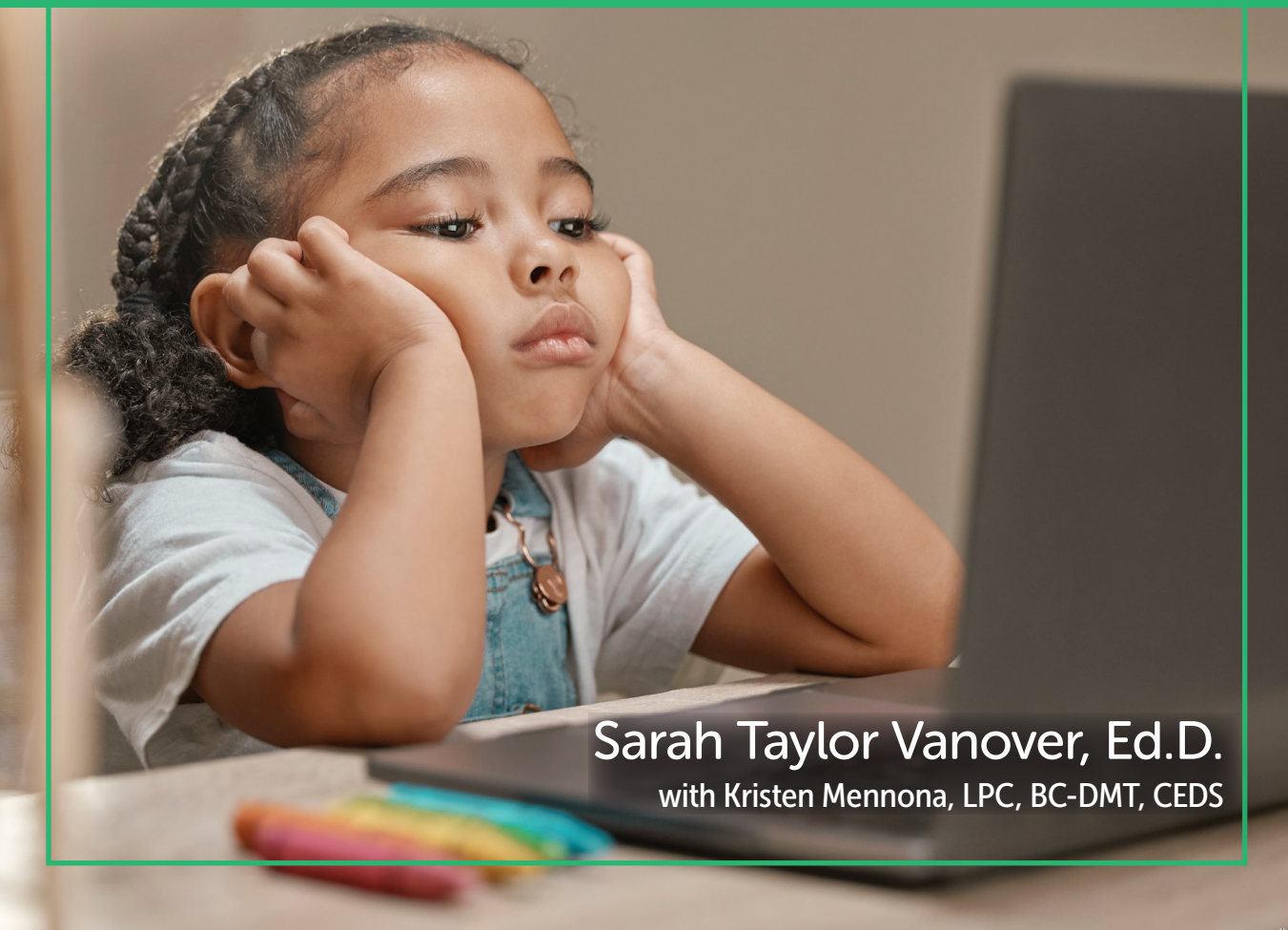
Addressing ANXIETY IN YOUNG LEARNERS

A Teacher's Guide to Recognizing Needs and Resolving Behaviors



Sarah Taylor Vanover, Ed.D.
with Kristen Mennona, LPC, BC-DMT, CEDS

Addressing Anxiety in Young Learners

Excerpted from Addressing Anxiety in Young Learners:
A Teacher's Guide to Recognizing Needs and Resolving Behaviors by Sarah Vanover, Ed.D.

