

Cincinnati
Child Anxiety Center

TIME IS NOW



ANXIETY DISORDERS

FACT

As little as 1% of youth with anxiety seek treatment in the year their symptoms begin, and most anxiety symptoms go untreated for years.

LETS TALK ABOUT IT

- most common disorders of childhood and adolescence,
- affect 30% of young people at some point before the age of 18
- described as the “invisible condition” because symptoms are so often ignored
- increase the risk for depression, academic difficulties , and substance abuse

EDUCATIONAL CLIMATE

Teaching and learning in schools have strong social, emotional, and academic components (Zins, Weissberg, Wang, & Walberg, 2004). Students typically do not learn alone, but rather in collaboration with their teachers, in the company of their peers, and with the encouragement of their families. Emotions can facilitate or impede children's academic engagement, work ethic, commitment, and ultimate school success. Because relationships and emotional processes affect how and what we learn, schools and families must effectively address these aspects of the educational process for the benefit of all students (Elias et al., 1997).

EDUCATIONAL CLIMATE

"A meta-analysis of 213 school-based, social and emotional learning programs involving 270,034 kindergarten through high school students. Compared to controls, participants demonstrated significantly improved social and emotional skills, attitudes, behavior, and academic performance that reflected an 11-percentile-point gain in achievement." (Durlack et. al, 2011)

EDUCATIONAL RELEVANCE

Integrated Mental Health Support is an integral part of education and human development

- mitigate and/or resolve mental health crisis
- develop healthy identities
- manage emotions to achieve personal and collective goals
- feel and show empathy for others
- establish and maintain supportive relationships
- make responsible and caring decisions.

PREVENTION, IDENTIFICATION, & INTERVENTION

As progressive schools move towards preventative models of service delivery (MTSS) they have become our strongest buffer against mental illness by

- Providing programming for (a) social emotional development (b) building resiliency/protective factors
- Screening students who show heightened levels of risk and monitoring their progress.
- Providing a continuum of supports to remediate socio-emotional problems in their early stages
- Building the capacity of staff to identify mental illness and understand its treatment and educational impact.

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OUR TEAM



JESSICA RIGAS



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BRENDA ALEXANDER



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ROBYN COLEMAN



CHRISTA NEWMAN



CLARA TAVAREZ

TREATMENT REIMAGINED

We provide treatment the way
patients and therapists wish it
were done...

THE DIFFERENCE

A Higher Standard for Care



Technological Integration

We seamlessly integrate the best tech in therapy, including virtual reality, biofeedback, breathing retraining devices, smartwear, and mobile measurement-based monitoring.



Measurement-Based Care

Our treatment is guided by frequently monitoring patient symptoms and feedback using secure digital platforms to accelerate needed treatment adaptations for improved outcomes.



Medication Management

We provide a responsive patient-centered approach to medication management. Your prescriber will work within the context of your clinical team and deliver frequent symptom monitors to minimize the risk of side effects when medication is indicated.



Total Accessibility

We are accessible via text, phone call, and video conferencing to reinforce therapy skills and to provide relief to parents.



Team-Based Approach

Our clinicians are in constant collaboration and can quickly mobilize to provide intensive outpatient programming.



Mobility

We provide services wherever they are needed, whether in the office, at home, or in the community.



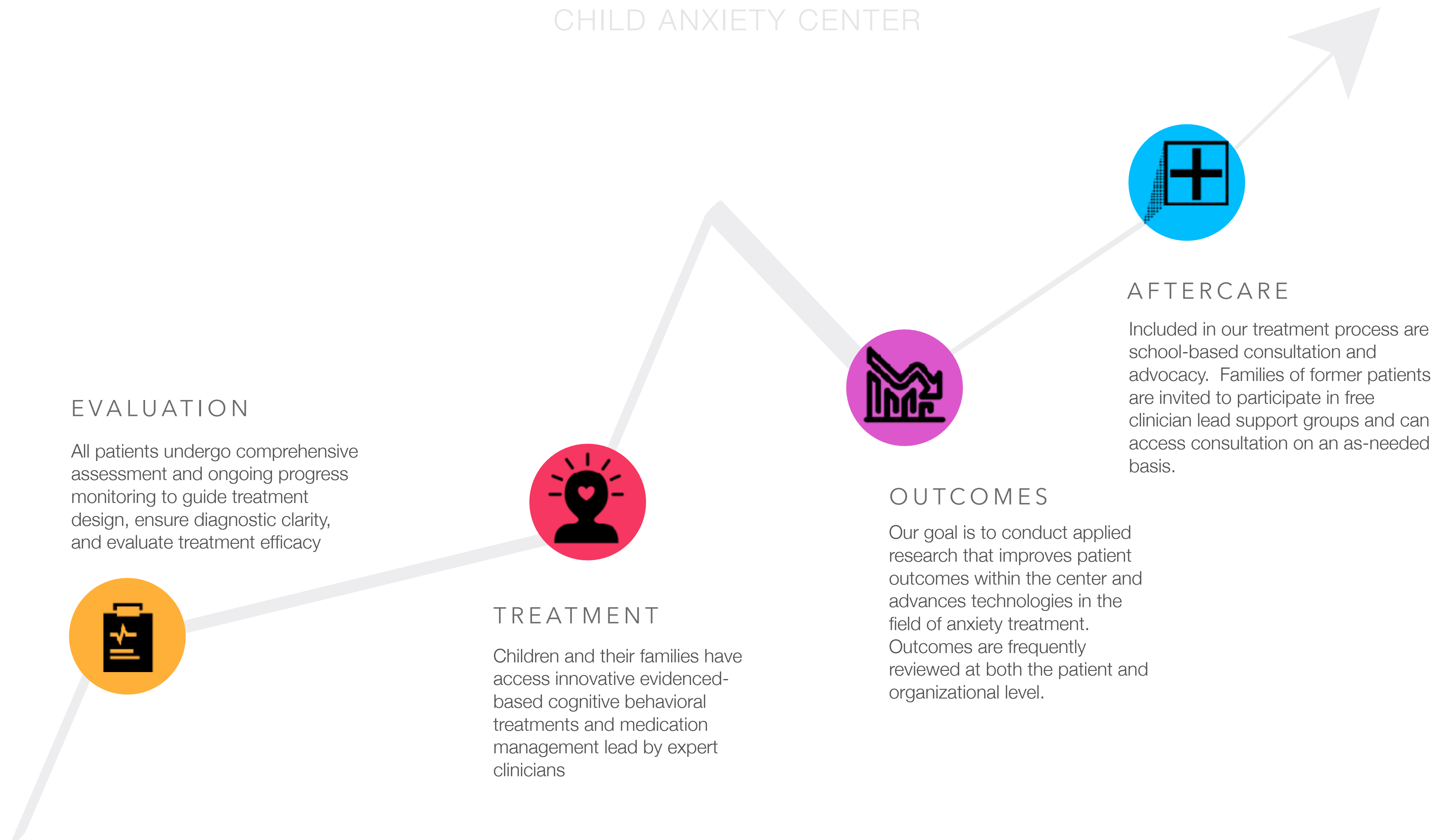
Continuity of Care

Our services extend beyond the center and include expert school-based consultation and advocacy, as well as comprehensive after-care programming.



Our Process

CHILD ANXIETY CENTER



EVALUATION

All patients undergo comprehensive assessment and ongoing progress monitoring to guide treatment design, ensure diagnostic clarity, and evaluate treatment efficacy



TREATMENT

Children and their families have access innovative evidenced-based cognitive behavioral treatments and medication management lead by expert clinicians



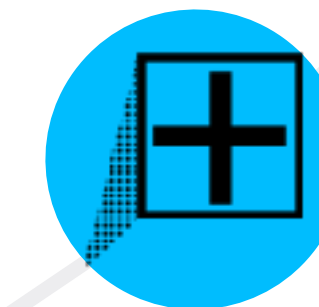
OUTCOMES

Our goal is to conduct applied research that improves patient outcomes within the center and advances technologies in the field of anxiety treatment. Outcomes are frequently reviewed at both the patient and organizational level.



AFTERCARE

Included in our treatment process are school-based consultation and advocacy. Families of former patients are invited to participate in free clinician lead support groups and can access consultation on an as-needed basis.



ACCURATE ASSESSMENT



IN USE FOR MORE
THAN 25 YEARS



TRANSLATED IN 70+
LANGUAGES



CLINICALLY VALIDATED
AND PEER REVIEWED



INDUSTRY GOLD
STANDARD

The M.I.N.I. is the most widely used
and clinically validated psychiatric
structured diagnostic interview
instrument in the world.

