ANXIETY DISORDERS

KEY FACTS

- Nine to 15 percent of U.S. children and adolescents have anxiety symptoms that interfere with their day-to-day functioning (Bernstein et al., 1996; Bernstein and Shaw, 1997).
- Shy children are at increased risk for developing anxiety disorders (Bernstein et al., 1996; Kagan et al., 1988).
- Children and adolescents with anxiety disorders are at risk for underachievement in school, low self-esteem, and psychiatric problems in adulthood, especially depression and anxiety (Bernstein et al., 1996).
- Up to 15 percent of female and 6 percent of male children and adolescents who experience trauma meet criteria for posttraumatic stress disorder (PTSD). However, rates of PTSD are much higher in children and adolescents who have witnessed a parental homicide or sexual assault (PTSD rate of nearly 100 percent), have themselves been sexually abused (90 percent), have been exposed to a school shooting (77 percent), or have been exposed to violence in an urban community (35 percent) (Hamblen, 2001; AACAP, 1998b).

Anxiety is a normal and sometimes life-saving response to threat. In children, fears of strangers, heights, or water are common and can serve as protection from harm. Adolescents are frequently anxious about being embarrassed in social situations or about performing poorly on important tests, in athletic competitions, and the like. Most parents learn how to help their child or adolescent cope with common fears. Young children may need night lights, "protective" stuffed animals, and parental presence, while older children and adolescents may find it most helpful to talk about their fears.

When usual coping strategies fail and a child's or adolescent's anxiety becomes severe enough to cause significant distress or to interfere with her schoolwork, fun, or relationships, the child or adolescent may be experiencing an anxiety problem or disorder.

DESCRIPTION OF SYMPTOMS

Anxiety falls along a spectrum of intensity. For some children and adolescents, anxiety symptoms may cause significant distress without impairing functioning enough to warrant the diagnosis of a disorder.

Anxiety Problem

(Diagnostic Code: V40.2)

Adapted from DSM-PC. Selected additional information from DSM-PC is available in the appendix. Refer to DSM-PC for further description.

Infancy/Early Childhood

- Excessive separation distress
- Clinginess
- Sleep difficulties

Middle Childhood

- Worrying, fears, and physical symptoms that do not prevent the child from participating in activities or affect his performance
- Stress may cause agitation, withdrawal, loss of developmental skills, or repetitive play focused on trauma; symptoms resolve when stressor does
- Sleep problems

Adolescence

- Worrying, fears, and physical symptoms that do not prevent the adolescent from participating in activities or affect his performance
- Stress may cause boredom, social withdrawal, sadness, aggression, and/or risk-taking (e.g., drug or alcohol use); symptoms resolve when stressor does, and they do not significantly interfere with activities or relationships
- Sleep problems

When anxiety significantly affects a child's or adolescent's functioning, it is classified as a disorder rather than a problem. There are various forms of anxiety disorders, including generalized anxiety disorder (GAD), panic disorder, specific phobias, social phobia, separation anxiety, acute stress disorder, posttraumatic stress disorder (PTSD), and obsessive compulsive disorder (OCD).

Generalized Anxiety Disorder

(Diagnostic code: 300.02)

Adapted from DSM-PC. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-PC and DSM-IV/DSM-IV-TR for full criteria and further description.

Infancy/Early Childhood

- Rarely diagnosed in infancy
- Crying, freezing, tantrums, clinging
- Excessive timidity, shrinking from contact with new people, significant distress in unfamiliar social settings

Middle Childhood/Adolescence

- Physical symptoms of anxiety (e.g., restlessness, sweating, tension, recurrent somatic complaints such as abdominal pain or headaches)
- Avoidance behaviors (e.g., school avoidance, social withdrawal)
- Worrying
- Sleep disturbances

Description of Symptoms *(continued)*

Panic Disorder

(Diagnostic code: 300.21—with agoraphobia[1]; 300.01—without agoraphobia)

Adapted from DSM-PC. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-PC and DSM-IV/DSM-IV-TR for full psychiatric criteria and further description.

