AS A RESULT OF THIS WEBINAR, PARTICIPANTS WILL BE ABLE TO:

- Identify five forms of anxiety disorders in children.
- Recognize the signs of anxiety
- Understand the possible co-existing conditions that impact anxiety
- List the steps parents and others working with children should take in decreasing and addressing anxiety
ANXIETY IS A NORMAL HUMAN EXPERIENCE

- Humans are biologically programmed to feel fear and worry

- Developmentally appropriate anxiety
  - stranger anxiety (6-8 months)
  - separation-anxiety (10-18 months)
  - fears of monsters & dark (toddlers)
  - shyness & self-consciousness (adolescence)

- Anxiety associated with physical complaints
NORMAL CURVE FOR ANXIETY
BUT TOO MUCH ANXIETY INTERFERES WITH FUNCTIONING . . . AND IS BAD FOR THE BRAIN

- Excessive worry
- Irrational fear
- Discomfort with others looking at us
- Stomachaches and bowel problems
- Other physical symptoms of stress
- Perfectionism
- Panic
- Compulsive/repetitive behaviors
WHAT IS ANXIETY?

You Tube video<iframe width="560" height="315" src="https://www.youtube.com/embed/Z_jkNmj5S0s" frameborder="0" allowfullscreen></iframe>
ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS

- Lifetime prevalence for anxiety disorders is high (approximately 28% of all adults)
- Prevalence between age 13 and 18 is 25%
- Median age of onset is 11 years
INCIDENCE OF ANXIETY DISORDERS IN ADULTS

Prevalence

- **12-month Prevalence:** 18.1% of U.S. adult population\(^1\)
- **Severe:** 22.8% of these cases (e.g., 4.1% of U.S. adult population) are classified as “severe”\(^2\)
LIFETIME PREVALENCE OF ANXIETY DISORDERS

Demographics
(for lifetime prevalence)⁵

- **Sex:** Women are 60% more likely than men to experience an anxiety disorder over their lifetime.
- **Race:** Non-Hispanic blacks are 20% less likely, and Hispanics are 30% less likely, than non-Hispanic whites to experience an anxiety disorder during their lifetime.

- **Age:**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percent of U.S. Adult Population</th>
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<tr>
<td>18-29</td>
<td>30.2</td>
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<tr>
<td>30-44</td>
<td>35.1</td>
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<td>45-59</td>
<td>30.8</td>
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<td>60+</td>
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TAKEAWAY MESSAGE

- Anxiety disorders are common
- Onset is early (usually by adolescence)
- Condition is chronic – without intervention
ANXIETY DISORDERS TAKE MANY FORMS

- Adjustment Disorder with Anxiety
- Separation-anxiety disorder
- Generalized anxiety disorder
- Social anxiety disorder
- Specific phobias
- Panic disorder
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
ADJUSTMENT DISORDER WITH ANXIETY

- Anxiety is related to situational stress or environmental factors
- Death of a parent or loved one, parental divorce, catastrophic event, bullying
- School stressors—talk to the school nurse
- Complaints of headaches, stomachaches, avoidance
SEPARATION ANXIETY DISORDER

- Excessive anxiety about separation from attachment figures
- Reactions are extreme and beyond what would be expected given child's developmental age
- Unrealistic worry about harm to self or parents
SEPARATION ANXIETY DISORDER

- About ¾ of children with separation-anxiety disorder have school refusal
- Reluctance to sleep alone or away from parents
- Repeated nightmares with themes of separation
- Physical complaints (headaches, nausea, vomiting) at times of separation
SEPARATION ANXIETY DISORDER

- Seen most often in pre-pubertal children
- Gender ratio about equal
- Associated with panic disorder in later life
- May also be related to a mood regulation disorder
SPECIFIC PHOBIAS

- Often emerge in elementary school years
- Include fear of dogs, people breaking into house, heights
- Are excessive and out of proportion to demands of the situation
- Beyond voluntary control
- Lead to avoidance
- Persist over time
- Maladaptive
SOCIAL ANXIETY DISORDER

- Intense, irrational fear of social or performance situations in which the person is exposed to unfamiliar people or possible scrutiny by others
- Person anticipates humiliation or embarrassment
- More prevalent in girls than boys
SOCIAL ANXIETY DISORDER

- Early onset: can be as early as age 5 and through teen years and into adulthood
- Usually chronic course
- Self-medication with alcohol is common
SELECTIVE MUTISM

- Extreme form of social phobia (social anxiety)
- Child do not talk outside of home or to unfamiliar people
- Child is able to understand language and talks at home
- Overall behavior and interaction with others is restricted
- Interactions and emotions are normal within home
GENERALIZED ANXIETY DISORDER

- “What if” thinking
- Unrealistic worry about future events
- Worry about competence, school performance, future
- Concerns about competence have perfectionistic quality
- Self-consciousness due to excessive worry and self-focus
GENERALIZED ANXIETY DISORDER

- Somatic complaints common: headaches, g.i. upset, muscle tension
- Child finds it difficult to control worrying
- Gender ratio equal until adolescence after which predominates in females
PANIC DISORDER

- Panic attack: discrete period of intense fear that develops acutely and is associated with multiple physiologic symptoms
- Palpitations, shortness of breath, sweating, tremors, nausea, dizziness, numbness/tingling, feeling of impending doom
PANIC DISORDER