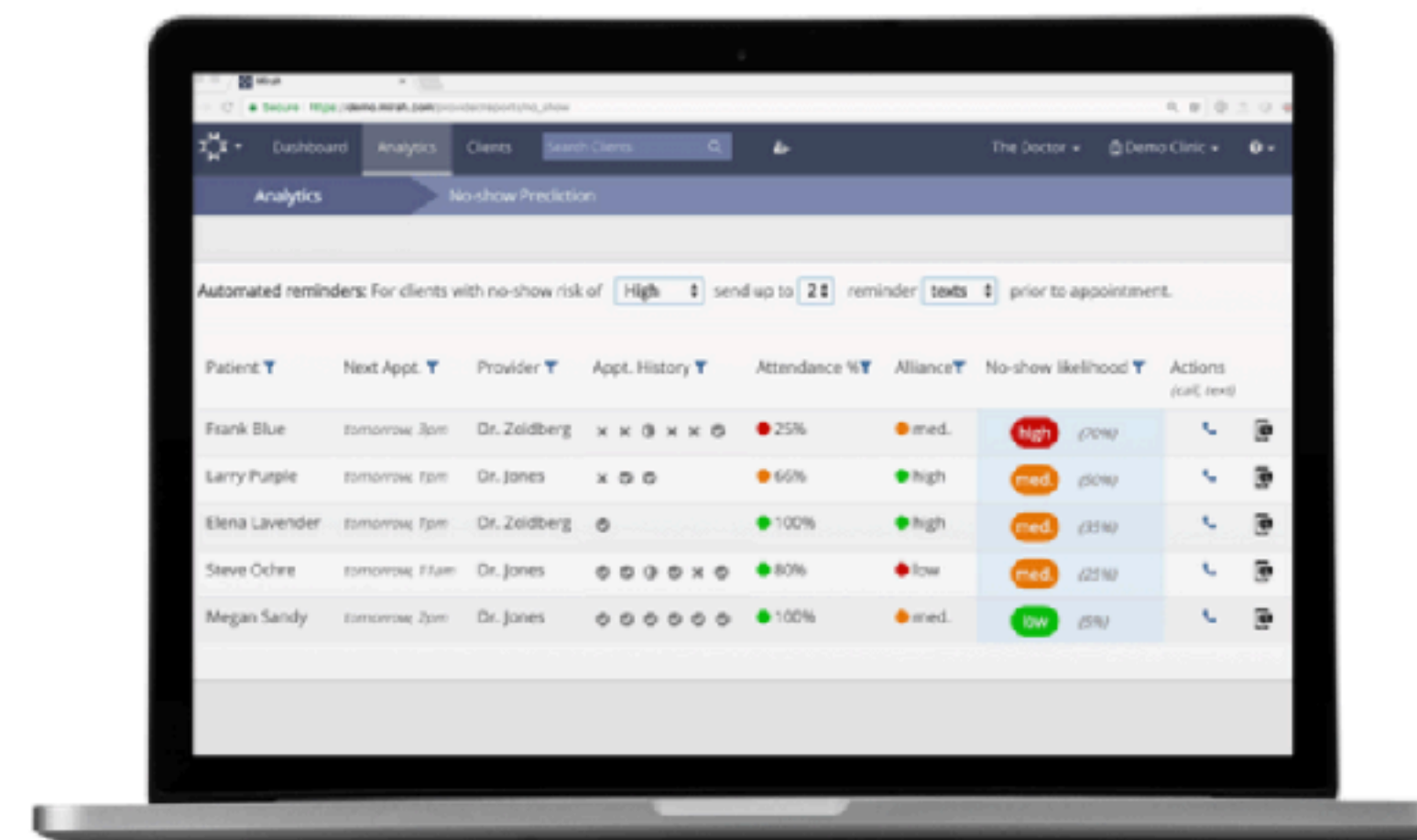
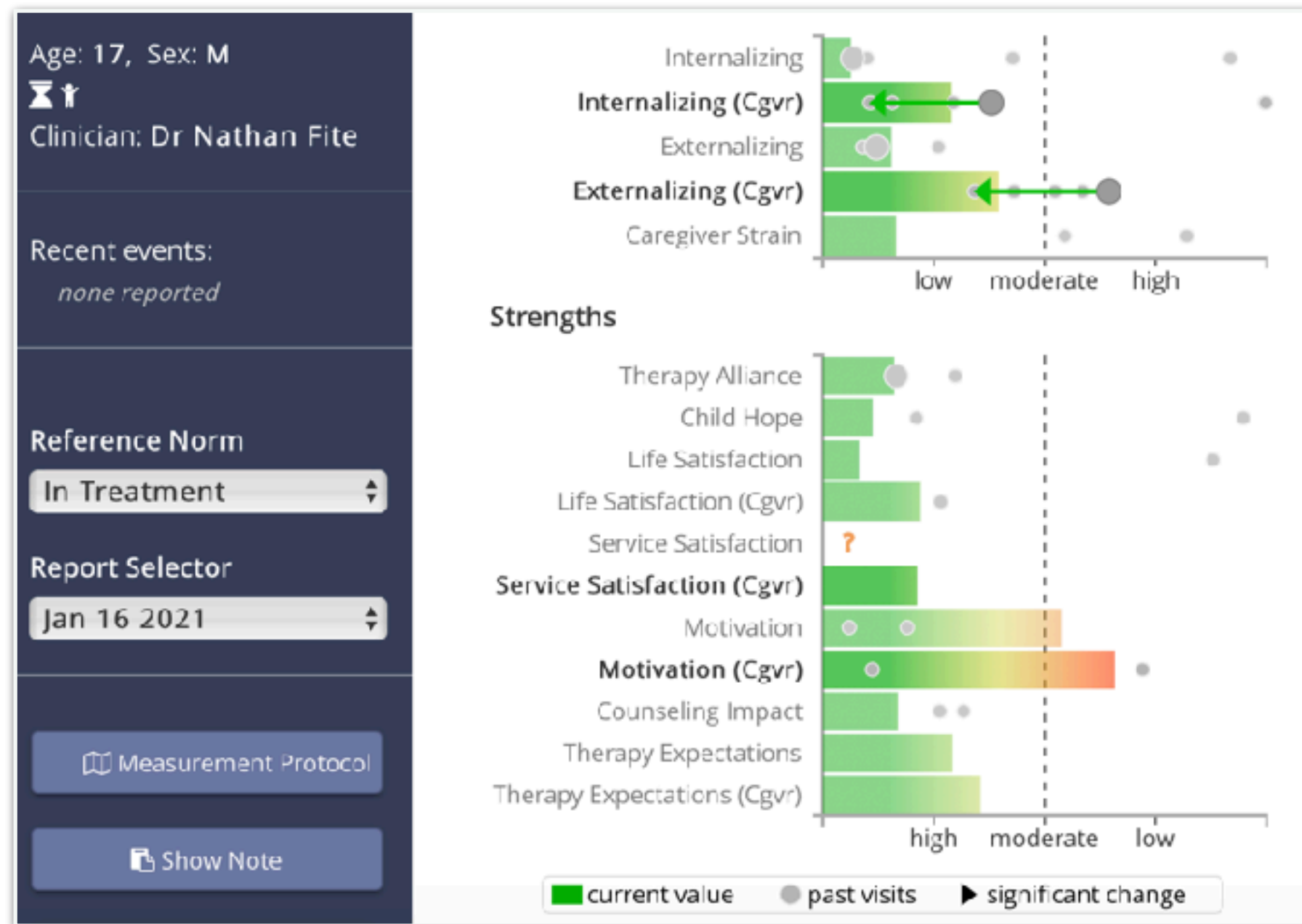