Possible presentations of panic disorder at different stages of childhood and adolescence include the following:

Infancy

- Does not present at this stage

Early Childhood

- Extreme distress may be expressed by intense crying, tantrums, freezing, clinging, or staying close to a familiar person during a panic attack

Middle Childhood and Adolescence

- Sense that something terrible will happen; feeling that events are unreal; fear of "going crazy"
- Tachycardia, palpitations, chest pain, shortness of breath, sensation of choking or of being smothered, dizziness, sweating, nausea, paresthesia (tingling and numbness in extremities), extreme tension

[1] Children and adolescents with agoraphobia avoid places from which escape might be difficult or in which help might not be available in the event of a panic attack, and/or they experience intense anxiety about being in such places.

Specific Phobia

(Diagnostic code: 300.29)

Adapted from DSM-PC and DSM-IV-TR. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-IV/DSM-IV-TR for full criteria and further description.

The key feature of specific phobias is a marked or persistent fear cued by the presence or anticipation of the presence of a specific object or situation. This fear may result in physical symptoms that approach the intensity of panic. The symptoms interfere significantly with the child's or adolescent's normal routine or functioning. Specific fears are particularly common in childhood and are usually transient during this period. In children and adolescents, specific phobia is diagnosed only if symptoms persist for more than 6 months.

Social Phobia

(Diagnostic code: 300.23)

Adapted from DSM-PC and DSM-IV-TR. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-IV/DSM-IV-TR for full criteria and further description.

The key feature of social phobia is a marked and persistent fear of social or performance situations in which the child or adolescent may be under the scrutiny of others. The child or adolescent fears that he or she will act in a humiliating or embarrassing way. The physical symptoms of social phobia may approach the intensity of panic when the child or adolescent is in a social situation. These symptoms may lead to school avoidance and/or avoidance of age-appropriate social activities (e.g., sleepovers, school dances).

Description of Symptoms *(continued)*

Separation Anxiety Disorder

(Diagnostic code: 309.21)

Adapted from DSM-PC. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-PC and DSM-IV/DSM-IV-TR for full psychiatric criteria and further description.

Infancy

- Separation anxiety is developmentally normal

Early Childhood/Middle Childhood

- Separation from parents leads to social withdrawal, apathy, sadness, difficulty concentrating on work or play, reluctance to engage in outside activities (e.g., school or preschool avoidance, refusing to attend parties or sleepovers)
- Fearfulness (e.g., fear of animals, monsters, the dark, muggers, kidnappers, burglars, car crashes)
- Concerns about death and dying
- Concerns about harm coming to themselves or loved ones

Adolescence

- Feels anxious but may deny it; engages in only limited independent activity and is reluctant to leave the home (e.g., avoids school; refuses to participate in sleepover camps or parties, take trips without family, or take part in activities requiring extended periods away from home)
- Concerns about death and dying
- Concerns about harm coming to themselves or loved ones

Acute Stress Disorder; Posttraumatic Stress Disorder

(Diagnostic codes: 308.3, acute stress disorder; 309.81, posttraumatic stress disorder)

Adapted from DSM-PC and DSM-IV-TR. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-PC and DSM-IV/DSM-IV-TR for full psychiatric criteria and further description.

Symptoms of posttraumatic stress disorder (PTSD) and acute stress disorder may occur after a child or adolescent experiences an extreme traumatic event. An extreme traumatic event is one that involves actual or threatened death, injury, or threat to the physical integrity of the child or adolescent or to someone close to the child or adolescent, or the witnessing of such an event (e.g., sexual abuse or assault, a shooting, an earthquake). The child's or adolescent's response to the event is one of intense fear, helplessness, or horror. In acute stress disorder symptoms resolve within 1 month of the occurrence of the traumatic event, while in PTSD symptoms are present for more than 1 month afterwards.

PTSD as defined for all ages involves intrusive re-experiencing of the trauma, avoiding traumatic reminders, and persistent physiological arousal. The manifestation of these symptoms varies according to the developmental stage of the child or adolescent (Perrin et al., 2000). Children and adolescents in situations of chronic traumatic stress (e.g., living in a war zone, living with inner-city violence, experiencing multiple foster home placements or traumatic disruptions in basic care) are at increased risk for PTSD (Davies and Flannery, 1998; Garbarino, 1992). Children and adolescents with PTSD may experience a range of related emotional and behavioral problems (e.g., aggression, difficulty with relationships,

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Description of Symptoms *(continued)*

Acute Stress Disorder; Posttraumatic Stress Disorder *(continued)*

problems with school performance). PTSD frequently co-occurs with other mental disorders such as substance abuse, other anxiety disorders (e.g., separation anxiety, panic disorder, generalized anxiety disorder [GAD]); attention deficit hyperactivity disorder (ADHD); and oppositional defiant disorder and conduct disorder (Hamblen, 2000). Signs of PTSD in children and adolescents include the following:

