Tutorial: Anxiety and Anxiety Management

WHAT IS ANXIETY?

Anxiety is the most common mental health issue for persons of all ages. Although everyone experiences anxiety from time to time, anxiety becomes a problem when these feelings begin to interfere with day-to-day functioning. Anxious feelings include both physical responses, such as increased heart rate and blood pressure, trembling, and sweating, and a variety of emotional responses to either a feared or actual threat. Anxiety disorders can be short term or long lasting. Young children may express symptoms of anxiety indirectly as physical complaints, such as headaches and stomach aches, over-activity, acting out, separation difficulties, or sleep difficulties. Older children and adolescents are better able to describe their anxiety, but more likely than adults to display disruptive behaviors as a part of their anxiety disturbance.

Anxiety manifests itself in many different ways with differing psychiatric labels given to differing cluster of symptoms:

Generalized anxiety disorders (GAD) are the most common anxiety disorders. A person with GAD experiences constant worry and anxiety that is out of proportion to the level of an actual (or perceived) stress or threat. The anxiety occurs most days, lasts for more than six months, and is usually accompanied by complaints of fatigue, difficulty concentrating, irritability, and sleep problems. Persons with GAD often feel unsure of themselves, tend to be overly perfectionist and rule bound, and may experience bouts of depression between episodes of anxiety. **(See Tutorial on Depression)**

Obsessive compulsive disorders (OCD) are common and long lasting anxiety disorders. Individuals with OCD experience repeated, persistent thoughts, images, or impulses that are unavoidable and very distressing; often these thoughts or impulses are accompanied by repetitive or ritualistic behaviors, called compulsions, which are performed in an attempt to control the fears. OCD behaviors interfere with daily functioning and consume considerable amounts of time each day. Frequently OCD is not identified since persons are often embarrassed by these symptoms and hide them from others. In children, OCD behaviors can be mistaken for behavior problems, for example, taking too long to do homework because of perfectionism, or refusing to perform a chore because of fear of germs.

Panic disorders (PD) include periods of intense, but short-lived attacks of extreme anxiety accompanied by intense physical discomfort (e.g., rapid heart beating, sweating, shakiness, shortness of breath). These "attacks" may occur spontaneously or only in response to a particular situation. Recalling or re-experiencing even harmless circumstances surrounding an original attack may trigger subsequent panic attacks. Adolescents are at increased risk of developing PD.

Phobias involve overwhelming and irrational fears that cause a person to avoid specific situations whenever possible. In some cases, the anxiety related to the feared object or situation can be incapacitating. Phobias are categorized by the type of situation that causes the problem: for example, a paralyzing terror of being in places or situations from which the person feels there is neither escape nor accessible help is called agoraphobia; a fear of being publicly scrutinized and humiliated is called a social phobia; an irrational fear of a specific object or situation is called a specific phobia.

Post-traumatic stress disorders (PTSD) are chronic anxiety reactions to a violent or traumatic event that is usually outside the "norm" of human experience. Such events can include experiencing or even witnessing sexual assaults, accidents, combat, natural disasters (such as earthquakes), a near death experience, or an unexpected death of a loved one. Symptoms of PTSD can occur months or even years after the traumatic event and can include emotional withdrawal, avoidance of reminders of the trauma that interferes with personal and work activities, feelings of hopelessness, self-destructive behavior, personality

changes, mood swings, difficulty with sleep, and guilt over surviving the event. In children, engaging in play in which traumatic events are repetitively enacted is common.

Separation anxiety disorders are the most common anxiety disorders in young children. Symptoms include extreme distress from either anticipating or actually being away from home or separated from a parent or other loved one, extreme worry about losing or about possible harm befalling a loved one, intense worry about getting lost, being kidnapped, or otherwise separated from loved ones, and/or refusal to go to school or to sleep away from home. When faced with separation from loved ones, a child may also experience increased physical symptoms such as headache, stomach ache, or vomiting.

WHY IS ANXIETY AND ITS MANAGEMENT IMPORTANT FOR MANY STUDENTS AFTER TBI?

Both children and their families experience a wide range of emotional reactions, including significant anxiety, during the initial few months after onset of a brain injury. Initially there is anxiety about whether a child will survive the injury. Early recovery of physical abilities often inspires hope that the child will be able to return to normal day-to-day activities in the near future. For many students and their families, there is a gradual realization that some changes in thinking and behavior may persist. These changes can result in increased anxiety in both the child and her parent.

