Team-Based Care Episode: Anxiety and Stress in Children and Adolescents: Part 2

Marcia Slattery: Welcome to the Team-Based Care podcast for the Interprofessional Healthcare team produced by the Office of Continuing Professional Development at the UW Madison School of Medicine and Public Health.

I'm Dr. Marcia Slattery, your guest host for this episode. I am a Board Certified Child and Adolescent Psychiatrist, a Professor of Psychiatry and Pediatrics at the University of Wisconsin School of Medicine and Public Health, and the Director of the UW Pediatric Anxiety Disorders program. I'm joined today by two expert colleagues, Elizabeth Bartholomew and Hannah Koerten.

This episode is Part 2 of "Anxiety and Stress in Children and Adolescence" where we will focus on specific treatment interventions for pediatric anxiety problems as well as addressing the impact of stress.

This episode is approved for continuing education credits for physicians, advanced practice providers, nurses and other members of the healthcare team through the Interprofessional Continuing Education Partnership at UW-Madison. At the time of this recording, I, Marcia Slattery, Elizabeth Bartholomew, and Hannah Koerten have no relevant financial relationships with ineligible companies to disclose. For detailed disclosure about the planning committee and additional continuing education information, see the show notes. Information on how to claim continuing education credit will be shared at the end of this episode.

Liz and Hannah–would you please introduce yourselves for Part 2 of this podcast?

Liz Bartholomew: I'm Liz Bartholomew, licensed clinical social worker. I currently work in a pediatric primary care clinic at UW Health providing short-term treatment to kids and young adults with anxiety disorders. Previously, I worked in an outpatient psychiatry clinic for over 10 years, treating children and teens with various anxiety disorders.

Hannah Koerten: And I'm Hannah Koerten, I'm a UW Health clinical psychologist at the Wisconsin Psychiatric Institute and Clinic. I work primarily with kids and teens in an outpatient setting. I do psychotherapy, psychological testing, and research. I also get to run a family-based adolescent DBT group in our clinic

Marcia Slattery: Thank you to both of you for being part of this podcast series and sharing your expertise!

For quick review: Part I of this podcast emphasized the importance of recognizing the symptoms and behaviors associated with different types of pediatric anxiety disorders—starting with highlighting the important fact that anxiety is the most common pediatric mental health problem, affecting up to 1 in 5 kids, and yet despite this, often being missed or misdiagnosed in the clinic, school, even at home.

Kids with anxiety are often referred to as silent sufferers. Asking about different symptoms is critical including worries, irritability or behavioral outbursts, and avoidance of whatever triggers the anxiety.

This podcast will focus on the treatment of anxiety including types of psychotherapy and pharmacotherapy–with the goal of providing healthcare providers with a framework of what to use and when, and how to coordinate treatment components using a team-based approach, that is, integrating primary care health care providers, mental health professionals, school staff, and importantly, the role of parents. We'll also talk about the close relationship of stress and anxiety, and how many of the strategies used to treat anxiety can also be very helpful for stress management.

So, let's get to it, starting with discussing psychotherapies commonly used to treat symptoms of anxiety. There are many different evidence-based psychotherapies for pediatric anxiety— for this podcast, we're focusing on 3 of the more commonly used therapies for anxiety in children including cognitive behavioral therapy (CBT), dialectical behavior therapy (DBT), and mindfulness.

Liz, you've treated many children and teens with anxiety using CBT. Can you start us off by describing what CBT is and why it's among the most widely used type of psychotherapy for anxiety?

Liz Bartholomew: Yes–Cognitive Behavior Therapy is an evidence based therapy for anxiety for youth and adults. CBT focuses on the connections between a person's thoughts, emotions and behaviors. The "C" in CBT focuses on replacing anxious thoughts with more balanced and helpful thinking. One way kids and teens learn to do this is by recognizing cognitive distortions or what therapists commonly refer to as "thinking traps".

At the core of all thinking traps is the expectation that something negative will happen. I'd like to share 3 common examples:

The first is jumping to conclusions: thinking that the chances of something happening are much greater than they actually are. For example, a child might worry that their family will get into a car crash if they drive on the highway.

A second example is thinking the worst–telling yourself that the very worst is going to or could happen. For example a teen might worry that if I don't get straight A's, then they wlll not get into college and won't be able to support themselves.

A third thinking trap is mind reading—believing you know what others are thinking without considering other, more likely, possibilities. I hear this cognitive distortion a lot from teens with social anxiety. For example, a teen I'm working with expressed certainty that his classmates would judge him and think something was wrong with him if he returned to class.

