Child and Adolescent Anxiety

A Handbook For Families (Second Edition)

Kim Poling, LSW
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University of Pittsburgh Health Systems

Services for Teens at Risk

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Foreword

STAR-Center is a treatment, training, outreach, and research program of the Division of Child Psychiatry, University of Pittsburgh School of Medicine. We acknowledge with gratitude the funding of the Pennsylvania General Assembly, which makes our services possible.
Introduction to This Manual

Services for Teens at Risk (STAR-CENTER) is a research program designed to address the increasing problems related to adolescent suicide and depression. Our program was founded by David Brent, M.D. and Mary Margaret Kerr, Ed.D. in 1986. STAR-CENTER is funded by the Pennsylvania General Assembly with the primary mission of preventing adolescent suicide.

Our program provides individual assessment and treatment to teens who are experiencing depression and suicidality. Through our work with teens and their families, we have learned that depressive and anxiety disorders frequently occur together.

This manual will provide you with an overview of the types of anxiety disorders, information about the possible causes, types of treatment available, as well as suggestions that may help your family member cope with, and recover from his/her illness. We believe that understanding the illness is the essential step toward recovery.

As we will report in this manual, anxiety disorders do tend to run in families. If you or your partner have an anxiety disorder, this may interfere with your ability to help your child. Untreated parental anxiety and or depression will hinder the child's recovery. If you feel you have symptoms similar to those listed in this manual, talk with your clinician. Please let us know how we can help. We hope you find this information helpful, and we look forward to working with you.
Introduction to Anxiety Disorders

Identifying Anxiety

Anxiety disorders are among the most common childhood psychiatric illnesses. Children and adolescents who are afflicted with anxiety often experience considerable distress and impairment in their day to day functioning. They may avoid situations that are important for their optimal development, such as school, peer involvement and functioning independently from parents. Anxious children/teens are also more likely to experience problems with their mood, conduct and overall functioning with family and peers.

Anxiety disorders can be very responsive to treatment. Treatment for anxiety disorders often involves psychotherapy, medication, or a combination of the two.

Anxiety Disorder or "Case of the Nerves"?

We all know what it is like to feel anxious during certain situations. It is common to experience "butterflies in your stomach" before your first date or your first day at your new school or job. Experiencing tension when your teacher or boss is upset, or having your heart pound harder when you are faced with a dangerous situation, are familiar experiences. A certain amount of anxiety may actually inspire us to work harder or study harder for that upcoming exam. It may help focus you when you make a speech in front of a large group of people. These occasional experiences of "anxiety" can actually help you cope and are completely normal.

However, if you have an "anxiety disorder", this normally helpful emotion can do just the opposite. Anxiety disorders can actually prevent you from coping and can disrupt your daily life. Anxiety disorders are not just a "case of the nerves." They are illnesses often related to the biological makeup and life experience of the individual. Anxiety disorders frequently run in families. There are several types of anxiety disorders, each with its own distinctive features.

An anxiety disorder may make you feel nervous most of the time, without any apparent reason. The anxious feelings may be so uncomfortable that to avoid them, the individual may stop some everyday activities. Some individuals may have occasional periods of intense anxiety that immobilize them. The individual experiencing an anxiety disorder may worry most of the time. The worry may come and go, or may be constant. Remember, it is normal to experience realistic worry about a troubling situation such as a family member being hospitalized. However, with anxiety disorders, the worry is usually excessive, exaggerated and ongoing.
Common Misunderstandings About Anxiety

Children and adolescents with anxiety disorders often feel frustrated and misunderstood. Many adults may not realize the child/teen is suffering from an illness. Indeed, the child/teen may not understand that what they are experiencing are symptoms of a treatable illness. Like with many other emotional illnesses, many people believe that children and adolescents could not suffer from what was commonly thought of as the "adult" illnesses. Comments like, "what does he have to be worried about, he has his whole life ahead of him?", "why would he be worried, he's just a kid?", are common misconceptions. In fact, we know that children and adolescents may worry a lot and they can suffer from these illnesses, at times causing significant difficulty that may increase their risk for adjustment problems during their childhood and adult years.

Another common misconception is the idea that the anxious child/teen is simply "putting on an act." Often the child has not received help because of the belief that these symptoms are purely intentional attention-seeking behaviors.

Sometimes anxiety disorders present as medical problems. For example, if the child/adolescent is having panic symptoms, the family may believe the symptom to be a sign of an underlying medical condition. The panic symptoms are so frightening, the family may make repeated visits to medical emergency rooms and expend time and resources on diagnostic medical examinations/tests, attempting to determine what medical condition is causing the child's symptoms. They may find no physical explanation for the child's symptoms. After hearing over and over again that there is no apparent physical cause for the child's symptoms, families may begin to doubt their child's honesty. Families may begin to think the child's "symptoms" are being exaggerated or "made up." Understandably, the situation may frustrate the whole family, including the child or teen.

Another common myth about anxiety occurs when people believe that the child was "born this way and nothing can change." Subsequently, the symptoms are explained away as "personality traits." "He's just that way." "He's always been a worry-wart." "He just has bad nerves." These are common responses adults may use to describe the child. Although the child indeed may be shy or "nervous" since very early childhood, he/she may be experiencing an anxiety disorder that could be treated effectively.