FOR MORE, go to: bpub.fyi/anxiety

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by
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Kentucky Youth Advocates
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with Kristen Mennona, LPC, BC-DMT & CEDS

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Contents

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About the Author

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Dr. Sarah Vanover has been working in the field of early childhood education for more than 25 years and has had the opportunity to be a teacher, a director, a trainer, and a college professor for other early childhood educators. She also served as Director for the Division of Child Care in Kentucky for almost 4 years, supervising Child Care and Development Block Grant (CCDBG) funding and creating child care policy. Dr. Vanover is currently Policy and Research Director for Kentucky Youth Advocates, focusing on early childhood education policy and research on positive outcomes for young children. For the past several years, she has focused her work and research on increasing access to child care for children with special needs and improving state systems that would help stabilize the child care infrastructure nationwide.

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About the Contributor

Kristen Mennona, LPC, BC-DMT & CEDS, Founder, Nurture Family Counseling, LLC, Denver, Colorado

Kristen Mennona is the founder of Nurture Family Counseling, LLC, in Denver, Colorado. Her practice specializes in the treatment of pediatric eating disorders, obsessive-compulsive disorder (OCD), and anxiety within the context of the family. She is a licensed professional counselor, a board-certified dance/movement therapist, a certified eating disorder specialist (CEDS), a registered yoga instructor (RYT 200), and a Behavior Therapy Training Institute (BTTI)–trained clinician for pediatric OCD. Ms. Mennona combines best clinical practices with ancient, embodied experiences for her clients. She believes in the inherent wisdom of the body to bring forth that which needs healing.

Ms. Mennona presents nationally on the topic of body image acceptance and the integration of expressive arts. She enjoys teaching clinicians how to incorporate nonverbal methods to help clients tolerate body sensations (e.g., anxiety). She hosts an Instagram account (@the_body_as) to inspire more people to work on body image acceptance and to pass that acceptance on to the next generation. She appeared on *The Return to Embodiment* podcast in the spring of 2023.

Generalized Anxiety Disorder 2

Although there are several different types of anxiety, generalized anxiety disorder (GAD) is by far the most pervasive (NASP, 2022). Children who are diagnosed with GAD have very high levels of anxiety across a wide range of situations with no obvious triggers for their attacks (NASP, 2022). The level of the child's worry may not match the severity of the situation. The child may have the same level of anxiety over the death of a loved one as she does for a substitute teacher. These children often have perfectionist tendencies and have a hard time dealing with less than perfect behavior.

Children with GAD worry almost every day (Nemours Children's Health, 2022a). They have some of the same worries as other children their age, such as fear of the dark or monsters in the closet, but they also worry about much more serious issues like war,

natural disasters, the safety of loved ones, illness, and their own personal safety (Nemours Children's Health, 2022a). This consuming worry often makes it difficult for children with GAD to focus during the day, especially on schoolwork. They also struggle to fall asleep at night when they are distracted by worrying. The same children may miss school frequently because the all-consuming worrying makes them feel sick and tired from fear (Nemours Children's Health, 2022a).

Because children with GAD worry more often and more intensely than other children, their worries can prevent them from participating in normal daily activities (Boston Children's Hospital, 2022a). Children with GAD may be misdiagnosed with conditions like attention-deficit/hyperactivity disorder because they cannot focus. Many children with GAD focus on their inability to be perfect. They are extremely self-critical, and they even begin to avoid activities where they cannot be perfect. Because of these insecurities, children with GAD frequently seek reassurance from parents, teachers, and other important adults in their lives. Even frequent reassurance only supports the children for a small amount of time, and these children fall back into a pattern of prolonged worry.

GAD can begin gradually, but without early intervention from trained professionals, it can escalate to chronic and intense adolescent and adult anxiety (Boston Children's Hospital, 2022a). This diagnosis affects approximately 3% of children and adolescents between 3 and 17 years of age, but most of those cases are diagnosed in the older age range. Although boys and girls can both be diagnosed with GAD, twice as many girls are typically diagnosed with this condition in comparison to boys.

