywarts," Dr. Charney says. "They feel the world in general is not a safe place, that bad things happen to good people like themselves. They are always feeling distressed." They become restless, fatigued,

medication, it's important not to stop using it abruptly. Certain drugs have to be tapered off under the supervision of your physician.

When you find a health care professional that you're satisfied with, the two of you will be working together as a team. Together you will be able to develop a plan to treat your anxiety disorder.

You may be concerned about paying for treatment for an anxiety disorder. If you belong to a Health Maintenance Organization (HMO) or have some other kind of health insurance, the costs of your treatment may be fully or partially covered. Your doctor may also know of public mental health centers that charge people according to how much they are able to pay. If you are on public assistance, you may be able to get care through your state Medicaid plan.

Source: NIMH

What Are the Treatments for

irritable, and tense.

"People with GAD have chronic, moderate levels of symptoms associated with lots of worrying," Dr. Charney explains, "but they don't have panic attacks that send them to the emergency room." About six percent of the U.S. population suffers from GAD.

Panic disorder. People with panic disorder have recurrent, unexpected feelings of extreme fear and dread that strike for no apparent reason, causing their heart to race, rapid breathing, sweating, and shakiness. These "attacks" can send people to the hospital believing they are having a heart attack.

"It could come right out of the blue for no apparent reason," Dr. Charney explains, "when you're not in a situation that would normally make you feel stress or anxiety or fear."

People with this condition often avoid places where they've had panic attacks, and in severe cases, may become housebound. Two to four percent of the people in America suffer from panic disorder.

Obsessive-compulsive disorder (OCD). People who suffer from OCD become trapped in a pattern of repetitive thoughts and behaviors that are senseless and distressing but extremely difficult to stop. If severe and left untreated, OCD can destroy a person's capacity to function at work, at school, or even in the home. OCD affects more than two percent of the country's population.

Why Me?

Scientists aren't quite sure why some people get anxiety disorders. Different people exposed to the same situation can react in very different ways. Part of this difference may be in the genes they have inherited.

"These disorders run in families," Dr. Charney explains. So if a parent has

Anxiety Disorders?

Treatments for anxiety disorders are extremely effective and often combine medication and psychotherapy.

More medicines are available than ever before to effectively treat anxiety disorders. These include antidepressants and benzodiazepines. If one medication is not effective, you and your doctor can discuss others.

The two most effective forms of psychotherapy used to treat anxiety disorders are behavioral therapy and cognitive-behavioral therapy. Behavioral therapy tries to change actions through techniques such as breathing exercises or through gradual exposure to what is frightening. Cognitive-behavioral therapy teaches patients to understand their thinking patterns so they can react differently to the things that cause them anxiety.

Source: NIMH

an anxiety disorder, the chance of their children having one of these conditions is higher. That may be due to the genes they've inherited, but Dr. Charney points out, "The environment that a child is brought up in may be important too. Ultimately, it's probably an interaction between genetic predisposition and environment."

Scientists have recently been gaining insights into the development of anxiety disorders. "Children of parents with panic disorders have a higher incidence of behavioral disorders very early in life, before you would think major environmental impacts would occur," Dr. Charney says.

A growing body of evidence shows that infants who tend to be shy, timid and constrained in social situations – even in the very first weeks of life – have higher rates of anxiety disorders when they get older. "We're actively searching for other behavior manifestations that might relate to the development of other anxiety and mood disorders early in life," Dr. Charney adds. Scientists hope that understanding the development of these disorders will lead them to better ways of preventing and treating them.

Researchers are taking several approaches to figure out the underlying scientific bases for anxiety disorders. Using advanced imaging techniques, they are mapping the brains of people with anxiety disorders to see how they differ from those without the disorders. Much current effort is focused on a region of the brain called the amygdala, which plays a central role in feelings of fear and anxiety.

Scientists are also trying to better understand how the body deals with the stress that accompanies anxiety, a complex reaction that involves another region of the brain called the hippocampus, as well as many other systems of the body. And they are studying the many different chemicals both in the brain and throughout the rest of the body that are involved in the experience of anxiety and fear.

