example, is our daughter withdrawing more? Is our son sleeping less? Is our pre-
schooler clinging more? Is our primary school-aged daughter missing a lot of school?
Has our adolescent son started worrying just a bit too much?

3 - How long does it last?
Normal worries don't last long in childhood. They fade quickly. However if our children's
fears or worries stay around for more than three weeks we too should begin to get
worried. If they stay around for three months (a whole school term), we need to ask for
professional help.

How do we find out if there's a real problem with our child?
Our children mix and mingle with other children and adults in many situations every
day. Talking with the key people across these different settings is often helpful. Some
of these people may have noticed a change in our child's behaviour or they may be
able to explain the cause of the behaviour. Sometimes when we know the cause we
just have to be a little more understanding and give our child time and space to adjust.
Other times we have extra reasons to seek help.

How to tell the difference between normal worries and an anxiety that needs treatment?
Worries and fears are very common in both children and adults. We have to think
carefully about whether we are making 'mountains out of molehills' or missing a very
real problem which could be putting obstacles in the way of our child's progress. If we
as parents treat every worry in a child as a serious problem, it will do more harm than
good. Our children will become worried that the world is a very dangerous place.

Not all worries and fears need professional help. Some fear reactions are normal for
the child's age and may even show that they are maturing.

Apply the following yardsticks to know whether your child's reactions are out of the
normal range.
1 - It won't go away
   Let's say that our child was bullied in the playground and that for some time after she
was very anxious and frightened every time other children were around and did not
want to go to school. A meeting with the school leads to the bullying stopping.
   However, the fears go on. Even when she goes to a friendly playgroup she continues to
   have panic or fear reactions.

   If she continues to have anxiety attacks with fear and panic after the initial event has
   been resolved for more than 3 months, it needs further attention.

2 - The worries have grown worse with time
   We need to look into what is happening if the initial anxiety reaction has given way to a
whole lot of new worries and physical symptoms such as vomiting, tummy ache,
headache etc. Again if our son had a bad fall from the swing and was fearful to try it
again and gradually starts avoiding the park where the swings are, then begins
avoiding going out in the street and then finally avoids other children, refusing to leave
home.

3 - It shows in other parts of his life.
   If our children are not able to do the things they used to do before because of fear or
anxiety, whatever the setting, we should be concerned. If we are feeling that our
children's anxious behaviour or fearful reactions interfere with their normal lives and
progress in growing up we should be asking for help.

What are the signs that our children are moving from normal worries to anxiety?
Anxiety varies from child to child. Some children are simply anxious of one thing, like
ghosts, and others worry about many things. Almost all children show the following
features when they get anxious.

1 - Anxious children will worry a lot about some danger or threat. For example, they
worry about getting hurt, being laughed at, or someone close to them falling ill.

2 - When our children become anxious, their breathing becomes faster; there may be
sweating, feelings of nausea, diarrhoea, pain in different parts of the body such as
headache and generally feeling uncomfortable and miserable.

3 - When children get anxious they also get nervous. They may cry, cling, or fidget.
4 - Anxious children usually tend to avoid the things that they fear. For example, not going to the playground for fear of meeting new children, refusing to go to parties for fear of separating from parents. Avoidance is one of the most important signs of being anxious.

How can we help our children when they are anxious?
Anxious children often view the world as a dangerous place. Sometimes this is because they interpret our love, control and protection as a sign that "there must be something nasty out there." At other times they can see that we are anxious and it makes them anxious even when they do not know why. There are times when the world around proves not to be safe. However, living in constant fear that everything can go wrong will eventually paralyse both us and our children and makes it impossible to enjoy the good things that are happening. To help our children when their worries are interfering with daily life, we can begin by listening without trying to provide answers or reassuring them that their worries are not true. We try to encourage them gently but firmly not to avoid situations that frighten them. However, sometimes all of these things do not work and it is time to ask for help outside the family. Initially this might be a wise and trusted friend, a mulla, pastor or priest. But if the problem persists it is best to consult with professionals who can help anxious children. These are by and large general practitioners, paediatricians, counsellors in school, psychologists, psychiatrists and therapists from different disciplines. They use a variety of helpful ways including relaxation, realistic thinking, improving self esteem, boosting confidence, assertiveness training and so on and so forth to treat anxiety. Sometimes when all these do not work and the worries are severe, medication can also be used.

Are there different ways of getting worried in different cultures?
Yes. What one culture sees as an anxiety reaction, another culture may view as normal behaviour. For example, not looking at people while talking is normal in Navajo Indians and is not seen as a sign of being anxious while around others. Talking softly, particularly by women and children is normal in some cultures and is not considered a sign of fear or uneasiness. There can be differences of opinion or disagreement between school and parents, or doctors and parents as to whether the child's fears are normal or not. Under these circumstances it would be useful to try and understand a child compared to other children their age from the same cultural group, background and family values. It can be unhelpful and confusing to try to make sense of every child's behaviour in the same way as if 'one size fits all'.

As a parent we try to do what is best for our children. If we are concerned about particular behaviours in our children it is worthwhile to look into it a little further. On the other hand, if we feel comfortable about the behaviours that others are concerned about in our children, so long as it does not create obstacles in their lives or prolonged distress it is unlikely to be serious.

Remember that worries and fears are normal in children. But when our children do show abnormal patterns or persistence of worries and fears, good effective treatments are available and we should not let our children go on suffering unnecessarily.
When a Family Member Has an Anxiety Disorder

1. Be predictable, don't surprise them. If you say you are going to meet them somewhere at a certain time, be there. If you agree to respond to a certain anxious habit in a certain way, stick to the plan.

2. Don't assume that you know what the affected person needs, ask them. Make a mutual plan about how to fight the anxiety problem.

3. Let the person with the disorder set the pace for recovery. It's going to take months to change avoidance patterns, expect slow but increasingly difficult goals to be attempted.

4. Find something positive in every attempt at progress. If the affected person is only able to go part way to a particular goal, consider that an achievement rather than a failure. Celebrate new achievements, even small ones.

5. Don't enable. That means don't let them too easily avoid facing their fears, yet DO NOT FORCE them. Negotiate with the person to take one more step when he or she wants to avoid something. Gradually stop cooperating with compulsive or avoidant habits that the person may be asking you to perform. Try to come to an agreement about which anxiety habit you're going to stop cooperating with. Take this gradually, it's an important but difficult strategy.

6. Don't sacrifice your own life activities too often and then build resentment. If something is extremely important to you, learn to say so, and if it's not, drop it. Give each other permission to do things independently and to also plan pleasurable time together.

7. Don't get emotional when the person with the disorder panics. Remember that panic feels truly horrible in spite of the fact that it is not dangerous in any way. Balance your responses somewhere between empathizing with the real fear a person is experiencing and not overly focusing on this fear.

8. Do say: "I am proud of you for trying. Tell me what you need now. Breathe slow and low. Stay in the present. It's not the place that's bothering you, it's the thought. I know that what you are feeling is painful, but it is not dangerous." Don't say: "Don't be anxious. Let's set up a test to see if you can do this. Don't be ridiculous. You have to stay, you have to do this. Don't be a coward."

9. Never ridicule or criticize a person for becoming anxious or panicky. Be patient and empathetic, but don't settle for the affected person being permanently stagnant and disabled.

10. Encourage them to seek out therapy with a therapist who has experience treating their specific type of problem. Encourage sticking with therapy for as long as steady attempts at progress are being made. If visible progress comes to a stop for too long, help them to re-evaluate how much progress they can realistically make.
they did make, and to renew their initial efforts at getting better.

What was Donny Osmond's secret?

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http://www.freedomfromfear.com/aanx_factsheet.asp?id=27
Helping Your Anxious Child

Dr David Lewis

This is a practical book to help parents solve a widespread problem. The format of the book makes it particularly easy for the reader to go directly to the specific problem which is causing concern.

Sadly, as the author reminds us, many parents do treat their child's anxieties far too lightly. They hope that they will be 'outgrown' or convince themselves that the child could overcome them if only 'he would make an effort.' At the same time, in Dr Lewis' experience 'excessive anxiety is the greatest single threat to successful intellectual, social, emotional, sexual, physical and personal development that any child faces.'

He provides answers to questions such as 'How can I tell if my child has an anxiety problem?' 'Why is my child scared of so many things?' and 'Will my child just grow out of his or her fears?' And then provides strategies to guide you in helping your child.

Lewis explains the many causes of anxiety, and is not afraid to consider that there are times when a child's anxieties reflect stresses and tensions within the family as a whole. In a way, perhaps he does not underline enough the pressure children are under when there is a family break-up.
Even the most loving parent needs to be reminded that children often go to great lengths to hide their anxieties, and this is caused by fear of not being taken seriously or appearing babyish, incompetent or unmanly and more. Remember, anxiety can come in many guises, and Lewis gives clear a explanation of what lies behind avoidance, projection, repression, displacement and denial. Tools frequently used, in my experience, when there is a parent or sibling with a disability at home.

There are clear and precise guidelines about how to help your anxious child, and a chapter dealing with the most common anxieties, including school phobia, maths anxiety, exams, and social anxiety.

The extra plus when reading this book is that it will help you to consider your own anxieties, and there is advice about ways to help you reduce your own levels of stress. So, apply Dr Lewis' straightforward advice and rid your life of anxiety, and help your child to be a happy, confident person.


and available from amazon.co.uk

Review published 18 June 2002 © Jill Curtis 2002

Click for more book reviews.

Return to Jill's homepage
Resources for Parents and Children

Click on the links below for a list of hand-selected books for children and parents on ways of dealing with difficult emotions and anxiety.

I Can Relax! Relaxation CD for Children
Created by Dr. Donna Pincus the "I Can Relax! CD for Children" focuses on teaching children relaxation skills while also promoting positive self-image for children.

New! Coping Cards
Appropriate for children between the ages of approximately 5-14 years, COPING CARDS are a great tool for boosting youngsters' confidence in their ability to cope with stress and anxiety.