Anxiety symptoms can also intensify once a child is back home and attempts to return to school. The older the child at time of brain injury, the more aware and more self-critical she may be of these brain injury related losses. Self-critical statements fuel anxiety. At the same time, the student may begin experiencing academic difficulties, losing friendships, and becoming more isolated, all situations that will increase anxiety reactions. Thus, students with brain injury are at increased risk of an anxiety disorder. Unless treated, the anxiety symptoms can worsen, creating further functional decline for the student, which in turn will lead to depression. **(See Tutorial on Depression)**

Research has shown that younger children are more apt to experience GAD, specific phobias, or separation anxiety disorders after brain injury. Children who experienced brain injury as a result of a "near death" experience (e.g., a car accident) and those who are anxious during hospitalization are at increased risk of developing a PTSD after hospital discharge. OCD behaviors after brain injury (e.g., making extensive lists) are more likely to occur in adolescents who attempt to compensate for new onset thinking difficulties with OCD behaviors. Students with a prior history of anxiety symptoms are at greater risk of developing an anxiety disorder post injury. Finally, anxiety disorders after brain injury are in part due to specific damage to part of the brain that modulates emotional responses – the bottom sides of the prefrontal parts of the brain Thus, there is a neurological basis for development of anxiety disorders post injury as well.

WHAT ARE THE CLINICAL SUPPORTS AND INTERVENTIONS NEEDED FOR STUDENTS WITH BRAIN INJURY WHO ARE ANXIOUS?

Supports for students to address and limit anxiety symptoms include timely identification of the problem, accurate diagnosis, implementation of mental health services, medications if warranted, and support from both school personnel and family members.

1. Identification of the student's anxiety: The initial step in dealing with anxiety is to recognize that the child is anxious. The first step in identifying an anxiety disorder is to ensure that it is truly anxiety that is the problem. Parents and school staff are keen observers of a child's behaviors and often the "front line" identifiers of the child's anxiety symptoms. Consultation with parents, the school psychologist, and teachers may be helpful to determine if the student presents as anxious in all or only select settings. For example, a young child may be presenting with separation anxiety only at home but is quite calm during the school day;

an adolescent may be nervous and avoiding specific activities involving friends at school but not at home. These behaviors would suggest situation-specific anxiety issues rather than a sign of an anxiety disorder.

2. Timely assessment of the student's anxiety: Referral to a physician or other mental health professional to assess the severity and scope of the child's anxiety is the next step in obtaining needed treatment. In younger children, the diagnosis of an anxiety disorder is more difficult, because younger children may lack words to describe their thoughts and feelings. Clinicians often must rely on parents, teachers, and other professionals to assess possible physical manifestations of anxiety (e.g., headaches, stomach aches) as well as behavioral change in younger students.

3. Starting needed medications or therapy: Management of anxiety disorders depends on the severity and symptoms presented by each student. Interventions typically are supportive in nature with anxiety medications added if symptoms are significantly affecting the student's day-to-day activities.

Psychological intervention or "talk therapy" is typically the first approach to anxiety management. In older children, therapy can be done individually, with family members, or in structured group settings. Most psychotherapy approaches use a cognitive behavioral therapy (CBT) model in which a child is taught how to alter faulty (or negative) self-thoughts that are maintaining anxiety. Stress management, biofeedback, hypnosis, relaxation training, desensitization, and exposure treatments are alternative approaches. In younger children, play therapy may be utilized in lieu of talk therapy.

Anxiety medications are likely to be used when the student's anxiety is interfering with day-to-day activities. Typically, antidepressants (usually a serotonin reuptake inhibitor (SSRI), or anti-anxiety medications are prescribed. Family and school staff need to ensure that the student complies with prescribed medications, as well as monitor the benefits of the prescribed medications in helping the student control anxiety on a day-to-day basis.

4. Helping students manage their own anxiety: There are many ways that teachers and parents can help the student manage and/or minimize anxiety:

Limit comparisons of before and after injury: A student with brain injury has potentially experienced "real" losses in thinking, physical abilities, and emotional/behavioral abilities. The older the child at the time of onset of injury, the more aware she is of potential differences before and after the injury. These discrepancies often fuel the student's anxiety. Parents and teachers can contribute to the student's self-esteem by helping her minimize negative comparisons which serve to increase anxiety. For example, the student might become anxious before an examination and say "I was really good at spelling before, but now I will probably fail this test"; the parent/teacher could reframe the same statement to a less critical response such as "You didn't do a bad job on the spelling test yesterday and your average is higher than it was last week, so there are clear signs that your spelling abilities are getting stronger."

