

# Managing Anxiety in Children

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Anxiety in children is the most commonly experienced presenting problem in psychotherapy. It is speculated that as much as 12 to 20% of children seen in the mental health settings suffer from extremes of anxious-nervous manifestations (Knell & Dasari, 2006; Schaefer, 2009). Behavioral problems resulting from anxious reactions to their world, cause disruption in the child, their family, and their community. Parents often misunderstand the source of the problem as being anxiety, and rather describe it as "attitude" or "spoiled" or attention-seeking behavior. Particularly in very young children, parents frequently ask, "Is this anxiety developmental or situational, or is it chronic and necessitating treatment?" (Palvuluri, et al 1996). Most parents seek medical consultation when the anxiety displayed by their children interferes with daily functioning; most primary care providers subscribe to the former theory, that is, anxiety is of developmental origin that the child will outgrow. Increasingly however, the research indicates the contrary (Chu & Harrison, 2007; Campbell, Shaw & Gilliom, 2000). In fact, it is now understood that chronic, extreme anxious reactions have far-reaching consequences in the mental health of the child when left without intervention (Schaefer, 2009).

Research into anxiety in children, the neurological and biological experience of anxiety, and thus the management through psychotherapy, has expanded in the most recent decade. (Goodyear-Brown in Schaefer, 2009). The neurobiological process of the experience of anxiety appears now to be commonly discussed in articles and presentations. The anxious feelings, and the concurrent physical discomfort, are confusing and fear producing in children, and thus, the experience of anxiety naturally causes an avoidant or distracting response. For example, when a child is faced with a stranger, their mind initiates the process associated with being unfamiliar and the child experiences anxiety; the mind produces a fight-or-flight physical response. The child cries, reaches away (flight/avoidance) from the stranger to their known caregiver, and the process of calming begins. However, when the neuro-biological stimulation is somewhat constant without calming, like in the case of sensory defensiveness, when the process for self-soothing is too primitive to cope, or when parental support is lacking, the neurological process can repeat over and over, flooding the child with repeated fight or flight messages. The result can become externalized raging, selective mutism, obsessive compulsive behaviors, or panic attacks from the anxiety disorder, all with the unconscious goal of avoiding the anxiety producing experience or coping with the anxiety and the physical response.

Treatment of anxiety has taken many forms and has employed multiple modalities. The most efficacious in the research is Cognitive Behavioral Therapy, (CBT). Implemented in a developmentally appropriate manner, such as play therapy, the treatment through Cognitive-Behavioral Play Therapy (CBPT) engages the child and their parents in the process of managing the anxious responses. Evidenced-based CBT interventions in play therapy have proven to be developmentally appropriate and highly successful in teaching children to cope with anxiety (Goodyear-Brown in Schaefer, 2009; Knell & Dasari, 2006). Following the CBT protocol – psychoeducation, somatic management, cognitive restructuring, exposure and relapse prevention - play therapists can, with the assistance of the child’s caregiver, lessen the negative effects of the environment on the child, and improve the child’s ability to self regulate and to cope with their anxiety. Play-based approaches to the treatment of anxiety can give children confidence and a sense of personal power, and may aid in dispelling the intimidation often inherent for anxious children in the counseling process (Schaefer,2009).

In the next few pages, I want to discuss the foundations in the literature regarding the presence of anxiety disorders in children of all ages and the generally-held causes of anxiety in childhood. I present the neuro-biological process in the production of anxiety in response to environmental stimuli. Finally, I

discuss an effective protocol for teaching children to manage anxiety and how this protocol is implemented through play therapy.

In studying anxiety and learning the best methods for treatment, it is important to remember that anxiety is a normal, regularly experienced emotion for most children. Wehrenberg & Prinz (2007) identify three situations or circumstances that may be causes of this naturally-occurring anxiety to become clinical. First, there may be a genetic propensity for extreme anxiety; second, a child might have experienced a traumatic event (or chronic trauma from ongoing abuse) resulting in high levels of anxiety; third, an overanxious response might be due to a medical condition, perhaps from prenatal drug abuse (parental), hormones, or other physical cause. As a parent, it might be difficult to understand a child's inner experience of anxiety (Knell and Dasari, 2006) or as I mentioned before, they might think that it is a phase of childhood and will pass. In order for clinicians and parents to differentiate between organic, situational, or developmental anxiety, Klein & Pine (2002) offered that clinicians look at three dimensions: 1) intensity; 2) impairment, and 3) lack of flexibility; to determine the clinical nature of the problem compared to naturally occurring anxious feelings. Again, one must examine the situational context of the feelings; that is, have they been present since birth at increasing levels, did they just become manifest

and are increasing, and are there genetic and family considerations for the diagnosis. (Wehrenberg & Printz, 2007)