Don't Pop Your Cork on Mondays: The Children's Anti-stress Book.

A Boy and a Bear: The Children's Relaxation Book.
Lite, L. (1996)

Wemberly Worried

http://www.childanxiety.net/Resources_for_Parents.htm
Mama, Don't Go!
Wells & Wheeler (2001)

The Good-Bye Book
Viorst (1982)

My Mama Says There Aren't Any Zombies, Ghosts, Vampires, Creatures, Demons, Monsters, Fiends, Goblins or Things
Viorst (1987)

The Giving Tree

The Velveteen Rabbit
Bianco, Williams, & Nicholson (1958) A classic tale since 1922, and a favorite for parents and children of all ages.

Harold and the Purple Crayon

Alexander and the Terrible, Horrible, No Good, Very bad Day
Viorst & Cruz (1987)

Where the Wild Things Are
Sendak (1988)

Goodnight, Moon
Brown & Hurd (1991)
Tell Me Something Happy Before I Go to Sleep.
Dunbar & Gliori (1998)

Night Light: A Story for Children Afraid of the Dark.
Dutro & Boyle (1991)

Love You Forever

Guess How Much I Love You
McBratney & Jeram (1996)

Stellaluna
Jannell Cannon (1993)
This is an award winning book with underlying messages in it about place, acceptance, home and family.

Fears, Doubts, Blues, and Pouts: Stories of Handling Fear, Worry, Sadness and Anger
H. Norman Wright (1999)

I'm Scared (Dealing With Feelings)
Crary & Whitney (1996)

The Brand New Kid
Katie Couric (2000)

Where Do Balloons Go?
Curtis & Cornell (2000)

Freeing Your Child from Obsessive Compulsive Disorder: A Powerful, Practical Program for Parents of Children and Adolescents.
Tamar E. Chansky Ph.D. (2001)


Frankel, F. H. & Wetmore, B. (1996)

Get Out of My Life, But First Could You Take Me and Cheryl to the Mall.
*Uses a humorous approach to teach parents to understand and cope with teenagers.

Rapee (2000)

Ready, Set, Relax: A Research-Based Program of Relaxation, Learning and Self Esteem for Children
Jeffery Allen & Roger Klein (1997)

Don't Sweat The Small Stuff For Teens
Richard Carlson (2000)

Field Guide to the American Teenager: A Parent's Companion
Joseph Di Prisco & Michael Riera (2001)

Your Anxious Child: How Parents and Teachers Can Relieve Anxiety in Children
John Dacey (2000)

Anxiety Disorders in Children and Adolescents.

Children's Stress and Coping: A Family Perspective (Perspectives on Marriage and the Family).
Sorenson, E. S. (1993) *Provides a perspective on how children deal with stress and how parents and clinicians can teach them effective coping

http://www.childanxiety.net/Resources_for_Parents.htm
strategies.

*Excellent parent workbook helping parents to understand how to intervene appropriately when children refuse school due to anxiety concerns.

Books on Health

Mayo Clinic Family Health Book: The Ultimate Home Medical Reference
David Larson & Robert Waller (1996)

Harvard Medical School Family Health Guide
Anthony Komaroff (1999)

Healthy Kids: Help Them Eat Smart and Stay Active for Life!
Marlou Henner (2001)

Solve Your Child’s Sleep Problems
Richard Feber (1986)

Your Child's Health: The Parents' Guide to Symptoms, Emergencies, Common Illnesses, Behavior and School Problems
Barton Schmitt (1991)

The Children's Hospital Guide to Your Child's Health and Development
Alan Woof et al (2001)

What to Expect When You're Expecting
Arlene Eisenberg et al (1999)
Children and Anxiety

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Common Questions, Quick Answers

- What is anxiety?
- What can cause anxiety in children?
- What are the different kinds of anxiety a child might feel?
- What are the symptoms of anxiety?
- How can I help my child?
- How long will my child's anxiety last?
- How is anxiety treated?
- When should I call the doctor?

What is anxiety?

- Anxiety is a feeling of uneasiness caused by fear. It can make children feel tense, nervous, or afraid.
- All children feel some anxiety at different stages in their lives. This is normal.

What can cause anxiety in children?

- It is normal for children to feel some anxiety. But if it interferes with their daily lives or with the family, then they may need help from a doctor.
- Children often feel anxiety when they have to be separated from a parent or other loved one.
- Children and adolescents may worry about making friends at school, doing well in sports, or getting good grades.
- Some children are afraid to meet new people.
- Children often worry about things that could happen. They worry, "What if..."
- Some children worry about one thing over and over again. For example, a child might constantly worry that someone will forget to pick him up from school.
- Children can feel anxiety if they have low self-esteem (feel bad about themselves).
- Children ages 2-6 are often afraid of make-believe things, such as monsters or being in the dark.
- Children ages 7-12 often are afraid of things that could happen to them, such as getting hurt in a car accident or losing a parent.
What are the different kinds of anxiety a child might feel?

Generalized Anxiety Disorder
- A child with generalized anxiety worries a lot about everyday events.

Obsessive Compulsive Disorder (OCD)
- Children with OCD can't seem to stop themselves from doing something over and over again.

Panic Disorder
- A child with panic disorder has an extreme fear that hits all of a sudden.
- It can cause chest pain, a fast pulse, shortness of breath, dizziness, or stomach pain.

Stranger Anxiety
- Infants often feel stranger anxiety. When they are around someone they don't know, they cling to their parents.

Separation Anxiety
- At around 10-18 months old, toddlers feel separation anxiety. It upsets and frightens them to be away from a parent or other loved one.
- Children may refuse to go to school or stay at a friend's house.
- They may be clingy.
- They may throw tantrums or panic when a parent or loved one tries to leave.
- They may have nightmares or trouble sleeping.

Post-traumatic Stress Disorder
- A child might feel anxiety after a very bad life event, such as a housefire.
- The memory of the bad event is usually vivid.

Phobias
- A phobia is when a child is very afraid of one kind of thing, such as flying, insects, storms, or meeting new people.
- The fear is extreme and hard for the child to control.
- Children usually grow out of their phobias.

What are the symptoms of anxiety?

- Children may be tense or get upset easily.
- They may seek reassurance, wanting to be told again and again that they are okay.
- They may not want to take part in activities.
- They may be quiet and withdrawn.
- They may be eager to please.
- Anxiety increases the heart rate and children may sweat.
- The child might have a stomach ache or stomach cramps.

How can I help my child?

- Pay close attention to your child. If his anxiety goes unnoticed, it can lead to bigger problems.
- If you think your child is feeling anxiety, talk to him about his fears.
- Teach your child how to rate how afraid he is. Is he very, very afraid, kind of afraid, or just a little afraid? Talking about the fear will help your child control it.
- Do not ignore your child's fears. Acknowledge that they exist. Tell your child that it's okay to be afraid but also try to show why he doesn't have to be afraid. Show him ways he can control his fear.
- Do not give in to your child's fears. For example, if your child is afraid of dogs, don't avoid them. Act normal when you are around dogs. Use it as a chance to teach your child that he does not have to be afraid of them.

Help your child take small steps to overcome his fears. For example, work toward leaving a night light on instead of a brighter closet light. Or, work toward getting closer and closer to a dog until your child is no longer afraid to pet it.

**How long will my child's anxiety last?**

- Children usually grow out of their fears. Sometimes, they grow out of an old fear but start having a new fear.
- You should talk to your doctor if your child is unable to overcome his fear or if the fears interfere with his daily activities or with the family.

**How is anxiety treated?**

- The doctor might advise you to take your child to a child or adolescent psychiatrist, a doctor who will help your child talk about his fears and teach him ways to control it.
- Treatment is different for every child.
- It may include talking to only the child about his fears, talking to the child and the family together, medication, teaching the child how he can change his behavior, or talking to teachers about how they can help.

**When should I call the doctor?**

- Call if your child's anxiety greatly disrupts his social, academic, or personal life.
- Call if you have questions or concerns about your child's health.

**Quick Answers**

- Anxiety is a feeling of uneasiness caused by fear. All children feel anxiety sometimes. This is normal.
- Anxiety can be caused by worries about school, friends, family, or by other fears, such as fear of meeting strangers or fear of being separated from loved ones.
- Children can feel many different kinds of anxiety.
- Children who are feeling anxiety may be tense or get upset easily.
- Do not ignore your child's fears. Acknowledge that they exist. Tell your child that it's okay to be afraid but show him reasons for not being afraid.
- Children usually grow out of their fears.
- The doctor might advise you to take your child to a psychiatrist. Treatment is different for every child.
- Call if you have questions or concerns about your child's health.

**References**

See related Patient Topics Anxiety, Mental Health, Mental Health and Behavior or Wellness and Lifestyle.

See related Provider Topics Mental Health, Mental Health and Behavior or Wellness and Lifestyle.
Anxiety Disorders in Children and Adolescents

PART I

What Are Anxiety Disorders?

Young people with an anxiety disorder typically are so afraid, worried, or uneasy that they cannot function normally. Anxiety disorders can be long-lasting and interfere greatly with a child's life. If not treated early, anxiety disorders can lead to emotional, behavioral, and mental disorders. They include depression, attention deficit/hyperactivity disorder, and anxiety, conduct, and eating disorders. Mental health problems affect one in every five young people at any given time.

"Serious Emotional Disturbances" for children and adolescents refers to the above disorders when they severely disrupt daily functioning in home, school, or community. Serious emotional disturbances affect 1 in every 10 young people at any given time.

• missed school days or an inability to finish school;

• impaired relations with peers;

• low self-esteem;

• alcohol or other drug use;
• problems adjusting to work situations;
• and anxiety disorder in adulthood.

What Are the Signs of Anxiety Disorder?

There are a number of different anxiety disorders that affect children and adolescents. Several are described below.

Generalized Anxiety Disorder. Children and adolescents with this disorder experience extreme, unrealistic worry that does not seem to be related to any recent event. Typically, these young people are very self-conscious, feel tense, have a strong need for reassurance, and complain about stomachaches or other discomforts that don't appear to have any physical basis.

