Kinder- en Gesinseenheid **Child & Family Unit**

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ANXIETY IN CHILDREN

1 The nature of anxiety

Anxiety is one of many **normal human emotions** that can fulfil an very helpful and motivating role. It urges the individual to strive for the best possible effort and motivates him to produce at his best. When, however, anxiety becomes excessive, it can inhibit the effective functioning of the individual.

Although anxiety disorders affect an estimated 13 percent of children and adolescents during any given six-month period, making them the most common class of psychiatric disorders in that age group, the disorders are often not recognized, and most who have them do not receive treatment.

Common signs of anxiety disorders in children are **excessive worrying** about ordinary activities. At times, there are **physical symptoms** such as palpitations, sweating, trembling, stomach ache, or headache. There may be **avoidance** of certain situations that are perceived by the child to be sources of anxiety. This avoidance can cause **social withdrawal**. When these symptoms cause extreme distress and interfere with the functioning of the child in usual activities, a child is diagnosed as having an "anxiety disorder."

The combined prevalence of the group of disorders known as anxiety disorders is higher than that of virtually all other mental disorders of childhood and adolescence.

2 Causes of anxiety

- Hereditary factors
- Shy & cautious temperament
- Unpredictable lifestyle
- Stressful experiences
- Learning from anxious parents
- Habit patterns of avoidance

3 Separation anxiety

Although separation anxieties are normal among infants and toddlers, they are not appropriate for older children or adolescents. To reach the diagnostic threshold for this disorder, **the anxiety or fear must cause distress or affect social, academic, or job functioning and must last at least 1 month**

Children with separation anxiety may **cling** to their parent and have **difficulty falling asleep** by themselves at night. When separated, they may **fear** that their parent will be involved in an accident or taken ill, or in some other way be“lost” to the child forever.

Their need to stay close to their parent or home may make it difficult for them to attend school or camp, stay at friends’ houses, or be in a room by themselves. Fear of separation can lead to dizziness, nausea, or palpitations.

Separation anxiety is often associated with symptoms of depression, such as sadness, withdrawal, apathy, or difficulty in concentrating, and such children often fear that they or a family member might die. Young children experience nightmares or fears at bedtime.

About 4 percent of children and young adolescents suffer from separation anxiety disorder. Among those who seek treatment, separation anxiety disorder is equally distributed between boys and girls.

The remission rate with separation anxiety disorder is high. However, there are periods where the illness is more severe and other times when it remits. Sometimes the condition lasts many years or is a precursor to panic disorder with agoraphobia. Older individuals with separation anxiety disorder may have difficulty moving or getting married and may, in turn, worry about separation from their own children and partner.

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Normal Development of Separation

Most common times for separation fears: eight months, twelve months and anywhere between 18 months to three years.

Separation anxiety generally emerges around nine months of age and peaks around 12-24 months. The child's crying and clinging can express two different messages: they fear that the parent will be gone forever or they begin to cry when the parent returns. This reminds the child of how he or she felt when the parent left.

Separation anxiety generally decreases between 2 and 3 years of age. The child often tends to be shy with strangers, but morning separations become easier. The degree of separation difficulty may vary from day to day.

For toddlers, those who have had either very few or very frequent separations from loved ones experience the most separation anxiety.

Adults too experience anxiety when separated from loved ones, but it is usually not so overwhelming. The adult has a better concept of time and has had more experience dealing successfully with separation.

Factors that may contribute to separation anxiety

- Runs in families
- Families that are very close-knit;
- After a stress such as death or illness in the family or a move;
- Trauma, especially physical or sexual assault;
- Tiredness
- Minor or major illness
- Changes in the household routine
- Family changes such as birth of a sibling, divorce, death or illness.
- Change in caregiver or routine at day care center.

Parents usually are not the cause of the separation anxiety, but they can make things worse or better.

Warning signals

- Child is inconsolable for more than 2 weeks.
- Repeated physical complaints in the morning before preschool.
- Separation anxiety continuing into elementary school years and interfering with activities that other children do at that particular age.
- No separation anxiety at any time.
- School refusal in an older child or adolescent is often a more serious problem.

Diagnosis and Symptoms of a Separation Anxiety Disorder

Severe, persistent anxiety about being separated from home or parents. The anxiety must be severe enough to **interfere with normal activities**. The child generally shows **distress when separated** from parents, and **worries** that the parents may suffer harm when away from the child. When separated, the child may have **nightmares** and **sleep problems**. **Physical symptoms** such as nausea, headaches and abdominal pain may occur before or during a separation.