Limit situations that trigger anxiety: Teachers and parents should be aware of situations, people, or events (triggers) that typically provoke anxiety reactions (e.g., perceived rejection by others, withdrawal of friends, over-crowded rooms). For example, if a student gets anxious in over-crowded environments, moving her gym activities to a smaller room with fewer students would help decrease her anxiety and allow her to participate more fully in the gym activity. Whenever possible, attempts should be made to remove triggers proactively from the student's daily routines. As the student becomes aware of what these "triggers" are, she should be empowered to remove herself from these events.

Help the student re-interpret social cues: Students with brain injury often have decreased ability to correctly "read" social situations and the intent of others' behavior. When social cues are misread – for example, a student misperceives someone making an insulting remark when none was intended – the student will feel rejected or demeaned. This reaction is magnified by the anxious student and serves to reinforce her sense of social failure. Parents and teachers can help the student reframe a misinterpreted social interaction and

offer ways for the student to rethink the situation in a less critical fashion. This reframing will help to limit the negative emotional response by the student. **[See Tutorial on Social Perception]**

Ensure that strategies are in place to enhance a student's self-esteem and self-concept. Anxious students develop a reduced sense of self, which includes a strong sense of failure and futility. The student tends to think of self in negative terms of "failure", "helpless" or "hopeless". For these students, it is essential that they be provided ample opportunities to be successful and contribute to helping others, thus rebuilding optimism about their own abilities, enhancing their self-esteem, and minimizing their "learned helplessness". Anxiety can further reduce a student's already taxed cognitive abilities after brain injury. Teachers should ensure that the student is given academic tasks within her current abilities to ensure feelings of mastery, minimize anxiety symptoms, and slowly rebuild self-esteem. **[See Tutorials on Instructional Routines; Apprenticeship Teaching; Sense of Self]**

Help the student learn to "reframe" critical self-statements: Overly critical and negative self-statements make an anxious student more anxious. The student typically internalizes and believes these self-statements, thus maintaining her anxiety. Similarly, the student frequently "catastrophizes", that is makes small concerns into major problems without realizing that she is doing this. Alternatively, the student may use extreme terminology when describing her situation, "I never get a chance to answer questions in class" "She always makes fun of me" "I never do anything right" and so on. In such situations, adults can model "reframing" of negative self-statements into a less critical response. For example, a less critical reframe might be, "While you often stay silent and let others answer questions, when you volunteer a response, it usually turns out ok". With modeling, the student can learn to reframe critical self-statements into less critical and more positive messages to self.

Help the student learn to identify anxious feelings: Young children and older students with significant brain injury may experience physical symptoms of anxiety without knowing what the emotions underlying these symptoms are. These feelings are simply nameless feelings that lead to negative and regressive behaviors. These students need help in identifying anxiety feelings, giving these feelings a name, and understanding that these symptoms can be addressed in order to gain control of their anxiety. For example, when a young child suddenly withdraws from an activity, the teacher may ask her to think about what she is feeling inside (bodily symptom) that made her remove herself from the activity. Often providing suggestions of possible reasons (e.g., tightness in your stomach, fear or sense of something bad happening) will help the child associate words with the feeling.

Help the student to "self-motivate": Anxious students often over-react to challenging situations, minor annoyances, or unexpected changes in their daily routines with increased anxiety and self-doubt, and as a result, often refuse to engage in the task or activity. Their refusal only fuels their feeling of failure and leads to further isolation. In such situations, it is helpful to provide the student with a "self-talk script", for example a series of questions that the student can ask herself in order to evaluate the relative merit and limitations of a task or activity, thus encouraging her to think more flexibly about the specific task and her actual abilities. For example, the student can ask "Is this really a big deal or a little deal to do the activity?" or "If I start this task, will there be any benefit to me?" or "What will be the down side of not doing this activity?" These self-regulation scripts can be practiced by the student across a variety of tasks, allowing her to gradually internalize the self-talk script, thus minimizing rejection, failure and isolation. **[See Tutorial on Self-Regulation Scripts]**

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