Phobias. A phobia is an unrealistic and excessive fear of some situation or object. Some phobias, called specific phobias, center on animals, storms, water, heights, or situations, such as being in an enclosed space. Children and adolescents with social phobias are terrified of being criticized or judged harshly by others. Because young people with phobias will try to avoid the objects and situations that they fear, the disorder can greatly restrict their lives.

Panic Disorder. Panic disorder is marked by repeated panic attacks without apparent cause. Panic attacks are periods of intense fear accompanied by pounding heartbeat, sweating, dizziness, nausea, or a feeling of imminent death. The experience is so scary that the young person lives in dread of another attack. He or she may go to great lengths to avoid any situation that seems likely to bring on a panic attack. A child with panic disorder may not want to go to school or be separated from his or her parents.

Obsessive-Compulsive Disorder. A child with obsessive-compulsive disorder becomes trapped in a pattern of repetitive thoughts and behaviors. Even though the child may agree that the thoughts or behaviors appear senseless and distressing, the repetitions are very hard to stop. The compulsive behaviors may include repeated hand washing, counting, or arranging and rearranging objects.

Post-Traumatic Stress Disorder. Post-traumatic stress disorder can develop in children or adolescents after they experience a very stressful event. Such events may include physical or sexual abuse; being a victim of or witnessing violence; or being caught in a disaster, such as a bombing or hurricane. Young people with post-traumatic stress disorder experience the event again and again in strong memories, flashbacks, or troublesome thoughts. As a result, the young person may try to avoid anything associated with the trauma. They may also overreact when startled or have difficulty sleeping.

Important Messages About Children's and Adolescents' Mental Health: Every child's mental health is important. Many children have mental health problems. These problems are real and painful and can be severe. Mental health problems can be recognized and treated. Caring families and communities working together can help.

Information is available - publications, references, and referrals to local and national resources and organizations--call 1.800.789.2647; TTY 301.443.9006 or go to http://www.mentalhealth.org

http://www.counselingnotes.com/parents/child/child_anxi.htm 5/2/2003
Anxiety Disorders in Children and Adolescents

What are anxiety disorders?

Anxiety disorders cause people to feel excessively frightened, distressed, and uneasy during situations in which most others would not experience these symptoms. Left untreated, these disorders can dramatically reduce productivity and significantly diminish an individual's quality of life. Anxiety disorders in children can lead to poor school attendance, low self-esteem, deficient interpersonal and alcohol abuse, and adjustment difficulty.

Anxiety disorders are the most common mental illnesses in America; they affect as many as one young people. Unfortunately, these disorders are often difficult to recognize, and many who suffer from them are either too ashamed to seek help or they fail to realize that these disorders can be treated effectively.

What are the most common anxiety disorders?

- **Panic Disorder** -- Characterized by panic attacks, panic disorder results in sudden feeling terror that strike repeatedly and without warning. Physical symptoms include chest pain, heart palpitations, shortness of breath, dizziness, abdominal discomfort, feelings of unreality, and fear of dying. Children and adolescents with this disorder may experience unrealistic worry, self-consciousness, and tension.

- **Obsessive-compulsive Disorder (OCD)** -- OCD is characterized by repeated, intrusive, and unwanted thoughts (obsessions) and/or rituals that seem impossible to control (compulsions). Adolescents may be aware that their symptoms don't make sense and are excessive, but younger children may be distressed only when they are prevented from carrying out their compulsive habits. Compulsive behaviors often include counting, arranging and rearranging objects, and excessive hand washing.

- **Post-traumatic Stress Disorder** -- Persistent symptoms of this disorder occur after experiencing a trauma such as abuse, natural disasters, or extreme violence. Symptoms include nightmares, flashbacks, the numbing of emotions, depression, feeling angry, irritable, and distracted; and being easily startled.

- **Phobias** -- A phobia is a disabling and irrational fear of something that really poses little or actual danger. The fear leads to avoidance of objects or situations and can cause extreme feelings of terror, dread, and panic, which can substantially restrict one's life. "Specific" phobias center around particular objects (e.g., certain animals) or situations (e.g., heights or enclosed spaces). Common symptoms for children and adolescents with "social" phobia are hypersensitivity to criticism, difficulty being assertive, and low self-esteem.

- **Generalized Anxiety Disorder** -- Chronic, exaggerated worry about everyday, routine life events and activities that lasts at least six months is indicative of generalized anxiety disorder. Children and adolescents with this disorder usually anticipate the worst and often complain of fatigue, tension, headaches, and nausea.

http://www.nami.org/helpline/anxiety.htm

5/2/2003
Other recognized anxiety disorders include: agoraphobia, acute stress disorder, anxiety disorder medical conditions (such as thyroid abnormalities), and substance-induced anxiety disorder (such from too much caffeine).

Are there any known causes of anxiety disorders?

Although studies suggest that children and adolescents are more likely to have an anxiety disorder than their caregivers have anxiety disorders, it has not been shown whether biology or environment plays the greater role in the development of these disorders. High levels of anxiety or excessive shyness in children aged six to eight may be indicators of a developing anxiety disorder.

Scientists at the National Institute of Mental Health and elsewhere have recently found that some of obsessive-compulsive disorder occur following infection or exposure to streptococcus bacteria. Research is being done to pinpoint who is at greatest risk, but this is another reason to treat strep throats seriously and promptly.

What treatments are available for anxiety disorders?

Effective treatments for anxiety disorders include medication, specific forms of psychotherapy (known as behavioral therapy and cognitive-behavioral therapy), family therapy, or a combination of these. Cognitive-behavioral treatment involves the young person's learning to deal with his or her fears by modifying the way he or she thinks and behaves by practicing new behaviors.

Ultimately, parents and caregivers should learn to be understanding and patient when dealing with children with anxiety disorders. Specific plans of care can often be developed, and the child or adolescent should be involved in the decision-making process whenever possible.
Common anxiety and related problems among children

For more information, click on the disorder that interests you:

- Fears of being away from Mom and Dad or of sleeping alone
- Fear and avoidance of elevators, heights or water
- Fear and avoidance of certain animals, insects
- Unreasonable fear of needles or blood
- Physical sensations like racing heart, trouble catching breath, dizziness
- Panic attacks or feeling really scared out of the blue
- Frequent prolonged worrying
- Worries that are hard to control
- Uncomfortable shyness
- Reluctance to talk or interact or attend social events
- Intrusive unpleasant thoughts
- Need to repeat certain actions
- Involuntary muscle movement
- Repetitive vocalizations
- Repetitive pulling of hair

http://www.npi.ucla.edu/caap/anxieties/anxiety_problems.htm
Anxiety symptoms and disorders are the number one health problem in America, ranging from a simple Adjustment Disorder to more difficult and debilitating disorders such as Panic Disorder and Posttraumatic Stress Disorder. According to the most recent data, the lifetime prevalence for anxiety disorders as a whole in adults is about 25%; the frequency in children is unknown, but felt to be significantly underreported and under-diagnosed. More specifically Social Anxiety Disorder has a lifetime risk of 17%, while Panic Disorder occurs in approximately 1-3% of the adult population.

Although quite common, Anxiety Disorders in children often are overlooked or misjudged, despite them being very treatable conditions with good, persistent medical care. What does seem to be developing in the medical literature is the consensus that many “adult” psychiatric disorders likely have their first (although perhaps subtle or ignored) manifestations in childhood, and that if left untreated these anxiety disorders in children likely progress to adult versions.

Symptoms of Anxiety Disorders

Anxiety is a subjective sense of worry, apprehension, fear and distress. Often it is normal to have these sensations on occasion, and so it is important to distinguish between normal levels of anxiety and unhealthy or pathologic levels of anxiety. The subjective experience of anxiety typically has two components: physical sensations (e.g., headache, nausea, sweating) and the emotions of
nervousness and fear. Anxiety disorders, when severe, can affect a child's thinking, decision-making ability, perceptions of the environment, learning and concentration. It raises blood pressure and heart rate, and can cause a multitude of bodily complaints, such as nausea, vomiting, stomach pain, ulcers, diarrhea, tingling, weakness, and shortness of breath, among other things.

Types of Anxiety Disorders

Diagnosis of normal versus abnormal anxiety depends largely upon the degree of distress and its effect on a child's functioning in life. The degree of abnormality must be gauged within the context of the child's age and developmental level. The specific anxiety disorder is diagnosed by the pattern and quality of symptoms as follows:

- **Generalized Anxiety Disorder.** Defined as excessive worry, apprehension, and anxiety occurring most days for a period of 6 months or more that involves concern over a number of activities or events. The person has difficulty controlling the anxiety, which is associated with the following: restlessness, feeling "keyed up" or on edge; being easily fatigued; difficulty concentrating or having the mind go blank; irritability; muscle tension; difficulty falling asleep or staying asleep, or restless sleep. The anxiety causes significant distress and problems functioning.

- **Panic Disorder.** Panic Disorder is different from Panic Attacks; panic attacks are defined as sudden, discrete episodes of intense fear and/or discomfort accompanied by 4 out of 13 bodily or cognitive symptoms, often manifesting with an intense desire to escape, feeling of doom or dread, and impending danger. These symptoms peak within 10 minutes, and often subside within 20-30 minutes. The 13 symptoms are: heart palpitations or fast heart rate; sweating; trembling or shaking; shortness of breath or smothering; choking sensation; chest discomfort or pain; nausea or abdominal distress; feeling dizzy, lightheaded, faint or unsteady; feelings of unreality or being detached from oneself; fear of losing control or going crazy; fear of dying; numbness or tingling sensations; chills or hot flashes. Panic Disorder consists of recurrent unexpected panic attacks with inter-episode worry about having others; the panic attacks lead to marked changes in behavior related to the attacks. Panic attacks are frequently associated with Agoraphobia (anxiety and avoidance of situations from which escape might be difficult or help might not be available).