Case Study: Jonathon

Jonathon is 6 years old and has recently been diagnosed with GAD. He continuously worries about his mother's safety when they are apart, and he worries about whether his

dog is safe when they leave him at home alone during the day. His parents have enrolled him in gymnastics classes, swim lessons, and soccer, but he demanded to quit each activity when he realized that he could not immediately perform the skills perfectly. Although he has never seen a house fire, he is constantly worried that his house will catch on fire when the family is away during the day or on a vacation.

Jonathon wakes up each day and tells his mother that he has a stomachache. She has taken him to the doctor many times, but the pediatrician has found nothing that is medically wrong, such as Crohn's disease or an ulcer. After blood tests and an ultrasound, the doctor believes that the stomachaches must be related to stress. Jonathon's mother is perplexed by her son's stress level because he has not really been exposed to high amounts of stress in his life. Jonathon's biological parents are married and the family lives in the same home that Jonathon has lived in his entire life. The family has never had intense stressors like worrying where the next meal will come from or where they will live. Despite the security that Jonathon has experienced in his life, he continues to worry about situations that are unlikely to happen.

Jonathon's intense worry has led to emotional outbursts at home and at school. Sometimes, Jonathon will react by crying and screaming, but other times he will run away in the house and hide for an extended period of time. The classroom teacher has disciplined him for hiding in the classroom and not following directions, but Jonathon still refuses to participate in classroom activities when he becomes this upset. The most confusing part of this behavior is that the teacher can never figure out what triggered his emotional outburst. The teacher has asked Jonathon's mother to meet with her and make a plan for how to handle these emotional outbursts, but neither one has any ideas about how to stop the behavior from happening when they don't know what is causing it in the first place.

SYMPTOMS

When making a diagnosis of GAD, a mental health specialist will look for specific symptoms. One of the first criteria that children with GAD will display is exhibiting anxiety more often than they do not exhibit anxiety (ZERO TO THREE, 2016). It is a constant theme in the life of the child that does not go away. He or she may worry about things in the future, but the child could also be worrying about events that happened in the past. The anxiety will be based on more than one area or setting so that it is not limited to just social anxiety or anxiety about being separated from a loved one.

Other criteria for a GAD diagnosis are that the child cannot regulate his or her emotions about the anxiety (ZERO TO THREE, 2016). He may have to ask his parents for continual assurance that everything is okay. She may want her friend to constantly remind her that she likes her. There is no way for the child to avoid a sense of dread, so family members and friends must help the child work through these emotions. This can also mean that he may have aggressive behaviors or meltdowns when he feels overwhelmed by a sense of anxiety.

To be diagnosed as GAD, the anxiety must occur in different settings and in two or more relationships. If a child is only displaying anxiety at school, then that is a specific type of anxiety. For example, she may be experiencing separation anxiety due to being separated from a parent while at school; however, once she is reunited with her parents, the anxiety is no longer present.

In GAD, the child can show agitation, irritability, muscle tension, difficulty relaxing, fatigue, sporadic lack of attention, and dysregulated sleep all due to higher levels of anxiety (ZERO TO THREE, 2016). Many adults may expect children with anxiety to show only nervous or shy behaviors; however, anxiety can cause many different emotions to surface.

Many children and adults lose sleep when they are anxious because they stay awake worrying when it is time to sleep. Anxiety can also cause a great deal of fatigue for the body because it has worked so hard being anxious. In those cases, a child with anxiety may sleep for a large portion of the day to deal with the stress. A lack of focus is also a common characteristic of anxiety. A child consumed by worry may seem to be staring off into space when it is time to do schoolwork or be part of a classroom project. The symptoms of a child distracted by anxiety may appear to be like symptoms of attention-deficit/hyperactivity disorder. A skilled medical professional will be able to look at the root cause of the distraction and determine the true reason for the inattention.

Medical professionals must also make sure that the anxiety symptoms are not related to medication that a child is taking. Medications such as steroids or asthma medication may have an unintended side effect of anxiety. In those cases, a substitute medication may have the same benefits without the negative side effects. It is important to track side effects of any new medications that the child takes and to share that information with the child's doctor to see if a different medication may be needed.

There are physical symptoms associated with GAD. Many children with GAD will complain of physical pain or body aches (Bilmes & Welker, 2006). This is often stomach pain. When a child is extremely anxious, he or she will have persistent stomachaches, even to the point of developing ulcers. Unfortunately, the pediatrician must rule out all other reasons for stomach pain (e.g., Crohn's disease, celiac disease) before determining that the stomach pain is specifically related to anxiety. Headaches, heightened heart rate, persistent sweating, and pain from muscle tension may also be physical symptoms that children demonstrate.

