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Highlights...

Our page 1 stories look at exposure therapy and emergencies in life, and noncardiac pain treatment.

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Monthly reports on the problems of children and adolescents growing up

Anxiety

Managing emergent life events in exposure therapy for pediatric anxiety

By Maddi Gervasio, B.S., and Jennifer Herren, Ph.D.

Over the past several decades, there has been a focus on increasing access to evidence-based practices (EBPs) for youth with psychological disorders. While many well-tested and efficacious treatments exist, the dissemination and implementation of EBPs in community practice has been met with challenges at both the macro (e.g., systemic) and micro (e.g., therapist and client) levels. Emergent life events (ELEs) are one identified barrier found to decrease fidelity to EBPs in practice settings (Guan, Kim et al., 2019).

ELEs are defined as "acute client stressors disclosed within psychotherapy sessions that have a significant negative impact on the client(s)" (Guan, Kim et al., 2019, p. 3). They are unpredictable and separate from the primary focus of treatment. Examples may include family conflict, school suspension, risk behaviors, and peer challenges. In a sample of 274 therapy sessions of youth receiving MATCH, a modular treatment approach using EBPs, Guan and colleagues (2019) found 13% of sessions included an ELE and providers often responded using non-EBP strategies. Therapist response to an ELE can extend beyond that session, which is associated with reduced adherence to EBP content and slower rates of clinical improvement (Guan, Park, & Chorpita, 2019).

Despite the prevalence and potential disruption of ELEs, treatment manuals do

*See **Anxiety**, page 3...*

Pain

Understanding and treating pediatric noncardiac chest pain

By Barbara Jandasek, Ph.D.

Experiences of pain, especially chest pain, can be not only uncomfortable but also frightening. Among children and adolescents, symptoms of chest pain are relatively common, affecting about one in 10 youth. Chest pain symptoms can vary widely in presentation, in terms of their quality, frequency, severity, and history. When presenting during childhood and adolescence, chest pain rarely signifies a cardiac or health problem. Identifiable causes of chest pain typically are related to underlying pulmonary or gastrointestinal conditions. Less than 5% of pediatric chest pain cases are estimated to be related to actual heart disease. The vast majority of cases of chest pain, estimated at 80% to 85%, are benign and are described as "idiopathic," with an unknown cause. These cases are generally labeled as noncardiac chest pain (NCCP).

Given the alarming nature of chest pain, it is a frequent cause for seeking emergency treatment and is the second most common referral to pediatric cardiologists. Medical evaluation is extensive, involving expensive procedures, such as a full physical examination by a pediatric cardiologist, radiography, electrocardiography, and other diagnostic tests.

*See **Pain**, page 4...*

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Anxiety

From page 1

not adequately provide guidance on how to address such barriers within the context of EBPs. Additionally, ELEs are clinically and personally relevant to a client and family and need to be addressed rather than ignored. More research and guidance are needed on how to respond to ELEs and reduce their potential negative impact on treatment across practice settings.

Using the 'teaching moment'

One potentially effective way to address ELEs is to use a relevant EBP strategy as a "teaching moment" (Guan, Kim et al., 2019). Some EBP strategies such as problem-solving and relaxation may be more easily identified as relevant to ELEs, while other strategies may be perceived as less applicable, such as gradual exposure.

If providers are unsure about how to use exposure to address an ELE, it could potentially be more disruptive to treatment. In a current study at the Pediatric Anxiety Research Center examining exposure use with youth and young adults in community practice, ELEs were identified as a barrier to exposure completion. In a sample of 519 sessions with no exposure, therapists self-identified ELEs in 53% of these sessions as a reason why an exposure was not completed. This finding underscores the potential challenge of ELEs in exposure therapy and the necessity of additional guidance on how to manage ELEs within exposure therapy.

Approaching ELEs during therapy

The remainder of this article will focus on ways to approach ELEs during exposure therapy (see Figure 1) and examples of how to use exposure as a "teaching moment." It is important to note that the nature of ELEs can be widely variable, and this article is meant to offer ways to respond to ELEs that do not require immediate intervention to manage risk or possible trauma (e.g., community violence, active suicidality, disclosure of abuse). While outside the scope of this article, these types of ELEs should be addressed with a priority on safety and individual needs of the client and emergent event.

When an ELE is presented during exposure therapy, the first step is to engage in a brief assessment of the stressor to guide the intervention. This assessment will likely include gathering pertinent information and engaging in nonspecific strategies of empathic listening and emotional validation. One important goal of this brief assessment is to determine whether there is a relevant anxiety target and if exposure is an applicable treatment skill. Using exposure as a "teaching moment" enables therapists to use naturalistic opportunities to practice the treatment skill of exposure in ways that are meaningful to the client and can improve learning.

Asking questions about behavioral avoidance, presence of fears (e.g., embarrassment, morality), distress level, and precipitating events can provide helpful information to determine the relevance of using exposure.

It is not uncommon that anxious youth may feel embarrassed or avoidant while discussing an ELE. If a life event is disclosed and the child appears visibly anxious and has difficulty talking and/or hearing about the situation, the therapist can assess if the conversation itself could be an exposure target. Exposure is an important EBP skill for building distress tolerance more broadly and helping youth approach a situation in a manageable way rather than avoid.

For example, a 16-year-old client, Matthew, and his parents disclose there was an incident this week involving a family fight and Matthew punching a hole in the wall (ELE). The family denies safety concerns and plans to have Matthew help repair the wall. Through initial questions, you learn that the fight started because Matthew refused to go to chorus or practice at home (precipitating event) despite it previously being an important activity to him. Matthew shares that he stopped going to chorus about a month ago (behavioral avoidance), is uncomfortable going back (anxious distress), and worries about messing up (presence of fear). Based on the information shared, using exposure to address his anxious avoidance would be applicable.