- **Obsessive-Compulsive Disorder.** Defined by persistent Obsessions (intrusive, unwanted thoughts, images, ideas or urges) and/or Compulsions (intense uncontrollable repetitive behaviors or mental acts related to the obsessions) that are noted to be unreasonable and excessive. These obsessions and compulsions cause notable distress and impairment and are
time consuming (more than one hour a day). The most common obsessions concern dirt and contamination, repeated doubts, need to have things arranged in a specific way, fearful aggressive or murderous impulses, and disturbing sexual imagery. The most frequent compulsions involve repetitive washing of hands or using handkerchief/tissue to touch things; checking drawers, locks, windows, and doors; counting rituals; repeating actions; and requesting reassurance.

- **Posttraumatic Stress Disorder.** A person is exposed to a traumatic event in which he or she experiences, witnesses, or is confronted by an event or events that involved actual or perceived threat of death or serious bodily injury, and the person’s response involves intense fear, helplessness, or horror. The traumatic event is continually re-experienced in the following ways: recurrent and intrusive distressing remembrances of the event involving images, thoughts, or perceptions; distressing dreams of the event; acting or believing that the traumatic event is recurring; intense anxiety and distress to exposure to situations that resemble the traumatic event; bodily reactivity on exposure situations that resemble the traumatic event. The person avoids situations associated with and remind him of the traumatic event, leading to avoidance of thoughts, feelings or conversations associated with the trauma; activities, places, or people that remind him of the traumatic event; inability to remember details of the event; markedly diminished participation and interest in usual activities; feeling detached and estranged from others; restricted range of emotional expression; sense of a foreshortened future or lifespan; persistent signs of physiologic arousal, such as difficulty falling asleep or staying asleep, irritability or anger outbursts, difficulty concentrating, excessive vigilance, and exaggerated startle response. The above symptoms persist for more than one month and cause significant distress and impairment of functioning.

- **Acute Stress Disorder.** A person is exposed to a traumatic event in which he or she experiences, witnesses, or is confronted by an event or events that involved actual or perceived threat of death or serious bodily injury, and the person’s response involves intense fear, helplessness, or horror. The traumatic event is continually re-experienced in the following ways: recurrent and intrusive distressing remembrances of the event involving images, thoughts, or perceptions; distressing dreams of the event; acting or believing that the traumatic event is recurring; intense anxiety and distress to exposure to situations that resemble the traumatic event; bodily reactivity on exposure situations that resemble the traumatic event. The person avoids situations associated with and remind him of the traumatic event, leading to avoidance of thoughts, feelings or conversations associated with the trauma; activities, places, or people that
remind him of the traumatic event; inability to remember details of the event; markedly diminished participation and interest in usual activities; feeling detached and estranged from others; restricted range of emotional expression; sense of a foreshortened future or lifespan; persistent signs of physiologic arousal, such as difficulty falling asleep or staying asleep, irritability or anger outbursts, difficulty concentrating, excessive vigilance, and exaggerated startle response. The above symptoms persist for less than one month and cause significant distress and impairment of functioning.

- **Social Phobia.** Persistent and significant fear of one or more social situations in which a person is exposed to unfamiliar persons or scrutiny by others and feels he or she will behave in a way that will be embarrassing or humiliating. Exposure to the feared social situations almost always causes significant anxiety, even a panic attack despite the fact that the anxiety is seen as excessive and unreasonable. This belief may lead to avoidance of such situations or endurance under extreme distress, leading to marked interference in the person's functioning and routine.

- **Specific Phobia.** Persistent and significant fear that is recognized as unreasonable and excessive that is triggered by the presence or perception of a specific feared situation or object; exposure to this situation or object immediately provokes an anxiety reaction. The distress, avoidance, and anxious anticipation of the feared situation or object significantly interfere with a person's normal functioning or routine. Animal Type: animals or insects; Natural Environmental Type: storms, heights, water, etc.; Blood-Injection-Injury Type: getting injections, seeing blood, seeing injuries, watching or having invasive medical procedures; Situational Type: elevators, flying, driving, bridges, escalators, trains, tunnels, closets, etc.

- **Adjustment Disorder with Anxiety** (with or without depressed mood). When the development of emotional and/or behavioral symptoms occur within 3 months in response to an identifiable stressor. These symptoms and behaviors cause marked distress in excess of that which could be expected and results in significant occupational, social, or academic performance. Once the initiating stressor has ceased, the disturbance does not last longer than 6 months.

- **Anxiety Disorder Due to a General Medical Condition.** When the physiologic consequences of a distinct medical condition is judged to be the cause of prominent anxiety symptoms.

- **Drug-Induced Anxiety Disorder.** When the physiologic consequences of the use of a drug or medication is judged to be the cause of prominent anxiety symptoms.

- **Anxiety Disorder Not Otherwise Specified.** When the prominent symptoms of anxiety and avoidance exist but do
not fully meet the above diagnostic criteria.

Etiology/Causes of Anxiety

- **Psychological.** Anxiety can result when a combination of increased internal and external stresses overwhelm one's normal coping abilities or when one's ability to cope normally is lessened for some reason.
  - Psychodynamic: When internal competing mental processes, instincts and impulses conflict, causing distress.
  - Behavioral: Anxiety is a maladaptive learned response to specific past experiences and situations that becomes generalized to future similar situations.
  - Spiritual. When people experience a profound, unquenchable emptiness and nothingness to their lives, often leading to distress concerning their mortality and eventual death.

- **Genetic.** Studies show 50% of patients with Panic Disorder have at least one relative affected with an anxiety disorder. There is a higher chance of an anxiety disorder in the parents, children, and siblings of a person with an anxiety disorder than in the relatives of someone without an anxiety disorder. Twin studies demonstrate varying but important degrees of genetic contribution to the development of anxiety disorders.

- **Biologic.** Evidence exists that supports the involvement of norepinephrine, serotonin, and GABA. In some cases there appears to be a dysregulation of the noradrenergic and serotonergic neural systems, two systems that are complexly interrelated in the brain. Theories and some experimental evidence suggest abnormal functioning in the brain's GABA receptors. Brain imaging and functional studies have shown some evidence of abnormal function is several regions of the brain.

- **Medical.** Illnesses such as cardiovascular disease (mitral valve prolapse, arrhythmias), lung disease, certain tumors (pheochromocytoma), endocrine disorders (hyperthyroidism), infections, and neurologic disease can all cause anxiety disorders. Therefore it is important to see your doctor in order to exclude medical diseases as potential causes or contributors to anxiety disorders.

Anxiety Treatments

- **Psychological Treatments**
  - Cognitive-Behavioral Therapy: addresses underlying "automatic" thoughts and feelings that result from thoughts, as well as specific techniques to reduce or replace maladaptive behavior patterns
  - Psychotherapy: Centers on resolution of conflicts and
stresses, as well as the developmental aspects of an anxiety disorders solely through talk therapy

- Behavioral Therapies: focus on using techniques such as guided imagery, relaxation training, progressive desensitization, flooding as means to reduce anxiety responses or eliminate specific phobias

- Psychopharmacological Treatments
  - Benzodiazepines: Long-acting are best (Klonopin, Ativan, Valium, Librium, Serax) to quickly reduce the symptoms of an anxiety disorder. However, if used long term the result may be that tolerance develops.
  - Serotonergic Agents: newer antidepressants act as antianxiety agents as well, with excellent tolerability and effectiveness. Takes 4 to 6 weeks for full response (Luvox, Prozac, Zoloft, Paxil).
  - Tricyclic Antidepressants (TCAs): older antidepressants with more side effects typically than the serotonergic agents, but also effective. Takes 4 to 6 weeks for full response (Tofranil, Elavil, Pamelor, Sinequan).
  - Combination Serotonin/Norepinephrine Agents: new medications such as Effexor, Serzone, and Remeron, also with excellent tolerability and effectiveness. Takes 4 to 6 weeks for full response.
  - Antihistamines: older medications used for mild to moderate anxiety for many years. These, like the benzodiazepines, work fairly quickly (Atarax, Vistaril).
  - Buspirone (BuSpar): a new serotonergic combination agonist/antagonist. Is nonaddicting, but may take 2 to 4 weeks for full effect.
  - Major Tranquilizers (also called neuroleptics): medications that act on a variety of neurotransmitter systems (acetylcholine, dopamine, histamine, adrenergic). Most are somewhat sedating, and have been used in situations where anxiety is severe enough to cause disorganization of thoughts and abnormal physical and mental sensations, such as the sense that things around you aren't real (derealization) or that you are disconnected with your body (derealization). Commonly used neuroleptics include: Zyprexa, Risperdal, Seroquel, Mellaril, Thorazine, Stelazine, Moban, Navane, Prolixin, and Haldol.

- Environmental Treatments
  - Avoidance or minimization of stimulants. No caffeine, minimize use of asthma medications if possible (bronchodilators, theophylline), avoid use of nasal decongestants, some cough medications, and diet pills.
  - Good sleep habits. Getting adequate, restful sleep improves response to interventions to treat anxiety disorders.
  - Reduction of stressors. Identify and remove or reduce
stressful tasks or situations at home, school and work.

Support: Where to look for help.

There are several convenient sources of information and support, many of which can be found on the internet or in your community's libraries. Below are several good internet starting points. Additionally, your physician, nurse, pastor or counselor can be good sources of information.