A true case of GAD will limit the child's ability to function in his or her normal environment (ZERO TO THREE, 2016). This can be interpreted in a wide variety of outcomes. The child's anxiety may cause unnecessary hardship on the child, but it could also make it very difficult for the child to create friendships with peers and strong bonds with caregivers. The anxiety may make it challenging for a child's development to stay on track. It may prevent a child from trying new things or participating in typical classroom activities.

It is very difficult to make a diagnosis of anxiety below the age of 2 1/2 years of age (ZERO TO THREE, 2016). This is particularly true because many toddlers show separation anxiety and other fears as a part of normal development. Once a child is past these typical developmental milestones, it is easier to determine if the anxiety is a persistent problem. It is also developmentally normal for a young child to have a short bout of anxiety, such as fearing that a monster is in the closet; however, if the fears begin to last beyond 2 months and are persistent, it may be time to consider that the anxiety is more significant than initially believed.

CAUSES

Although no specific cause has been determined for GAD, there are factors that may be related to why certain individuals receive the diagnosis. The contributing factors are the following:

- Genetics
- Temperament
- Biology
- Environment

- Children exposed to significant family stressors such as family instability, poverty, or violence

Even though these characteristics may influence a child who develops GAD, children with a stable family history and a positive environment may still display a diagnosis of pervasive anxiety regardless of their family history.

Age is also a factor in GAD. Although anywhere from 9% to 20% of children may be diagnosed with some type of anxiety disorder, most of the cases are diagnosed in adolescents (ZERO TO THREE, 2016). Research has also found that higher percentages of anxiety disorders are associated with girls even though both boys and girls can be diagnosed with these types of conditions.

Anxiety is often called a comorbidity, or a condition that is frequently diagnosed at the same time as another disorder or disability. In this case, GAD is often diagnosed at the same time as conditions like attention-deficit disorder, attention-deficit/hyperactivity disorder, depression, disruptive behavior disorder, oppositional defiant disorder, and autism (ZERO TO THREE, 2016). Children with elevated anxiety frequently have a hard time processing sensory stimuli; therefore, many of these children may also struggle with a sensory processing disorder. They could be picky eaters, react strongly to loud noises, or have a hard time dealing with unique smells.

TRIGGERS

Triggers for GAD may be very different than those for other types of anxiety. Because GAD can be irrational fears and elevated worrying, the trigger may be just as irrational as the source of the anxiety. When dealing with an individual type of anxiety, the professional may be asked to look for the antecedent, the behavior, and the consequence (known as the ABC). In this case, the teacher or mental health professional would want to find out what happened right before and right after the anxiety occurred. In a case of separation anxiety, the mother may drop her child off at school for the day so the child is now left with a nonpreferred caregiver. In that case, the trigger seems logical in the progression of events.

In a case of GAD, where the child's fears may be nonstop and irrational, the progression of events may not be as logical. For example, if a child has been constantly worried about his or her home catching on fire, the trigger may be that another child in the classroom mentions his or her own home. Then, the child with anxiety may be overwhelmed with emotions due to fear of the home catching on fire, but the teacher has no visible triggers and the child is now too emotional to describe why he or she is violently crying.

In order to understand what is causing the child to become emotional or have an anxiety meltdown, it may be that the teacher and the family need to continue to document what happens before and after the anxiety outbursts in order to try and determine a pattern. This type of documentation, over days or weeks, may allow the adults to try to determine behavior patterns. For example, if a child has an outburst at the same time of day or in the same setting, adults may observe what triggers could be associated with those factors. It could also be important to look at whom the child is with when the outburst occurs, if the routines have been consistent before and after the outburst, if medication is constant or changing, and if a child's sleep patterns have changed. Big changes in a child's schedule, such as a classroom change or a parent taking a trip, may be much easier to document. Depending on the age of the child and his or her verbal skills, it may be too difficult to determine every trigger.

TREATMENTS

Depending on the severity of the child's diagnosis, the family may choose to take several different paths for treating GAD. There are therapeutic approaches and medical approaches to assist a child with GAD. There are also ways to utilize behavior therapy or occupational therapy to assist a child with regulating his or her anxiety. A family may choose one type of treatment, or they could create a treatment plan that allows them to use multiple treatments to best support the child.