ADMINISTERED HUNDREDS OF
THOUSANDS OF TIMES

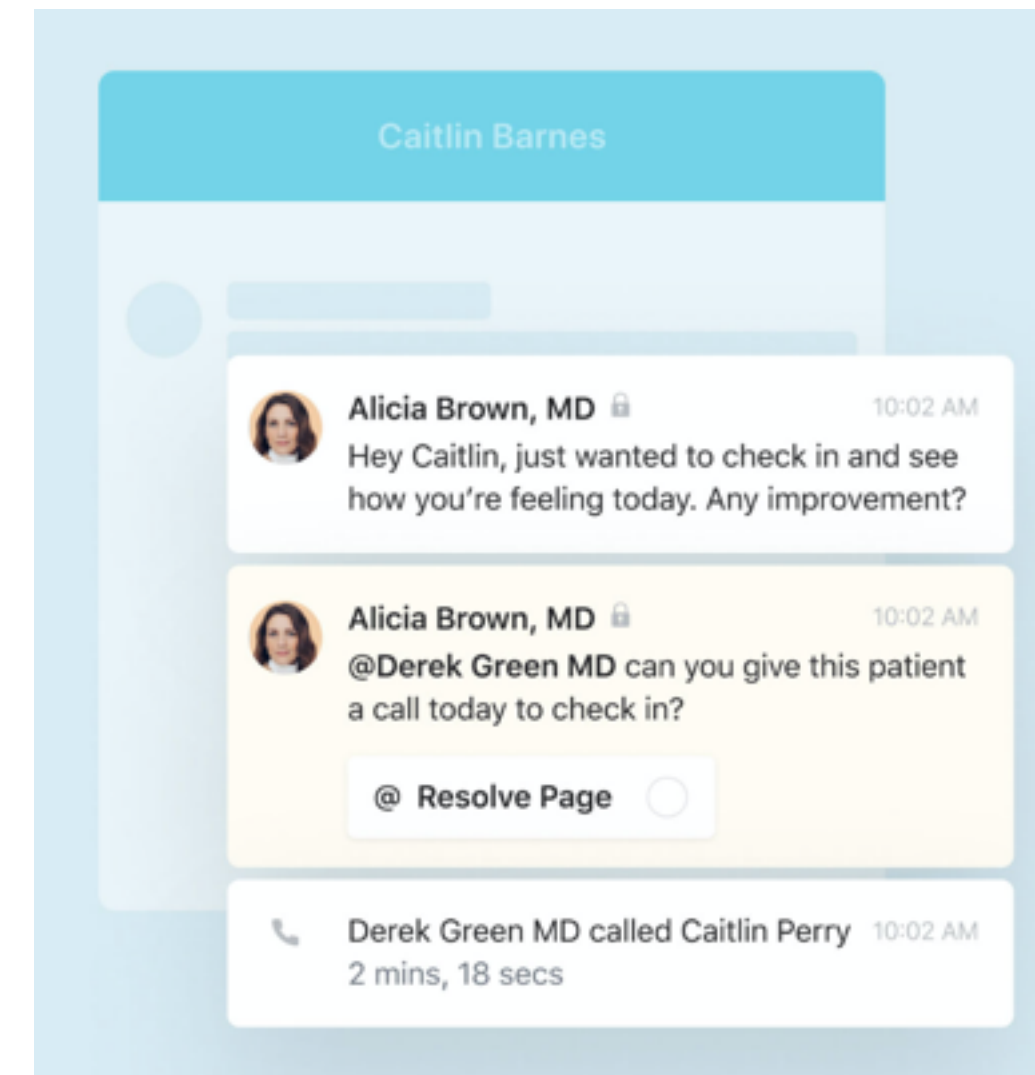


USED IN 100+ COUNTRIES

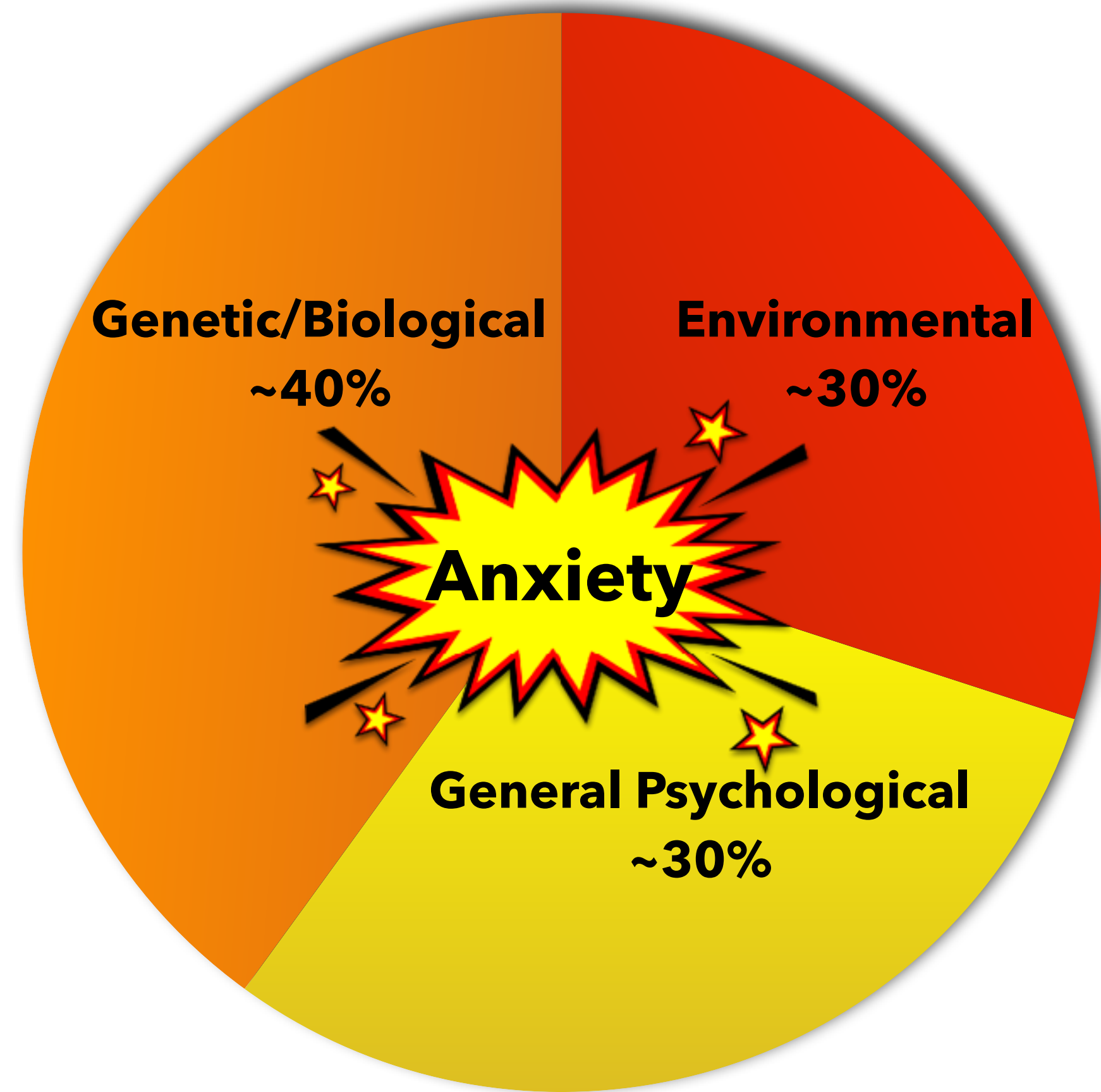
MEASUREMENT BASED CARE



TOTAL ACCESSIBILITY



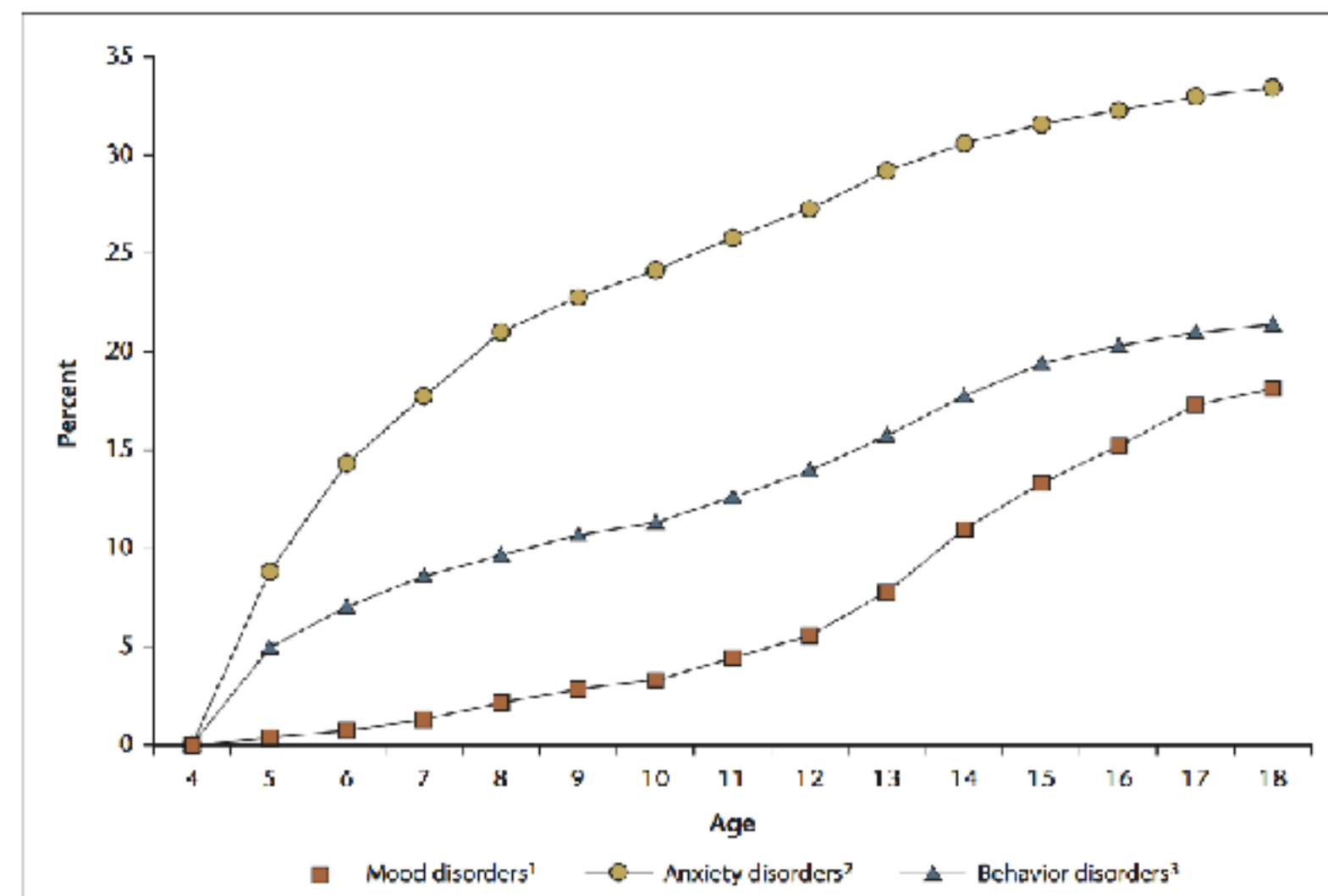
WHAT CAUSES ANXIETY?