According to recent literature, anxiety at clinical levels impacts a large percentage of children (Schaefer, 2009). One in 200 children suffers from different manifestations of anxiety (March & Mullen, 1998) to the extent that the disorder disrupts academic, social, and family functioning. It is estimated that approximately 6% to 20 % of children suffer from an anxious mood (Costello, Egger, & Angold, 2004). One study, Wilens, et al. (2002), found that in a sample of 200 clinically referred youngsters, 28% met criteria for an anxiety disorder. The early and ongoing presentation of the disorder in a child's behavior highlights the dilemma of whether to seek treatment or to allow the child to outgrow the disturbance over time. (Schaefer, 2009) However, studies have shown that, untreated psychologically and unsupported by consistent parenting, anxiety disorders are most likely to impact a child's functioning at increasing levels. (Campbell, Shaw & Gilliom, 2000).

For most children however, there are practicalities and barriers to receiving treatment (Schaefer, 2009). First, the research into anxiety in children and adolescents is fairly recent. With it, fairly recently as well, came the studies into neurological sources of anxiety (Wehrenberg & Prinz, 2007) and efficacious treatments for children (Chu & Harrison, 2007) which may not be widely read or

implemented. As a result, parents may feel that therapy is not a value or not working if improvement is not noticeable in a short period of time. Second, parents may believe that the observed anxiety is normal behavior for a child, or parents may feel guilty (as in, it is something they should be able to manage as parents) and avoid seeking treatment, (Pavuluri, et al 1996). Third, parents are under pressure from work and the needs of other children and time is of a premium. Barriers to treatment also include lack of accessibility to providers, financial wherewithal, denial of the problem, or the legal constraints of divorcing parents, which have different implications. (Schaefer, 2009)

Including parents as co-therapists in the treatment process, teaching them about the source of anxiety and its manifestations, and giving them a specific role to play, often mitigates some of these barriers and can also create an increased investment in the outcome, more compliance with treatment, and a better outcome for the child and the family. (Bratton, Landereth, Kellan & Blackard, 2006; Knell and Dasari, 2006; Goodyear-Brown in Schaefer, 2009).

Exciting research is being done studying the interaction between life experience and its impact on brain development, the basis of one's psychological expression (Wehrenberg & Prinz, 2007). This research has also given us more information about why psychotherapy is effective at relieving anxiety; that is, therapy actually changes the brain functioning when altering thinking (Wehrenberg & Prinz, 2007). In the discussion of effective management of

anxiety in children, we need to briefly review the overall mind-body experience of anxiety.

According to Wehrenberg & Prinz (2007) regardless of the source of the sensory stimuli, there is a predictable and explainable neuro-biological process to the experience of anxiety. There are of course, two hemispheres of the brain – left and right – and functions are divided between them. The Left Hemisphere is the locus of logic, language, the making of meaning of experiences, problem solving, and decision-making. Sequencing, numerical operations, time and order are the responsibility of the Left Hemisphere. The Right Hemisphere of the brain is responsible for non-verbal activities – reading faces and body language, emotions and assigning emotional significance to a situation, creativity and creative responses to circumstances, spatial relationships, the melody and rhythm of speech, music – receptive and expressive - and regulation of the nervous system.

In these hemispheres, there is an area – the Prefrontal Cortex – that is particularly important in the discussion of anxiety. Again, according to Wehrenberg & Prinz (2007), these are the orbito-frontal cortex (controlling working memory) and the anterior cingulated gyrus (a control center that filters and amplifies information to and from other regions of the brain). Within each of the hemispheres is a region referred to as the limbic system, the regulator of emotion and memory, the parts of which ring the upper part of the brainstem, and are responsible for

categorizing sensory input. In the limbic system are: the amygdala – responsible for assigning positive or negative emotional value to input; hippocampus – responsible for memory storage and retrieval; thalamus – which relays outside information to various parts of the brain and regulates brain waves; and the hypothalamus – which relays internal information about the body and commands the response. These various functions are important in the discussion of how anxiety is produced. (Wehrenberg & Prinz, 2007)

The most significant focus of anxiety is in the anterior cingulate gyrus (ACG), the area of the Prefrontal Cortex responsible for moving between cognition and emotion, the creative process and flexibility in thinking (Wehrenberg & Prinz, 2007). When the ACG is not functioning properly (i.e. overactive) it fails to move smoothly between thoughts and emotions. The ACG malfunction inhibits the reviewing of all the possible options of response and the proper sequencing of ideas and actions. Then, rather than alerting the brain to multiple solutions, the child's ACG becomes stuck on one inappropriate response. One such inappropriate response might be, for example, opposition. In a typical situation, a parent's request is met with an inappropriate 'no' response (from the ACG), before other, more logical parts of the brain can suggest logic as to why 'yes' is better. (Wehrenberg & Prinz, 2007). When danger becomes associated with a previously learned experience, the opposition response from the malfunctioning ACG can be coupled with the physiological response of fight or flight, and can

then be manifest in behavioral outbursts, emotional meltdowns, or panic attacks.