Play-based therapy is the most common and developmentally appropriate method of counseling for young children. Because children in preschool and even elementary school may not be able to walk into a counselor's office and describe the source of their stress, play-based therapy allows the counselor the opportunity to interact with the child in a friendly environment. The counselor can develop a relationship with the child and interact with them in a safe environment. Then, once the two are engaged in play together, the counselor can begin to interject questions about how the child is feeling. If the child's language skills are limited, the counselor may be able to help him or her describe their fears through drawing, playing with dolls, or other nontraditional methods.

When the child's level of anxiety and reactions to triggers begins to affect every member of the family, then family counseling may be the most appropriate treatment. In family counseling, the counselor may choose to meet with the children and adults separately or to meet with the family as a whole. Again, play-based therapy may be the most appropriate when speaking to the youngest members of the family; however, the adults may need counseling on how to interact with their children during these fits of anxiety or on how to redirect the children's negative behaviors. GAD rarely affects only one member of the family, so it can help to make sure that all the caregivers have a unified approach on how to support the children as they deal with their anxiety. The adults may be overwhelmed and fatigued from supporting their children and need counseling of their own.

It is also possible that the child's support team of medical and mental health professionals recommend parent education for the primary caregivers. Parent education can look very different depending on the professional who offers the support services. Some professionals offer education in the form of a book club or a support group. Parents experiencing the same situations may meet on a regular basis to talk about their children's symptoms and how they are trying to help their children. This may include some homework, such as reading a book together outside of the group time. Other professionals offer parent education as a type of class where the child's primary caregiver comes to class, sits at a desk, and learns about the theories on how to help children experiencing anxiety.

If a parent or caregiver is attending counseling or parent education, it is also possible that he or she may need additional information or guidance from the child's teacher. Because a teacher spends up to 7 or 8 hours a day with the child while he or she is awake. It is possible for the teacher to see behaviors that a parent may not have the opportunity to observe, especially when the child is in a group setting. The whole evaluation process for a child with anxiety can include the teacher offering information for behavioral assessments, but the teacher's job does not end after the diagnosis is offered. Every time part of the child's therapy plan or treatment play is altered, the teacher is in a wonderful place to observe behavior changes that accompany the plan.

If a child experiences severe anxiety, the child's doctor may recommend medication treatment to help the child be as successful as possible. Every doctor and family is going

to look at this treatment option in a different way. One of the key factors involved in choosing medication is whether the family can continue to function at the child's current level of anxiety. If the child's anxiety level is so high that it is making normal family activities very challenging, then a doctor may recommend medication as a relief for the child and for the family as a whole.

Although pediatricians can prescribe anxiety medication, many pediatricians will recommend that a young child see a child psychiatrist in order to make sure that the medication and dosage are exactly what the child needs for their condition and development (e.g., height and weight). Once the psychiatrist starts a child on a particular course of medication, it is essential to observe specific details about how the child is reacting to the medication. The doctor may not choose to place the child on a full dose initially. Instead, he or she may start the child out on a small dose and build up to the full amount of medication.

It is also critical to remember that not every child will react positively to a new medication. There may be behavioral or medical side effects to a medication; because the child is with the teacher for a large portion of the day, it may be the teacher who first sees these side effects. It is essential for the teacher and the child's parents to communicate closely during these medication changes. For example, if a child begins a new medication and sleeps during large portions of the school day, it is possible that the dose is too large and the child is overmedicated. This is essential information for the family and the medical professionals. Teachers need to make sure to share this type of observation frequently and regularly.

Many teachers have strong feelings about placing young children on medication for behavioral disabilities or mental health needs. Despite any personal feelings the teacher holds, it is not the teacher's job to discourage the family from any specific type of intervention that the child may need to be successful. The primary role of the teacher is to support the family once they pick a treatment plan for the child. This includes encouraging the family that they are trying to take care of the child to the best of their ability when the child has challenging days. It also includes documentation of the child's reaction to the medication, as well as communicating those observations to the family.

It is important for teachers to remember that they are there to *observe* when these medical and mental health treatments are put into place. The teacher should not diagnose that the child is taking too much medication because the teacher is not a medical professional. Instead, it is more appropriate for the teacher to observe that the child frequently falls asleep in class since she began taking her new medication and to tell the family that they might want to share that information with the child's doctor. Veteran teachers have been in the classroom for years and have seen children with a variety of diagnoses. Many teachers may be accurate in their assumptions of the child's medical condition and side effects; however, it is always better to present the information to the family in the form of an observation so that the family never comes back to the teacher with accusations about a false diagnosis.