Infancy

- Not commonly diagnosed, but may take the form of failure to thrive, feeding problems, or extra fears or aggression in response to stress

Early Childhood and Middle Childhood

- Distressing dreams of the event may change to generalized nightmares of monsters or other threats to self and others
- Persistent reexperiencing of the traumatic event through repetitive play, drawing, or storytelling; possible constriction of other play
- Physical symptoms (recurrent abdominal pain, headaches)
- Increased arousal or hypervigilance; sleep problems
- Avoidance of activities related to the traumatic event
- Failure to progress or regression in developmental skills, such as toilet learning, language development, socializing, and learning in school; difficulty concentrating
- In young children, disturbed patterns of social relatedness (e.g., indifference, extreme ambivalence, failure to show preference for parents and caregivers)

Adolescence

- Distressing dreams of the traumatic event or flashbacks to the traumatic event
- Persistent reexperiencing of the traumatic event, sometimes through risk-taking behavior
- Physical symptoms (e.g., recurrent abdominal pain, headaches)
- Increased arousal or hypervigilance; sleep problems
- Avoidance of activities related to the traumatic event
- Failure to progress, or regression in academic skills; difficulty concentrating
- Impulsive or aggressive behaviors
- Absence of thoughts about or plans for the future

Obsessive Compulsive Disorder

(Diagnostic code: 300.3)

Adapted from DSM-PC and DSM-IV-TR. Selected additional information from DSM-IV-TR is available in the appendix. Refer to DSM-PC and DSM-IV/DSM-IV-TR for full psychiatric criteria and further description.

Obsessive compulsive disorder (OCD) is a disorder in which obsessions (repetitive, intrusive thoughts, images, or impulses) and/or compulsions (repetitive behaviors or mental activities employed to diminish anxiety, distress, or tension) interfere with functioning or cause marked distress (King and Scahill, 1999; Pollock and Carter, 1999).

Infancy

- Rarely presents at this age

Early Childhood

- Play or interests take on a compulsive or ritualistic quality (e.g., lining up toys in certain sequences); interruption results in intense distress (e.g., refusing to let go of a particular object)

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Description of Symptoms *(continued)*

Obsessive Compulsive Disorder *(continued)*

Middle Childhood/Adolescence

- Possible symptoms include repetitive handwashing, checking and counting rituals, repeating words silently, repetitive praying, hoarding, and arranging objects so that they are "just right"
- Concerns about harm coming to themselves or others if compulsion is not carried out
- Symptoms cause significant distress and are severe enough to interfere with functioning, including school performance

COMMONLY ASSOCIATED DISORDERS

Anxiety problems and disorders often occur together with depressive and attention deficit hyperactivity disorder (ADHD) symptoms in children and adolescents, and each disorder's independent contribution to impaired functioning, particularly in school performance, is hard to isolate. Studies indicate that 30–70 percent of children and adolescents with anxiety disorders have a depressive disorder, and 15–25 percent of children and adolescents with anxiety disorders meet the criteria for ADHD (Bernstein and Shaw, 1997).

Substance use can co-occur with anxiety problems and disorders. Alcohol or other drugs may be used to lessen acute anxiety but can ultimately worsen symptoms. Drugs such as cocaine and amphetamines can cause anxiety symptoms.