"Anxiety and mood disorders are diseases of the brain and the body, not just the mind," Dr. Charney stresses.

Getting Help

Scientists have found that adolescence is an important period for the diagnosis and treatment of anxiety disorders.

Dr. Charney says, "Of adolescents who have any one of the mood or anxiety disorders, 42 percent still have an anxiety or depressive disorder in adulthood." In contrast, only five percent of adolescents who were healthy go on to develop one of the disorders.

"It is likely that if we aggressively treat adolescents who suffer from mood and anxiety disorders, we can prevent many of these disorders from becoming chronic," Dr. Charney says. "We want to make these diagnoses

as early as possible."

But treatments can be effective at any age. If you think you may have an anxiety disorder, don't hesitate to discuss it with your health care provider. There are many different types of treatments available, and these can be tailored to specific problems. In some cases, psychotherapy, or counseling, is sufficient. In other cases, medication alone can be very effective. Some people may need both. Researchers are now looking at ways to define at an early stage who will do well with which treatments.

"Probably in a majority, it's a combination of both medication and psychotherapy that works," Dr. Charney says. "Psychotherapy teaches you things that are very effective and helpful for the long run. But in many patients, that may not be enough because there's also a biology that the psychotherapy may not be able to overcome. The therapy helps you learn better behaviors and the medications help treat the biologic or genetic disturbance."

"The take home message is that treatment can work," Dr. Charney says. "We're working to make it better, and that's why we're doing research at places like NIMH. But there are treatments available now that can work. Patients have to believe in that, because it's true."

-a report from The NIH Word on Health, October, 2002

For more information about anxiety disorders, see http://www.nimh.nih.gov/anxiety or contact:

National Institute of Mental Health
Office of Communications and Public Liaison
6001 Executive Boulevard, Room 8184, MSC 9663
Bethesda, MD 20892-9663
Toll-Free: 1-88-88-ANXIETY (1-888-826-9438)
Phone: 301-443-4513
Fax: 301-443-4279
Mental Health FAX4U: 301-443-5158
TTY: 301-443-8431
E-mail: nimhinfo@nih.gov

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Learn about anxiety & depression from the experts

Treatment of Anxiety Disorders

Effective treatments for each of the anxiety disorders have been developed through research. In general, two types of treatment are available for an anxiety disorder-medication and specific types of psychotherapy (sometimes called "talk therapy"). Both approaches can be effective for most disorders. The choice of one or the other, or both, depends on the patient's and the doctor's preference, and also on the particular anxiety disorder.

Medications

Psychiatrists or other physicians can prescribe medications for anxiety disorders. These doctors often work closely with other mental health professionals who provide psychotherapy. Although medications won't cure an anxiety disorder, they can keep the symptoms under control and enable you to lead a normal, fulfilling life. The major classes of medications used for various anxiety disorders are described below.

Antidepressants

A number of medications that were originally approved for treatment of depression have been found to be effective for anxiety disorders. If your doctor prescribes an antidepressant, you will need to take it for several weeks before symptoms start to fade.

Some of the newest antidepressants are called selective serotonin reuptake inhibitors (SSRIs). These medications act in the brain on a chemical messenger called serotonin. They are started at a low dose and gradually increased until they reach a therapeutic level. SSRIs tend to have fewer side effects than older antidepressants. People do sometimes report feeling slightly nauseated or jittery when they first start taking SSRIs, but that usually disappears with time. Some people also experience sexual dysfunction when taking some of these medications. An adjustment in dosage or a switch to another SSRI will usually correct bothersome problems. It is important to discuss side effects with your doctor so that he or she will know when there is a need for a change in medication.

Similarly, antidepressant medications called tricyclics are started at low doses and gradually increased. Tricyclics have been around longer than SSRIs and have been more widely studied for treating anxiety disorders. For anxiety disorders other than OCD, they are as effective as the SSRIs, but many physicians and patients prefer the newer drugs because the tricyclics sometimes cause dizziness, drowsiness, dry mouth, and weight gain. When these problems persist or are bothersome, a change in dosage or a switch in medications may be needed.

