Child Planning: A Treatment Planning Overview for Children with Anxiety Disorders

A Treatment Overview for Children with Anxiety Disorder

Duration: 3 hours

Learning Objectives:

Obtain a basic understanding of how to identifying, causes, symptoms of children with lying problems or history, and learn different options to complete a treatment plan that includes:

a. Behavioral Definitions
b. Long Term Goals
c. Short Term Goals
d. Strategies to Achieve Goals
e. DSM V diagnosis Recommendations

***For a full list of 18 short term goals with dozens strategies listed next to each goal check the Child Treatment App for Windows or Apple PC and Android Devices, under our main menu Windows-Apple Apps. Download the Free Demo to Evaluate***

Course Syllabus:
Introduction

Symptoms

Probable Causes and Symptoms

Diagnosis and Treatment

Steps to Develop a Treatment Plan that includes Behavioral Descriptors, Long Term Goals, Short Term Goals, Interventions/Strategies and DSM V CODE Paired with ICD_9 and 10-CM Codes for ODD

Sample Treatment Plan

Introduction:

Many children experience an occasional bout of shyness, anxiety when left alone, or a stomach ache the first day of school or camp. These are normal and common anxiety reactions that typically lessen as the child matures. However, if a child or adolescent experiences persistent and excessive anxiety that interferes with their academic, behavioral, emotional and social development, they may have an anxiety disorder. It is important for both parents and teachers to be aware of the signs and symptoms of childhood anxiety disorders, which are serious, yet treatable conditions. With the school year recently underway, the symptoms of certain anxiety disorders, such as separation anxiety disorder and social anxiety disorder (also called social phobia), might become more apparent. Read on to learn more about recognizing and treating anxiety and related disorders in children.

What are the main types of anxiety disorders and associated features in children?

Separation Anxiety Disorder - Many children experience separation anxiety between 18 months and three years of age. At this time, it is normal for children to feel anxious or upset when a parent is out of sight, leaves the room or drops them off at daycare for the first time. Children can generally be distracted from these feelings and often will not feel distressed once they become engaged in their surroundings. Typically, children are able to leave their parents without becoming upset around four years of age. If a child is still distressed at this age without his or her parents, the child might have separation anxiety disorder. This disorder affects approximately 4 percent of children and occurs when a child experiences extreme anxiety when removed from familiar people or surroundings. For example, children with separation anxiety disorder often have difficulty leaving their parents to attend school. In this case, the desire to be in contact with the missed person(s) is excessive. While separated, it is not uncommon for these children to have fears regarding the health and safety of their parents. The onset of separation anxiety disorder can occur any time, but it is most common in children between the ages of seven and nine.

Causes and Symptoms:
Signs of separation anxiety disorder in children may include:

Avoidance of going places alone.

Refusal to attend school or camp.

Reluctance or refusal to participate in sleepovers and other social activities.

Following a parent around.

Demands that someone stay with them at bedtime or "appearing" in their parent's bedroom at night.

Sleep disturbances from nightmares about being separated from loved ones.

If left untreated, anxiety disorders can lead to academic, behavioral, emotional and social problems that may include:

Poor school performance.

Repeated school absences or an inability to finish school.

Impaired relations with peers, siblings or others.

Low self-esteem.
Social Anxiety Disorder - Social anxiety disorder (social phobia) is characterized by an intense fear of social and performance situations. Initiating conversations, participating in peer activities, performing in front of others, speaking in class and inviting others to social activities are some of the most commonly feared situations for children with social anxiety disorder. Children with social anxiety are not just shy. When faced with their feared situation(s), children with the disorder might suffer from symptoms such as sweating, racing heart, stomach ache, dizziness and crying. They may avoid situations where they may have to engage in such activities, which can significantly interfere with their lives. School performance and attendance, as well as the child's ability to socialize with peers and develop relationships, can all be impaired as a result. While social anxiety disorder can develop at any time, onset usually occurs during adolescence, when independently establishing and managing relationships plays a key part in healthy development.

Signs of social anxiety disorder in children may include:

- Hesitance, passivity and discomfort when in the spotlight, including reading aloud or being called on in class.