To summarize, CBT teaches kids and teens to look for facts or evidence to challenge anxious thoughts and expected outcomes. Kids learn that just because we have a thought, like a worry, does not mean it is true. Our goal is to learn that facts are objective and can deflate the worries, which helps the child feel less anxious, calmer, and more in control .

Marcia Slattery: So to summarize, the C in CBT focuses on the cognitions, or thoughts, associated with anxiety such as worries, and learning to challenge and replace the worry with more objective, constructive thoughts which in turn makes us feel less anxious. What about the "B" of CBT?

Liz Bartholomew: The "B" of CBT focuses on behaviors associated with anxiety, such as avoidance of situations that make us anxious–we've talked about how common avoidance is in all types of anxiety.

At the heart of CBT treatment is graduated behavioral exposure. This might be the most important and challenging part of therapy for kids and teens. In this section of treatment, a child or teen is invited to test out their fears/worries. The goal of exposure is to help the child and teen learn that they can manage whatever emotions show up (for example, anxiety) and get through the experience without avoiding, leaving or shutting down. Exposures help build new and more helpful ways of thinking about a feared situation.

An important first step in exposure work is creating a fear ladder. This process allows the child and teen to map out their feared outcomes, from least to most distressing. For example, if someone fears embarrassment in social situations, a lower level exposure might be talking with a colleague in my office. If there is school avoidance, then the parent and therapist would work closely with the school counselor to develop a plan to gradually re-enter the building. First, the student might start by attending school for an hour in the counselor's office. Gradually, we would increase the time the teen is both in the building and in different areas of the school, with the goal of full re-entry into the classroom.

Marcia Slattery: Hannah, Liz has nicely outlined examples of using graduated exposure for avoidance of feared situations or experiences— A key point to once again emphasize, what

I like to think of as triple A–avoidance amplifies anxiety. And that by gradually doing the very things that make us anxious through graduated exposure, we in turn feel less anxious. Avoidance can also occur when well-meaning parents try to protect their child from feeling anxious, and allow them to avoid anxiety-provoking experiences–what we refer to as parental accommodation. Can you explain more about parental accommodation and how this might unknowingly reinforce the child's anxiety?

Hannah Koerten: Accommodation is important to watch out for because families often mistake accommodation as a helpful response to anxiety. Examples might include allowing their child to stay home from school because they feel nauseous in the morning, attending birthday parties with their child because they are afraid to go alone, or staying with them as they fall asleep because they are afraid to sleep independently. Providing reassurance is one of the most unsuspecting ways families can unintentionally accommodate anxiety. Giving certainty to reduce anxiety is actually not helpful, because it does not allow the child to experience tolerating uncertainty and using their own skills to cope with a situation.

Rather than using accommodation to reduce the anxiety in the moment (which actually makes the fear bigger in the long-term), exposure therapy teaches parents to step back and allow their child to experience anxiety as part of the exposure process, and the role of parents is instead to support and encourage them in their graduated exposure practice. This helps kids learn to develop a greater sense of confidence in their own abilities by reducing avoidance and improving their ability to tolerate doubt and uncertainty.

Liz Bartholomew: As Hannah described, parental accommodation is very common, and can unknowingly reinforce a child's anxiety. Because of this, there are evidence based treatments designed specifically for parents of children with anxiety. One such treatment is called SPACE (Supportive Parenting for Anxious Childhood Emotions). SPACE focuses on working with caregivers to gradually reduce accommodations, such as providing reassurance or supporting avoidance. SPACE teaches caregivers that anxiety is not something to be avoided and that kids can tolerate difficult emotions. SPACE helps parents respond to avoidance or reassurance seeking with supportive statements. These statements have two parts. The first part acknowledges a child's emotions through the use of validation. The second part relays confidence that the child can and will get through their emotional experiences. This treatment has been very effective, especially when a child or teen is not ready or willing to engage in therapy themselves.

Marcia Slattery: That's a really important point, Liz—the child's anxiety improves when parents consistently validate the anxiety, and communicate confidence in the child's ability to manage it, and not avoid it.

We've also talked about how anxiety can also contribute to a child feeling very anxious or nervous, and many times, becoming upset or agitated. What are some other behavioral interventions that can be helpful in decreasing the emotional distress associated with anxiety. In other words, helping to calm and feel more in control of one's emotions?