Treatment – A wholistic approach

Therapy for child & parent

Parents, child and family may benefit from therapy. Parent education and family therapy are often beneficial. Coordination is a key factor.

The child, depending on age, can benefit from play therapy of cognitive-behavioural therapy (Therapy that is focused of changing the child's beliefs and associated behaviours in such a way that he can better cope with the anxiety). Relaxation techniques and hypnotherapy is also effective with some children.

Medication

Medication is needed for a minority of children who have persistent symptoms, resistant to behavior modification and psychotherapy.

Psychiatrists or other physicians can prescribe medications for anxiety disorders. These doctors often work closely with psychologists, social workers, or counselors who provide psychotherapy.

Although medications won't cure an anxiety disorder, they can keep the symptoms under control and enable you to lead a normal, fulfilling life.

There have been significant strides in knowledge of psychiatric medications for children.

Trycyclic Anti-depressants:

Antidepressant medications called tricyclics are started at low doses and gradually increased. Tricyclics have been around longer than SSRIs and have been more widely studied for treating anxiety disorders. For anxiety disorders other than OCD, they are as effective as the SSRIs, but many physicians and patients prefer the newer drugs because the tricyclics sometimes cause dizziness, drowsiness, dry mouth, and weight gain.

Imipramine (Tofranil) can help separation anxiety disorder. However, one needs to follow EKGs (heart tests) and blood tests for safety reasons. Sometimes, high doses were necessary for improvement.

SSRI: (Selective Serotonin Reuptake Inhibitors): In the past 10-15 years, a new class of antidepressant medications has made treatment of childhood depression and anxiety disorders safer and more effective.

The SSRIs, Prozac, Zoloft, Paxil etc., when used carefully and monitored closely, can help separation anxiety disorder. At this point, an SSRI would be the medication of choice instead of Imipramine.

If your doctor prescribes an antidepressant, you will need to take it for several weeks before symptoms start to fade. So it is important not to get discouraged and stop taking these medications before they've had a chance to work.

These medications act in the brain on a chemical messenger called serotonin. SSRIs tend to have fewer side effects than older antidepressants. People do sometimes report feeling slightly nauseated or jittery when they first start taking SSRIs, but that usually disappears with time. Some people also experience sexual dysfunction when taking some of these medications. An adjustment in dosage or a switch to another SSRI will usually correct bothersome problems.

Monoamine oxidase inhibitors, or MAOIs, are the oldest class of antidepressant medications. The most commonly prescribed MAOI is phenelzine, which is helpful for people with panic disorder and social phobia. Tranylcypromine and isoprocarboxazid are also used to treat anxiety disorders. People who take MAOIs are put on a restrictive diet because these medications can interact with some foods and beverages, including cheese and red wine, which contain a chemical called tyramine. MAOIs also interact with some other medications, including SSRIs. Interactions between MAOIs and other substances can cause dangerous elevations in blood pressure or other potentially life-threatening reactions.

***Anti-Anxiety Medications*.** High-potency benzo-diazepines relieve symptoms quickly and have few side effects, although drowsiness can be a problem. Because people can develop a tolerance to them - and would have to continue increasing the dosage to get the same effect - benzodiazepines are generally prescribed for short periods of time. One exception is panic disorder, for which they may be used for 6 months to a year. People who have had problems with drug or alcohol abuse are not usually good candidates for these medications because they may become dependent on them.

Some people experience withdrawal symptoms when they stop taking benzodiazepines, although reducing the dosage gradu-ally can diminish those symptoms.

Buspirone, a member of a class of drugs called azipirones, is a newer anti-anxiety medication that is used to treat GAD. Possible side effects include dizziness, headaches, and nausea. Unlike the benzodiazepines, buspirone must be taken consistently for at least two weeks to achieve an anti-anxiety effect.

Other Medications. Beta-blockers, such as propanolol, are often used to treat heart conditions but have also been found to be helpful in certain anxiety disorders, particularly in social phobia.

4 Obsessive-compulsive disorder

Introduction

Community surveys of adolescents have suggested that at any given time, 1% to over 3% are experiencing symptoms of OCD. Children as young as 5 or 6 can show full-blown OCD. Between 30% and 50 % of adults with OCD reported that their symptoms started during or before mid-adolescence. Fortunately, there are now more effective treatments for OCD.