- Avoidance or refusal to initiate conversations, perform in front of others, invite friends to get together, call others on the telephone for information or order food in restaurants.

- Avoidance of eye contact and soft speaking voice/mumbling.

- Minimal interaction and conversation with peers, including sitting alone in the library or cafeteria.

- Extreme concern about negative evaluation, humiliation or embarrassment.

Selective Mutism - Many children become shy when faced with strangers or when speaking in front of a large group. However, children who refuse to speak in situations where speech
is expected or necessary, to the extent that this refusal interferes with school and making friends, might be suffering from selective mutism. The onset of selective mutism, a condition that can in some cases represent a severe form of social anxiety disorder, is usually before the age of five, but it often becomes most noticeable when children enter school. Although diagnosis generally occurs between ages four and eight, children with selective mutism often exhibit "extreme shyness" at an earlier age. In sharp contrast to their school/outside behavior, children with selective mutism can be talkative and even boisterous when at home or in a place where they feel comfortable.

Children with selective mutism may:

Stand motionless and expressionless, turn their heads, chew or twirl hair or withdraw into a corner when expected to speak.

Become anxious before entering an uncomfortable situation, causing physical symptoms such as stomach aches, headaches and other physical ailments.

Display additional signs of severe anxiety such as separation anxiety, frequent tantrums and crying, moodiness, sleep problems and extreme shyness.

School Refusal/Avoidance. School refusal or avoidance is not an anxiety disorder. However, anxiety in children with conditions such as separation anxiety disorder or social anxiety disorder can manifest as a refusal to attend school. Because this is particularly distressing for families, issues of school refusal warrant careful scrutiny. It is common for children to suffer from "school jitters," particularly on the first day of school or before a test or presentation. However, school refusal is diagnosed when a child refuses to go to school on a regular basis or has problem staying in school once there.

It is usually marked by certain fears related to school such as being separated from caregivers, riding the bus, interacting with classmates or teachers or being picked on by peers or older students. School refusal is often a symptom of a deeper problem and, if not treated, can have a negative impact on socialization skills, self-confidence, coping skills and education. Anxiety-based school refusal affects 2 to 5 percent of school-aged children. It is most often found in children between the ages of five and six and ten and 11. School refusal is common during times of transition, such as graduating from elementary to middle school and middle to high school. It is important for parents to keep a child with school refusal or avoidance in school, as allowing him or her to miss days reinforces the anxiety instead of
Signs of school refusal/avoidance in children include:

Physical symptoms such as headaches, stomach aches, nausea and diarrhea.

Tantrums.

Inflexibility.

Avoidance of school and school-related activities.

Defiance.

Extreme preoccupation with appearance, sleeplessness or rebellion (older children/adolescents).

Also check for:

A specific fear that has become generalized

A specific fear that interferes with daily life

Excessive anxiety
Worry due to parents' threat of abandonment

Excessive anxiety or worry due to poor family dynamics

Friction between parents

Poor physical activity

Excessive anxiety or racing thoughts

Excessive worry, or fear that markedly exceeds normal expectations

High level of motor tension

Restlessness or racing thoughts

Tiredness

Shakiness

Muscle tension

Trouble falling or staying asleep

General state of irritability
Autonomic hyperactivity such as rapid heartbeat—shortness of breath

Dizziness or dry mouth—nausea or diarrhea

Hyper-vigilance such as feeling constantly on edge

Concentration difficulties

Diagnosis and Treatment:

Can children also have any of the anxiety disorders that adults may suffer from, such as obsessive-compulsive disorder or generalized anxiety disorder? Like adults, children can also suffer from all the major recognized anxiety disorders, including generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), panic disorder, posttraumatic stress disorder (PTSD) and specific phobias (as well as social anxiety disorder, already described above). A brief description of each disorder and how they may manifest in children is included below:

GAD in children is characterized by excessive worry or apprehension about everyday events in multiple settings (school, home, social events, extracurricular activities, etc.). Sources of worry may include grades, athletic performance, punctuality and health concerns. Children with GAD tend to be very hard on themselves, striving for perfection and sometimes redoing tasks repeatedly in an effort to do them "perfectly." These children may also seek constant approval or reassurance from others. OCD is characterized by unwanted and intrusive thoughts that people can't seem to get out of their heads (obsessions) and strong urges to repeatedly perform ritualistic behaviors and routines (compulsions) to try and ease their anxiety.

