

# Initial Approaches to Addressing Behavioral & Emotional Concerns in Primary Care

## Module 2 – Anxiety

### Rationale

This module is meant to be completed after Module 1 – Brief Intervention. It assumes residents are familiar with the prevalence of mental health disorders in primary care and know the components of a common factors approach to mental health concerns. It provides a brief review about anxiety disorders and uses case vignettes and role playing to promote group discussion on utilizing a common factors approach to the clinical situations presented.

### Goal

Recognize and provide initial management for children and youth with mild to moderate anxiety in the primary care setting.

### Objectives

1. Appreciate that anxiety symptoms and disorders commonly present in primary care and may represent typical behavior, a primary anxiety concern, and/or be secondary to other concerns or conditions.
2. Know and recognize the common symptoms and clinical findings in children and youth that suggest anxiety at different developmental stages
3. Practice use of the common factors approach to assess and manage children and youth with anxiety.

### Materials Needed

1. Background handout on anxiety
2. Tool: Generic or Common Factors Interventions (HELP)
3. PowerPoint presentation: Module 2 – Anxiety. This facilitator's guide provides points for preceptors to highlight.
4. Role play materials

### Time

- Presentation, role play, and facilitated discussion could last anywhere from 30 to 50 minutes, depending on whether 1 or 2 case vignettes are discussed. Role play can be used as a substitute for case #2 to engage residents in a more active learning exercise.

### Preparing to Facilitate Module

1. Review and assign residents to review the background handout on anxiety prior to session
2. Review PowerPoint presentation, case vignettes, and role play materials
3. Review facilitation/discussion suggestions for indicated slides
4. Encourage residents to share their thoughts after each component of a vignette and/or be active participants in role play

### Background on PowerPoint Presentation

The PowerPoint presentation begins with a brief review of the assessment and management of anxiety. It is followed by 2 case vignettes. The first case vignette involves a 3 ½-year-old with symptoms of separation anxiety, and the second case vignette involves an 11-year-old with school avoidance presenting as abdominal pain. The first case vignette emphasizes ways in which pediatricians may respond to behavioral concerns that discourage discussion of the concern and how a common factors approach may elicit important information from parents. The second vignette shows a pediatrician talking with a mother and child using the common factors approach and basic knowledge about anxiety to gather history and develop an initial management plan. Depending on the time available you may want to discuss one or both vignettes during one seminar.

### Facilitation Points to Consider

This section highlights key points to make or discussions to have related to each slide. For facilitators interested in more information, some topics have more details provided in an Appendix. These topics are noted with an **(A#)** to help you find further discussion in the Appendix.

#### *Slide 1: Title Slide*

#### *Slide 2: Goals & Objectives*

Review the goal and objectives of the session.

#### *Slide 3: Anxiety: Brief Review – Anxiety is common and can be adaptive*

Before showing this slide ask residents how they distinguish a child with a normative level of anxiety from one with an anxiety disorder. The intent of the discussion is for residents to recognize:

- Both genetic and environmental factors influence anxiety
  - Heritability of anxiety is 0.4–0.6
- Mild levels of anxiety are common in many childhood experiences
  - Separations for school and camp
  - New experiences
  - Increasing expectations for performance
- Anxiety may help protect one from danger or motivate completion of a task
- Anxiety disorders are diagnosed when anxiety interferes with child functioning or causes the child subjective distress.

#### *Slide 4: Anxiety: Brief Review – Anxiety changes with age and developmental stage*

Before showing this slide ask residents how the types of anxiety symptoms a child has may change with age. The intent of this discussion is for residents to recognize:

- The progression of anxiety symptoms from:
  - Concerns about separation and imaginary creatures to
  - Concerns about harm to self or loved ones to
  - Concerns about performance, health, and social concerns **(A1)**

**Slide 5:** *Anxiety Management – Intervention Strategies*

Before showing this slide ask residents how one might intervene to help a child with anxiety. Look for residents to include ideas that indicate an understanding of both a common factors approach and some approaches more specific to anxiety symptoms.

- Common factors approaches (sample of possible responses below)
  - Expressing hope that the child will learn to adapt and empathy for the current difficulty
  - Getting adequate sleep
  - Getting adequate exercise
- Anxiety specific strategies
  - Gradually increase exposure to feared stimulus or situation—this is a core component of almost all successful interventions for anxiety and is the behavioral component of Cognitive-Behavioral Therapy, the type of therapy with the strongest evidence-base for anxiety treatment.