Once a family completes their child's treatment plan with the help of a medical professional or mental health specialist, it can be beneficial to the child and the teacher for the family to schedule a parent–teacher conference in order to share the details of the plan and have all of the important people in the child's life using the same plan of action. However, it is also important for teachers to remember that a medical or mental health treatment plan is confidential medical information. The family may not want to share this information with anyone in order to keep labels and bias away from their child. No matter what the family

decides, they are attempting to work in the child's best interest. The teacher can always remind the family that he or she is there to help in any way possible. Once that invitation has been extended, it is up to the family to include the teacher any further.

Case Study: Jada

Jada is a 10-year-old girl in fourth grade at an accelerated school in Colorado. She began reading at age 4 and by age 6 was reading chapter books without assistance. She is highly verbal but struggles to connect with her peers. Her parents describe her as serious and empathic. She is a deep thinker and a deep feeler. Jada approaches her schoolwork with intense perfectionism that can be debilitating at times. She often feels unsafe and panicky due to her thoughts about shootings both at school and in her community. She complains of frequent stomachaches and worries that something is seriously wrong with her body. She has needed to miss several days of school this year due to physical complaints, worries about completing assignments adequately, and fear of school shootings. Physical causes for her symptoms have been ruled out by her medical team. Her parents decide to seek counseling services to help her gain skills in managing the following:

- Intense fear regarding shootings at school and in her community
- Somatic complaints
- School perfectionism
- Social relationships

Jada was born right on her due date. She was a healthy baby girl and breastfed easily but frequently. Her mother notes, "It was like I could not quench her thirst, but I think her thirst was for physical closeness to me. She didn't eat for a long time when she was breastfed but requested it often." Just 20 minutes after eating, she would cry to be fed again. Her language developed early, and she walked on time. Jada had a big startle response; if she heard a loud noise, her body would jolt as if struck by an electric current. "It startled me too," her mother shared. When Jada was startled, it would take at least an hour before she returned to her baseline state. She had frequent stomach issues that were exceedingly difficult to diagnose or soothe. Her parents tried a variety of changes to her diet to see if they could ease her pain.

Jada's parents reported that when she was 2 years old, they took her along with them to a birthday party. Upon entering the room and seeing so many faces, she began to cry. She clung to her parents. They stayed at the party for a brief time but decided to leave early because she was red-faced and crying. As they walked out of the party and got into their car, she exhaled a large, snotty sigh and began to calm herself.

When her mother left for work each day, even though this was a familiar routine, Jada would scream and cry. It often took her more than an hour to return to a calm state with her babysitter. Everyone in the family began to dread the daily transition from parents to babysitter.

When watching a cartoon with her parents, she became frightened of one of the characters in the program. Even when her parents tried to explain that the character was not "bad" or "dangerous," she was convinced he was "a bad man." For the next 2 weeks,

she cried at bedtime because "Green Man" (she named him this because he wore a green shirt) would "get me!" She was traumatized by the image of Green Man for 2 years.

Her parents reported Jada having a sense of dread when school arrived, but they found that other than her initial separation, she was not too anxious. They were relieved to see her thrive in the structure of school. As she entered grade school, they noticed that her anxiety heightened when a school project was due, but her ease with learning made it possible for her to face her fears. Her parents were pleased.

Academic rigor increased in third grade and although Jada was able to keep up with the material at school, she began to become fixated on getting her assignments "just right." Her parents noticed that she completed most of an assignment only to rewrite the entire thing because "My handwriting needs to be neater." Her parents tried as best they could to encourage her to not rewrite assignments, but Jada would end up in a puddle of tears on the floor if she could not rewrite it. Her parents assumed that it was better to let her have control over this aspect of her life because they knew their daughter often seemed overwhelmed.

Jada also needed to miss school a couple of times on the day an assignment was due because "I don't have it right yet! I can't turn it in like this!" Her parents were baffled because she would spend many hours worrying and working on her projects. In two cases, her parents agreed to let her miss the day to complete the assignment because they felt she needed the extra time to let go of the product. Missing school to complete an assignment helped Jada in the moment, but her parents soon felt the pressure from her to do this more often. Her parents also felt that her accelerated school fit her academic needs in terms of assignments but found that Jada often compared her work to other high achievers at school.