While many forms of anxiety can lead to intrusive thoughts or actions, the thoughts and actions in OCD are very stereotyped in nature. For example, a child might have a stereotyped thought that "I am dirty" and this might lead to a stereotyped pattern of hand washing. These obsessions and compulsions take up a great deal of time and can cause significant distress. Some children and adolescents with OCD spend hours performing complicated rituals involving hand-washing, counting or checking in order to ward off persistent, unwelcome thoughts, feelings or images. Others live in terror that they will accidentally do something wrong, such as harm someone or throw something out by mistake. The peak age for
diagnosis is ten years old, although OCD can affect children as young as two or three. Panic Disorder in children is diagnosed when they suffer at least two unexpected panic attacks (the abrupt onset of an episode of intense fear or discomfort that might include trembling, heart palpitations, shortness of breath, dizziness and/or feeling the need to escape), followed by at least one month of concern over having another attack, losing control or "going crazy."

Panic disorder is not common in young children, but can begin in adolescence. PTSD can occur in children who are exposed to an extreme stressor such as a natural disaster, the sudden death of a parent or other loved one, an accident or physical assault, or witnessing of a traumatic event. Symptoms of PTSD may include not sleeping or eating; excessive clinging; re-experiencing the event through nightmares, recollections or play; emotional numbing; or persistent fears about the event happening again. While many children will experience these symptoms following a traumatic event, they will pass within a few weeks.

Children with PTSD, however, will continue to experience such symptoms weeks or months later, interfering with their home, school and social functioning. Some children with PTSD may have a delayed onset of symptoms, which can occur several weeks or even months after the trauma. Specific Phobias are intense, irrational fears of specific objects, places or situations. Common childhood phobias include animals, heights, storms, water, blood, medical procedures and "the dark." These fears often go away on their own. If a child’s fear persists for at least six months and interferes with his or her daily life, the child may have a phobia. Children with a phobia may throw a tantrum, freeze, cling, cry or suffer stomach aches/headaches when confronted with their fear. Unlike adults with phobias, children do not usually recognize that their fear is irrational. At what age do anxiety disorders develop in children?

While children of almost any age can suffer from anxiety, certain disorders are more common during specific stages of development. Separation anxiety disorders and specific phobias tend to occur between the ages of 6 to 9. Generalized anxiety disorder (GAD) and social anxiety disorder generally occur during middle childhood and adolescence. Panic disorder sometimes begins in adolescence. How are anxiety disorders in children different than in adults?

While children often experience the symptoms of anxiety disorders in ways similar to adults, children might display and react to symptoms differently (i.e., crying, tantrums, clinging). They also may not understand that their anxiety is irrational, as most adults with anxiety disorders recognize, and may not be able to verbalize their feelings. This makes it important for parents and other adults to pay close attention to a child’s symptoms. What affect can an anxiety disorder have on a child?

What treatment options are available for children? Therapy, medication or a combination of
both are treatment options for children with anxiety disorders. Specific options include the following:

Cognitive-Behavioral Therapy (CBT) teaches young people skills and techniques to reduce their anxiety. Children learn to replace negative thinking patterns and behaviors with positive ones. Group Psychotherapy provides a child a safe place to talk with other children to practice social and symptom-controlling skills in a structured setting. School-Based Counseling can help children with anxiety deal with the special demands of a school setting.

Medications including a class of antidepressants known as selective serotonin reuptake inhibitors (SSRIs) are sometimes used for treating children with anxiety disorders. SSRIs include fluoxetine (Prozac), sertraline (Zoloft), paroxetine (Paxil), fluvoxamine (Luvox), citalopram (Celexa), and escitalopram (Lexapro). Tricyclic antidepressants (e.g. imipramine) and benzodiazepines (e.g. lorazepam) are less commonly used in the treatment of childhood anxiety disorders. Any medication must be prescribed and followed by a psychiatrist or medical physician.