FACE THE FACTS

- Anxiety disorders are the most prevalent disorder among adolescents (31%)
- Lowest median age of onset of any disorder at age 6

Figure 2-1. Cumulative lifetime prevalence of selected mental health disorder classes among children and adolescents, by age: 2001–2004

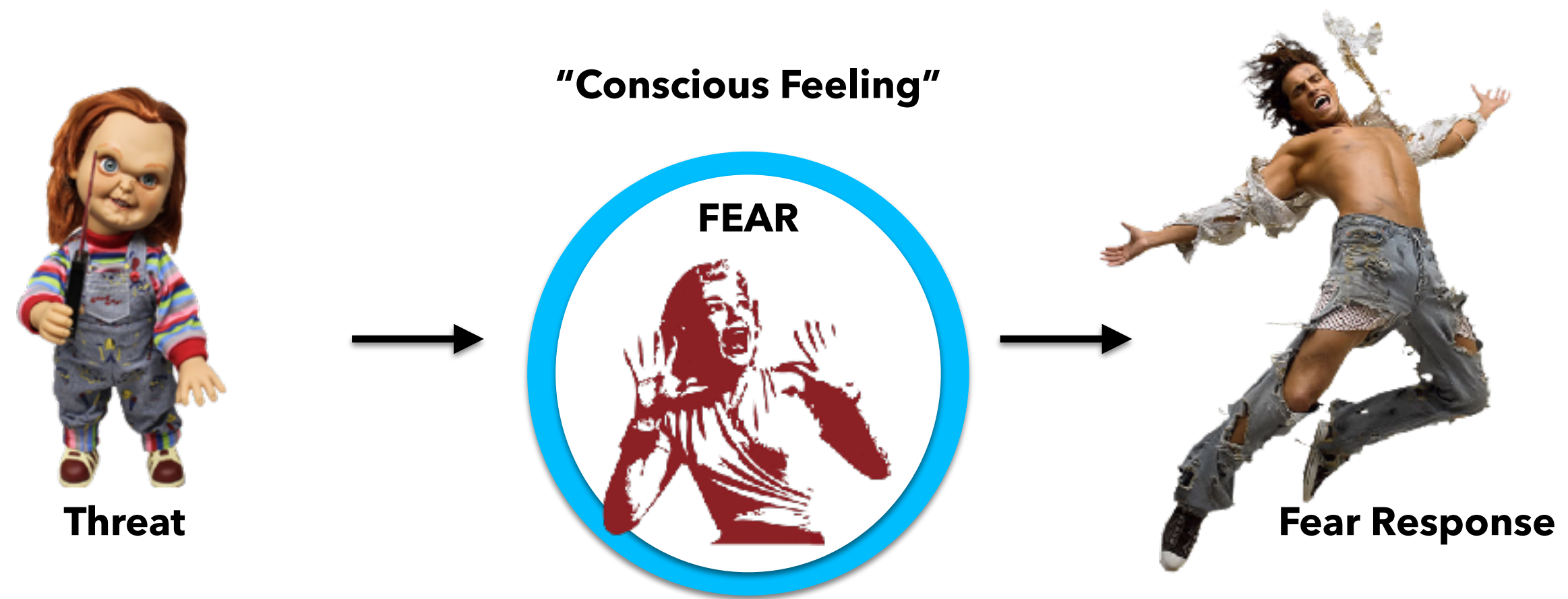


¹ Mood disorders include disorders such as bipolar disorder and major depressive disorder.

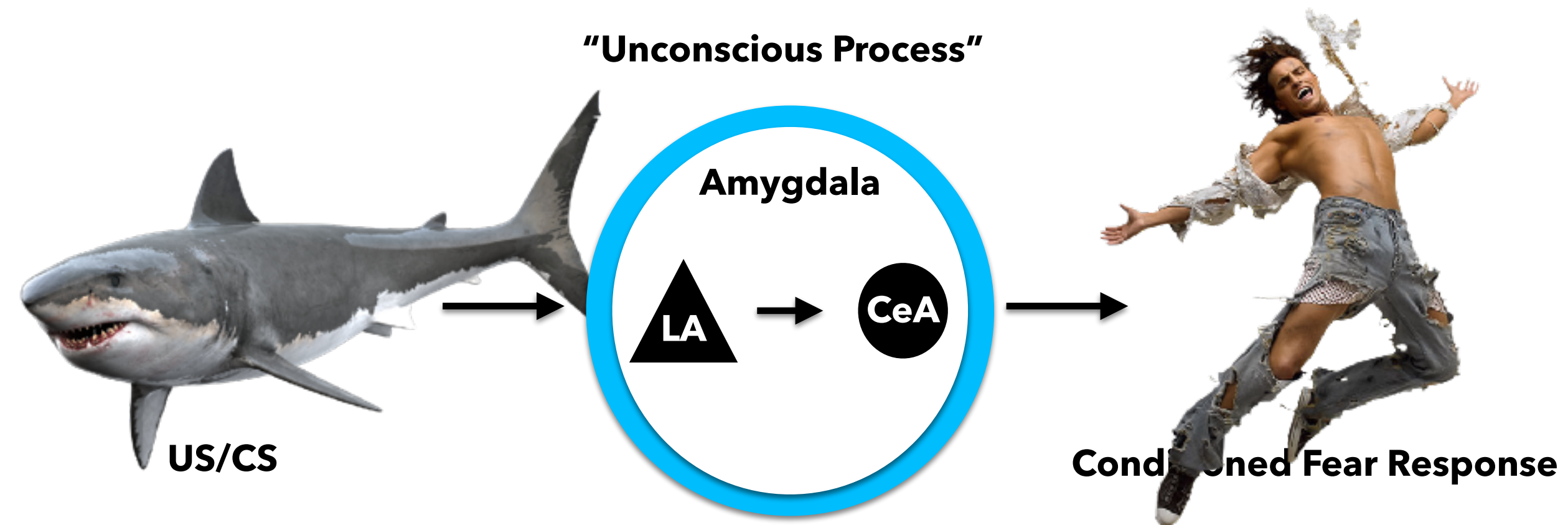
² Anxiety disorders include disorders such as generalized anxiety and specific phobia.

³ Behavior disorders include disorders such as attention-deficit/hyperactivity disorder, conduct disorder, and oppositional defiant disorder.