**Slide 6:** *Anxiety Management – Intervention Strategies*

Other components of managing anxiety can be grouped into 3 different categories:

1. Cognitive (the cognitive component of cognitive-behavioral therapy) often involves understanding the biological response to fear (increased heart rate, sweating, increased intestinal motility), why this response is not needed in the situation causing anxiety, and developing helpful responses instead of fear inducing thoughts (dogs are loved pets and have helped save children's lives as opposed to dogs are mean animals that bite)
2. Distraction or relaxation strategies are often taught to help individuals manage anxiety producing situations. Having children blow bubbles during vaccinations or blood draws has been shown to decrease this type of procedural anxiety. Intentionally tensing and then relaxing muscles from the face through the legs and feet can help individuals to relax
3. Giving children increased control can also help. This can be done by giving fixed choices (I can listen to your heart and then look in your ears or look in your ears and then listen to your heart, which would you prefer?) or for younger children having them imagine that they have super powers "to beat" a scary situation.

**Slide 7:** *Anxiety Management – When to Refer*

Discuss situations when it is appropriate to refer a child to a behavior or mental health professional.

**Slide 8:** *Common Factors Review*

Before beginning the video case vignettes, review the common factors approach.

**Slide 9:** *Case #1: Separation Anxiety*

Have residents read the introduction to the case vignette.

*You are seeing Ben, a 3 ½-year-old boy, whose parents come in together due to concerns about his tantrums when dropped off at child care. He is a healthy child who you last saw for his 3 year well-child visit. During that visit there were no concerns raised about his behavior or development (he passed his 3-year-old developmental screen), but his mother had expressed concern about how Ben would do in child care now that she was going back to work.*

Consider asking the residents if they've encountered this type of situation with any of their continuity clinic patients. If so, you might want to ask how they handled the situation.

**Slide 10-11: Case #1 | Video #1**

Before playing the video clip ask residents to observe the pediatrician for things she does well and things she could do better in approaching this case.

- What does the pediatrician do well in approaching this case?
  - Pediatrician understood that allowing the child to avoid a developmentally appropriate separation would be problematic.
- What could the pediatrician have done differently or better?
  - Advice was given with very little assessment of the problem and minimized or reframed the problem inaccurately suggesting that Ms. Smith's feelings about Ben were somehow just the "normal" response of a parent dropping their child off at child care.
- Advice was overly authoritative. Parents would not feel comfortably raising objections to the advice the pediatrician was giving.
- Advice was simplistic (scripted) and likely would have made the child's behavior worse. **(A2)**

**Slide 12: Pediatrician Responses That Discouraged Discussion**

Pediatricians have often been found to respond to behavioral or mental health concerns in ways that discourage the parent from discussing the concerns. Some of the ways that pediatricians do this should have been discussed in response to the last slide. This slide provides a summary of some of the ways this occurred in the video.

**Slide 13: Case #1: Discussion of Video #1**

What additional history would you want to obtain? There are many correct answers, but at a minimum they should focus on:

- Description of anxiety including other situations in which it occurs, coping strategies the family has identified, previous attempt to intervene
- Assessment for health or developmental problems that may be contributing
- Assessment of psychosocial stressors
- Assessment for anxiety symptoms or anxiety disorders in the family

Ask residents to think about the common factors approach when thinking about how they may approach this situation differently. If residents need further prompting:

- How would one respond differently to express hope and empathy?
- How would one respond differently using parent's language in discussing the problem?
  - Ben's mother is perceiving him as angry at her. Using this term may help build the partnership, "I understand Ben seems very angry when you drop him off...."

**Slide 14-15: Case #1 | Video #2**

Ask residents to observe for:

- Factors that they think are typical or unusual for a child with separation anxiety
- Examples of use of common factors approaches by the pediatrician, and how this approach helps to elicit additional information is important in understanding the situation.

What is typical or unusual about Ben's separation anxiety?

- Typical
  - Situations in which it occurs: separations and sleep
  - Behavioral reaction: tantrums and clinging

- Unusual
  - Age—separation anxiety usually peaks between 9 and 15 months of age and is improved by 2 years of age, although it can recur in the face of stressors at an older age

How did the pediatrician use a common factors approach?