Liz Bartholomew: I love teaching coping skills! Not only is it a chance for a child and teen to learn new skills, but it gives me a chance to pause and relax during a hectic day. I tend to teach a variety of relaxation and mindfulness strategies, such as square breathing and Do the 5. Square breathing is a widely used relaxation skill. It teaches kids and teens to imagine a box or square while they slowly inhale for a count of 4, hold for a count of 4, exhale for a count of 4 and rest for a count of 4. Ideally you repeat for a total of 4 times.

"Do the 5" is a popular mindfulness strategy that focuses on using our senses to shift attention back to the present moment. This skill is especially helpful when a person is stuck in worried thoughts. Kids/teens learn to name 5 things they can see, 4 they can hear, 3 they can touch, 2 they can taste and 1 they can smell. I always have gum or mints in my office to help with this practice.

Hannah Koerten: I also love using "Do the 5". That's a great example of a mindfulness grounding exercise, which means helping us focus on the present moment, rather than worrying about the past or future, by intentionally noticing our environment or other specific objects of focus, like our breath. Grounding exercises are great ways to support kids and teens who are feeling anxious. Other examples besides "Do the 5" are looking around and finding every color of the rainbow (which I call "Find the Rainbow"), or choosing a category and trying to come up with as many examples as possible (like naming all the cereals you can think of). We will include a link to a handout for grounding strategies in the show notes.

Liz Bartholomew: Another skill I teach is helpful self talk or brave brain self talk. As we discussed, replacing unhelpful thoughts is an important focus of CBT. Helpful self talk is based on facts and validation of emotions: recognizing that we can do hard, scary things and be okay. Examples of helpful self-talk are "I can do hard things" "I can get through this!" "This feeling will pass and I don't need to do anything about it".

Visualization is another example of a coping skill that kids and teens can use when anxious or stressed. One example I teach is favorite place thinking. First, we draw our favorite place and then use our senses to help us visualize what the place feels like, looks like, and smells like. Bonus if you can think of something you like to taste or eat in your favorite place. Using your senses is always a helpful way to shift your attention off of worry.

Marcia Slattery: These are really great skills that are easy to learn for primary care providers, therapists, teachers and parents to teach and practice with kids–we can all attest that in-person practicing really helps to solidify learning the skills and modeling that it's important. Hannah, as we discussed in Part I of our podcast, some youth with anxiety, especially during the teenage years, can experience more pronounced dysregulation or sometimes risky behaviors when feeling anxious, such as having suicidal thoughts or self-harm thoughts, substance use, or sometimes impulsively engaging in unsafe online behaviors such as sharing sexually explicit pictures of themselves or others. What types of interventions should health care providers consider in these situations for their patients?

Hannah Koerten: An effective treatment for teens with anxiety and high risk behaviors is Dialectical Behavior Therapy, or DBT. DBT is a cognitive-behavioral therapy that treats more extreme emotional and behavioral dysregulation, especially suicide or self-injury behaviors. The goal is to replace problem behaviors with more skillful behaviors.

Marcia Slattery: Can you give us some examples of coping skills you teach teens in DBT?

Hannah Koerten: DBT has several skills to cope with anxiety, but one of my favorites for replacing unhealthy behaviors, such as self-harm or suicide, is TIPP. TIPP, which is an acronym, stands for Temperature, Intense Exercise, Paced Breathing, and Progressive Muscle Relaxation. TIPP skills change body chemistry by activating the parasympathetic nervous system, which helps to decrease emotional and physical symptoms of anxiety and reduce the intensity of emotions quickly within seconds.

Marcia Slattery: Thanks, Hannah— your comment highlights a really important point –how psychotherapy can not only change emotions and behavior, but can also have a biological impact in the brain and in the body. In a state of acute stress and anxiety, the sympathetic arm of the autonomic nervous system is activated and the fight or flight response kicks in. Physical symptoms are common such as rapid heart rate, shortness of breath, and shakiness, and in the brain, pathways and connections to the frontal cortex become muted or blocked. This is why many people will report that when feeling very anxious and overwhelmed, they don't know what to do including not being able to remember what anxiety management skills to use–they can't access the "thinking" part of the brain because of the intense anxiety; many will describe that their mind "went blank".

As you mentioned, DBT skills help to biologically activate the other arm of the autonomic nervous system, the parasympathetic system which immediately dampens down the sympathetic response, with the goal of restoring homeostasis in the autonomic nervous system.