Understanding that anxiety is a neurological process which transforms into physical, emotional, and behavioral manifestations, can help to remove the guilt and shame associated with the disorder, both for parents and for children (Wehrenberg & Prinz, 2007; Cohen, Mannarino, & Deblinger, 2006; Goodyear-Brown in Schaffer, 2009). Developing control over the response to external stimuli is key and thus becomes the focus of treatment and management of anxiety.

Many research studies have determined that Cognitive Behavioral Therapy (CBT) is the most efficacious treatment for anxiety across the lifespan (Chu & Harrison, 2007; Wehrenberg & Prinz, 2007). In keeping with evidence-based best practices, many play therapists have incorporated cognitive-behavioral techniques into play therapy (CBPT) using a prescriptive, directive-techniques approach (Goodyear-Brown in Shaffer 2009; Knell & Dasari, 2006). In CB Play Therapy (CBPT), as in CBT, the protocol is the same: 1) psychoeducation; 2) training how to manage the physical response of anxiety; 3) change thoughts and beliefs; 4) graduated exposure to feared situations; 5) relapse prevention. However, in CBPT, children engage in playful activities that instruct, train the brain, expose the child to fearful events, and develop mastery over the intrusive

thoughts. Parental involvement is an integral part of CBPT, both for preschool and older children, as parents are called upon as co-therapists, to engage the children in playful exercises in the home to reinforce the work done in the playroom. Educating the parents that anxiety is a neurological problem, not one of opposition, and not one that children generally can 'grow out of,' helps them to be more patient, soothing, and assist the children to manage their fearful responses (Goodyear-Brown in Shaffer, 2009).

Paris Goodyear-Brown (2009), in conjunction with others through a grant from Vanderbilt University, has developed a companion methodology to CBPT for treatment of anxiety in young children, utilizing parents as "co-regulators" (Goodyear-Brown, 2009, pg 110) of the physiological arousal in their child. The process follows the acronym SOOTHE: **S**oft tone of voice; **o**rganization; **o**ffering reduced choices or solutions; **t**ouching or connecting physically with the child when stressed; **h**earing the child's message through their non-verbal and verbal expressions; and what Goodyear-Brown refers to as "end and let go" (p. 115). That is, complete de-escalation of the child's emotions before returning to regular activity and assuring that the parent is able to emotionally regroup themselves after their child's reaction.

One important aspect of CBPT is the concept of a transitional object. Because reinforcement of the change in the brain is critical to success of the treatment process, a tangible object that reminds the child of the therapy is often created

or presented, and sent home with the child, encouraging parents to interact with it in ways that imitate the process outlined in session. Examples of transition objects are detailed below.

CBPT involves playful activities to accomplish each of the steps of treatment. In the psycho-education phase, several activities can be employed to help children become aware of their brain's response to perceived dangers in their environment. One such example for preschool children is a game utilizing 'seek and find.' Goodyear-Brown calls the game "Worry Worms": the therapist hides rubber (or gummy) worms around the playroom, and encourages the child to find them; when one is found, the child will share something they worry about. The therapist and parent help the child to find similarities and generalizations from these reports and create a 'worry book' writing down the child's list of worries. The worry book becomes the transitional object, with parents encouraged to add to the book as new worries arise. Using gummy worms in this game makes the finding also a possible treat. In the worry book, each worry is given a 'value' using the Fearful Thermometer (see below) which helps the parent and therapist to understand how significant the experience is to the child.

Another method employed by Knell & Dasari (2006) incorporates puppets into the process, having the therapist model identifying specific worries, triggers, and

obsessive, intrusive thoughts and beliefs through the puppet, encouraging the parent and child to join in. To reinforce the therapy, the child can construct a puppet out of a sock with craft paint, or small lunch sack and construction paper, to create a transitional object to be used for homework in the home.

Another very useful technique from March & Benton (2007) is the Fearful Thermometer, to help children, therapists and parents visualize just how fearful they are of a specific event. It is a simple technique: the therapist creates a handout in advance with a thermometer drawn on a piece of paper, and three gradations – low, medium, and high. For young children, an animal picture can assist in this process, i.e. a mouse, a horse, and an elephant, to identify the intensity of their fear. The child then colors the thermometer (or the animal representing the level) up to the level of their fear. This process can also be used as a before and after measure for a calming technique, for example, helping the child understand that low or small is the desired effect, and the pictures can be transitional objects.