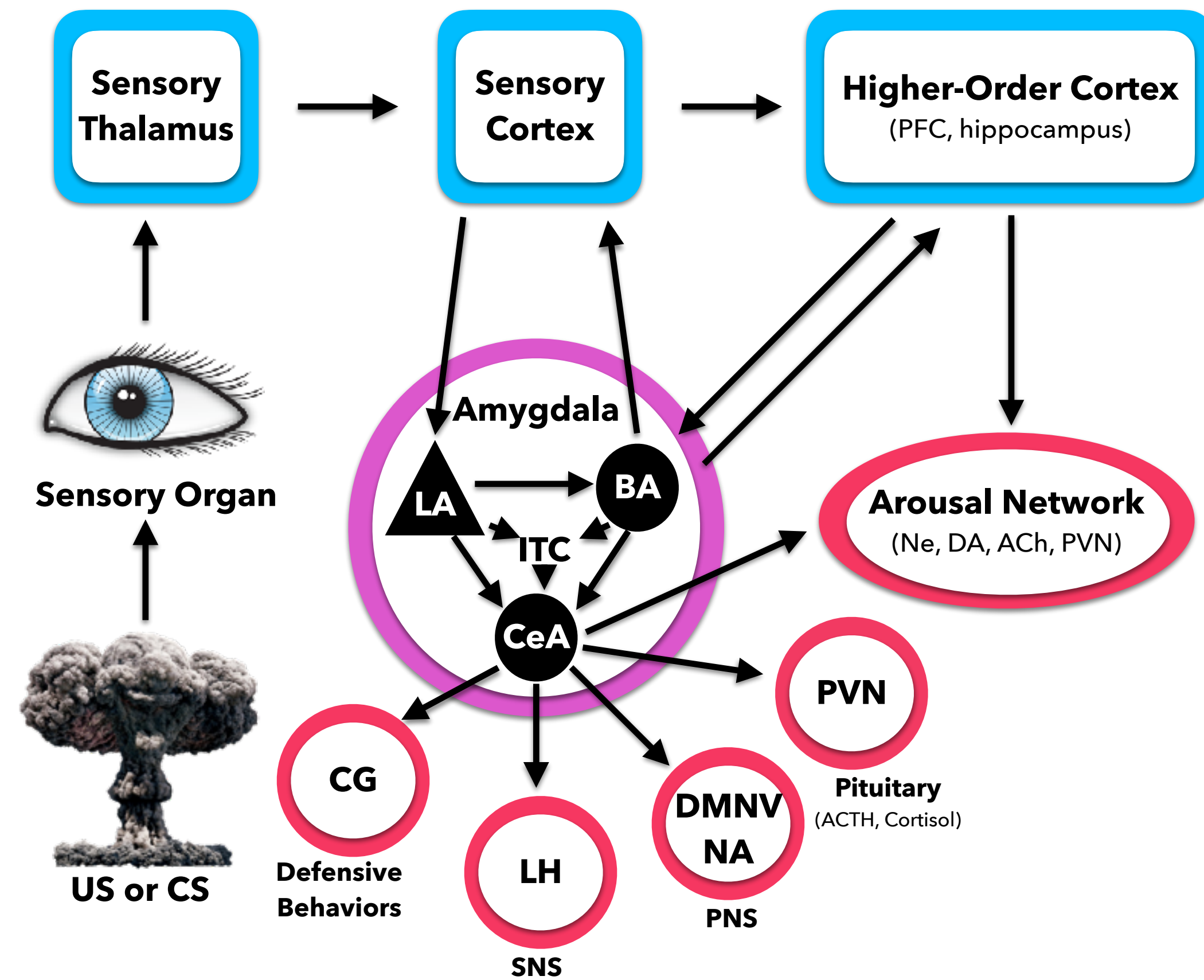
DARWIN'S COMMON SENSE VIEW OF FEAR



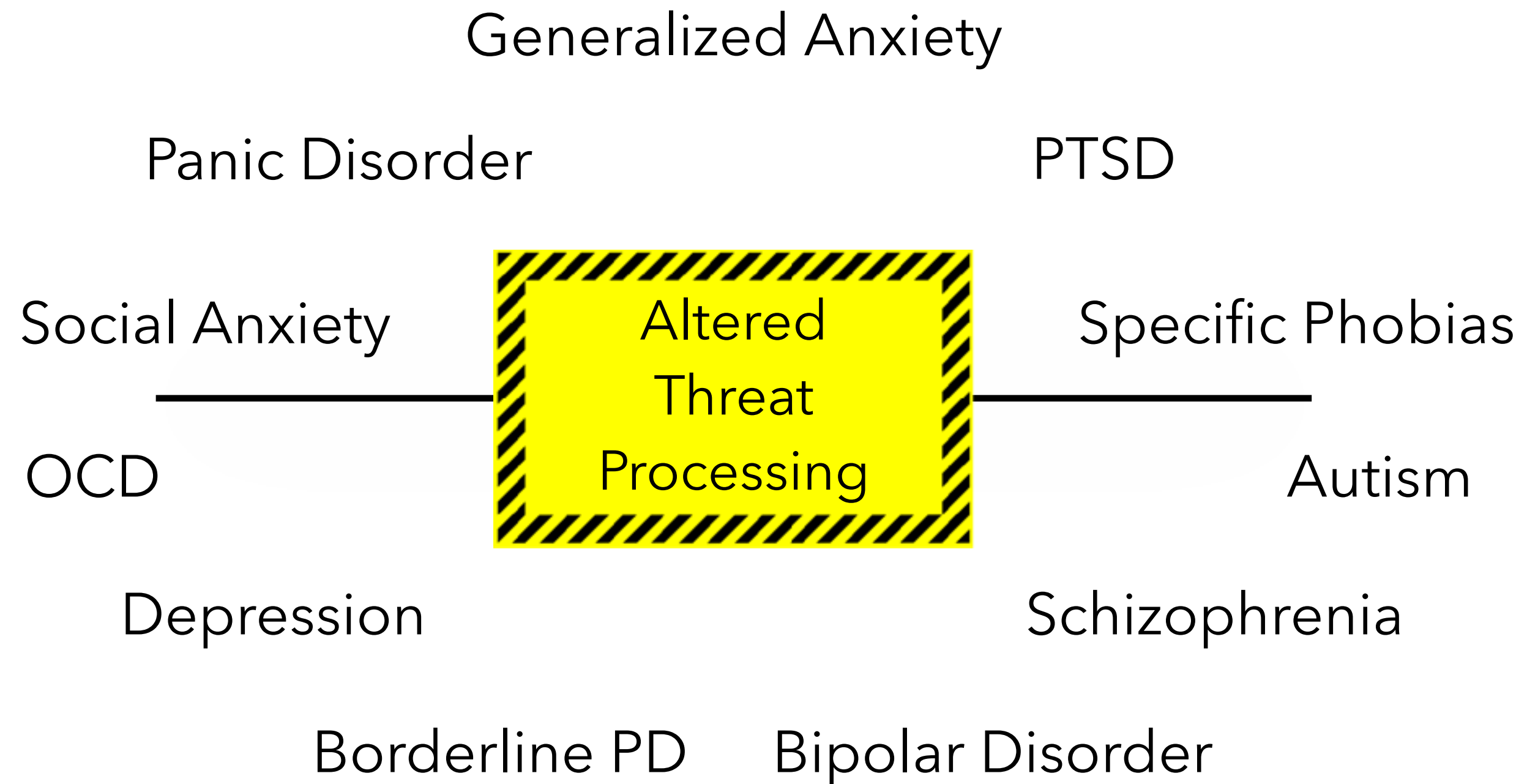
JOSEPH LEDOUX'S SIMPLE ILLUSTRATION



IF YOU REALLY WANT TO GEEK OUT



TRANSDIAGNOSTIC MECHANISMS



TREATMENT STANDARDS

First-line psychotherapeutic intervention for children and adolescents with mental illness is Cognitive Behavior Therapy

- With few exceptions best practice is to begin with CBT and add pharmacological augments when indicated
- In clinical research CBT generally outperforms waitlist controls, placebo controls, other psychological treatments (for example, psychodynamic therapy), and in some cases, psychiatric medications
- Medication management can be done through our center so that we are able to closely coordinate the psychological and biological treatment efforts.

TREATMENT STANDARDS

First-line psychotherapeutic intervention for children and adolescents with mental illness is Cognitive Behavior Therapy


- Empirically Validated
- Short-term
- Collaborative
- Data Driven
- Goal Oriented
- Homework
- Present Moment

"As clinicians, we have historically relied on anecdotal data to inform practice. We now have longitudinal, empirical data to support our clinical judgment and decisions."

- Carl Clark, MD, Director of Evaluation & Research Mental Health Center of Denver

TREATMENT TARGETS

Range of Core Treatment Targets

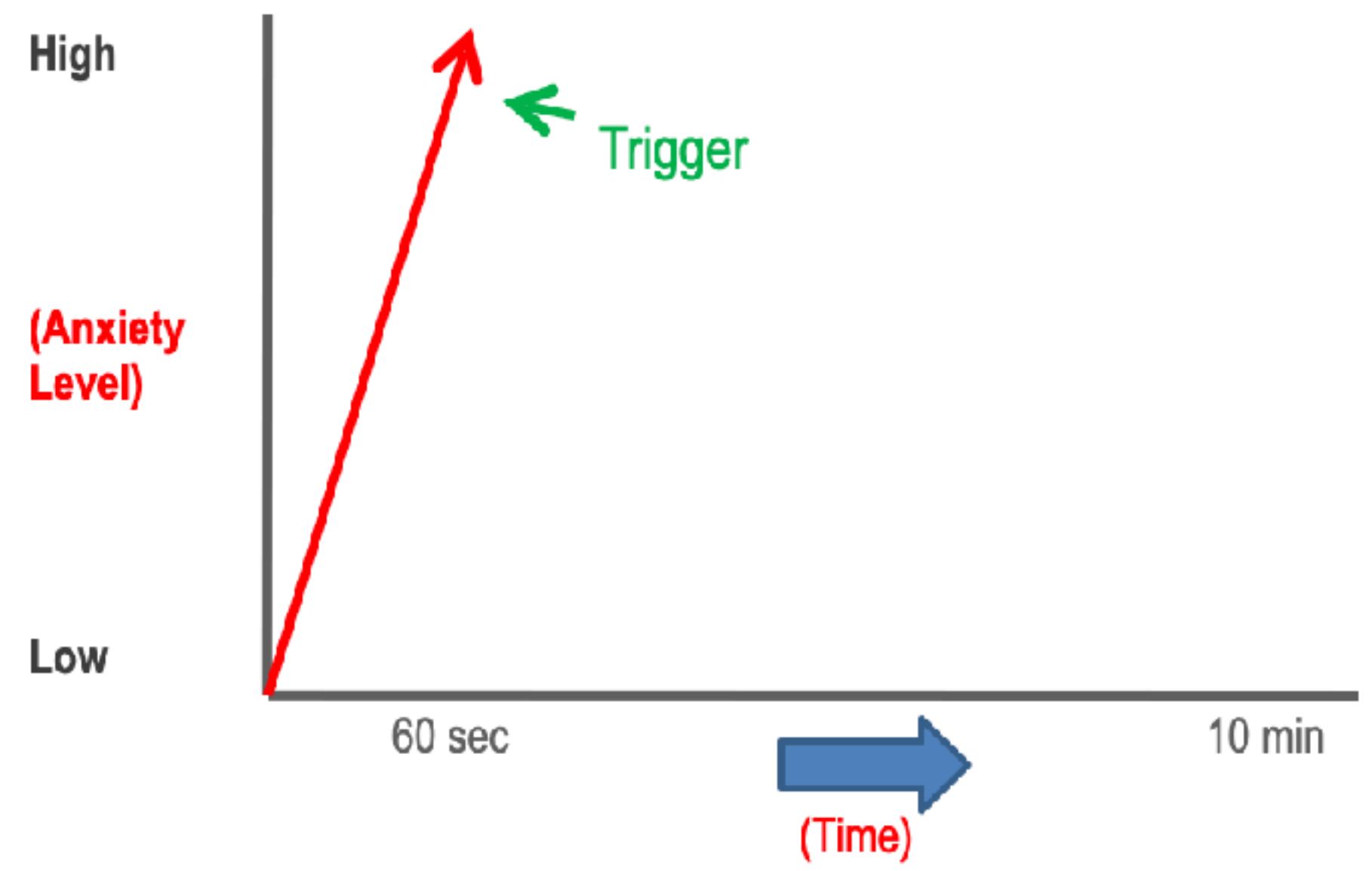
- Mindfulness
 - Behavioral Activation
 - Social Skills Training
 - Crisis Management/Problem Solving
 - Interpersonal Effectiveness
 - Emotion Regulation
 - Walking the Middle Path
 - Distress Tolerance
 - Anxiety Reduction through Exposure
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EXPOSURE THERAPY