- Empathy
  - *"I am sorry to hear this"*
  - *"It sounds like this has been hard for both of you"*
- Hope, Loyalty, and Partnership
  - *"I am very glad that you came to talk with me about this. I think if we work together on this we can help Ben and both of you"*
- Language
  - Use of family terms "clingy and angry"

**Slide 16:** *Case #1: Potential Barriers to Intervention*

The beginning of developing a partnership with families is to identify significant barriers to successful management. Encourage residents to think about barriers in the 3 areas shown on the slide.

Child factors:

- Temperament **(A3)**
  - Ben's tantrums are intense and persistent.
  - These may be characteristics of Ben's temperament. One could explore whether this is how Ben responds to other situations.

Parent factors:

- Parental anxiety
- Marital disagreement or discord
  - Learning more about the severity of this disagreement and the number of factors that the parents disagree on will be critical in determining if one is likely to be successful with counseling in primary care or should refer the family.

School/Community factors:

- It would be reasonable to explore whether something about the child care setting makes Ben's mother uncomfortable. She mentions concern about infection—is this a general concern or specific to hygiene practices at the child care center?

**Slide 17:** *Possible Management Strategies*

Make the point that there are many possible plans. Our goal is to get the family to identify things they can do that might help. This might include:

- Involving the father more in the separation at school so Ben separates from his mother at home (making sure Ben sees his mother as confident and happy during separation).
- Getting Ben involved in one of his favorite activities before his mother leaves school (but never leave without telling him—that will only increase his anxiety).
- Offer rewards for being brave (eg, tolerating the separation). The rewards could involve stickers, special privileges, or getting to do an activity he particularly likes, etc.

- With a babysitter one could plan a fun activity to happen while the parents are gone or use the reward of having the parents call in 30 minutes (set a timer so the child can see the time passing) and if everything is going well the parents will come home.

Part 2 features a different example of a pediatrician using a common factors approach with a parent and child to address a concern related to anxiety. Facilitators may choose to use the role play materials and have residents practice using the common factors approach. If the role play is used, the prompts below can still be applied (ie, what does the pediatrician do well?). You may consider asking for a volunteer to play the role of the physician and assign the other roles. Provide each participant a copy of their role and allow them to review the scenario and role for 2 to 3 minutes. Time-outs can be called by role-players and the facilitator. The person for calling the “time out” should state why he/she asked for a break. The first person to provide thoughts should be the resident playing the physician role. The facilitator can ask the physician to reflect on how the scenario is going, then request insights from the other role play participants and any observers. Participants can change roles and re-do the scenario or pick up where the first person left off. The facilitator may consider playing the physician role to demonstrate other common factors skills and/or show the video after the role play is performed.

### Facilitation Points to Consider

**Slide 18:**      *Title Slide*

**Slide 19:**      *Case #2: School Avoidance*

Have residents read the introduction to the case vignette.

*You are seeing Maria, an 11-year-old girl for a well-child visit/school physical. You last saw her for her 10-year well-child visit. She has no chronic medical problems and has been growing and developing well. She comes to your office with her mother. You discover she is having frequent episodes of abdominal pain.*

**Slide 20-21:**   *Case #2 | Video #1*

Ask residents to observe for:

- What does the pediatrician do well in approaching this case?
- How did the pediatrician use a common factors approach with the parent and the child?

Ask the residents about possible causes of this child’s symptoms. The list may include common gastrointestinal conditions mentioned by the pediatrician (constipation, gastroesophageal reflux, celiac disease) as well as other diagnoses including school avoidance.

After viewing the video you may want to discuss with the residents the symptoms commonly seen in children with school avoidance.

- Gastrointestinal and pain complaints
  - Dizziness, headaches, chest pain, musculoskeletal pains are other frequent concerns among children with school avoidance
- Frequent visits to the school nurse
- Child is frequently sent home from school
- High levels of family stress and worry
- See **(A3)** for further discussion

What components of a common factors approach did the pediatrician use?

- Hope
  - *"I am glad you came in today"*
- Empathy
  - Expresses concern that Maria is having pain
- Loyalty
  - Acknowledges all the things that are going well
- Language
  - Pediatrician restates the concern to make sure he has it right: *"It sounds like you are very worried about Maria, and her symptoms are starting to impact your job."*
- Partnership
  - Asking Maria about her symptoms begins to form a partnership between her and pediatrician
  - Asks for Maria's permission to contact school

**Slide 22:** *Case #2: Key History Reviewed*

The pediatrician finds out that Maria's abdominal pain is located in the periumbilical region. She describes her pain as crampy and it comes and goes. Nothing makes it better or worse. It doesn't seem to be triggered by any particular foods. In school, the abdominal pain can occur at any time, but usually happens before math class and around lunchtime. Her review of systems is negative. Her vital signs and growth parameters are unremarkable. She has a completely normal physical exam.

