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Child and Adolescent Anxiety Disorders

The American Psychiatric Association defines anxiety as “apprehension, tension, or uneasiness that stems from the anticipation of danger, which may be internal or external.” The word anxiety comes from the Latin *anxietas*, “troubled mind.” Fear is a psychophysiological response to a real, external, demonstrable threat to safety and life. Anxiety produces the same responses as fear, but the danger is symbolic rather than actual and is associated with unresolved problems and conflicts that are often unconscious.

In 1869, anxiety was referred to as “neurasthenia”; after the Civil War it was described as the “irritable heart syndrome,” and after World War I as “effort syndrome.” Research over the last 50 years has consistently shown that all children have a large number of fears and anxieties. Two separate studies of several hundred 4–16 year olds reported that each child had an average of 5–8 fears. These fears and anxieties vary not only with age, but also with sex and economic status. Girls report more fears and anxieties than do boys. Anxiety disorders (panic disorder, obsessive-compulsive disorder, generalized anxiety disorders, social phobia, and posttraumatic stress disorder) are, in fact, the most common mental health problems that occur in children and adults. In one large-scale study of 9–17 year olds, as many as 13% had an anxiety disorder in a year. In a 1989 pediatric study (Costello) of 800 patients 7–11 years old, 8.9% met the criteria for at least one anxiety disorder. At least one-third of children with anxiety disorders meet criteria for two or more anxiety disorders.

In anxiety, there is usually a subjective feeling of dread or apprehension ranging from excessive concern about the present or future to feelings of panic. The feeling is accompanied by a variety of physical symptoms such as palpitations, shortness of breath, trembling, skin pallor, and dry mouth. Traditionally, anxiety has been divided into two broad categories according to its etiology: (1) exogenous, when anxieties arise as a result of external events and is psychological, rather than biological, in nature; and (2) endogenous, when it occurs as a result of an underlying biological cause and can have a predictable developmental path, such as in anxiety with panic attacks.

Separation Anxiety Disorder

This is probably the most common anxiety disorder in young children. A 1992 study of 188 children in an anxiety disorders clinic determined that there was an equal

gender distribution and an earlier age of onset (mean of 7.5 years) than in other anxiety disorders, and that these children were more likely to come from low socioeconomic status and single-parent homes. For them the situation is separation from a significant attachment figure. DSM-IV-TR defines Separation Anxiety Disorder as “developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three or more of the following:”

- Recurrent excessive distress when separation from home or major attachment figures occur or is anticipated
- Persistent and excessive worry about losing, or about possible harm befalling major attachment figures
- Persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
- Persistent reluctance or refusal to go to school or elsewhere because of fear of separation
- Persistent and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
- Persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
- Repeated nightmares involving the theme of separation
- Repeated complaints of physical symptoms (such as headaches, stomach aches, nausea, or vomiting) when separation from major attachment figure occurs or is anticipated

The duration of the disturbance is at least 4 weeks; the onset is before age 18. The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important areas of functioning. The disturbance does not occur exclusively during the course of a PDD, schizophrenia, or other psychotic disorder and, in adolescents and adults, is not better accounted for by panic disorder with agoraphobia.

Treatment

Children with anxiety disorders respond very well to treatment with SSRIs, which are medications that contribute to the relief of the typical physiological symptoms of anxiety and are also quite effective in addressing the cognitive aspects of these disorders, such as worrying, initial insomnia, rumination, decreased concentration, and repetitive or intrusive thinking or behaviors. Antihistamines like Benadryl and Atarax or Vistaril are the two most commonly used medications in treating anxiety disorders in children.

Instruments for Assessment of Anxiety in Children and Adolescents

There are diverse measures available to assess symptoms in children. One is the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS). This is a semi-structured interview of both parents and child to identify the presence and severity of a broad range of symptoms. Based on the interview results, DSM-IV diagnoses can be made for affective and other disorders. Other diagnostic interviews available include the

Diagnostic Interview for Children and Adolescents-Revised (Weiner et al., 1987), the NIMH Diagnostic Interview for Children (Chambers et al., 1985), the Anxiety Disorders Interview Schedule for Children (Silverman & Nelles, 1988), and the Anxiety Rating for Children-Revised (Bernstein et al., 1996). There are more assessment tools, depending on the circumstance.