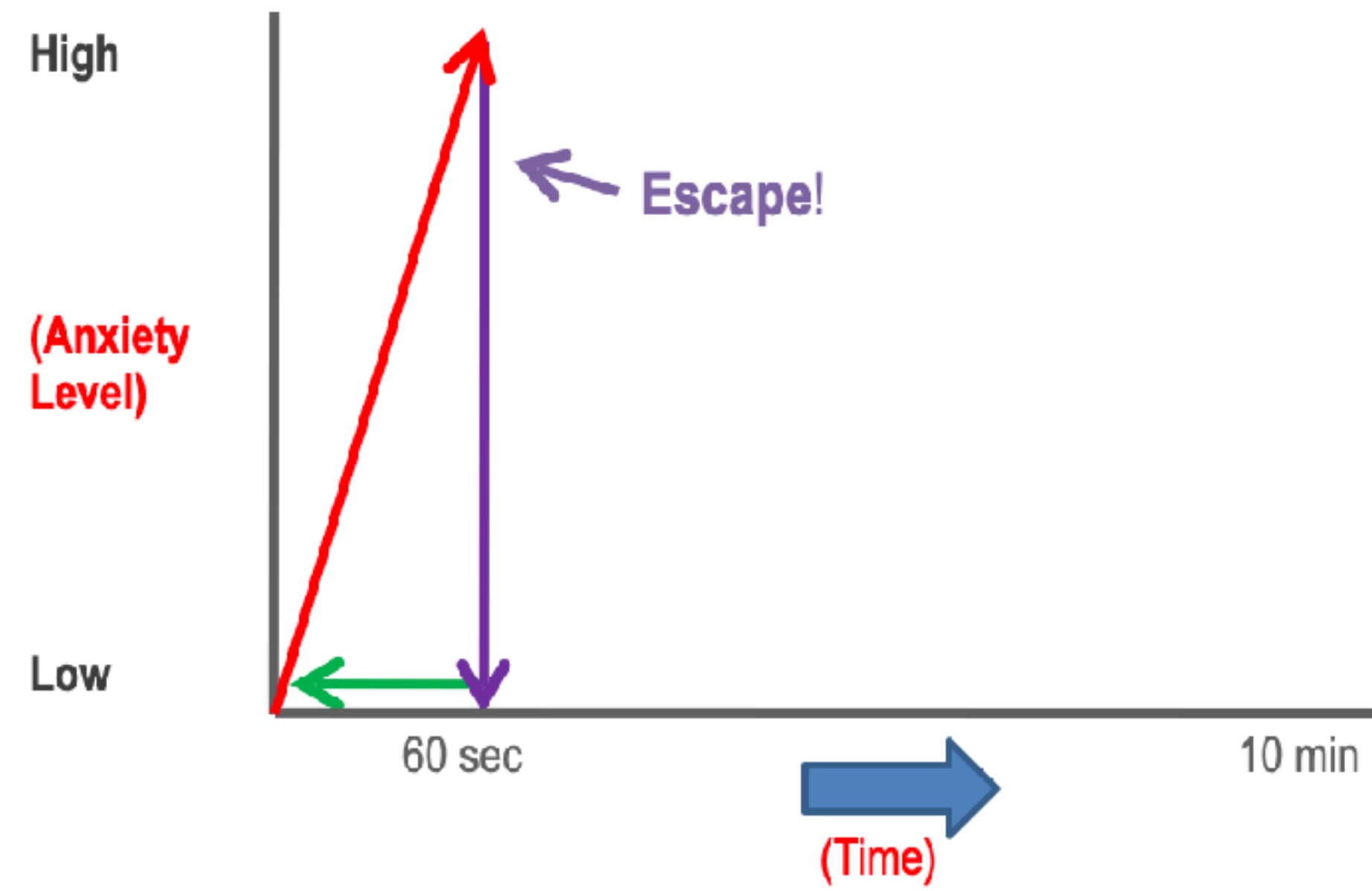
Repeated, systematic exposure to feared stimuli

- In vivo – situations, objects, places, people
- Interoceptive – sensations
- Imaginal – images and memories