- **The Anxious Child:** Article from the American Academy of Child and Adolescent Psychiatry about anxiety in children.
- **Childhood Mental Health Resources:** A guide to your children's mental health, with links to information about depression, anxiety disorders, ADHD, bipolar disorder and behavioral problems.
- **Anxiety Disorders Association of America:** Descriptions and treatment guides for different types of anxiety disorders. Includes message boards and chat.
- **Anxiety Disorders:** Information about anxiety disorders from the National Institute of Mental Health, including quick facts, treatments and where to get help.
- **Anxieties.com:** "A free internet self-help site for persons suffering from anxiety, panic attacks, phobias, obsessive-compulsive disorder - OCD, fear of flying and post traumatic stress disorder - PTSD"
- **Mental Health Net:** the most comprehensive source of online mental health information, news and resources.
- **Online Psych:** Online Psych gives you a variety of interactive tests, quizzes, and surveys to challenge, inform, intrigue, and educate you. You'll find everything from online screening tests for mental health issues to fun surveys about relationships.
- **Medication Effective in Treating Anxiety Disorders in Children and Adolescents:** a press release that describes a 'multi-site study to evaluate treatments for anxiety disorders in children and adolescents, funded by the National Institute of Mental Health (NIMH), found that a medication (Fluvoxamine) was more than twice as effective as the placebo, or sugar pill.'
Important disclaimer: The information on keepkidshealthy.com is for educational purposes only and should not be considered to be medical advice. It is not meant to replace the advice of the physician who cares for your child. All medical advice and information should be considered to be incomplete without a physical exam, which is not possible without a visit to your doctor.
Description of Child Anxiety Disorders

Below you will find a list of anxiety related disorders that may be experienced during childhood. Please select the disorder for which you would like to receive more information. This section also provides readers a general idea of the types of treatment strategies used with children and adolescents with anxiety disorders. It is important that a child be assessed and treated with the guide of a properly trained therapist.

- Generalized Anxiety Disorder
- Panic Disorder
- Separation Anxiety Disorder
- Specific Phobias
- Selective Mutism
- Social Phobia
- Obsessive Compulsive Disorder
Fears, Phobias and Anxiety

What is child anxiety?
All humans experience anxiety, it serves as a means of protection and can often enhance our performance in stressful situations. Children who are able to experience the slight rush of anxiety that often occurs prior to a math test or a big track race often can enhance their performance. However, experiencing too much anxiety or general nervousness, at inappropriate times, can be extremely distressing and interfering. Although children have fears of specific objects, the feeling of anxiety is more general...children may feel constantly “keyed up” or extremely alert. Given the wide range of tasks children must accomplish throughout their childhood, it is important to be sure that their level of anxiety does not begin to interfere with their ability to function. If it does, it is important that they begin to learn some skills for coping more efficiently with their anxious feelings.

What are fears and phobias?
Children’s fears are often natural, and arise at specific times in their development. Children may develop fears from a traumatic experience (e.g. traumatic dog attack), but for some children, there is no clear event that causes the fear to arise. Some children become fearful simply by watching another child acting scared. Some children may refuse to sleep alone due to fears of creatures in their closet, while other children report feeling afraid of the dark. Children’s fears are often associated with avoidance, discomfort, and physical complaints, such as rapid heart beat, stomach distress, sweaty palms, or trembling. Researchers have found certain fears arise at specific ages in all children, and these fears tend to disappear naturally with time, as the child grows older. When children’s fears persist beyond the age when they are appropriate, and begin to interfere with their daily functioning, they are called phobias. Typically, children who are experiencing a phobia should be referred for treatment by a psychologist.

Which of my child’s fears are normal?
Most children, when asked, are able to report having several fears at any given age. Some research shows that 90% of children between the ages of 2-14 have at least one specific fear. If your child’s fear is not interfering with his/her daily life (e.g., sleep, school performance, social activities), or your family’s life, then most likely you will not need to bring your child to a psychologist for help. Here are a list of fears that are found to be VERY COMMON for children at specific ages:

- INFANTS/TODDLERS (ages 0-2 years) loud noises, strangers, separation from parents, large objects
- PRESCHOOLERS (3-6 years) imaginary figures (e.g., ghosts, monsters, supernatural beings, the dark, noises, sleeping alone, thunder, floods)

http://www.childanxiety.net/Fears_Phobias_Anxiety.htm 5/2/2003
SCHOOL AGED CHILDREN/ADOLESCENTS (7-16 years)
more realistic fears (e.g., physical injury, health, school
performance, death, thunderstorms, earthquakes, floods.

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Social Anxiety in Children & Adolescents

What is it?

Social anxiety (also known as social phobia) is the fear of being watched or evaluated by others. Basically, children and teenagers with Social Anxiety Disorder are extremely afraid that they say or do something to embarrass themselves or expose themselves to criticism. Unlike shyness, which many children and teenagers outgrow, social anxiety disorder does not tend to go away on its own.

Children and adolescents with social anxiety may feel that they don't fit in, that they will be criticized, that they will look stupid, or that no one will like them. They may also experience physical symptoms such as dizziness, "butterflies" in stomach, shaky hands, blushing, and muscle tension.

Recent national surveys found that approximately 5% of children and adolescents in the United States have Social Anxiety Disorder. As a result of their symptoms, most of those affected experience some type of impairment in school, at home, and in their relationships.

Some children may exhibit a very severe form of social anxiety called Selective Mutism. These children may be able to socialize with family members but when it comes to peers and adults who are not family members, they become very uncomfortable and refuse to speak. Common signs may include refusing to answer questions in class or refusing to talk to children who are not family members.
Is your child or teenager experiencing Social Anxiety?

✓ Does your child fear answering questions in class?
✓ Get nervous around people?
✓ Worry a lot about giving speeches?
✓ Refuse to attend group activities?
✓ Worry a lot about embarrassing himself/herself in front of others?

Is Social Anxiety causing problems for your child or teenager?

✓ Has social anxiety affected your child's ability to make friends?
✓ Has social anxiety resulted in poorer academic performance or do teachers comment on your child's lack of participation in class?
✓ Does social anxiety prevent your child from doing things he/she would like to do?

If you answered "yes" to some of these questions, your child may have Social Anxiety Disorder.

Is there help?

Yes. UCSD Anxiety and Traumatic Stress Disorders Clinic currently has a 16-week research treatment study for social anxiety in children. This clinical trial involves using a medication called Venlafaxine Extended Release (Effexor
Effexor is currently FDA approved for the treatment of depression and generalized anxiety disorder in adults. This clinical trial includes:

- A comprehensive assessment to determine if your child has social anxiety disorder.
- A complete physical examination including blood tests, urinalysis (urine test) and an electrocardiogram (ECG or "heart tracing").
- Females of childbearing years, will receive a pregnancy test.

For a detailed study explanation, please see A Double-Blind, Placebo-Controlled, Parallel-Group, Flexible-Dose Study of Venlafaxine Extended Release (Effexor ER™) In Childhood and Adolescent Outpatients With Social Anxiety Disorder.

In order to help young children understand "what is social anxiety" as well as our combination treatment approach for social anxiety disorder, click here.
Anxiety Disorders

Major Characteristics
Anxiety disorders are the most common problem seen by psychologists and psychiatrists. Recent national surveys have indicated that a startling 25% of the population reported having symptoms severe enough to warrant the diagnosis for an anxiety disorder at some point in their lives. The demands of stressful situations or even everyday life will cause most of us to feel anxious at different points in our life. What makes these feelings an "anxiety disorder" is that the problem persists for weeks and begins to interfere with occupational and/or social functioning. Symptoms can vary from mild, to severe in which case almost total disability can occur. Anxiety disorders are actually a group of separate but sometimes overlapping disorders, they include: phobias (social phobia, agoraphobia, simple phobia), panic disorder, obsessive-compulsive disorder, generalized anxiety disorder, post-traumatic stress disorder and separation anxiety disorder (a common childhood problem). These separate disorders will be discussed as a group since they share so many of the same symptoms.

Physical & Emotional Symptoms
One of the primary characteristics of all anxiety problems is of course fear. While the experience of fear under certain situations is a part of life, fear that significantly interferes with our daily functioning doesn't have to be. Emotionally fear can vary from experiencing anticipation and tension, to at worst, acute panic attacks. Physical symptoms can include difficulties sleeping, loss of appetite, stomach upset, diarrhea, restlessness, muscle aches and tension headaches. Acute fear otherwise known as a panic attack can include a sudden feeling of terror accompanied by: trembling/shaking, sweating, hot/cold flashes, faintness, unsteadiness, dizziness, difficulty concentrating, disorientation, racing heart, chest discomfort, difficulty breathing, dry mouth, numbness in body parts, etc.

Cognitive Characteristics
Cognitions are simply thoughts. These include the ideas or images that come to mind while a person is feeling anxious. Anxious thoughts are generally characterized by the belief that you or someone you know is in some type of danger that something dangerous is about to happen. One of the main definitions of a phobia is believing that something is dangerous when it really is not, the fear is irrational or excessive. Most anxiety sufferers can see that their thoughts are unrealistic, distorted or excessive but find it very difficult to stop thinking these thoughts. For social phobia, fears are centered around social situations in which one focuses on not getting approval, failing, or being embarrassed. Thoughts during panic attacks include ideas about losing control, going crazy, or dying. Agoraphobic thoughts are often connected to believing that certain sensations or situations are going to lead to another full panic attack, and that without someone else around this cannot be stopped or may even be dangerous. Obsessive-compulsive thoughts often include the inability to stop thinking about, contamination, germs, illness, death, sex, religion, personal responsibility, loosing control and getting violent with oneself or others. Post-traumatic stress disorder includes flashbacks from some traumatic event,
which may also be present in nightmares, and often thoughts about being responsible for the event. Generalized anxiety disorder produces almost constant worry about what might happen in a wide variety of areas in a person's life (e.g. health, financial, etc.). Younger children may be less able to express their fears clearly, or may report more primitive fears of harm such as monsters, eyes in the dark, or something bad happening to themselves or parents if they are separated.

Behavioral Characteristics
Behavioral characteristics are primarily different forms of avoidance. Avoidance can take a variety of forms, often it's as simple as giving in to the urge not to go to a certain place, or to quickly escape if the discomfort gets to powerful. Sometimes avoidance can take on more complicated forms such as compulsions or rituals in which certain actions may be excessively repeated even though it doesn't make sense to repeat them. Examples would include excessive cleanliness, ordering, or checking. Avoidance is a natural, almost automatic way that people try to reduce anxiety, physical distress and panic attacks. Unfortunately avoidance never helps a person to learn how to cope and instead worsens the problem.