Relaxation Training/Techniques can teach a child how to reduce their worries and alleviate the physical symptoms associated with many anxiety disorders. These can include deep breathing, counting to 10 or visualizing a calming place.

Steps to Develop a Treatment Plan:

The foundation of a good treatment plan is based on the gathering of the correct data. This involves following logical steps the built-in each other to help give a correct picture of the problem presented by the client or patient:

The mental health clinician must be able to listen, to understand what are the struggles the client faces. This may include:

issues with family of origin,

current stressors,
present and past emotional status,
present and past social networks,
present and past coping skills,
present and past physical health,
self-esteem,
interpersonal conflicts
financial issues

cultural issues

There are different sources of data that may be obtained from a:

clinical interview,
Gathering of social history,
physical exam,
psychological testing,
contact with client’s or patient’s significant others at home, school, or work

The integration of all this data is very critical for the clinician’s effect in treatment. It is important to understand the client’s or patient’s present awareness and the basis of the client’s struggle, to assure that the treatment plan reflects the present status and needs of the client or patient.

There 5 basic steps to follow that help assure the development of an effective treatment plan based on the collection of assessment data.

Step 1, Problem Selection and Definition:

Even though the client may present different issues during the assessment process is up to the clinician to discern the most significant problems on which to focus during treatment. The primary concern or problem will surface and secondary problems will be evident as the
treatment process continues. The clinician may must be able to plan accordingly and set some secondary problems aside, as not urgent enough to require treatment at this time. It is important to remember that an effective treatment plan can only deal with one or a few problems at a time. Focusing in too many problems can lead to the lost of direction and focus in the treatment.

It is important to be clear with the client or patient and include the client’s or patient’s own prioritization of the problems presented. The client’s or patient’s cooperation and motivation to participate in the treatment process is critical. Not aligning the client to participate may exclude some of the client’s or patient’s needs needing immediate attention.

Every individual is unique in how he or she presents behaviorally as to how the problem affects their daily functioning. Any problems selected for treatment will require a clear definition how the problem affects the client or patient.

It is important to identify the symptom patterns as presented by the DSM-5 or Diagnostic and Statistical Manual or the International Classification of Diseases (ICD).

ANXIETY BEHAVIORAL DESCRIPTOR:

1. A specific fear that has become generalized to and interferes with daily life.

2. Excessive anxiety or worry due to parents’ threat of abandonment or poor family dynamics.

3. Friction between parents.

4. Poor physical activity.

5. Excessive anxiety, worry, or fear that markedly exceeds normal expectations.

6. High level of motor tension (such as, restlessness, tiredness, shakiness, muscle tension).

7. Trouble falling or staying asleep.

8. General state of irritability

9. Autonomic hyperactivity (such as, rapid heartbeat, shortness of breath, dizziness, dry mouth, nausea, diarrhea).

10. Hyper-vigilance (such as, feeling constantly on edge, concentration difficulties).

Step 2, Long Term Goal Development:
This step requires that the treatment plan includes at least one broad goal that targets the problem and the resolution the problem. These long term goals must be stated in non-measurable terms but instead indicate a desired positive outcome at the end of treatment.

**LONG TERM GOALS FOR ANXIETY DISORDER IN CHILDREN:**

1. Diminish the frequency of the anxiety response to improve daily functioning.
2. Diminish the intensity of the anxiety response to improve daily functioning.
3. Stabilize the level of anxiety.
4. Increase the ability to function on a daily basis.
5. Identify and solve any issues that may be producing anxiety.
6. Identify and solve any issues that may be producing fear.
7. Increase interactions with others without excessive fear.
8. Increase interactions with others without excessive worry.
9. Increase interactions with others without excessive anxiety.

**Step 3, Objective or Short Term Goal Construction:**

Objectives or short term goals must be stated in measurable terms or language. They must clearly specify when the client or patient can achieve the established objectives. The use of subjective or vague objectives or short term goals is not acceptable. Most or all insurance companies or mental health clinics require measurables objectives or short term goals.