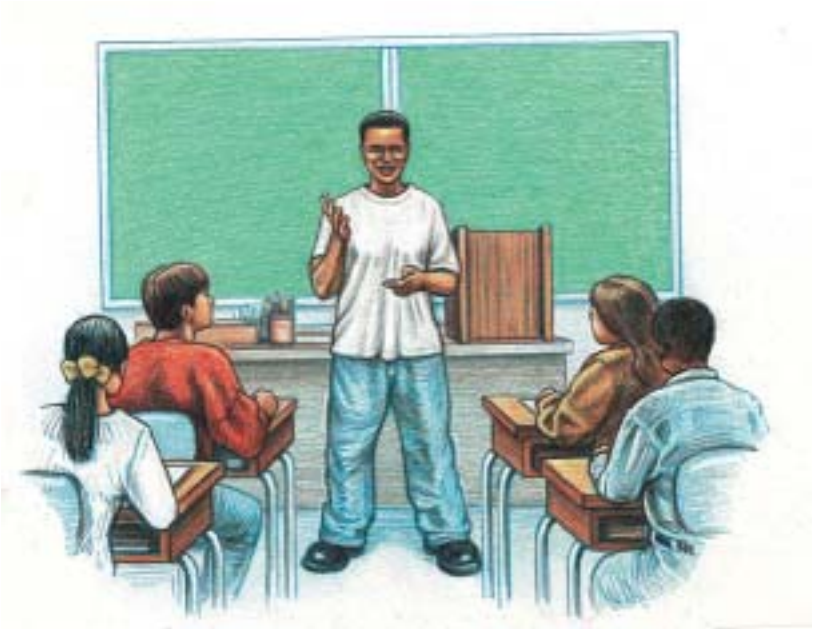
INTERVENTIONS

These interventions may help children and adolescents with anxiety problems or disorders manage their symptoms.

Child or Adolescent

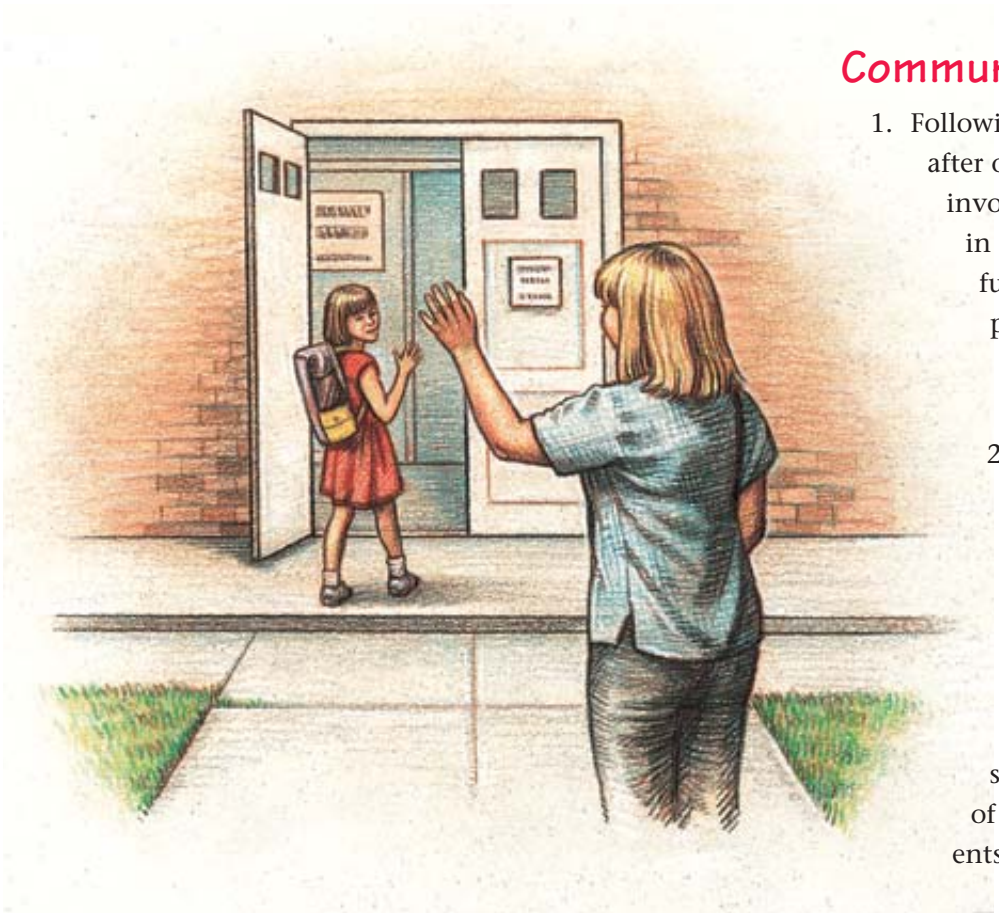
1. Talk directly with the child or adolescent about her worries and fears. Reassure her that others experience similar worries, and that there is help available to address these concerns.
2. Encourage the child or adolescent to pursue her natural talents and interests and to have fun.
3. Help the child or adolescent ease gradually into new situations, and praise her for confronting her fears.
4. Most children in middle childhood and adolescence can be taught to relax. Enrolling children and adolescents in programs that teach specific relaxation techniques such as deep breathing, guided imagery, muscle training, and meditation can be helpful.
5. Help the child or adolescent address realistic concerns (e.g., "If I get up in front of the class I'll be laughed at" or "I'll have an accident") and correct distorted thoughts (e.g., "If I get up to talk in front of the class, I'll die").