Obsessive-Compulsive Disorder (OCD)

Unwanted, intrusive, and repetitive thoughts (obsessions) and rituals (compulsions) occurring out of a feeling of urgent need characterize this disorder. At least one-third to one-half of adult cases start between the ages of 10–12 years old. This is the fourth most common neurobiological illness, with 1 in 40 adults and 1 in 200 children having a lifetime occurrence. Common obsessions are: concern with order, counting, fear of acting on aggressive impulses (30%), dirt, germs, and contamination (35%). Typical compulsions we see most often include: repetitive handwashing (75%), checking and rechecking, repetitive actions such as stepping only on the cracks in the sidewalk, and concern with arranging. This neurological illness is believed to affect specific pathways in the brain using the serotonin transmitter. There is a relationship between a subgroup of children with OCD and tic disorders.

Panic Disorder

This is characterized by feelings of extreme fear and dread that strike unexpectedly and repeatedly for no apparent reason, often accompanied by intense physical symptoms such as dizziness, abdominal distress, chest pain, pounding heart, and shortness of breath. This is differentiated from a generalized anxiety attack because there's no apparent reason, and no identifiable worry that brought it on. Panic disorder can also include agoraphobia, so this needs to be assessed when making the diagnosis. Four or more of the following symptoms may develop abruptly and peak in 10 minutes:

- Palpitations, pounding heart, or accelerated heart rate
 - Sweating
 - Trembling or shaking
 - Sensations of shortness of breath or smothering
 - Feeling of choking
 - Chest pain or discomfort
 - Nausea or abdominal distress
 - Feeling of dizziness, unsteadiness; lightheaded or faint
 - Feelings of unreality or being detached from self
 - Fear of going crazy or losing control
 - Fear of dying
 - Numbness (paresthesia)
 - Chills or hot flushes
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Panic Disorder with Agoraphobia

This refers to anxiety about being in places or situations from which escape might be difficult or embarrassing. Certain situations are avoided or are endured with marked distress or with anxiety about having a panic attack or require a companion to be near. Other mental disorders such as social phobia, OCD, PTSD, and separation anxiety need to be ruled out. Treatment consists of behavior modification and individual and family therapy.

Phobias

Social phobias are characterized by extreme fear of being embarrassed or scrutinized. Exposure to the situation almost invariably provokes immediate anxiety response. Children do not always recognize that this fear is unreasonable.

Specific phobias refer to an excessive fear of an object or situation, such as heights, animals, places, noises, etc. In individuals under 18, the symptoms must have been present for at least 6 months. The five types of specific phobias are:

- Animal Type
- Natural Environmental Type
- Blood-Injection-Injury Type
- Situational Type (e.g., airplanes, elevators, enclosed places)
- Other Type (e.g., phobic avoidance of situations that may lead to choking, vomiting, or contracting an illness; in children, avoidance of loud sounds or costumed characters.)

Posttraumatic Stress Disorder (PTSD)

All children experience a crisis of some degree every day in their young lives. To a child, it is a crisis when they can't find their homework, they can't find a matching sock, their best friend didn't play with them yesterday, etc. When children are unable to cope with the crisis and it begins to dictate how they sleep, eat, think, feel, and behave, then the crisis has caused and continues to produce trauma which interrupts their normal growth and development. In younger children, scary dreams of traumatizing events can turn into nightmares that are played out throughout the day because they don't realize they're reliving the event. They may feel that their lives will be so short they'll never make it to adulthood and may even believe that they have an ability to foresee future untoward events.

PTSD can occur at any age and usually occurs within 3 months after a trauma. The duration of the symptoms varies, but in half the cases, complete recovery occurs within 3 months after the symptoms begin. In children, the response to the traumatizing event must involve disorganized or agitated behavior to meet the criteria for the DSM-IV-TR diagnosis of PTSD, which links anxiety to a catastrophic event such as rape, assault, combat, earthquake, airplane crash, act of terrorism, or war. The anxiety associated with the event brings about general arousal, such as hypervigilance, and diminishes the range of emotions and interest in significant activities.

The kinds of experiences or conditions that can seriously traumatize children are: 1) victimization, which includes assault, robbery, rape, serious accidents, and incest; 2) loss such as divorce, moving, changing schools, leaving home, and separation from family member(s); and 3) family pathology, which includes incest, chemical dependency, abuse, domestic violence, and other forms of dysfunction.