How common is anxiety?
Anxiety related disorders are the most common psychological problem. Recent national surveys reveal that a startling 25% percent of the population will suffer from an anxiety disorder at sometime in the course of their lives.

Complications
Without proper treatment a variety of possible complications may arise in conjunction with simple anxiety. Left untreated anxiety may begin to interfere with social functioning, resulting in difficulties in professional and/or personal relations. Often after a prolonged period of suffering from an anxiety disorder a person may become frustrated, hopeless and eventually depressed. Estimates vary but as many as 59% of anxiety sufferers may at some point also simultaneously suffer from clinical depression. Another common complication is the use of alcohol or other drugs as a way to feel calmer. Of course this only worsens the condition in the long run, this is commonly referred to as "self-medicating".

Treatment
Behavior and cognitive-behavior therapies are among the treatments which have been most extensively evaluated and have repeatedly proven their effectiveness for treating anxiety disorders. Behavior Therapy (BT) is often confused with behavior modification, they are not the same. Behavior modification is using a plan of rewards and punishments to change behavior, this may help with children but IS NOT what is meant by BT for adult anxiety disorders. Behavior therapy emphasizes unlearning avoidant and compulsive behavior, and re-learning new alternative behaviors. These behavioral alternatives may include deep muscle relaxation, breathing retraining, assertiveness training, conflict resolution, etc. The primary purpose is to gradually replace escaping, avoiding and compulsions, which only worsen the problem, with other new behaviors. Learning alternative coping skills gradually allows a person to start confronting or exposing themselves to the triggers for the anxiety. This gradual exposure is an important but difficult part of behavior therapy. Done in a planned systematic way, exposure eventually desensitizes a person and the triggers no longer cause anxiety, or at least not as intensely.
Most people experience a certain amount of anxiety and fear in their lifetimes. It is a normal part of living.

For millions of Americans, however, anxieties and fear are persistent and overwhelming, and can interfere with daily life. These people suffer from anxiety disorders, a group of five psychiatric disorders that can be terrifying and crippling, but are treatable. Experts believe that anxiety disorders are caused by a combination of biological and environmental factors, much like physical disorders such as heart disease or diabetes. Anxiety disorders are real, serious, and treatable.

Fortunately, the vast majority of people with an anxiety disorder can be helped with the right professional care. Alone or in combination, psychotherapy, cognitive-behavioral therapy, and medication therapy are effective treatments. There are no guarantees, and success and treatment rates vary with the individual. One reason for this is that individuals can have more than one disorder, which might prolong treatment. Also, patients with an anxiety disorder sometimes suffer from clinical depression and substance abuse.

The five anxiety disorders are identified as: Panic Disorder, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder, Generalized Anxiety Disorder and Phobias (including Social Phobia, also called Social Anxiety Disorder). Click on the following buttons for more information about these disorders and treatment options:

- Anxiety Disorders Overview
- Generalized Anxiety Disorder (GAD)
- Obsessive-Compulsive Disorder (OCD)
- Panic Disorder and Agoraphobia
- Specific Phobias
- Social Phobia
- Post-Traumatic Stress Disorder (PTSD)
- Treatment Options
- Medication
- Find A Therapist

http://www.adaa.org/Public/index.cfm
All children experience anxiety. Anxiety in children is expected and normal at specific times in development. For example, from approximately age 8 months through the preschool years, healthy youngsters may show intense distress (anxiety) at times of separation from their parents or other persons with whom they are close. Young children may have short-lived fears, (such as fear of the dark, storms, animals, or strangers). If anxieties become severe and begin to interfere with the daily activities of childhood, such as separating from parents, attending school and making friends, parents should consider seeking the evaluation and advice of a child and adolescent psychiatrist.

One type of anxiety that may need treatment is called separation anxiety. This includes:

- constant thoughts and fears about safety of self and parents
- refusing to go to school
- frequent stomachaches and other physical complaints
- extreme worries about sleeping away from home
- overly clingy
- panic or tantrums at times of separation from parents
- trouble sleeping or nightmares

Another type of anxiety (phobia) is when a child is afraid of specific things such as dogs, insects, or needles and these fears cause significant distress.

Some anxious children are afraid to meet or talk to new people. Children with this difficulty may have few friends outside the family.

Other children with severe anxiety may have:

- many worries about things before they happen
- constant worries or concern about school performance, friends, or sports
- repetitive thoughts or actions (obsessions)
- fears of embarrassment or making mistakes
- low self esteem

Anxious children are often overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities. Because anxious children may also be quiet, compliant and eager to please, their difficulties may be missed. Parents should be alert to the signs of severe anxiety so they can intervene early to prevent complications. It is important not to discount a child's fears.

If you are concerned that your child has difficulty with anxiety you should

http://www.aacap.org/publications/factsfam/anxious.htm
consult a child and adolescent psychiatrist or other qualified mental health professional. Severe anxiety problems in children can be treated. Early treatment can prevent future difficulties, such as, loss of friendships, failure to reach social and academic potential, and feelings of low self-esteem.

Treatments may include a combination of the following: individual psychotherapy, family therapy, medications, behavioral treatments, and consultation to the school.

For additional information see Facts for Families: #7 Children Who Won't Go to School #50 Panic Disorder in Children and Adolescents #52 Comprehensive Psychiatric Evaluation #60 Obsessive Compulsive Disorder in Children and Adolescents #70 Posttraumatic Stress Disorder.


The American Academy of Child and Adolescent Psychiatry (AACAP) represents over 6900 child and adolescent psychiatrists who are physicians with at least five years of additional training beyond medical school in general (adult) and child and adolescent psychiatry.

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Pre-requisite skills needed for this Self-Study module:

1. Some graduate coursework in developmental psychopathology
2. A solid grounding and experience in behavioral interventions
3. Experience in working with children with internalizing problems and emotional/behavioral disorders in general.
4. Experience in family therapy and working with parents also strongly encouraged.
5. At least three years of professional experience in the above listed areas would be suggested before these types of interventions are implemented without supervision.

Individuals who lack the above prerequisite skills could still find this module very informative about the specific topic and how problem-solving processes can be used in clinical situations.

INTRODUCTION

Anxiety - the word alone may conjure up memories or feelings of those times when all of us have been "anxious" about some circumstance or event in our lives. In fact, anxiety is a normal part of everyday life for all of us, because there are many situations about which we can become "anxious". Anxiety is both a developmental phenomenon and an adaptive mechanism that is constantly manifested throughout the lifespan. Chronic anxiety or extreme episodes can have negative effects on personal, social, and academic functioning, and may require professional intervention. The goal of this self-study unit is to give the reader the opportunity to gain more information about anxiety and its relationship to children’s development and education and to practice some activities to help enhance knowledge and skills in assessment, consultation, and intervention.

Background

The first clearly recognizable stage of life that is termed "anxiety" is when babies are about seven to nine months of age. Until this time, the child’s world is focused on the primary caretaker(s) and there is little concern shown by the infant to unfamiliar people. At seven to nine months, the child is able to better differentiate people and show apprehension and stress (i.e., "anxiety") when around new people. Behaviors shown may include crying, clinging to
the parents, and resisting being held by strangers, hence, the term "stranger anxiety". This type of anxiety is normal because it reflects that the child’s cognitive development is progressing as expected and that s/he is becoming more aware of environmental differences. Failure to show this type of anxiety at this age may be a signal that some aspect of the child’s development is not keeping pace with expectations. As most parents are aware, this anxiety subsides within a few months, as the child becomes more comfortable around new people.

Separation anxiety appears during the second year of life, when the toddler becomes very distressed about being separated from the parents, and also shows clinging and crying. Although this type of anxiety also dissipates by the end of the second year of life for most children, signs of it may occur later, such as when the child starts school. For most children, however, anxiety about starting school is not "separation anxiety" per se, but is more related to apprehension about entering a new, unfamiliar environment. The parent may see this behavior and feel that the child has a separation problem, when such behavior is not uncommon. If we think of times when we have been forced to enter into unfamiliar situations and become anxious about it, perhaps we can better understand why a child would be anxious about leaving home and starting school. Fortunately, the vast majority of children survive these "normal" developmental milestones and function quite well, and usually do not require undue concern or professional intervention. As children progress through life, there will be many other times when they become anxious about real or imagined events, ranging from fear of animals at the preschool level to anxiety about being accepted by the peer group as an adolescent. The number and type of situations that can initiate anxiety are numerous and may be caused by a person’s own thinking processes or by the anticipation that external events are likely to cause problems.

Defining anxiety

Anxiety is a complex emotion, because it can be shown in cognitive, behavioral, and physiological ways, each of which may become the focus of intervention. It has been defined as "...apprehension, tension, or uneasiness related to the expectation of danger, whether internal or external. Anxiety may be focused on an object situation or activity that is avoided, as in phobia, or it may be unfocused" (Morris & Kratochwill, 1985, p. 14). A variation of this definition has been proposed by Huberty (1997a) as "...apprehension, distress, or tension about real or anticipated internal or external threats that may be shown in cognitive, behavioral or physiological patterns" (p. 305). Of course, an event that is anxiety-producing for one person may not be for another person, or the level of anxiety may be different.