6. Assess for other causes of anxiety, such as medical conditions (e.g., hyperthyroidism, respiratory/cardiac illness, medication effects), drug or alcohol abuse, and environmental stress (e.g., parental discord/illness).
7. If the primary care health professional has any suspicions about neglect or abuse, the child or adolescent should be asked about this privately in an age-appropriate fashion. Report suspected neglect or abuse to the appropriate child protection agency, and refer the family and the child or adolescent to a mental health professional for evaluation and treatment. (See bridge topic: Child Maltreatment, p. 213.)
8. Ascertain whether the child or adolescent has experienced or witnessed a recent traumatic event (e.g., neighborhood violence, death of or separation from a loved one, physical accident, abuse) or whether something serious has happened to a close relative or friend.
9. Refer children and adolescents who have anxiety symptoms severe enough to interfere with functioning (e.g., school performance, development of friendships) for appropriate mental health services (American Academy of Child and Adolescent Psychiatry, 1998a, 1998b; Bernstein and Shaw, 1997; Kendall 1994; Ollendick et al., 1994). These services may include the following:
   - Behavioral treatment, including relaxation techniques, role-playing stressful situations, exposure and desensitization techniques (for phobias, obsessive compulsive disorder [OCD])
   - Cognitive therapy, including identifying anxious thoughts, recognizing physical responses to anxiety, developing a plan to deal with symptoms in different settings
   - Individual psychotherapy to help a child or adolescent build self-esteem, cope with traumatic events, and develop a sense of independence
   - Group therapy to develop social skills and reinforce appropriate behaviors
   - Family/parent therapy to address separation issues, develop behavioral plans, support family functioning, and resolve conflicts
   - Pharmacological interventions (e.g., selective serotonin-reuptake inhibitors, benzodiazepines) (for further information on pharmacological interventions see Allen et al., 1995, and Birmaher et al., 1998)
   - Further evaluation to determine if a co-occurring problem (e.g., attention deficit hyperactivity disorder [ADHD], a learning disorder, a mood disorder, substance use) is contributing to the child's or adolescent's difficulties



Family

1. Talk with parents about their child's or adolescent's anxiety symptoms and their own support skills as caregivers. Discuss any concerns parents may have about handling their child's or adolescent's anxiety. Parents who respond to their child's or adolescent's fears with overprotectiveness may need help promoting his independence and autonomy. Other parents may need help recognizing when their child is highly anxious.
2. Assess for any family history of anxiety, depression, and substance abuse.
3. Refer to a mental health professional any parents or siblings experiencing high levels of stress, difficulty coping, or psychiatric symptoms.



Friends

1. If parents become aware early in their child's development that the child has a shy or anxious temperament, encourage them to schedule regular play dates with other children with whom their child is compatible. Their child may thus gain confidence in her ability to participate in group activities with other children.
2. Structured group play and activities can help children and adolescents learn social skills.
3. If structured activities do not help a child or adolescent feel more confident about peer interactions, consider a referral for a social-skills training group. Group therapy may be helpful for older adolescents.

Community and School

1. Following guidelines for confidentiality, and after obtaining appropriate permission, involve teachers and guidance counselors in assessing the child's or adolescent's functioning. Determine whether any particular stressors may be contributing to the child's or adolescent's anxiety.
2. Assess any possible learning disabilities or special education needs that may be contributing to the child's or adolescent's distress and possible underperformance in school. Be aware that children and adolescents with anxiety disorders may be eligible for special education services under the disability category of "emotional disturbance." Some parents may appreciate assistance from the

primary care health professional in contacting the school. Ensure that parents know that their child or adolescent may also qualify for services under Section 504 of the Rehabilitation Act. For further information about eligibility and services, families can consult the school's special education coordinator, the local school district, the state department of education's special education division, the U.S. Department of Education's Office of Special Education Programs (http://www.ed.gov/offices/OSERS/OSEP), the Individuals with Disabilities Education Act (IDEA) '97 Web site (http://www.ed.gov/offices/OSERS/IDEA), or the U.S. Justice Department's Civil Rights Division (http://www.usdoj.gov/crt/edo).