Ask the residents if there is additional history they would like to obtain from Maria or her mother. We learned about family stressors, but we don't know much about Maria's stressors (bullying, peer or sibling relationships, other changes to home or school environment).

**Slide 23-24:** *Case #2 | Video #2*

Ask residents to observe for:

- How did the pediatrician use a common factors approach to develop a management plan with Maria and her mother?
- What factors were typical or unusual for a child with school avoidance?
- You might consider asking the residents if they know some of the long-term sequelae of school avoidance like academic underachievement and increased risk for psychiatric disorders.

**Slide 25-26:** *Common Factors Approach Demonstrated*

Possible discussion points about Video #2:

- Hope
  - *"If we work together I think we can figure this out."*
- Language
  - Physician does not fall into the trap of discussing medical or psychological causes, but centers the discussion around both, "obtaining more information about the pain" and discussing ways for Maria to stay in school (allowing continued exposure to school).

- Permission
  - *“For today I would like us to work on 2 things: 1) obtaining a little more information about the pain; and 2) figuring out how to help Maria so you do not need to come and pick her up when she is having pain in school. Is it OK if we work on those things today?”*
- Partnership and Plan
  - Partnership with Maria—asking her to be a detective, making the diary her responsibility.

**Slide 27:** *Other Possible Management Strategies*

- If children have been missing a lot of school,
  - It may be helpful for them to initially return for only part of the day and then work up to a full day
  - It may be helpful for the child to have a script to use when people ask why s/he has missed school.
- Scheduled times to check in with the parents may be helpful to some students
- Children under stress due to a learning or other neurodevelopmental disability may need interventions for these stressors to be part of the plan

### A1: *Piaget's Stages of Development*

Piaget's stages of development can help one understand what children are likely to be concerned about at different ages. For example:

- Preoperational stage (2 years to approximately 6-7 years of age): At this stage children still have a "magical" understanding of cause and effect. They believe in imaginary creatures (eg, tooth fairy) and can be scared by magical creatures.
- Concrete Operations (6-7 years to approximately 11-12 years of age): At this stage children have a concrete understanding of cause and effect. They develop concerns about things that are "bad" like illness, death, or thieves, but have difficulty understanding the multiple factors that may be involved in these "bad" outcomes.
- Formal Operations (older than 12 years): The capacity for abstract reasoning develops at this stage. Concerns about how things that are happening now may affect one in the future develop. This may lead to increased anxiety about performance (will it hurt my chances to get into college, get a job, etc), or social or environmental factors that impact the future.

### A2: *"Extinction Burst"*

Understanding the behavioral concept of the "extinction burst" will help residents understand why the advice given by this physician may have worsened the behavior—at least in the short term. When problem behaviors are occurring frequently, there is usually something that is reinforcing this behavior. For young children the reinforcer frequently is parental attention. The scripted advice of "ignoring the behavior" or "just let the child cry" will work in some cases because it removes the reinforcer in that the child is no longer getting parental attention for the behavior. However, for many children the initial response to not getting the expected reinforcer is to "try harder" to get the reinforcer—perhaps by screaming louder, screaming longer, or exhibiting more disruptive or aggressive behavior. The initial increase in problem behavior is known as the "extinction burst". Often during the extinction burst parents perceive that the advice they have been given is not helpful and stop following the advice. If one is going to recommend that parents stop reinforcing a problem behavior they have reinforced in the past, one must warn parents that the advice may initially result in an increase in the problem behavior.

### A3: *History of School Avoidance*

The most common reasons for school avoidance do vary with a child's age. In kindergarten or early elementary school it is often related to separation anxiety. In older elementary and middle school age students it is often related to anxiety and other stressors occurring in the child's life, including concerns about performance in school or bullying. If problems begin in high school they are more likely to be associated with the presentation of a serious psychiatric disorder such as an anxiety disorder or depression. In teenagers, school avoidance needs to be distinguished from truancy which is often associated with other high risk behaviors (eg, substance abuse, delinquency) and the missing of school is usually hidden from parents and other adults.