The Components of Anxiety

Anxiety has been conceptualized as consisting of two primary phenomena: worry and emotionality (Leibert & Morris, 1967). Worry is the cognitive component and emotionality is the physiological/affective component. Worry appears to be most related to concerns about the ability to perform tasks, and has been defined as "...an anticipatory cognitive process involving repetitive thoughts related to possible threatening outcomes and their potential consequences" (Vasey, Crnic, & Carter, 1994). Worry also has some developmental implications, because it requires that a person be able to anticipate the future and consider several possible outcomes. Because young children generally lack the ability to anticipate the future and consider multiple possibilities, the ability to worry may not be developmentally possible until middle childhood. Emotionality is shown as an involuntary response that involves changes in physiological states, such as autonomic functioning.
Kendall, et al., (1992), Huberty (1997a), and others describe similar components of anxiety: cognitive, behavioral, and physiological. Cognitive symptoms include deficits in concentration, memory, problem-solving, attention, and perhaps to catastrophize events or be oversensitive to normal levels of stimuli. Included in the cognitive component are two categories of cognitive dysfunctions: distortions and deficiencies. Cognitive distortions occur when the person misconstrues or misperceives social and environmental circumstances and engages in irrational or illogical thinking. The author once worked with an eleven-year old boy who was having significant anxiety, because his parents were going on a long airplane flight and he was certain that they would die in a crash. Although such a possibility was extremely remote, he nevertheless believed a crash to be almost a virtual certainty. Distortion occurred in this situation because he was overestimating the probability that a crash would occur.

Cognitive deficiencies occur when the child demonstrates a lack of cognitive skills necessary to solve a problem and cope with real or perceived problems. Almost all of us have had the experience of taking an examination that seemed very difficult or upon which a great deal of importance was implicit. Upon initial exposure to the questions, the person may become so worried about being able to do well that a temporary state of being unable to perform may occur. In extreme cases, such anxiety may cause a person to fail, due to inability to engage in problem-solving necessary to complete the task. A child may show signs of both types of cognitive dysfunction at different times.

**Self-Study Activity #1**

**List Five Examples of Cognitive Distortions and Deficiencies**

<table>
<thead>
<tr>
<th>Cognitive Distortion</th>
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Behavioral symptoms may include restlessness, being "fidgety", erratic or irrational behavior, avoidance of anxiety-producing situations, frequent visits to the school nurse, frequently asking seemingly unnecessary questions, being too unassertive, "holding back" in sports due to lack of confidence in own ability, resisting staying overnight with friends, reluctance to participate or ask questions, preoccupied with perfection, crying, nail biting, shaking or tremors in the hands. Physiological symptoms may include stomach aches, nausea, headaches, muscle tension and discomfort, rapid heart rate or palpitations, excessive perspiration.
(especially palmar), hot or cold flashes, or feelings of suffocation (Kendall, et al., 1992).

**State and Trait Anxiety**

Most psychologists are aware of the concept of state and trait anxiety, which refer to anxiety experienced in specific circumstances (state) or as a general pattern of anxiety that is more pervasive and characteristic of a person’s functioning (trait). Children with high levels of trait anxiety are more likely to experience higher levels of state anxiety when encountering situations than are children with lower levels of trait anxiety (Spielberger, 1973). Children can experience either type of anxiety in a variety of ways. A child with high state anxiety, for example, may show the pattern only when taking tests. Conversely, the child with high trait anxiety may demonstrate this tendency in many situations, such as at home, in social groups, classroom activities, or sports. Either type of anxiety may require professional intervention at home or at school.

**Self-Study Activity #2**

List Five Examples of State and Trait Anxiety

<table>
<thead>
<tr>
<th>State Anxiety</th>
<th>Trait Anxiety</th>
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**When Anxiety Becomes Problematic**

Because anxiety is experienced by every person on a frequent basis, the psychologist may be uncertain when a problem exists that requires intervention. Although discussion will occur later about how to identify anxiety, the basic answer to such questions is that when anxiety is at a level high enough to interfere with social, personal, or academic functioning, then consideration for intervention may be warranted. Severe state anxiety may require some crisis intervention strategies, as well as helping the child to develop coping strategies for the specific anxiety-producing situations. When trait anxiety becomes severe, it may be of such intensity and cause dysfunction that it can be viewed as a disorder, consistent with the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV; American Psychiatric Association, 1994). It is beyond the scope of this
document to review the DSM-IV diagnostic criteria for all anxiety disorders. It should be noted, however, that separation anxiety disorder (SAD) is the only anxiety disorder specifically ascribed to children and adolescents. Other anxiety disorder diagnoses may be applied to children and adolescents, if their behavior is consistent with the criteria (e.g., social phobia). The reader should review thoroughly the DSM-IV diagnostic categories and criteria for all anxiety disorders and identify those which may be particularly pertinent to children and adolescents. The clinician also must be thoroughly familiar with normal developmental patterns of anxiety in order to determine if current behaviors represent a "disorder" or are variations in expected levels of performance.

**Self-Study Activity #3**

**List DSM-IV Anxiety Disorder Diagnostic Criteria for Children and Adolescents**

Incidence figures. Anxiety disorders are the most common psychological syndromes, and some estimates suggest that up to 15% of all persons will experience anxiety of such severity at one time in their lives to warrant a formal diagnosis and/or treatment. Approximately 7.5% to 10% of children demonstrate anxiety disorders (Bernstein & Borchardt, 1991; Kashani & Orvaschel, 1990). Many children who are given a diagnosis of anxiety disorder also are likely to be given an additional diagnosis, such as those that comprise the disruptive behavior disorders (e.g., ADHD, conduct disorder, oppositional defiant disorder) (Last, Strauss, & Francis, 1987). The classic Isle of Wight study by Rutter, Tizard, and Whitmore (1970) indicated that anxiety states were the most common in middle childhood, and represented about two thirds of all emotional disorders, with incidence figures ranging from 2.5% to 5%.

Gender differences. Some research has found that girls tend to show higher levels of trait anxiety than do boys, but these differences may be more related to social expectations. Girls may be given more social permission to report anxious symptoms (Harris & Ferrari, 1983; Ollendick, Matson, & Helsel, 1985). Marks (1987) suggests that at ages 10 to 11, boys are more likely to show fewer fears than do girls, resulting in girls showing more anxiety at early and late adolescence. Girls and boys tend to be anxious about different things. Girls may be more concerned about receiving approval from adults, whereas boys appear more concerned about how they are perceived by their peers (Dweck & Bush, 1976). Therefore, when social expectations are controlled for, there appear to be few, if any, gender differences in anxiety.

**Identifying Anxiety Problems and Disorders**

Determining the presence and nature of anxiety problems in children and adolescents can be challenging. If a child has specific anxiety about performing in a class, the behaviors are often apparent and can be readily identified. If an anxiety disorder is present, however, identification becomes more complex because anxiety is a normally occurring pattern and also tends to co-exist with other disorders, such as depression. The diagnostic challenge is to determine when anxiety is beyond normal expectations for the child’s age and circumstances and to use assessment methods that are likely to identify the problem(s). Comorbidity refers to the presence of two or more disorders in one client at the same time. Because anxiety is a normal developmental pattern and also tends to be comorbid with many other disorders, differential diagnosis is particularly challenging. Last, et al. (1987) compared comorbidity patterns in adolescents who were referred to an anxiety disorders clinic for overanxious

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disorder, separation anxiety disorder, or depression. When more than one diagnosis was given, anxiety disorders were identified in 50% to 75% of the cases, supporting the thesis that anxiety has high rates of comorbidity. Kovacs, Feinberg, Crouse-Novak, Paulauskas, and Finkelstein (1984) studied a sample of children referred for emotional or behavioral problems, and found that anxiety to be comorbid with attention deficit disorder, conduct disorder, depression, and dysthymia. The authors also attempted to determine the order of onset of these disorders and found that anxiety appeared to precede depression and that conduct disorders were antecedents to depression when they were comorbid.

Research over the past several years has focused on the relationship of anxiety to depression, and found that children who are given either diagnosis are likely to show symptoms of the other disorder (Ollendick & King, 1994). Thus, "pure" diagnoses of anxiety or depression are difficult to obtain in clinical practice or research. Some differences have been found between these disorders that have implications for understanding their comorbidity. Stark, Humphrey, Laurent, Livingston, and Christopher, (1993) compared children who were screened for anxiety and depression. The depressed children tended to have more negative attitudes toward themselves, the world, and the future; were more impulsive and angry; were more likely to live in a dysfunctional family; and more difficult to manage, as compared to children with anxiety disorders.

Self-Study Activity #4

Create a table with four columns and list and compare the DSM-IV Diagnostic Criteria for Anxiety, Depression, Conduct Disorder, and attention Deficit/Hyperactivity Disorder. Identify and group those criteria that overlap and those which are distinct from each other.

Assessment of Anxiety Problems and Disorders

As the first step to complete identification of anxiety and the development of intervention plans, the school psychologist should develop a strategy for systematic assessment. Because anxiety is a naturally occurring phenomenon in all persons, the clinician should first consider whether the presence of the anxiety in the child is normal for the current developmental level. Huberty (1997a) provided a list of developmental considerations that should be addressed prior to engaging in any type of formal or informal assessment of anxiety that can be used as a preliminary checklist:

- What is the child’s current developmental level?
- Are the signs of anxiety a normal aspect of development?
- If so, are these signs expected, considering the child’s developmental level?
- Are the signs of anxiety excessive for the child’s developmental level?
- Are the signs of anxiety of a long-standing nature or have they emerged as a temporary increase in severity for the child?
- If the anxiety is a normal developmental phenomenon (e.g., social anxiety at adolescence),

http://www.nasponline.org/certification/anxiety.html

5/2/2003
is it nevertheless sufficiently intense to require intervention?

It is important to determine if the anxiety is normal and expected for the child's current developmental level, so that the clinician may proceed appropriately and not "look for" a disorder that may not be present. It should also be noted, however, that, although a child might not meet the diagnostic criteria for an anxiety disorder, the symptoms may be of such intensity that intervention is warranted.