Assess motivation

If exposure is appropriate to address the ELE, introduce the connection to the client and assess their motivation to work on it with exposures. In the above example, a therapist might say, "Thank you for sharing that with me. It sounds like there is a worry that is getting in the way of you attending chorus, which led to fighting at home and you feeling really angry. I know it is hard, and this worry seems like something important to address. Would you be willing to complete an exposure focusing on this today?" If they agree, collaboratively engage in exposure task selection to identify a step that is appropriate for that session. In this example, the therapist could provide Matthew with several exposure options focused on approaching singing, such as showing a video of him singing, performing a familiar song in front of the therapist or alone in the office, or humming a song. They decide on practicing a familiar song while in the office alone, as Matthew identified this task as challenging, yet manageable. Like other exposure sessions, engaging in exposure homework planning to continue progress toward attending chorus would be beneficial.

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For example, the mother of a 13-year-old, Samantha, discloses that she is concerned because Samantha and her best friend had a major fight and have not spoken all week. Samantha is noticeably uncomfortable when her mom raises this concern. To approach the conversation as an exposure task, a therapist might say, "It seems like this is hard to hear and talk

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about. How are you feeling right now?" Samantha reports she is feeling embarrassed to share the situation with you. "Since this is feeling difficult right now and is important to discuss, would you be willing to continue this conversation as our exposure for the session? Let's think about where to start together and how hard it would be using your 0 (not at all anxious) to 10 (extremely anxious) scale?"

Exposure options could be related to how much of the story is shared, how it is shared, and who is present. For instance, the therapist might suggest options such as starting with yes/no questions, Samantha sharing a part of the story, her mother sharing while Samantha listens, or Samantha writing it down. Therapists can use this process to model ways the client can approach talking about uncomfortable topics in the future.

Additional interventions

While some ELEs are addressable using exposure, it is expected that a number of ELEs would need a different intervention. As previously mentioned, ELEs related to safety and trauma should be prioritized using interventions that meet the individual needs of the client and the situation. For ELEs unable to be addressed by exposure, therapists should consider introducing another EBP strategy. EBPs that are commonly incorporated during exposure treatment are problem-solving, psychoeducation, behavioral parenting training, and safety planning. For example, a family presents an ELE of your client getting suspended at school for being disrespectful to the teacher. The therapist determines that there does not seem to be anxious avoidance and chooses to introduce problem-solving to the client to highlight alternate solutions to deal with similar situations in the future. If the ELE is addressed with time remaining in session, a therapist could consider completing a shorter or easier planned exposure based on the patient's motivation. This would model the importance of completing exposures when life is unpredictable and ensuring your client feels supported through the stressor.

Overall, continued attention is needed on how to manage ELEs within the context of exposure and other EBPs. Approaching ELEs as possible naturalistic learning opportunities and "teaching moments" rather than a barrier can be a useful framework for therapists using exposure in practice. Additionally, using "teaching moments" can help providers approach ELEs with more confidence and minimize overall reduction in EBP fidelity.

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Pain

From page 1

Understandably, experiences of chest pain provoke worry and concern in children and their caregivers. Despite negative medical findings and attempts of medical providers to reassure patients and families, NCCP is often associated with increased attention to a child's cardiovascular health, prompting caregivers to seek repeated medical evaluation and care for their child. There is no established medical treatment for NCCP.

Without appropriate treatment, NCCP often persists following its initial presentation and diagnosis, for several months up to several years. This pattern of ongoing pain symptoms is often associated with occurrence of other somatic symptoms, and additional medical evaluation for those symptoms. The lives of many youth are negatively impacted by their NCCP, resulting in decreased quality of life and functional disability, including school absences, sleep problems, and restricted participation in extracurricular and social activities. Parents of children with NCCP may experience disruptions to work, lost wages, and medical costs.

Psychiatric symptoms and chest pain

Research efforts have sought to better understand associated individual and family factors, potential causes and mechanisms, and treatment options for youth suffering from NCCP. Some research studies have drawn comparisons to patients diagnosed with innocent heart murmur (IHM), another condition involving evaluation from a pediatric cardiologist, and eventual receipt of a benign diagnosis. Findings indicate that, compared to youth with IHM, youth with NCCP experience more internalizing symptoms, particularly anxiety disorders, as well as higher rates of depression (Lee et al., 2013; Lipsitz et al., 2012; Loiselle et al., 2012). Anxiety sensitivity — the fear of the feeling of physiological arousal, like bodily sensations associated with anxiety, such as trembling, irregular breathing, and heart palpitations — is also more common (Lee et al., 2013; Loiselle et al., 2012). Individuals with anxiety sensitivity are more likely to interpret these sensations as harmful, often intensifying their anxiety and the sensation itself.

The onset of psychiatric symptoms appears to occur prior to the chest pain, implying that they are not merely in response to the chest pain itself or to functional disability related to the chest pain (Lipsitz et al., 2012). Patterns of adjustment among youth with NCCP appear similar regardless of child age or gender. Especially for those youth with comorbid psychiatric disorder, chest pain predicts higher levels of functional disability and decreased quality of life (Lee et al., 2013; Lipsitz et al., 2012). It is unclear at this time whether comorbid psychiatric disorder predicts duration of chest pain in pediatric populations, although this has been found for adults.

Parental well-being and behaviors, such as modeling and response to their children's symptoms, are also important considerations. Parents of children with NCCP report higher levels of anxiety and somatization themselves (Loiselle et al., 2012), and their own adjustment and health care utilization predict children's health care utilization patterns (Loiselle et al., 2012). In addition, for children of parents who provide increased attention or alter children's participation in activities due to their pain,