Hannah Koerten: Exactly–The goal of the TIPP skills is to activate the parasympathetic system to dampen the emotional and physical symptoms of anxiety, and buy time to use other skills like distractions or hobbies. The effects typically last 5-20 minutes.

So to review the TIPP acronym: T is For Temperature, –The goal is to make your face cold and hold your breath, to trick your body into thinking you are diving into cold water. I coach teens to place their face in cold water while holding their breath OR hold an ice pack or frozen oranges on their cheeks while tilting their head down and holding their breath.

I is for Intense Exercise, I talk with teens about doing brief, intense aerobic exercise for a short while (usually less than 15 minutes) to let out stored up energy. This could be running in place, doing 20 jumping jacks, or doing a 30-second plank.

P is for Paced Breathing, we use counting to breathe out longer than we breathe in (for example, in for 5, out for 7). This is similar to what Liz referenced with box breathing earlier, but the focus here is breathing out longer.

Finally, P is for Progressive Muscle Relaxation (or PMR for short), where we tense and relax each muscle group from head to toe.

We will include links to an online handout on TIPP skills and guided videos in the program notes, which could also be shared with families in an After Visit Summary.

I will also mention that there is a great DBT-based app called Calm Harm, which has several coping strategies and skills to replace self-harm urges.

Also–for teens coming to a healthcare provider's office with recurrent or more severe safety concerns or risky behaviors, providers should consider helping the family find an individual therapist who specializes in DBT and/or DBT skills groups in their area.

Marcia Slattery: Thanks, Hannah. This is a great segway to expand a bit more about the biology of anxiety and the role of pharmacotherapy as another treatment approach–

Recall from our prior podcast, that anxiety has a biological basis – the brain.

Our brain allows us to have emotions, and to think and problem solve, in addition to a myriad of other functions.

Deciding when to use medications for anxiety can be similar to deciding when to use a medication for other medical conditions such as hypertension–Mild to moderately elevated blood pressure can often be managed with lifestyle changes and interventions. For example, exercise, stop smoking, eating well, etc

For many people however, blood pressure remains elevated despite making these lifestyle changes and a medication is needed to keep it in a normal, healthy range to prevent other more serious medical problems, while also still emphasizing the lifestyle variables are important to optimize.

Anxiety is similar–for many kids, psychotherapy and other psychosocial interventions will help to decrease symptoms of mild to moderate anxiety. For other kids, the anxiety can be more severe and persistent despite therapy and other interventions. The medications for anxiety are designed to optimize brain function in areas involved in emotion and anxiety management, in other words, to help it return to a healthier state of regulation---symptom severity decreases, and importantly, as brain biological function improves, the child is also able to engage in psychotherapy much more actively such as CBT, DBT and mindfulness which also improves symptoms as we recently discussed.

So, what types of medications do we use?

SSRIs, selective serotonin reuptake inhibitors are the most widely used medications for both pediatric and adult anxiety; there are numerous studies demonstrating their efficacy AND safety in children and adolescents. An important point – medications should ideally be used in conjunction with psychotherapy as we've been talking about, not instead of psychotherapy.

SSRI medications include fluoxetine, sertraline, citalopram, escitalopram and paroxetine. These medications are not taken "as needed". In other words, they will not decrease anxiety in the moment like some medicines. It's important that primary care providers emphasize the need to take the medication every day in order to reach a therapeutic level, usually within 4-6 weeks.

I often describe to parents that the medications are working at the root of the problem, not the symptoms themselves, and that improvement is very gradual. Doses of the medication are started low and gradually increased depending on the response–there is no "set" dose for everyone.

So after starting a dose, it's important to wait 4-6 weeks to assess what the response to a specific dose is. The medication gradually builds up to a steady state blood level during this time. Symptoms of anxiety likewise gradually improve over several weeks and months of treatment.

Most people describe a very gradual improvement in their anxiety symptoms—changes can often be very subtle. For example, parents will often say that the day seems to go easier for the child, or they don't get angry quite as quickly as they did in the past.

Liz –what questions do you typically hear from children and parents in your practice about medications?

Liz Bartholomew: I often hear parents express worry about possible side effects with medications, and if their child will be "changed".

Marcia Slattery: These are really good questions. To start with, most children and teens notice no side effects from the SSRIs. Side effects can affect a subset of youth, usually consisting of mild GI symptoms, headaches, or mild jitteriness that typically resolves within the first 1-2 weeks of treatment.