Symptoms and Features of OCD

In order to meet DSM-4 criteria for OCD, the individual must have either obsessions or compulsions. In actuality, most children and adolescents have both.

Obsessions: Recurrent and persistent thoughts, impulses or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress. The thoughts, impulses, or images are not simply excessive worries about real-life problems. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without as in thought insertion)

Compulsions: Repetitive behaviors (e.g. hand washing, ordering, checking) or mental acts (e.g. praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour per day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities.

Consequences of OCD

If not treated, OCD tends to be a long-term disorder. Some individuals experience waxing and waning symptoms over the years. Others experience

progressive worsening of their OCD until they are housebound and spend much of their days involved in obsessions and rituals. Chronic anxiety disorders may lead to depression. If a child spends a great deal of time obsessing or engaging in mental rituals, he or she may have trouble focusing on the school lessons. Individuals who need to repeatedly erase and rewrite assignments may need to spend hours of time of homework and lose time for friends and family. This same individual may not be able to finish projects because the work is never "just right." Some children and teens may become oppositional if others attempt to interrupt their rituals. For the large number of individuals who manage to hide their symptoms, the cost may simply be years of anxiety and low self-esteem.

Treatment

Although anxiety disorders are the most common disorder of youth, there is relatively little research on the efficacy of psychotherapy (Kendall et al., 1997). For childhood phobias, contingency management[10] was the only intervention deemed to be *well-established*, according to an evaluation by Ollendick and King (1998), which applied the American Psychological Association Task Force criteria (noted earlier). Several psychotherapies are *probably efficacious* for treating phobias: systematic desensitization[11] ; modeling, based on research by Bandura and colleagues, which capitalizes on an observational learning technique (Bandura, 1971; see also Chapter 2); and several cognitive-behavioral therapy (CBT) approaches

(Ollendick & King, 1998).

CBT, as pioneered by Kendall and colleagues (Kendall et al., 1992; Kendall, 1994), is deemed by the American Psychological Association Task Force as *probably efficacious*. It has four major components: recognizing anxious feelings, clarifying cognitions in anxiety-provoking situations,[12] developing a plan for coping, and evaluating the success of coping strategies. A more recent study in Australia added a parent component to CBT, which enhanced reduction in post-treatment anxiety disorder significantly compared with CBT alone (Barrett et al., 1996). However, none of the interventions identified above as *well-established* or *probably efficacious* has, for the most part, been tested in real-world settings.

In addition, psychodynamic treatment to address underlying fears and worries can be helpful, and behavior therapy may reduce the child's fear of separation or of going to school; however, the experimental support for these approaches is limited.

Preliminary research suggests that selective serotonin reuptake inhibitors may provide effective treatment of separation anxiety disorder and other anxiety disorders of childhood and adolescence. Two large-scale randomized controlled trials are currently being undertaken (Greenhill, 1998a, 1998b). Neither tricyclic antidepressants nor benzodiazepines have been shown to be more effective than placebo in children (Klein et al., 1992; Bernstein et al., 1998).

Moderate to severe OCD may merit starting with a combined approach of psychotherapy and medication.

Cognitive-Behavioral Psychotherapy

Near the beginning of this type of therapy, the child and family are educated about the biological basis of OCD. The symptoms are the fault of the disease, not the individual or family.

As the therapy progresses, the child should begin to expose himself to the anxiety-provoking object or situation and then try to avoid performing the usual compulsion. This is called exposure and response prevention. It may have to be done gradually because it can cause the child to experience significant anxiety. The child himself should have an important role in determining how quickly he wants to move through these steps. The parents can help with this too by reducing and then eliminating reassurances when a child asks obsessive questions. At the same time, they should be supportive and avoid blaming the child if he is unable to avoid performing some of the compulsions.

The child may benefit from learning relaxation techniques and learning mental self-monitoring.

Other specific techniques may help individual children tolerate the anxiety engendered by the exposure and response prevention.

When the symptoms are eliminated or at least reduced to a tolerable level, the therapist should talk to the child and parents about the future. Symptoms may start to come back at a later date. They should review the symptoms and discuss how to deal with them. Some individuals come in for intermittent refresher sessions.

Medication

Recent advances in medication have added to our treatment options. In the past few years there have been more studies testing these medications specifically on children.