3. Collaborate with the school (including school health staff, if available) in designing an anxiety and behavior management plan for the child or adolescent (e.g., the school may allow the child or adolescent to gradually begin doing things he has learned to avoid, such as speaking in front of a group or meeting new people).
4. Encourage school staff to foster alliances between the child or adolescence with an anxiety disorder or problem and other children or adolescents who will support him.

INTERVENTIONS FOR SPECIFIC ANXIETY DISORDERS AND RESPONSES

Panic Disorder

1. Ask about substance use, recent stressors, history of trauma, and symptoms of depression, PTSD, and drug use. Depression is a frequent complication of panic disorder. Use of amphetamines, cocaine, or LSD can trigger panic symptoms. Inquire about symptoms of avoidance and agoraphobia.
2. Ask the child or adolescent to tell you her own thoughts about her panic attacks. She may believe that she has a life-threatening illness or is "going crazy." Reassure the child or adolescent and her parents that she is not in physical danger from the attacks, and explain what panic disorder is in terms she can understand (e.g., "Your body's emergency reaction—or 'fight-or-flight' response—is being set off on its own, without a trigger of real danger." Or, for young children, "Your body feels like it's scared of something. But really there is nothing scary.").
3. Reassure the child or adolescent and her parents that effective treatments for panic disorder exist, and refer the child or adolescent to a mental health professional. Comprehensive treatment may include cognitive-behavioral psychotherapy and medication. (See the mental health services described under Interventions, #9, p. 197.)

School Avoidance

1. Ask about recent stressors at school or at home that may explain the child's or adolescent's symptoms (e.g., teasing or bullying, frightening events on the school bus or while walking to school, illness of a parent or sibling, marital discord, birth of a new child).
2. Discuss school avoidance with the child or adolescent and the parents, and stress that it is important for the child or adolescent to return to school as soon as possible (Bernstein and Shaw, 1997). For example, say, "Some children become

afraid of going to school, and their worrying makes them feel sick. Usually, the longer they stay out of school, the more worried they get about going back. These worries and fears frequently get better when they are helped to go back to school."

3. Reassure the child or adolescent and his parents that he is in no physical danger from his anxiety symptoms. For example, say, "Steven's stomachaches are his body's way of telling him he's worrying a lot." Protect the child or adolescent from unnecessary medical or surgical interventions.
4. Discuss strategies to ease the child's or adolescent's transition back to school—for example, having a parent drive him to school, allowing him to visit the school nurse briefly if he feels ill at school, and having him practice relaxation breathing in the morning. Encourage parents to praise and reward the child or adolescent when he is able to return to school.
5. After obtaining appropriate permission, contact the school staff, and discuss ways to help the child or adolescent return to school. For instance, the amount of missed homework that needs to be made up may be reduced to make returning to school easier. Ask school personnel to contact you if the child's or adolescent's attendance remains poor or if he asks to go home from school.
6. Schedule regular follow-up visits, especially after vacation breaks and at the start of the next school year.
7. Encourage parents to call you at the onset of any new symptoms so you can help decide whether the child or adolescent should stay home from school.
8. Consider further evalution and specific mental health services such as cognitive-behavioral therapy for children and adolescents with persisting or recurrent school avoidance. (See the mental health services described under Interventions, #9, p. 197.)

Resources for Families

Anxiety Disorders Association of America (ADAA)
11900 Parklawn Drive, Suite 100
Rockville, MD 20852
Phone: (301) 231-9350
Web site: http://www.adaa.org

National Center for PTSD
VA Medical Center (116D)
White River Junction, VT 05009
Phone: (802) 296-5132
Web site: http://www.ncptsd.org
Fact sheet on PTSD in children and adolescents: http://www.ncptd.org/facts/specific/fs_children.html

National Library of Medicine
Web sites (anxiety): http://www.nlm.nih.gov/medlineplus/anxiety.html; (OCD): http://www.nlm.nih.gov/medlineplus/obsessivecompulsivedisorder.html; (PTSD): http://www.nlm.nih.gov/medlineplus/posttraumaticstressdisorder.html

The National Library of Medicine offers an electronic resource guide for consumers and professionals with links to general information about anxiety, OCD, and PTSD.

Obsessive-Compulsive Foundation, Inc.
337 Notch Hill Road
North Branford, CT 06471
Phone: (203) 315-2190
Web site: http://www.ocfoundation.org

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