- Panic attacks occur unexpectedly
- Panic disorder: one attack/week for one month or one or more attacks followed by one month of persistent fear of another attack (anticipatory anxiety)
- Age of onset of panic attacks: age 15-19
- Person avoids situations in which panic attack has occurred
OBSESSIVE-COMPULSIVE DISORDER

- Obsessions: recurrent, persistent thoughts that are experienced as intrusive and senseless
- Compulsions: repetitive, purposeful behaviors or rituals
- Multiple obsessions and compulsions are common, especially in teens
- Self-consciousness about OCD increases with age
- 1/3 to ½ of adults with OCD report onset in childhood or adolescence
OBSESSIVE-COMPULSIVE DISORDER

- Average age of onset: age 10-12
- Obsessions less likely in younger children
- Children often attempt to engage parents in compulsive rituals
- Family and twin studies have clearly shown OCD is familial
- Evidence of serotonin and dopamine dysregulation in OCD
COMMON OBSESSIONS

- Contamination
- Aggression
- Religion (scrupulosity)
- Safety/Harm
- Need for exactness or symmetry
- Somatic (body) fears
COMMON COMPULSIONS

- Checking
- Cleaning/washing
- Counting
- Repeating
- Ordering/arranging
- Hoarding/collecting
POST-TRAUMATIC STRESS DISORDER

- Only recently applied to children
- Onset can occur at any age
- Precipitated by extreme stress or trauma involving threat of death or physical/emotional integrity of the person
- Traumatic stressor can be single event or chronic
POST-TRAUMATIC STRESS DISORDER

- Intrusive re-experiencing of the event via nightmares or play involving the event
- Avoidance of factors related to the trauma
- Chronically increased arousal (exaggerated startle response, autonomic reactivity, panic symptoms)
THE GOOD NEWS IS . . .

- Anxiety is treatable
- Studies have shown that it is the condition most responsive to psychological intervention in youth
- Interventions include psychotherapy and medication—and both have positive outcomes
ANXIETY IN YOUTH TAKES MANY FORMS

- Separation Anxiety Disorder (usually first symptom of anxiety to appear)
- Generalized Anxiety Disorder (persistent and excessive worry)
- Specific Phobias or fears (need to determine normal versus not typical)
- Panic Disorder
WHO IS AT RISK?

- Those with behavioral inhibition in childhood
- Being female
- Having few economic resources
- Being exposed to stressful life events
WHO IS AT RISK?

- Parental history of psychiatric disorders
- Those with genetic pre-disposition to anxiety
- Those with other psychiatric diagnoses
SIGNS OF ANXIETY IN YOUTH

- Outward nervousness like nail-biting
- Refusal to speak in some situations
- Trouble concentrating when stressed
- Stomachaches, headaches, other physical symptoms
- Avoidance
- Anger/aggression when pushed into situations that are anxiety-provoking
COMMON CO-EXISTING CONDITIONS

- Attention-Deficit/Hyperactivity Disorder
- Multiple anxiety disorders
- Mood regulation disorder (DMDD)
- Neurodevelopmental disorders such as intellectual disability, ASD, and SLD
ANXIETY AND CO-EXISTING CONDITIONS

- At least 1/3 of children with anxiety disorders meet criteria for 2 or more anxiety disorders
- Depression frequently coexists with anxiety (comorbidity rates 28%–69%)
- 15%-24% of children with separation-anxiety or generalized anxiety also have ADHD
- Severe anxiety at a young age may be the precursor to an underlying mood disorder
YOUTH WITH ANXIETY

- Have more difficulty realistically assessing danger
- Often respond to perceived stress before assessing it
- Can be easily discouraged and give up
- Can struggle with self-calming
TREATMENT OF ANXIETY

- Thorough assessment
- Parental/caregiver/teacher education about anxiety
- Education of the child/adolescent at level they can understand
- Building support at points of stress
- Cognitive-behavioral intervention
- Consideration of medication
ADULT ROLE IN TREATMENT

- Recognize that child does not chose to be anxious
- Anxiety cannot “get over it” easily
- Try to minimize but not eliminate sources of anxiety
- Treat adult sources of anxiety
ADULT ROLE IN TREATMENT

- Support, empathize but don’t identify with anxiety
- Provide consistency and routine
- Slow down, expect less based on what others expect but expect age-appropriate behaviors
CLASSROOM STRATEGIES

- Preferential seating near teacher's desk and away from students who are provoking: reduces situations that create worry
- Adequate emotional warmth and physical contact from the teacher for reassurance
- Provide small group learning and social opportunities
- Reward effort, persistence, and desired behavior frequently: anxious children often dependent on external feedback about performance
CLASSROOM STRATEGIES

- Set firm, clear-cut limits
- Break large assignments into smaller pieces if child seems overwhelmed or confused
- Offer as much predictability as possible; changes without warning may be difficult
- If child appears upset after being given feedback, try to clarify what he heard as anxiety may distort understanding
- Avoid public criticism of child/behavior; this will add to anxiety in the classroom setting
REFERENCES


https://www.nimh.nih.gov/health/topics/depression/index.shtml
REFERENCES

- American Psychiatric Association  www.healthyminds.org
- Non Profit Mental Health Resource  www.helpguide.org
- National Alliance on Mental Illness  www.nami.org
- National Institute of Mental Health  www.nimh.nih.gov
- Anxiety Disorders Association of America  http://www.adaa.org