Clomipramine, (Anafranil) ages 10 and up
Fluvoxamine, (Luvox) ages 8 and up
Sertraline, (Zoloft) ages 6 and up.
Fluoxetine, (Prozac) approved for adults, but may soon receive approval for pediatric use.
Paroxetine (brand name Paxil) approved for adults.

The main medications used for OCD are Clomipramine (brand name Anafranil) and the Selective Serotonin Reuptake Inhibitors. There are several other

medications that may be added if those medications produce only a partial response.

Clomipramine is chemically similar to the older tricyclic antidepressants. Its efficacy in OCD seems to be related to its ability to decrease serotonin reuptake. It used to be the only effective drug for OCD. At this point, it is usually not the first line drug for children with OCD. This is because of several potential side effects. It can be sedating. It can also cause dry mouth and eyes. It has been associated with some changes in EKGs. (A measure of the heart rate and the electrical conduction within the heart.) Because children may be more sensitive to this cardiac effect, we usually monitor EKGs and heart rate in children on Clomipramine. Despite this, when used carefully, it has helped many children and adolescents with OCD.

There are now several SSRI medications. They include Fluoxetine (brand name Prozac) Fluvoxamine (brand name Luvox) Paroxetine (brand name Paxil) and Sertraline (brand name Zoloft). All seem to be effective at reducing the symptoms of OCD, but different ones may be best for individual patients. Fluoxetine has the advantage of being available in liquid form. Using the liquid, one can start at very small doses and titrate the dose gradually. Common side effects include headache, GI complaints, tremor, agitation, drowsiness and insomnia. These medications may affect how other drugs are broken down in the liver. One must use caution when mixing medications. If a child taking an SSRI, it is a good idea to consult one's physician or pharmacist before taking other prescription or even non-prescription medications. Many children take a long time to achieve a good response to medication. 10 to 12 weeks is not uncommon. Some children will respond to one medication but not to another.

Dealing with Recurrences

Education about OCD often an early part of the therapy. Both parents and child are included. It is important for them to continue the education process. A good understanding of the disorder can help the child and family feel a greater sense of mastery and control.

The process of education should extend on after the end of the therapy. It can occur through reading age-appropriate books, attending support groups or having group therapy with peers. I have listed some recommended books and support groups at the end of the article. Secrecy and shame are common in individuals with OCD. Education and the support of others can help the individual keep the disorder in perspective.

Children and families should be aware that OCD can be chronic and that symptoms may return months or years later. Some children will schedule "check up" sessions every six months or each year. If symptoms reoccur, they may return to therapy for a shortened version of their previous treatment.

4.1 Associated disorders

Tourette's Disorder is more likely to be present in boys and in children who develop OCD at a younger age. It is important to identify this disorder because treatment may need to be modified. Children and adolescents with OCD are more likely to have Attention Deficit Disorder, learning disorders oppositional behavior, separation anxiety disorder and other anxiety disorders. Some of the anxiety disorders have similarities to OCD and are called obsessive-compulsive spectrum disorders. These include tricotillomania, (compulsive hair pulling and twirling,) body dysmorphic disorder (the obsession that part of one's body is unattractive or misshapen) and habit disorders such as nail biting and scab picking. The exact relationship between these two spectrum disorders and true OCD is not yet entirely clear.

4.2 Generalised Anxiety disorder

Children with generalized anxiety disorder (or overanxious disorder of childhood) worry excessively about all manner of upcoming events and occurrences. They worry unduly about their academic performance or sporting activities, about being on time, or even about natural disasters such as earthquakes. The worry persists even when the child is not being judged and has always performed well in the past. Because of their anxiety, children may be overly conforming, perfectionist, or unsure of themselves. They tend to redo tasks if there are any imperfections. They tend to seek approval and need constant reassurance about their performance and their anxieties (DSM-IV). The 1-year prevalence rate for all generalized anxiety disorder sufferers of all ages is approximately 3 percent. The lifetime prevalence rate is about 5 percent (DSM-IV).

About half of all adults seeking treatment for this disorder report that it began in childhood or adolescence, but the proportion of children with this disorder who retain the problem into adulthood is unknown. The remission rate is not thought to be as high as that of separation anxiety disorder.