The SSRIs and other antidepressant medications also have a warning of possibly developing self harm or suicidal ideation as outlined by the FDA in 2004, based upon a large study. In this study, youth who were on antidepressant medications for any reason had 4% risk of self harm or suicidal ideation, compared to 2% risk for youth not on these medications. It's important to note there were no suicides in that large study. It's important to note that self harm and self ideation are also common symptoms of anxiety and depression.

And one final note on this topic–it's also important to note that self harm and self ideation risk is not unique to SSRIs or other antidepressants–a similar warning is on other commonly used medications such as those used for the treatment of allergies and asthma. Bottom line–healthcare providers should ask about self harm and self ideation in all patients to assess safety, and potential causes of concern. Parents are always advised to call the clinic if they have questions to review with their healthcare providers about possible side effects.

As for whether these medications will change their kid? What I describe to parents is that anxiety is what has changed their kid–anxiety often severely limits a child. For example, activities or feeling happier and more carefree. Anxiety is like having your child wrapped in cellophane that I describe to them, it holds them back from being themselves. So yes, the medications, combined with psychotherapy, will hopefully change your child in a very good way. These treatments for anxiety will unwrap them from the cellophane, if you will, to be themselves again. It's very rewarding when parents will often say "I have my child back".

Medication use is also often a topic that comes up in therapy sessions as well. Hannah – can you add a few final words about how medications might be addressed in therapy sessions?

Hannah Koerten: I typically ask generally about how medications are going during therapy appointments. If there are difficulties with compliance, I will help families problem-solve ways to remember to take medications, such as setting alarms, changing the location of the medications, or using a reward system. When families bring up potential side effects (which is often feeling "numb" or experiencing stomach upset, but sometimes changes in suicidal thoughts), I either ask permission to reach out to their prescriber directly or encourage them to reach out via MyChart with their concerns. If families are wanting to stop the medications, I strongly advise asking their prescriber first to make sure they are stopping the medication in a safe way. We, as therapists, typically see patients more frequently than their primary care provider or psychiatrist, so we are often the first to hear of issues - which makes coordination with our prescribers so important.

Marcia Slattery: These are really great points and it's a great example of using team-based communication approach and coordination of care to optimize outcomes for kids with anxiety.

Finally, just a few words to introduce the final focus on this podcast, that of stress, especially given that anxiety and stress are very closely related.

Stress can exacerbate and amplify any underlying health vulnerabilities including anxiety, depression, asthma, diabetes and many other health-related conditions. In other words, stress stirs the pot – as with anxiety, it's important to notice it, and implement strategies to mitigate its impact.

It's also very important for healthcare providers to be aware of common sources of stress for kids of all ages, and to proactively ask about these areas during appointments –kids often will either not be aware of the stress, or may be hesitant to bring it up during their appointments.

Three common sources of stress for many children and teens include peer social stressors, school-related learning stress, and family and home changes.

Hannah— we very often hear kids talk about stress and conflict with other peers at school, and within their friend groups. What are some common sources of social stress that healthcare provides should have on their radar when talking with kids?

Hannah Koerten: We of course know that lots of kids and teens deal with bullying, which can vary from more mild peer conflicts to intense physical and emotional bullying. Another stressor that I commonly see for teens is conflict within friendships and romantic relationships both in-person and online, including losing a best friend, being excluded from a friend group, and break-ups. Many teens also experience individual and systemic discrimination, including based on race, gender identity, sexuality, or disability. These

social and interpersonal stressors can be overwhelming and very difficult to avoid –it can easily dominate social media, activities, and experiences at school.

Marcia Slattery: Thanks, Hannah—I agree –interpersonal stressors are often among the most potent sources of stress that we hear about, and can easily globally negatively impact the child's day to day life. This contributes to feeling more stress, feeling more anxious, depression, and just general unsettledness.

Another major source of stress that I'm especially attuned to is the stress of learning struggles for kids. Just imagine being surrounded every day in school by peers who easily understand what is being taught, have no difficulty completing their homework and exams, and repeated receive positive feedback from adults in the form of comments and high grades to mark their achievements.

While the child with a learning difficulty, for example reading or math, struggle to understand the basic constructs of the class, and work many more hours just to achieve a passing grade only to have your teachers or parents tell you you're not trying hard enough.

Kids with learning difficulties are often very bright but learn differently than their peers. Now while a subgroup of kids with more significant learning struggles might be receiving learning accommodations and support, many, many more students have learning struggles that are not identified and struggle in school every day.