Several play techniques can be adapted to teach children physical calming. Goodyear-Brown recommends using a pinwheel to teach deep breathing, useful in both daily calming and for coping with nightmares. Also, teaching a child to blow big bubbles with slow, gentle and controlled breathing, can be

practiced in the home by sending a bottle of bubbles as the transitional object. Another fun way to help school-aged children to focus their breathing, is to use bubble gum (if the child has learned to blow gum bubbles) and to slow themselves down to blow the bubble as big as possible without popping. These activities not only help with deep breathing and thus relaxation, but also slow the respiration rate and provide a visual focus point for the child, with mastery and positive reinforcement. Parents are encouraged to join in the process and to enhance confidence in the child's abilities.

Once several coping ideas are introduced and explored, another intervention "A coping menu," developed by Janine Shelby (Goodyear-Brown, Riviere, & Shelby, 2004) helps the child to put the strategies together to better cope with anxiety. In this activity, the child is introduced to the concept of a menu in a restaurant, helping to make choices between foods. In creating a "Coping Menu" the child lists their soothing strategies in a fun and visual manner. A 'menu' is created out of construction paper, with a digital photo of the child, or a catchy name (i.e. Café Joey) on the cover, then choosing pictures or drawing illustrations of their choices for each sensory item inside. The therapist and parent help the child to think of something they enjoy for each of the senses – a soft blanket for tactile, the smell of cookies for olfactory, a favorite song for

auditory, a favorite food for taste, etc. These are added to their menu with an illustration; the menu is sent home for use as the transitional object.

A variation on the "Coping Menu" is for the child to list all of their coping strategies – relaxation, deep breathing, walk away, talk it out, etc. – that have been learned and practiced, as a reinforcement of therapeutic work and recapping of previous sessions. Each strategy is illustrated by the child and the menu is sent home as usual.

Children often feel powerless toward their anxiety and anxious responses, and the teaching of cognitive restructuring can be difficult with children. One activity to employ in CBPT is Goodyear-Brown's intervention "Boss-back the Fear". In this activity, the child chooses a toy/puppet to represent their fear or anxiety; the therapist then has the child pretend not to notice as the 'fear' approaches them quietly. The child is then encouraged to 'boss' the fear – that is, use cognitive restructuring statements such as "I am stronger than my fear" or "I am strong and brave" and shout them at the chosen object. Including the parents to encourage the children, reinforces the experience. The child then can create a transitional object out of playdoh, clay, construction paper, or drawing that represents the fear. A brief, digital video of the child bossing their

fear could be made by the parent during the process and replayed for the child at home, to reinforce the power the child has over anxiety.

CBPT techniques assist in the gradual exposure to the anxiety producing event or situation of the child. Toys in the playroom, role play or puppet play, can be utilized to create an in vivo experience for the child in a non-threatening, playful manner. Serial drawings that depict the fearful experience and the child's mastery over the fear, coupled with the cognitive restructuring statements, have been another process that aids the therapist and the child in treatment.

Techniques that include a ladder or steps, with the child and parent deciding what each step in the exposure process will be and putting it on that step, and then devising a celebration or reward for achieving that step, are consistent with CBT programs (March & Benton, 2007; Goodyear Brown, 2009; Knell & Dasari, 2006; Cohen, Mannarino & Deblinger, 2006; March & Benton, 2007). Involving parents actively also enhances the process of relapse prevention.

In conclusion, anxiety is one of the most widely diagnosed mental conditions in children and adolescents. Approximately 12-20% of presenting problems by parents constitutes some form of anxiety, phobia, or trauma reaction with anxious response. The physical manifestations and avoidant behavior can

create disruption of the family system, and can impede the child's development, academic performance and social interaction.

Understanding anxiety as a neurologically-based phenomenon in children rather than a behavioral choice, is an imperative thinking-shift for parents and therapists. Educating parents and families about the source of anxiety, how it is produced in the brain and the physiological responses of the body, gives them an alternative way of viewing and empathizing with their child's symptomatic behavior. Therapy becomes a process of teaching and understanding that it is a fear of the internal experience – avoidance of the physiological response – that is the source of the symptoms children manifest. When children learn that they have power over their thoughts and their reactions, and parents develop their role of empathic witness, co-regulator, and encourager rather than providing advice, discipline or direction, the result is effective management and self confidence. Through CBPT children learn to manage their anxious emotions in enjoyable and developmentally appropriate ways. Engaging the child at their cognitive level through play, enhances their experience of mastery and assures the success of the therapy. Parents and children come to therapy seeking relief from the disruption that anxiety causes. CBPT can provide the relief they seek by giving children an awareness of their inner experience and coping strategies to manage those feelings. It improves self-confidence by

instilling an approach to managing the anxious feelings that can be employed over the lifespan.

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