In fourth grade, Jada's history class focused on the life of Martin Luther King, Jr. Jada was inspired by Dr. King and his legacy. However, as she learned about his assassination, she was overwhelmed. She talked about it often and began to have nightmares. Jada grappled with understanding that cruelty existed in her world.

During the same year, a school shooting occurred in Highlands Ranch, Colorado. Until this shooting, Jada had assumed that school lockdown drills were for potential situations that *could* happen but not that they were actual situations that occurred in the U.S. As Jada processed that school shootings have happened before and could happen again, panic surfaced for her. She reported many somatic symptoms when going to school now: pounding heart, sweaty hands, shaking, and feeling as though she needed to run out of the building.

Her newfound fears combined with her somatic complaints and her tendency toward perfectionism. This created the perfect storm for Jada. She no longer wanted to go to her friend's house for fear of panic symptoms emerging. She often complained of physical ailments that kept her from attending school. She obsessed about making sure assignments were written as though typed. She began to attempt to control her world in ways she had not previously.

Jada shared that she wants to feel better. She presented as a motivated client, eager to please her treatment team. Her parents are educated on how to stop accommodating Jada's anxiety by allowing her to miss school. Jada was referred to a psychiatrist for a medication evaluation for the beginning steps of her treatment. It was agreed that she and her parents may elect to stop medication as she feels better.

Three months into therapy, her parents have learned that her anxiety can hold the whole family hostage if they do not set limits on it. They were surprised to see that as they had faith that Jada could manage her anxiety and go to school, she was able to do just that. Jada reported an increase in her confidence. She also reported feeling more hopeful (but still scared) about her school and community. She has begun writing her homework only once and turning it in, even though she reports, "I hate it!" Her parents remind her that "perfection" is not helpful. With her parents' support, she began to go on social outings with peers. She still reports stomachaches and headaches, but the frequency has decreased and she can manage them better.

"An invaluable resource to recognize the causes and symptoms of young children's mental health challenges . . . The biggest beneficiary of all will be the students themselves, as adults gain a more nuanced understanding of their emotional responses and how best to support them."

—Ondine Gross, M.S., Ed.M., school psychologist and author of *Restore the Respect: How to Mediate School Conflicts and Keep Students Learning*

"If you are interested in what to do and not to do, how to discern the subtleties of different anxiety disorders, and how best to proceed, this text will be incredibly helpful in your work."

—Neal M. Horen, Ph.D., Director of Early Childhood, Georgetown University Center for Child and Human Development

Anxiety rates are skyrocketing among young learners—and their teachers need explicit training on how to recognize and support these students. A concise, reader-friendly guide written especially for teachers, this urgently needed book will prepare early educators to **recognize anxiety issues** in children ages 3–8, **identify the associated behaviors,** and **work effectively with students** who have anxiety symptoms.

Teachers will:

- **Get a primer on seven types of childhood anxiety,** with information on symptoms, causes, triggers, and treatment options
- **Review the assessment and evaluation process,** and understand the role a teacher should play
- **Recognize co-morbidities with anxiety**—including ADHD, autism, and depression—and how they may affect a child's symptoms and treatment plan
- **Understand the issues and emotions parents face,** so that teachers can offer them sensitive support
- **Use effective classroom interventions** to meet the needs of children with anxiety and create a nurturing learning environment
- **Learn which strategies to avoid,** from unrealistic expectations to excessive reassurance

Accessible information on:

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- separation anxiety disorder
- social anxiety
- selective mutism
- obsessive-compulsive disorder
- phobias
- anxiety rooted in childhood trauma

Ideal for both preservice and in-service professional development, this introductory guide gives teachers the accessible information they need to understand learners with anxiety and support their success inside and outside the classroom.

ABOUT THE AUTHORS: **Sarah Taylor Vanover, Ed.D.,** is Policy and Research Director at Kentucky Youth Advocates, Louisville. She has been working in the field of early childhood education for more than 25 years. **Kristen Mennona, LPC, BC-DMT, CEDS,** is the founder of Nurture Family Counseling, LLC in Denver, Colorado. Her practice specializes in the treatment of pediatric eating disorders, OCD, and anxiety.

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