4.3 Social Phobia

Children with social phobia (also called social anxiety disorder) have a persistent fear of being embarrassed in social situations, during a performance, or if they have to speak in class or in public, get into conversation with others, or eat, drink, or write in public. Feelings of anxiety in these situations produce physical reactions: palpitations, tremors, sweating, diarrhea, blushing, muscle tension, etc. Sometimes a full-blown panic attack ensues; sometimes the reaction is much more mild. Adolescents and adults are able to recognize that their fear is unreasonable or excessive, although this recognition does not prevent the fear. Children,

however, might not recognize that their reaction is excessive, although they may be afraid that others will notice their anxiety and consider them odd or babyish.

Young children do not articulate their fears, but may cry, have tantrums, freeze, cling, appear extremely timid in strange social settings, shrink from contact with others, stay on the side during social events, and try to stay close to familiar adults. They may fall behind in school, avoid school completely, or avoid social activities among children their age. The avoidance of the fearful situations or worry preceding the feared event may last for weeks and interferes with the individual's daily routine, social life, job, or school. They may find it impossible to speak in social situations or in the presence of unfamiliar people (for review of social phobia, see DSM-IV; Black et al., 1997).

Social phobia is common, the lifetime prevalence ranging from 3 to 13 percent, depending on how great the fear is and on how many different situations induce the anxiety (DSM-IV; Black et al., 1997). In survey studies, the majority of those with the disorder were found to be female (DSM-IV). Often the illness is lifelong, although it may become less severe or completely remit. Life events may reassure the individual or exacerbate the anxiety and disorder.

5 A model for supporting children with anxiety

- Taking stock of our own model of thinking and actions
    - Awareness of generational transfer
    - Rigid expectations Vs Expression of preferences
    - Unwillingness to tolerate frustration Vs Willingness to bear and manage discomfort
    - Self evaluation and generalization Vs a problem-focussed approach whilst retaining self-esteem
    - Enabling behaviours
- Acknowledgement
    - Positive experiences with caregivers, short times at first.
    - Help child become familiar with new surroundings and people before actually leaving the child there.
    - Rituals (bedtime and morning)
    - "Lovie" or "Cuddly" Represents closeness to parents. If possible, allow the child to take the "Lovie" along.
    - Do not give in. Let the child know that he or she will be all right.
    - Remind the child of previous brave things he or she has done. Talk about how a fictional character might handle it.
    - Let child know, in words he or she can understand that you appreciate how distressing it must be to be separated from loved ones. Understanding and acceptance, but not excessive sympathy.
    - Never make fun of a child's separation distress. Do not scold child for it.
    - Do not bribe child to mask the distress. If you plan a special activity after you pick the child up, let it be unconditional.
    - Focus on the positive things that happened in daycare. Don't let them dwell on fears or imagination of what might happen.
    - Minimize fears by limiting scary TV shows
    - If it is an older child, consider introducing him or her to some of the children who are to be in the class and arranging play dates in advance.
    - Preparing the child--reading books about going to preschool, pretending about going on voyages or quests.
    - Make shopping for school supplies a special event just for that child.
    - Expect a child to be more tired and possibly more irritable than usual when he or she starts Kindergarten or First grade for the first few weeks.
    - When leaving, give a quick kiss and hug and cheerfully say goodbye.
    - Don't prolong your departure or come back several times.
    - Don't sneak out of the room.
    - Even if you feel that a strict teacher or a bully might be part of the problem, keep your child going to school while these problems are being handled.
    - If your child does stay home, do not make it an extra fun, gratifying day.
- Structure
- Aids & resources
- Preparation & anticipation
    - Start occasionally using a babysitter by six months of age. This helps the child tolerate short periods away from the parent and encourages him or her to build trust in other adults.
    - Even though children of this age do not engage in cooperative play, start contact with peers by 12 months. By age three, the child should be experiencing play groups.
    - Some form of preschool may be helpful by age 3 or 4. This is especially important for children who seem overly dependent on their parents.
- Following through
- Affirming the child's capacity to take charge of the problem
- Encouraging emotional fitness

Suggested Books

The Good-bye Book by Judith Viorst
Into the Great Forest: A story for children away from their parents for the first time by Irene Marcus
Going to Daycare by Fred Rogers

Brain Lock: Free Yourself from Obsessive-Compulsive Behavior by Jeffrey M. Schwartz 1996, Regan Books.
Blink, Blink, Clop, Clop: Why Do We Do Things We Can't Stop? by Moritz and Jablonsky, ChildsWork, ChildsPlay (1998)
OCD in Children and Adolescents: A Cognitive-Behavioral Manual by John March and Karen Mulle1998, The Guilford Press.