Assessment of Anxiety Problems and Disorders

Anxiety is a complex emotion and assessment requires a multi-method, multi-setting, and multi-trait approach. There are many methods of assessment and not all may be needed or are possible to conduct in all situations. Multi-method approaches should emphasize objective measurement techniques, such as some of the following:

• Systematic observations
  Conduct observations across home, school, and other settings
  Use a structured observation system
  Record and summarize data according to frequency, intensity, or duration of the behaviors
  Use peer normative comparisons
  Observe at different times of the day
  Record data for different activities
  Obtain multiple data points, i.e., conduct multiple observations
• Behavioral interviews with child, parents, teachers, or others
  What anxious behaviors occur
  When anxious behaviors occur
  Settings where anxious behaviors occur
  What does the child do when the behaviors occur
  Effects do these actions have
  What do adults do when the behaviors occur
  Effects of those interventions
  Effects of these behaviors on the child’s personal, social, and academic functioning

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Desired outcomes by each person interviewed

**Behavioral Interview Form**

**Interviewee:** __________________
**Interviewer:** __________________ **Date:** ______

<table>
<thead>
<tr>
<th>Topic</th>
<th>Responses</th>
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<tbody>
<tr>
<td>Behaviors</td>
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<td>When behaviors occur</td>
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<tr>
<td>Settings where behaviors occur</td>
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<tr>
<td>Responses by child</td>
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<tr>
<td>Effects of child’s responses</td>
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<tr>
<td>Responses by adults</td>
<td></td>
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<tr>
<td>Effects of adults’ responses</td>
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<tr>
<td>Effects on personal, social, academic, func.</td>
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<tr>
<td>Desired outcomes by interviewees</td>
<td></td>
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</tbody>
</table>

**Behavior Rating Scales**

- Child Behavior Checklist (Achenbach, 1991a)
- Child Behavior Checklist-Teacher Report Form (Achenbach, 1991b)
- Child Behavior Checklist-Youth Self Report Form (Achenbach, 1991c)
- Behavior Assessment System for Children (C. R. Reynolds & Kamphaus, 1992)

Others that contain specific measures of anxiety

http://www.nasponline.org/certification/anxiety.html

5/2/2003
Self-report measures

Revised Children’s Manifest Anxiety Scale (Reynolds & Richmond, 1978)

Children’s Depression Inventory (Kovacs, 1981)

Reynolds Child Depression Scale (W. M. Reynolds, 1989)

Reynolds Adolescent Depression Scale (W. M. Reynolds, 1987)

Personal logs and journals assigned to record when anxiety occurs, circumstances, effects, child’s responses, and effects of coping (depends on age and sophistication of child to be able to independently record this information)

Thought listing tasks, where the child lists thoughts that occur while anxious

- Multi-dimensional personality measures

Personality Inventory for Children-Revised (Lachar, 1982)

Personality Inventory for Youth (Lachar & Gruber, 1994)

Minnesota Multiphasic Personality Inventory-Adolescent (Butcher, et al., 1992)

Millon Adolescent Personality Inventory (Millon, Green, & Meagher, 1982)

It is important to remember that when assessing children for possible anxiety problems, often there will be externalizing problems present. Conversely, a child may show externalizing behaviors (e.g., aggression, defiance, etc.), but internalizing problems such as anxiety may exist, but may not be readily apparent. Therefore, it is important to assess all aspects of the child’s behavior in order to gain a complete perspective of the child’s functioning. Finally, the psychologist should be prepared for the likelihood that when all the data are collected, some will be discrepant from other data. The reasons for these discrepancies are attributable to the type of instruments used and their psychometric properties, the accuracy and reliability of the informants, the pervasiveness of the problems, or other factors. For example, adults typically are not reliable informants of a child’s internal mood state. When assessing internalized patterns, it is common for discrepancies to occur among data. Parent and teacher ratings often do not correspond with each other or with the child’s self-report. If the child is young, obtaining reliable data from self-report measures may not be possible, and the practitioner will need to rely more on observations and interviews with the child. It will be necessary to place more emphasis on others’ reports if objective information is needed, e.g., behavior rating scales. Older children who can provide reliable self-reports may offer a more accurate picture of their anxiety. In cases where there are many discrepant data, the clinician should make conclusions based on the overall clinical picture, while not completely discarding other data which may have value in helping to determine interventions.

Self-Study Activity #5

Think of a case you have experienced or known about and develop a

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detailed assessment plan that includes observations, behavioral interviews, behavior rating scales, self-report measures, and multidimensional personality scales. How would you demonstrate consideration of developmental issues about anxiety that typically occur in children and adolescents?

Interventions for Anxiety Problems and Disorders

All interventions should be based on clearly established referral questions and what are the desired outcomes. Without this clarity, the clinician is likely to proceed in an unfocused way that, at the least, will consume unnecessary time. At the worst, there is the possibility of misidentification of the problem and the development of an inappropriate intervention plan. Each intervention plan must be individually tailored to the child, rather than trying to use one approach for all situations. Although the clinician may find the DSM-IV helpful in determining the presence or type of anxiety disorder, it should be remembered that the diagnostic criteria must be operationalized and defined for the student. Also, the DSM-IV criteria are polythetic, i.e., different combinations of symptoms may lead to the same diagnosis, but different children’s behaviors may vary considerably. For example, the diagnostic criteria for Generalized Anxiety Disorder under Section C indicate that only one of the six criteria are necessary to be present for children (p. 436). Therefore, any criterion may contribute to receiving this diagnosis, but the specific behaviors may become the focus of an intervention, independent of the label given. The interventions ultimately chosen must be linked to what are the referring questions and the desired outcomes that are in the best interests of the child.

Self-Study Activity #6

For the case you considered above, write down possible referral questions and desired outcomes indicated by the child or others, using the form below as a guide. Summarize the questions and outcomes for all informants.

Referral Questions and Desired Outcomes

Child: __________________________ Interviewer: ________________ Date: ________________

<table>
<thead>
<tr>
<th>Informant</th>
<th>Referral Questions</th>
<th>Desired Outcomes</th>
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<tbody>
<tr>
<td>Name: ___</td>
<td>Relationship: ___</td>
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http://www.nasponline.org/certification/anxiety.html 5/2/2003
A Problem-Solving Approach for Anxiety Problems and Disorders

All approaches to interventions for emotional and behavioral problems should have a problem-solving focus that will help to guide the development, implementation, and evaluation of the plan. Typically, problem-solving approaches have a series of steps or stages from problem identification to evaluation of the plan. Huberty (1997b) developed a six-step problem-solving plan that can be applied to anxiety disorders.

**Problem Identification**

In this stage, the psychologist emphasizes identification of the specific concerns of the referring persons, and uses multiple techniques to specify those behaviors that will become the focus of treatment. In general, the most useful information will be gained directly from the child, although the input of others will be of importance.

Self-report measures. A general measure of trait anxiety should be administered to the child, such as the Revised Children’s Manifest Anxiety Scale (C. R. Reynolds & Richmond, 1978). This scale contains a total anxiety score, but specific factors of Worry/Oversensitivity, Social Concerns/Concentration, and Physiological symptoms can be obtained. Although this scale is useful, its "yes" or "no" answer format may provide limited information about the specific aspects of anxiety identified in a "yes" response. For those responses, the psychologist can ask follow-up questions to gather more information about whether the concern is rather global or specific to a particular situation. The scale also may be useful at follow-up as a measure of intervention effectiveness.

Another useful scale is the Fear Survey Schedule for Children-Revised (Ollendick, 1983), which gives information about specific fears or worries. Some items reference specific concerns, such as fear of animals, while others emphasize more global concerns.

Think-aloud tasks and thought-listing techniques. With these techniques, the goal is for the child to identify and record thoughts and feelings of anxiety, when they occur, and the events that precipitate them. These tasks can be a part of clinical interviews or counseling sessions.
and may be done several times. Another technique is to have the child keep a daily log or journal and record specific information about anxiety-producing situations as they arise. These logs should be kept for several days and then analyzed for content and patterns of anxiety-producing situations and the child's reactions to them.

Interviews. Either structured or semi-structured interviews may be used to identify specific targets for intervention. In general, however, a functional, behavioral interview is likely to give valuable information about (a) target behaviors, (b) possible alternative appropriate behaviors, (c) controlling antecedent and consequent variables, (d) the mediational value of parents, teachers, and others, and (e) to identify positive and negative stimuli (Goss, 1984). A structured diagnostic interview specifically for anxiety is the Anxiety Disorders Interview Schedule for Children (ADIS-C; Silverman, 1991).

Behavior rating scales. These scales are frequently used in child assessment, and may be useful in gaining the perception of others about the nature of a child's symptoms. Because they tend not to correlate well with a child's self-reports of internalizing symptoms, however, (Achenbach, McConaughy, & Howell, 1987), they do not provide the same type of information as that gained directly from the child. Many of these scales have anxiety subscales or related factors that may identify specific behaviors for consideration as target behaviors.

Behavioral observations. Although observations may be useful in the Problem Identification phase, they are limited to identified behaviors. Little is gained about the child's thoughts and cognitions, which must be derived by other methods. If the behaviors are infrequent, systematic observation may not produce a large amount of data. Nevertheless, observations should be conducted and considered in this phase, so that precise information is available about the settings where anxiety occurs and the child's reactions. Observations also may be useful as measures of treatment effectiveness.

When this stage is completed, the "target" behaviors, i.e., those behaviors, cognitions, or feelings that will be the focus of problem-solving have been identified. It is essential that this stage be completed with specific descriptions of the problem(s), so that the remaining stages can focus on the development of interventions.

**Problem Analysis**

After the problems have been identified in the first stage, they must be analyzed in order to determine the nature, extent, severity, frequency, or duration of the symptoms. In this stage, the degree and type of interference with personal, social, and academic functioning is determined as precursors to developing interventions plans. The first task is to determine if the anxiety is comorbid with other patterns or disorders. Because of this tendency toward overlap, the psychologist should conduct assessment to determine if comorbidity exists. Often, objective personality measures and behavior rating scales will indicate elevations in subscales for both anxiety and depression. The reader is referred to Self-Study Activity #4 to review the common and unique criteria of those four disorders. It is not as important to place a label on the patterns as it is to identify the behaviors or thoughts that are problematic.

A key component of this stage is to analyze the effects of anxiety on the child's functioning. Personal problems may include difficulties with concentration or performance. Social problems may be shown in fear reactions or reluctance to enter into unfamiliar settings.

http://www.nasponline.org/certification/anxiety.html
5/2/2003