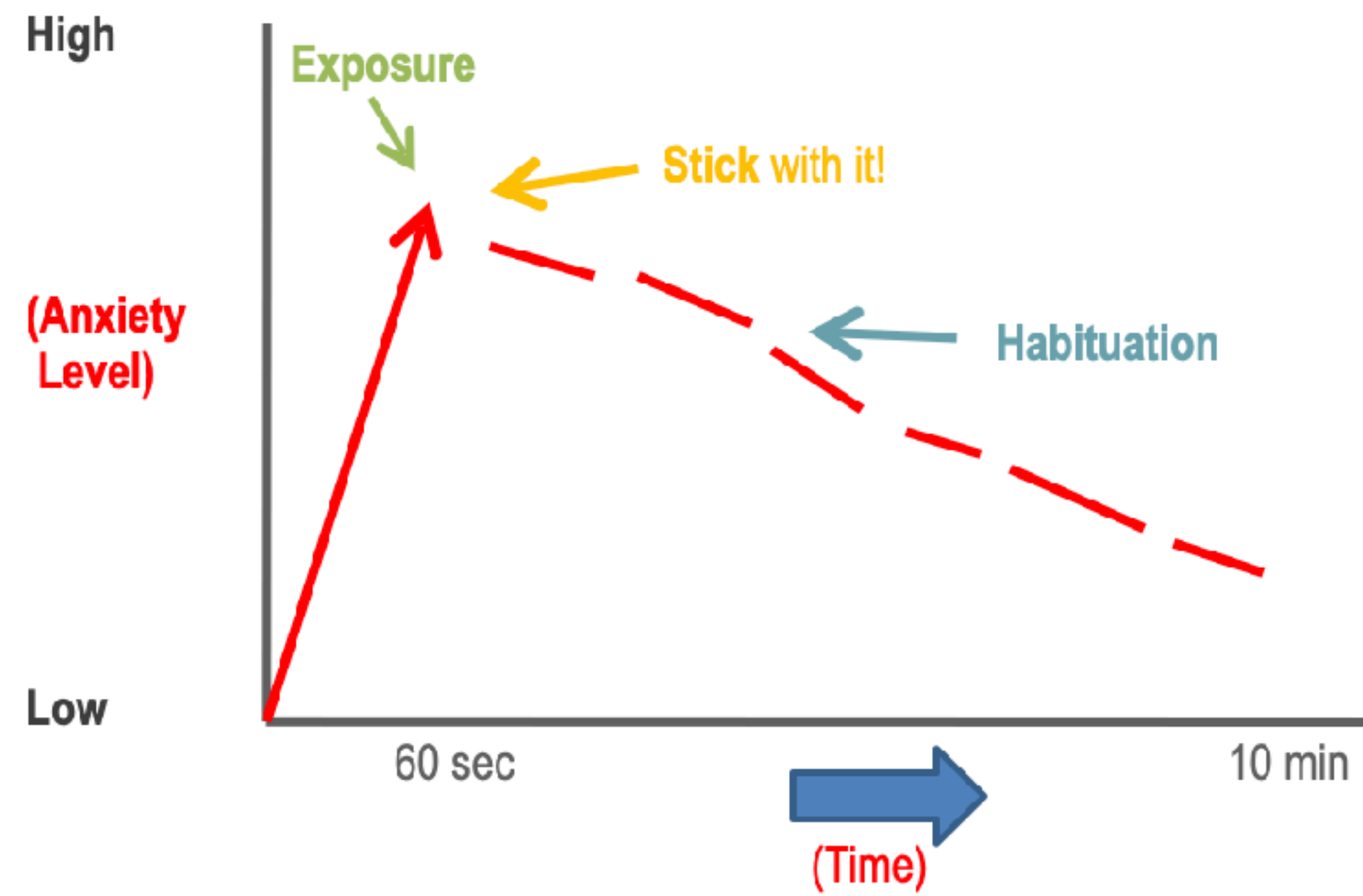
EXPOSURE THERAPY



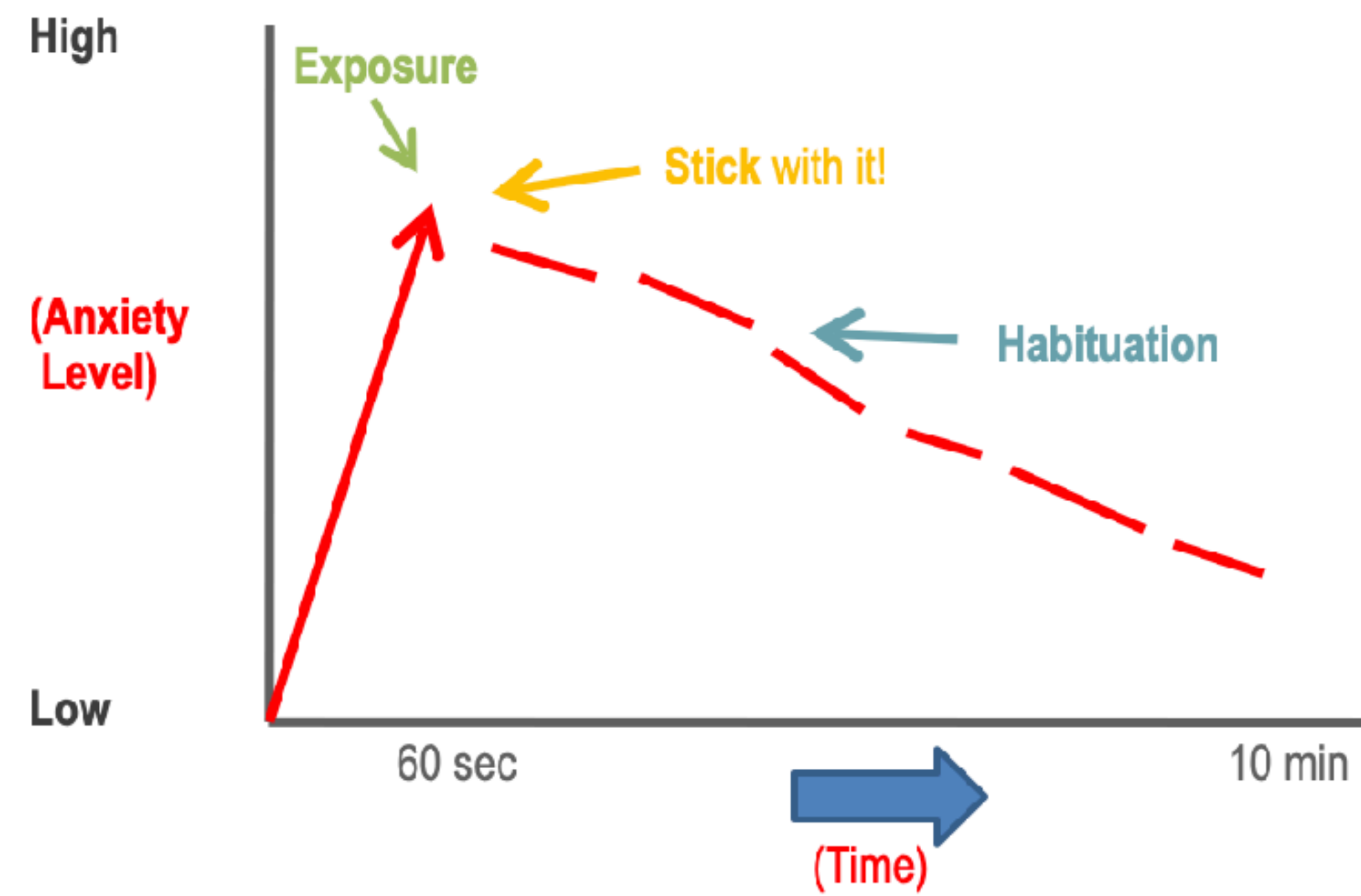
EXPOSURE THERAPY



EXPOSURE THERAPY



EXPOSURE THERAPY



EXPOSURE THERAPY

Exposure	Distress
Attend full day of school + work on completing all assigned homework	10
Attend full day of school (reduced work load)	9
Attend a half day of school + work on completing all assigned homework	8
Attend a half day of school that includes one difficult class (reduced work load)	8
Attend 3 classes (1 easy and 2 medium difficulty)	7
Attend 1 "easy" class (i.e., band, gym) and one "medium" difficulty class (i.e., English)	6
Attend 1 "easy" class (i.e., band, gym)	5
Meet with the counselor during school hours while other kids are in class	4
Walk through the school hallways during school hours (more crowded)	3
Practice the school drop-off process during pick-up/drop-off time by enter the school and going to my locker. Do not go to an in-person class right afterward.	3
Walk through the school hallways after school hours (less crowded)	2
Sit in the school parking lot in the car with my parents during pick-up/drop-off time	2

EXPOSURE THERAPY

Children

- More directive approach
- Use age-appropriate language and metaphors
- Greater use of goal-setting and reinforcement
- Greater family involvement

Adolescents

- More collaboration in exposure selection
- More realistic discussion of risk
- More identification of feared consequence, and greater use of disconfirmatory evidence

DIFFUSION

- Anxiety is seen as a separate or distinct from the child/teen. "I am not my anxiety."
- With young children we will often name the anxiety to make the idea more concrete (e.g., "Professor Poopy Pants")
- Therapy is conceptualized being the child vs the anxiety by the child, therapist, family, and school staff.



COGNITIVE ENGAGEMENT

- Developing ways to “boss back” the anxiety. Its a competition!
- Positive self-statements (make sure it is not a compulsion)
- Cognitive strategies should be to help the child/teen tolerate and benefit from exposures and to increase motivation to get back in the classroom.



COGNITIVE ENGAGEMENT

HELPFUL

Accepting absences as excused based upon having a medical condition makes it necessary for them to stay home. Working with parents and the child to define this.

Collaborating with the child's parents and medical and mental health providers on a school re-entry plan. Take a problem-solving approach.

Work with the child on using another strategy to manage his/her distress during the school day other than calling a parent or going home.

Option to meet with a school counselor 1-2x/week

UNHELPFUL

Continuously accepting anxiety-related excuses for children to stay out of school as excused absences.


Suggesting home or online schooling because school is too stressful.

Allowing students to go home from school when experiencing anxiety or physical symptoms accounted for by anxiety right away with no questions asked.


Continuously allowing multiple daily trips to the nurse/counselor's office



PARENTAL INVOLVEMENT

- We refrain from pointing fingers, "Although this nobody's fault we all have a responsibility to address the problem."
 - Research seems to suggest that parents account for approximately 4% of the variance in anxiety symptoms.
 - Help work with parents to identify mental health services from providers who deliver effective services.
- 

PARENTAL INVOLVEMENT

- For motivated students contingency management plans will likely be an important part of the treatment process.
 - These plans can be formalized to a functional behavioral assessment.
 - Parents will likely have to assist in the completion of the exposures
 - Increase incentives for the use of non-avoidant skillful behavior in the presence of anxiety
- 

ACCOMODATIONS

- Higher levels of accommodations predict poorer clinical outcomes.
 - It does not allow for extinction learning.
 - It does not allow for expectancy violation
 - It reduces the motivation to engage in meaningful behavior change
 - It allows for the maintenance of escapism

THE "MAC 'N CHEESE" APPROACH

The Two Parental Paradigms

Pusher vs. Pushover

The 2x Ingredient

Validation + Confidence=Supportive





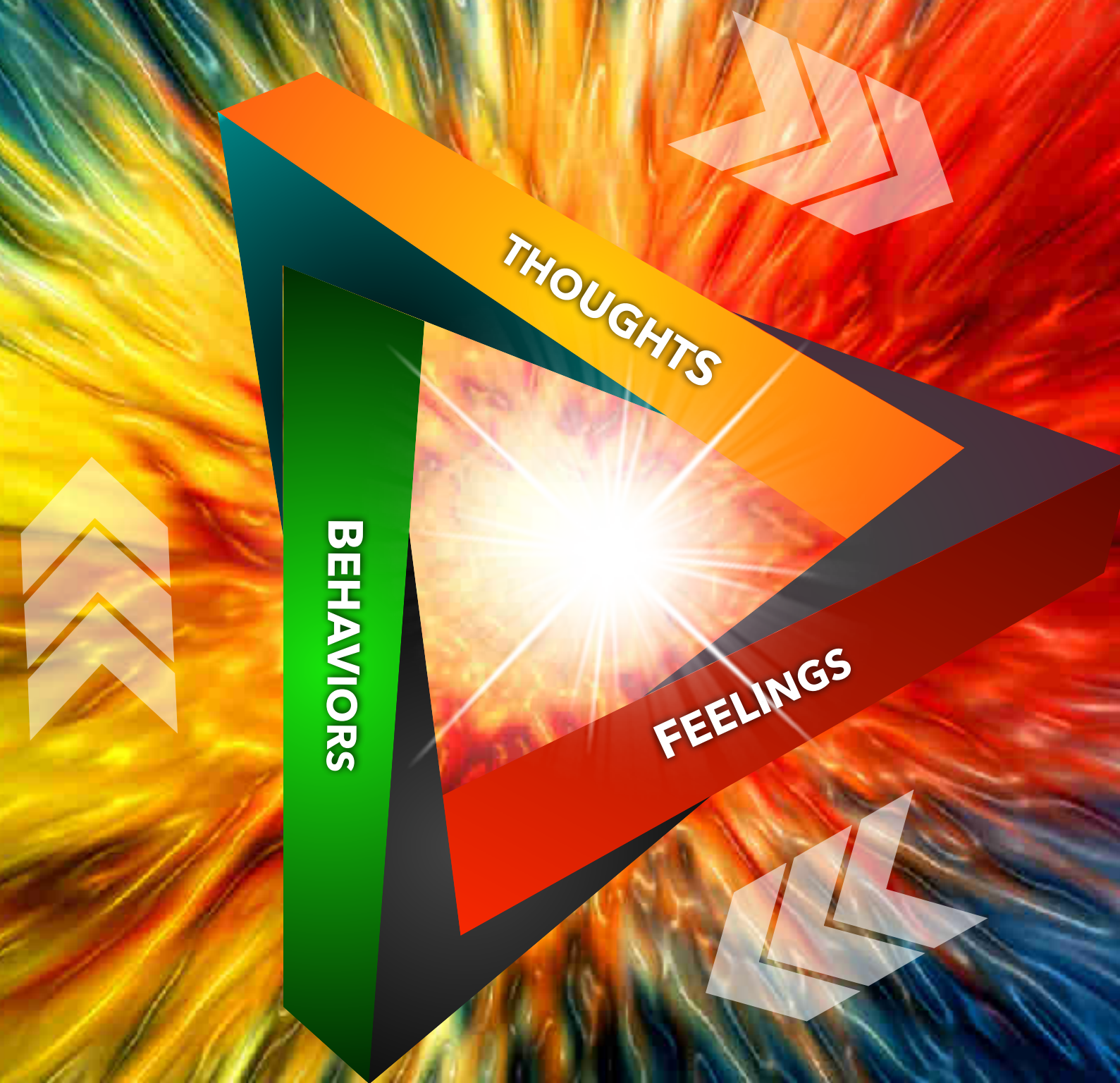
ROLEX METAPHORE

There is no power struggle to be had



TREATING ANXIETY
with DR. FITE

CBT Triforce



What if there is
Lion around the
farm???