It is important to include the patient’s or client’s input to which objectives are most appropriate for the target problems. Short term goals or objectives must be defined as a number of steps that when completed will help achieve the long-term goal previously stated in none measurable terms. There should be at least two or three objectives or short-term goals for each target problem. This helps assure that the treatment plan remains dynamic and adaptable. It is important to include Target dates. A Target day must be listed for each objective or short-term goal.

If needed, new objectives or short-term goals may be added or modified as treatment
progresses. Any changes or modifications must include the client’s or patient’s input. When all the necessary steps required to accomplish the short-term goals or objectives are achieved the client or patient should be able to resolve the target problem or problems.

If required all short term goals or objectives can be easily modify to show evidence based treatment objectives. The goal of evidence based treatment objectives (EBT) is to encourage the use of safe and effective treatments likely to achieve results and lessen the use of unproven, potentially unsafe treatments. To use EBT in treatment planning state restate short term goals in a way that steps to complete that goal and achieve results. For example, the short term goal “Increase positive self-descriptive statements.” Can be restated as; “By the end of the session the patient or client will list at least 5 positive self descriptions of himself or herself, and assess how they can help alleviate the presenting problem.” Remember, that it must be stated in a way one can measure effectiveness.

It is important to note that traditional therapies usually rely more heavily on the relationship between therapist and patient and less on scientific evidence of proven practices.

**EXAMPLES OF SHORT TERM GOALS FOR ANXIETY DISORDER IN CHILDREN:**

1. Teach and implement appropriate relaxation and cognitive diversion activities to lower the level of anxiety.
2. Identify and list any areas of conflict that underlie the anxiety behavior.
3. Teach positive self-talk to diminish or eliminate anxious behavior.
4. Allow minor to share anxious thoughts and feelings.
5. Identify and list any specific past and present family conflicts.

**Step 4, Strategies or Interventions:**

Strategies or interventions are the steps required to help complete the short-term goals and long-term goals. Every short term goal should have at least one strategy. In case, short term goals are not met, new short term goals should be implemented with new strategies or interventions. Interventions should be planned taking into account the client’s needs and presenting problem.
EXAMPLES OF INTERVENTIONS FOR ANXIETY DISORDER IN CHILDREN:

1. Help minor compete a list of things that make him or her anxious and what actions have been most effective in relieving the anxiety.

2. Train the client to use progressive relaxation or guided imagery techniques to induce calm and decrease the intensity and frequency of feelings of anxiety.

3. Assist minor work toward a resolution using problem solving, assertiveness, acceptance, and cognitive restructuring of past and present conflicts.

4. Use toys such as, puppets, felts, or a sand tray to elicit situations that bring anxiety in the minor, and the minor in creating such scenarios. Help minor learn new ways to model positive cognitive responses to the situations that bring on anxiety.

5. Use play therapy to help identify and talk about divorce, peers, alcohol abuse, or other situations that makes minor anxious.

Step 5, Diagnosis:

The diagnosis is based on the evaluation of the clients present clinical presentation. When completing diagnosis the clinician must take into account and compare cognitive, behavioral, interpersonal, and emotional symptoms as described on the DSM-5 Diagnostic Manual. A diagnosis is required in order to get reimbursement from a third-party provider. Integrating the information presented by the DSM-5 diagnostic manual and the current client’s assessment data will contribute to a more reliable diagnosis. it is important to note that when completing a diagnosis the clinician must have a very clear picture all behavioral indicators as they relate to the DSM-5 diagnostic manual.

DSM V CODE Paired With ICD_9-cm Codes (parenthesis Represents ICD-10-cm Codes Effective 10-2014):

309.21 (f93.0) Separation Anxiety Disorder
312.23 (f94.0) Selective Mutism
300.29 Specific Phobia
specify If:

(f40.218) Animal

(f40.228) Natural Environment

specify If Blood-injection-injury:

(f40.230) Fear Of Blood

(f40.231) Fear Of Injections And Transfusions

(f40.232) Fear Of Other Medical Care

(f40.233) Fear Of Injury

(f40.248) Situational

(f40.298) Other

300.23 (f40.1 0) Social Anxiety Disorder (social Phobia)

specify If: Performance Only

300.01 (f41.0) Panic Attacks

(only If Causes For Panic Attack Can Not Be Be Better Explained As A Specifier Within The Context Of That Main Disorder Such As Anxiety Disorder, Post Traumatic Stress Disorder Etc.,). panic Attack Specifier

