M.I.N.D

ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS

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ANXIETY DISORDERS

Introduction

It was not very many years ago that anxiety disorders in children were thought to be relatively rare and low impact conditions. Nevertheless, the past 15 to 20 years have seen a dramatic increase in the number of studies examining child anxiety and we are now building a good understanding of the nature, development and treatment of these disorders. Even more recently interest has started to focus on possible prevention of anxiety and, given the overlap between anxiety and depression as well as the continuity from childhood into adulthood, this work has far-reaching.

Description and diagnosis

The core feature of anxiety disorders is *avoidance*. In most cases this includes overt avoidance of specific situations, places, or stimuli, but it may also involve more subtle forms of avoidance such as hesitancy, uncertainty, withdrawal, or ritualized actions. These behaviours are relatively consistent across disorders and the key difference between specific disorders is the trigger for this avoidance. The avoidance is generally accompanied by affective components of fearfulness, distress or shyness. Some children, however, especially younger ones, may have difficulty verbalizing these emotions. Anxiousness occurs due to an expectation that some dangerous or negative event is about to occur - in other words an expectation of threat.
All of the anxiety disorders will involve an *anticipation of threat*, which may take the form of worry, rumination, anxious anticipation, or negative thoughts. Physical symptoms that are common among anxious children include: headaches, stomach aches, nausea, vomiting, diarrhea, and muscle tension. In addition, it is common for many anxious children, especially those that worry considerably, to have difficulty with sleep.

Epidemiology

Overall, around 5% of children and adolescents meet criteria for an anxiety disorder during a given period of time in Western populations. Anxiety disorders are more common in females than males in the general population. Most population studies estimate around 1.5-2 times as many females compared to males for most anxiety disorders.
Anxiety disorders are among some of the earliest disorders to appear and most commonly begin by middle childhood to mid adolescence.

Anxiety disorders are among the most stable forms of psychopathology and show relatively little spontaneous remission. Anxious children are also at increased risk of developing other disorders during adolescence and into adulthood. Longitudinal research has shown that anxious children are at significantly greater risk for anxiety and mood disorders in adolescence and for anxiety, mood, and substance use disorders as well as suicide in adulthood.

Assessment

Clinical evaluation generally includes a combination of questionnaires, diagnostic interview and behavioural observation. Several structured diagnostic interviews exist to assist in determining criteria for childhood disorders including anxiety. Most interviews include a large number of questions aimed to tap each of the relevant diagnostic criteria and generally differ in their degree of structure.
Anxious children are often thought to "fake good" – in other words, to deny feeling anxious or to provide answers that they think are socially acceptable. However, many parents are also anxious and in some cases will exaggerate the child's difficulties due to their own distress. Hence, the interviewer needs to obtain sufficient detail to allow a judgment about which is the most accurate report and which aspects of the information may be inaccurate for various reasons.

Risk and maintaining factors

Family transmission

Anxiety runs in families. First degree relatives of people with anxiety disorders are at significantly increased risk to also have anxiety as well as mood disorders. The same is true more specifically for anxiety in children and adolescents. Anxious children are considerably more likely to have parents with anxiety disorders and adults with anxiety disorders are more likely to have anxious children.
Of course family transmission can reflect both genetic and environmental influences, so it is tempting to speculate that genetic transmission confers a broad, general risk, while family environment may shape that risk into specific manifestations.

Genetic factors

There is little doubt that anxiety disorders are heritable. Best estimates suggest that around 40% of the variance in anxiety symptoms and in diagnoses of anxiety disorder is mediated by genetic factors.

Temperamental factors

Temperamental risk for anxiety is probably the best studied and most clearly established risk factor. A variety of similar temperaments have been associated with child anxiety including: behavioural inhibition, withdrawal, shyness and fearfulness.

The most common assessment of inhibition occurs in children from around 2-5 years of age. This may be done via questionnaires or direct observation. Common features of inhibition include:

- Withdrawal in the face of novelty
- Slowness to warm up to strangers or peers
- Lack of smiling
- Close proximity to an attachment figure
- Lack of talk
- Limited eye contact or "coy" eye gaze
- Unwillingness to explore new situations.

Children who show these characteristics during preschool age are 2-4 times more likely to meet criteria for anxiety disorders by middle childhood and this increased risk has been shown to continue at least into adolescence.

Parent and family factors

Given the evidence for the transmission of anxiety within families described above, it has commonly been assumed that parents and the family environment must contribute to the development of anxiety disorders. However, evidence has been difficult to obtain and data have not been entirely consistent. The most extensive research has focussed on parenting and parent-child interactions. It has often been assumed that anxious parents increase risk for anxiety in their children by modelling their own fears and coping strategies.
More importantly, socially anxious mothers have been shown to transmit a fear of strangers to their infants in this way, and the extent of fear that the infant develops depends partly on the pre-existing level of inhibited temperament that the infant displays. Thus it seems that fear of strangers can be increased through an interaction between the infant's temperament and the mother's overt indications of fear. Among older children it has been shown that verbally transmitted information about danger can increase fear of particular cues. For example, when children are presented with information about a novel cue that suggests the cue might be dangerous, they show increases in fear, physiological arousal, threat beliefs, and avoidance of the cue that can last for several months.

One specific form of life event that has received particular attention is *bullying and teasing*. There is considerable evidence that anxious children are more likely to be teased and bullied than non-anxious children and that they are often neglected or even rejected by their peers. Once again the direction of causation is unknown but it is very likely that anxious children elicit teasing from others due to their behaviours; in turn, it is likely that teasing will further enhance their anxiety.

Cognitive biases

Anxious children report heightened threat beliefs and expectations. To some extent this is a reflection of the diagnosis, but it is also argued to represent a core maintaining feature. Although there is considerable overlap, to some extent the threat expectancies are specific. That is, socially phobic children are more likely to have increased expectancies for social threat, children with separation anxiety will have increased expectancies for physical threat, and so on. Evidence suggests that these threat beliefs are greater among anxious children than among children with other psychopathology and that they decrease with successful treatment.

Treatment

Psychopharmacology

Pharmacological management of anxiety in children has typically focused on the use of selective serotonin reuptake inhibitors (SSRIs). Several studies have demonstrated significant efficacy of SSRIs in the management of broad-based anxiety disorders. Outcome results indicate that 50% to 60% of children are considered treatment responders at the end of treatment compared with around 30% of those on placebo.

Skills-based programs

Most evidence-based psychological treatment for childhood anxiety falls under the broad category of cognitive-behavioural or skills-based treatment. The fundamental basis is teaching the child (and sometimes the parents) specific skills to help manage the child's anxiety.

Sources and Links

http://www.aacap.org
http://www.iacapap.org