Anxiety



Thalymus

(AKA the UPS Center)

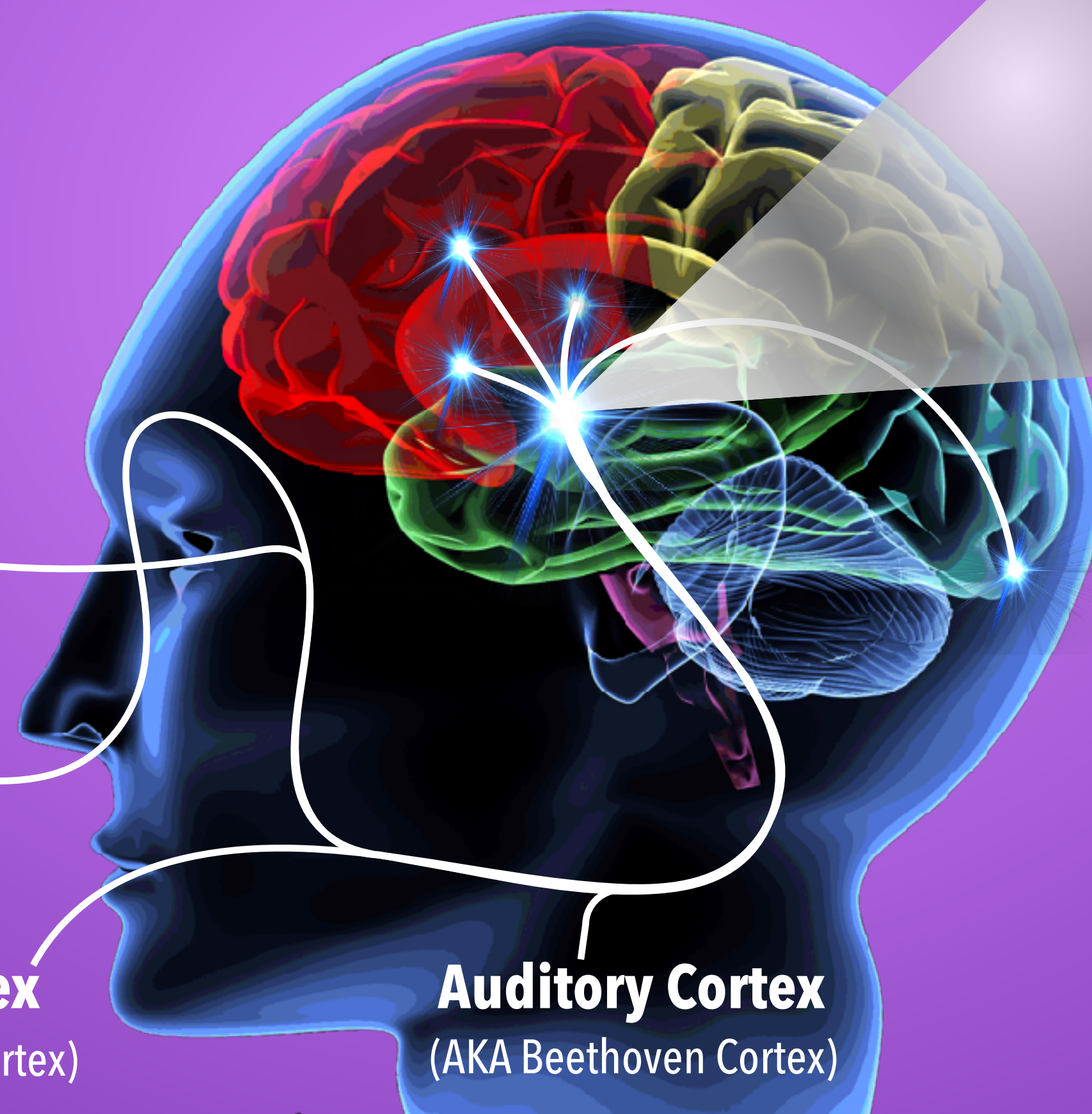


Visual Cortex
(AKA Picasso Cortex)

Olfactory Cortex
(AKA Chanel Cortex)

Gustatory Cortex
(AKA Gordon Ramsay Cortex)

Auditory Cortex
(AKA Beethoven Cortex)



Threat Response

(HPA Axis)

Hypothalamus

This is the command center receiving input from the amygdala and mobilizes the body for action

Circulatory System

With the activation of SNS there is an immediate increase in heart rate, a narrowing of arteries, and an increase in blood glucose levels

Epidermal Activity

There is a rapid increase or decrease in skin temperature. There are also changes to skin tone, texture, and moisture

Cognition

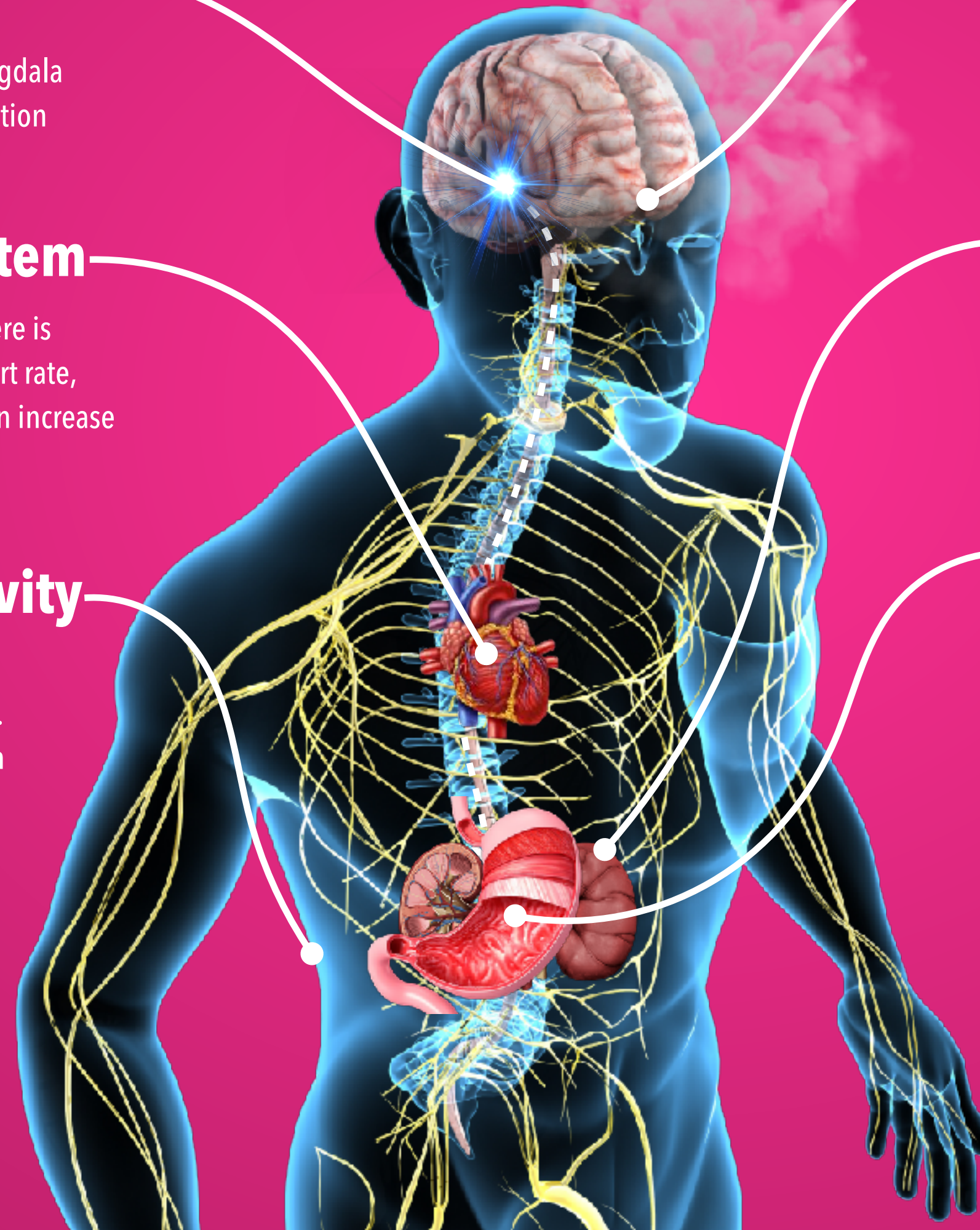
Bottom-up activation of the PFC creates brain fog, difficulty concentrating, rumination, feelings of loss of control

Adrenal Gland

This Release of hormones such as cortisol and neurotransmitters such as acetylcholine. The body prepares for action

Gastrointestinal System

With the initiation of the fear response there a decrease in nutrient absorption and changes in motility. Levels of inflammation increase and alteration in micro-biome are common.





Inside the UPS Center



Fear Conditioning

How did this happen to me?



BACK TO SCHOOL



Your outfit looks awful. I can't believe you came to school looking that way.



Let's Walk Through Case Scenarios...



Cincinnati
Child Anxiety Center