Monoamine oxidase inhibitors (MAOIs) are the oldest class of antidepressant medications. People who take MAOIs are put on a restrictive diet because these medications can interact with some foods and beverages, including cheese and red wine, which contain the chemical tyramine. MAOIs also interact with some other medications, including SSRIs. Interactions between MAOIs and other substances can cause dangerous

elevations in blood pressure or other potentially life-threatening reactions.

Anti-Anxiety Medications
High-potency benzodiazepines relieve symptoms quickly and have few side effects, although drowsiness can be a problem. Because people can develop a tolerance to them-and would have to continue increasing the dosage to get the same effect-benzodiazepines are generally prescribed for short periods of time. One exception is panic disorder, for which they may be used for 6 months to a year. People who have had problems with drug or alcohol abuse are not usually good candidates for these medications because they may become dependent on them. Some people experience withdrawal symptoms when they stop taking benzodiazepines, although reducing the dosage gradually can diminish those symptoms. In certain instances, the symptoms of anxiety can rebound after these medications are stopped.

Buspirone, a member of a class of drugs called azipirones, is a newer anti-anxiety medication that is used to treat GAD. Possible side effects include dizziness, headaches, and nausea. Unlike the benzodiazepines, buspirone must be taken consistently for at least two weeks to achieve an anti-anxiety effect.

Other Medications
Beta-blockers, such as propanolol, are often used to treat heart conditions but have also been found to be helpful in certain anxiety disorders, particularly in social anxiety. When a feared situation, such as giving an oral presentation, can be predicted in advance, your doctor may prescribe a beta-blocker that can be taken to keep your heart from pounding, your hands from shaking, and other physical symptoms from developing.

Taking Medications

Before taking medication for an anxiety disorder:
? Ask your doctor to tell you about the effects and side effects of the drug he or she is prescribing.
? Tell your doctor about any alternative therapies or over-the-counter medications you are using.
? Ask your doctor when and how the medication will be stopped. Some drugs can't safely be stopped abruptly; they have to be tapered slowly under a physician's supervision.
? Be aware that some medications are effective in anxiety disorders only as long as they are taken regularly, and symptoms may occur again when the medications are discontinued.
? Work together with your doctor to determine the right dosage of the right medication to treat your anxiety disorder.

Psychotherapy

Psychotherapy involves talking with a trained mental health professional to learn how to deal with problems like anxiety disorders.

Cognitive-Behavioral and Behavioral Therapy
Research has shown that a form of psychotherapy that is effective for several anxiety disorders, particularly panic disorder and social anxiety, is cognitive-behavioral therapy (CBT). It has two components. The cognitive component helps people change thinking patterns that keep them from overcoming their fears. For example, a person with panic disorder might be helped to see that his or her panic attacks are not really heart attacks as previously feared; the tendency to put the worst possible interpretation on physical symptoms can be overcome.

The behavioral component of CBT seeks to change people's reactions to anxiety-provoking situations. A key element of this component is exposure,

in which people confront the things they fear. An example would be a treatment approach called exposure and response prevention for people with OCD. If the person has a fear of dirt and germs, the therapist may encourage them to dirty their hands, then go a certain period of time without washing. The therapist helps the patient to cope with the resultant anxiety. Eventually, after this exercise has been repeated a number of times, anxiety will diminish.

A major aim of CBT and behavioral therapy is to reduce anxiety by eliminating beliefs or behaviors that help to maintain the anxiety disorder. CBT or behavioral therapy generally lasts about 12 weeks. It may be conducted in a group, provided the people in the group have sufficiently similar problems. Group therapy is particularly effective for people with social phobia.

Medication may be combined with psychotherapy, and for many people this is the best approach to treatment. As stated earlier, it is important to give any treatment a fair trial. And if one approach doesn't work, the odds are that another one will, so don't give up.

If you have recovered from an anxiety disorder, and at a later time it recurs, don?t consider yourself a ?treatment failure?. Recurrences can be treated effectively, just like an initial episode. In fact, the skills you learned in dealing with the initial episode can be helpful in coping with a setback.