300.22 (f40.00) Agoraphobia

300.02 (f41.1) Generalized Anxiety Disorder

specify If:

Substance/medication-induced Anxiety Disorder

specify If: With Onset During Intoxication

with Onset During Withdrawal,

with Onset After Medication Use

293.84 (f06.4) Anxiety Disorder Due To Another Medical Condition

300.09 (f41.8) Other Specified Anxiety Disorder

300.00 (f41.9) Unspecified Anxiety Disorder

problems Related To Family Upbringing
v611.20 (z62.820) Parent-child Relational Problem
v61.8 (z62.891) Sibling Relational Problem
v61.8 (z62.29) Upbringing Away From Parents
v611.29 (z62.898) Child Affected By Parental Relationship Distress
other Problems Related To Primary Support Group
v611.03 (z63.5) Disruption Of Family By Separation Or Divorce
v61.8 (z63.8) High Expressed Emotion Level Within Family
v62.82 (z63.4) Uncomplicated Bereavement

Child Maltreatment And Neglect Problems Child Physical Abuse

Child Physical Abuse, Confirmed
995.54 (t74.1 2xa) Initial Encounter
995.54 (t74.1 2xd) Subsequent Encounter

child Physical Abuse, Suspected
995.54 (t76.12xa) Initial Encounter
995.54 (t76.1 2xd) Subsequent Encounter

Child Sexual Abuse

Child Sexual Abuse, Confirmed
995.53 (t74.22xa) Initial Encounter
995.53 (t74.22xd) Subsequent Encounter

Child Sexual Abuse, Suspected
995.53 (t76.22)(a) Initial Encounter
995.53 (t76.22xd) Subsequent Encounter

Child Neglect, Suspected
995.52 (t76.02xa) Initial Encounter
995.52 (t76.02xd) Subsequent Encounter

Child Psychological Abuse

Child Psychological Abuse, Confirmed
Sample Treatment Plan:

Present Behavioral Descriptors of Problem:

1. Excessive anxiety or worry due to parents' threat of abandonment or poor family dynamics
2. Excessive anxiety, worry, or fear that markedly exceeds normal expectations
3. Trouble falling or staying asleep

Long Term Goals:

1. Diminish the frequency of the anxiety response to improve daily functioning.
2. Diminish the intensity of the anxiety response to improve daily functioning.
3. Identify and solve any issues that may be producing anxiety.
4. Identify and solve any issues that may be producing fear.

Short Term Goals Objectives:

1. Teach and implement appropriate relaxation and cognitive diversion activities to lower the level of anxiety.
2. Use family therapy sessions to identify and list solutions for conflicts between family members.
Strategy or Intervention for Goal 1:

1. Train the minor how to relax and become focused on breathing and self-calming techniques to use when tension, anger, or frustration is building

Increase minor connection with the family unit by helping minor create a photo album of family and major memories by gathering a diverse collection of photographs, and allow him to verbalize feelings about changes in the family system.

Build level of trust with the minor using consistent eye contact, active listening, and unconditional positive regard to help promote the open expressions of thoughts and feelings.

Encourage minor to learn to identify and list ways to handle angry feelings in a controlled, effective way

Strategy or Intervention for Goal 2:

Conduct a family therapy where each member of the family where minor takes part in a trust walk, (one family member is blindfolded and led around by a guide through a number of tasks. this repeated with other members.) to increase the client's awareness of trust issues and to expand sense of trust.

Encourage parents to send minor to an adventure-based summer camp to build self-esteem, trust in self and others, conflict resolution skills, and relationship skills.
Teach parents how to give constant feedback, structure, and repeated emphasis of expectations, to reassure minor that they in control and that they will not allow minor's intense feelings to get out of hand

DSM V Diagnosis:

309.21 (f93.0) Separation Anxiety Disorder

300.23 (f40.1 0) Social Anxiety Disorder (social Phobia)