Their learning difficulties commonly contribute to feeling anxious and stressed. The anxiety and stress can in turn worsen attention and focus, and negatively impact the ability to process information and learn. It becomes a very stressful recurrent and reinforcing negative loop.

The years of day to day stress that these kids experience in school can be devastating to their learning, their social experiences, and their sense of self worth, not to mention the anxiety and stress that they experience every day.

Many of these kids will start to resist going to school, will have physical symptoms like stomachaches or will go to the school nurse, or simply stop trying to do the work since they don't understand it, and it's too stressful to try. And then are often told that they're lazy or uninvested in their learning, or are given consequences at home and at school for not keeping up.

We absolutely need to do better at identifying learning struggles for kids at school, and provide the necessary learning support to help them achieve academically and feel positive about themselves and their abilities.

Liz–we know that family and home can also be key sources of stress for children and teens–what are some of these stressors, and what should healthcare providers ask about?

Liz Bartholomew: In primary care, I often hear about family related stressors, such as divorce or parental separation. For kids and teens, changes at home can create uncertainty about where they will live and when they will see their parent.

School related stress is another example that I hear about in my work. Towards the end of summer, I typically receive a number of referrals for kids experiencing stress because they are transitioning to a new school or new grade. Many kids and teens are especially stressed about the transition to middle and high school.

In addition, some kids and teens are moving to the area mid year and are learning a whole new school system and need to find new friends. This is especially challenging for kids when they are coming from another country due to language and cultural differences. As a result of these changes, kids and teens might report feeling sad, anxious, and more isolated.

Stressors at home can also create real life stress for kids and families. For example, many families experience financial and housing stress. Kids and teens often describe feeling stressed because they worry about having enough money for things at home, and they worry and stress about seeing their parents worried and stressed.

As we talked about earlier, parents often underestimate how stressful and anxiety provoking it is for kids to see their parents anxious and stressed. We like to think of home as safe and calm, and sometimes these real life stressors can make home feel very stressful and unpredictable.

Finally, another common stressor is parent child conflict. Although disagreements can be more typical during the teenage years, more conflict in the home between parents, and between parents and kids, can also exacerbate anxiety and stress symptoms for children and teens.

Marcia Slattery: Thanks, Liz. These are excellent points including changes within a family and at home can easily disrupt a child's sense of security and contribute to stress. As we all can attest, parents are often unaware of the impact of parent and home changes and stress on their kids. Your points also underscore the importance of parents actively engaging their kids in communication including respectfully listening to their thoughts and feelings, and addressing changes and stressors together.

So in summary every generation of adults would say that stress existed while growing up and they're right. Many of the types of stress have not changed. For example, peer social conflicts, home changes, learning struggles.

There are however several different stressors that kids face on a daily basis that their parents did not. For example, the real risk of school violence and school shootings, and the 24/7 presence of social media that ironically has contributed to a society often feeling very vulnerable, socially isolated and alone– a perfect recipe for feeling more anxious, more uncertain, and more stressed with day to day experiences.

Liz and Hannah - Many of the coping skills we described for anxiety can also be used to cope with day to day stress that youth experience, and to help them feel more capable and resilient.

What key stress and anxiety management skills would you suggest that primary care providers talk with kids and parents about in the primary care setting?

We'll use this as our final lightning round!

Hannah.

Hannah Koerten: Avoid isolation–seek out a supportive friend or adult.

Marcia Slattery: Liz.

Liz Bartholomew: Write down your thoughts and emotions to get space from them.

Marcia Slattery: Back at you Hannah.

Hannah Koerten: Remember the TIPP skills (temperature, intense exercise, paced breathing, and progressive muscle relaxation)

Marcia Slattery: And Liz.

Liz Bartholomew: Encourage parents to actively engage in listening and talking with their kids at home. Make it a safe, welcoming, and calming place away from other stressors of the day.

Marcia Slattery: These are terrific points. Key points to bring up with the kids and parents in the office, and also providing links in aftercare summaries or other communication with the family.

My sincere thanks and gratitude to both of you for being part of this podcast and sharing your expertise.

We hope that this 2-part podcast has shed additional light on identifying and assessing the many different symptoms and behaviors associated with pediatric anxiety, what treatments to consider and when, the overlapping role of stress and stressors on anxiety and related emotions, and importantly, the essential need for a team-based approach to optimize the overall health and wellbeing of these children and teens.

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