The team of Coleman, Butcher, and Carson (1980) have identified four categories of family dysfunction that are associated with higher incidences of psychological disorders, leading to physical illness and various maladaptive behaviors. These four categories are:

- *Inadequate families* that lack the physical or psychological resources for coping with normal stressors.
- *Anti-social families* that have different values from those of their communities, which may encourage undesirable behaviors.
- *Discordant and disturbed families* with fraudulent interpersonal contracts and disturbances, e.g., fighting, gross irrationality, or enmeshment of the family in parental conflicts.
- *Disrupted families* that have inadequately adjusted to the loss of family members through death, divorce, and/or separation.

Assessment

Relatives, teachers, childcare workers, parents, friends—all can help put together the information for making the assessment.

Nonverbal signs of PTSD in children who are younger include:

- Sleep disturbances continuing more than several days, wherein actual dreams of the trauma may or may not appear;
- Clinging behavior or anxiety from separating, such as reluctance to go back to school;
- Phobias about distressing stimuli such as individuals, places, and events that remind the child of the precipitating event;
- Conduct disturbances at home or school that are responses to anxiety and frustration;
- Doubts about the self, including comments about body confusion, self-worth, and desire to withdraw.

Treatment

The best course of action is to provide a safe place for the child to discharge feelings, reactions, and negative behaviors so as to restore him/her to previous levels of functioning.

Table 9-1. Five key points for treatment of PTSD

- Assess the child as soon as possible after the critical incident.
 - Build a rapport with the child.
 - Involve family as much as possible.
 - Explore and correct inaccurate attributions regarding the trauma.
 - Use play therapy, art therapy, music therapy, cognitive behavior therapy, group therapy, sand tray, family therapy, and any combination thereof which seems appropriate to assist the child to recovery.
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Pharmacotherapy (See also chapter 12)

This usually consists of benzodiazepines and antidepressants, but the choice needs to be carefully made depending on the particular condition and the side effects of the chosen medication. The use of either benzodiazepines and antidepressants in the management of anxiety disorders in children remains poorly studied and understood.

**Overanxious Disorder of Childhood
(Generalized Anxiety Disorder)**

Even though more than half of the adults presenting for treatment for generalized anxiety disorder report onset of symptoms in their childhood or adolescence, onset after age 20 is common. In children and adolescents, the anxieties and worries often concern the quality of their performance or competence at school or in sporting events. They may have excessive concerns about punctuality or catastrophic events. The child may be overly conforming and a perfectionist as well as over zealous in seeking approval and reassurance. One of the following symptoms (as opposed to 3 or more for adults) must be present for more days than not over the past 6 months:

- Restlessness
- Easily fatigued
- Difficulty in concentrating or remembering
- Irritability
- Muscle tension
- Sleep disturbance

Assessment

There are diverse measures available to assess symptoms in children. One is the Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS). This is a semi-structured interview of both parents and child to identify the presence and severity of a broad range of symptoms. Based on the interview results, DSM-IV diagnoses can be made for affective and other disorders.

There are many diagnostic interviews available, including the Diagnostic Interview for Children and Adolescents-Revised (Welner et al., 1987); the Anxiety Disorders Interview (Silverman & Nelles, 1988); the Multidimensional Anxiety Scale for Children (1996), and the current popular one, the Manifest Anxiety Scale.

Bereavement (see also Chapter 11)

Kubler-Ross outline five major stages of bereaving: denial, anger, bargaining, depression, and acceptance, which apply to losses as well. In addition, Frears and Schneider (1981) present the following six-stage model:

- Initial awareness (including shock, loss of equilibrium, and lowered resistance to infection)
 - Strategies to overcome loss (including adaptive defense cycles of holding on and letting go)
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- Awareness of loss (including exploration of extent of loss and its ramifications, such as loneliness, helplessness, and exhaustion)
- Completions (healing, acceptance, resolution, and freeing the energy invested in the loss)
- Empowering the self (in areas that were out of balance prior to the loss)
- Transcending the loss (growth following completions and re-balancing)

Children under ten have not developed their ability to recognize, understand, and resolve loss. The following chart illustrates Wass's correlation of death concepts relating to development (1984).

Table 9-2. Development of Concept of Death

Life Period	Predominant Death Concepts
Infancy	No concept of death
Late infancy, Early childhood	Death is reversible; a temporary restriction, departure, or sleep
Middle childhood Late or preadolescence	Death is irreversible; external-internal, physiological explanations
Preadolescent Adolescent, adult	Death is irreversible, universal, personal but distant, natural; physiological and has theological explanations

What we can do as therapists is provide a safe place for the child to discharge feelings, reactions, and negative behaviors so as to restore him/her to previous levels of functioning.