In summary, anxiety disorders do occur in children and adolescents, often making them unable to function as expected in their roles. There are several types of anxiety disorders. They include: Generalized Anxiety Disorder, Separation Anxiety Disorder, Panic Disorder, Phobias, Obsessive-Compulsive Disorder and Post-traumatic Stress Disorder. In the following section, we will provide an explanation of each. Children and adolescents can suffer from any
one or more of these types of anxiety; however, the two most common for children are Generalized Anxiety and Separation Anxiety. It is also important to emphasize that anxiety disorders frequently co-occur with other psychiatric disorders (especially depression), which may complicate the presentation and diagnosis of the anxiety symptoms. It is also possible for an individual to have more than one anxiety disorder occurring at the same time,
Types of Anxiety Disorders

Generalized Anxiety Disorder (includes Overanxious Disorder of Childhood)

Generalized Anxiety Disorder (GAD) is much more than the normal anxiety people experience day to day. According to the Diagnostic and Statistical Manual of Mental Disorders, (Fourth Edition, DSM-IV), the essential feature of Generalized Anxiety Disorder is excessive anxiety and worry, occurring more days than not for at least 6 months, about a number of events or activities. The individual finds it difficult to control the worry. For adults with GAD, the anxiety and worry are accompanied by at least three additional symptoms from the following list. However, for children and adolescents only one additional symptom is required:

- restlessness or feeling "keyed up" or "on edge"
- fatigue
- difficulty concentrating or mind "going blank"
- irritability
- muscle tension

Although individuals with a Generalized Anxiety Disorder may not always recognize their worries as being "excessive", they do report significant distress from their constant worry, or they find it difficult to function in social, school, occupational, or other important areas of their lives. They cannot seem to escape their worries, even when they realize that their anxiety is more intense than the situation calls for. They may have trouble relaxing and or difficulty falling or staying asleep. Adults with Generalized Anxiety Disorder often worry excessively about everyday routine life circumstances such as job responsibilities, money matters, the health of family members, potential accidents involving their children, or being late for appointments. The intensity and frequency of the anxiety and worry far exceed the probability that the event could happen, or the potential impact if the event were to occur.

Generalized Anxiety Disorder effects approximately 5% of the child/adolescent population. Children and adolescents with Generalized Anxiety Disorder tend to worry about their competence or the quality of their performance. They may continue to worry about a poor grade they made weeks ago, or worry in advance about who their teacher will be the next school year. The anxious child/teen may have excessive concerns about being on time. They may spend a great deal of time worrying about the weather or potential natural disasters, like floods, earthquakes, and tornadoes. Excessive and frequent concern about global issues such as nuclear war can be evident too. Children with an anxiety disorder
may be overly conforming and perfectionistic. They are usually quite unsure of themselves and tend to redo tasks because of being dissatisfied with their "less than perfect" performance. Children with anxiety disorders may repeatedly seek approval of others and worry whether they are liked by others. They often require excessive reassurance about their performance and their other many worries. They worry excessively about past, current and future events. Children and adolescents with anxiety disorders make many "what if" statements. "What if they don't like me", "what if I don't pass the test", what if the teacher doesn't like me"...

In general, children and adolescents with Generalized Anxiety Disorder experience significant distress from these symptoms, and their overall normal development is often affected.

**Separation Anxiety**

All children experience occasional fear of being away from their parents. Anxiety in children is expected and normal at certain developmental stages. It is normal for children from approximately 7 months through the preschool years to experience intense anxiety at times of separation from their parents or other persons to whom they are closely attached. However, when the anxieties become severe and begin to interfere with the child's daily activities, such as separating from the parents, attending school and making friends, this may tell us that the child is experiencing a Separation Anxiety Disorder.

Separation Anxiety Disorder occurs in approximately 2% to 4% of children and adolescents. According to the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, DSM-IV), Separation Anxiety is defined as a disorder with developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by **three or more of the following symptoms. These symptoms must be present for at least 4 weeks and the onset must be prior to age 18 years:**

- recurrent and excessive distress or tantrums when separation from home or major attachment figures (e.g. parent) occurs or is anticipated
- persistent thoughts and fears about losing, or about possible harm occurring to major attachment figures
- persistent and excessive worry that a unfortunate event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
- persistent refusal or extreme reluctance to go to school or elsewhere because of fear of separation
- persistent and excessive fear or reluctance to be alone or without major attachment figures at home or without significant adults in other settings
- persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
- repeated nightmares involving the theme of separation
- repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated

Children with anxiety disorders may refuse to go to school and may complain of headaches, sore throats or complain that they are mistreated by their peers at school. Sometimes, when the child is forced to go to school, she/he may react by becoming verbally or physically aggressive. The child’s aggressive reaction may lead others to misunderstand or "mislabeled" the child as being "bad" or "stubborn".

**Panic Disorder**

Panic Disorder does occur in children and adolescents. It can appear at any age with symptoms similar to those found in adult panic patients. Not everyone who experiences panic attacks will go on to develop Panic Disorder. Some people may have one panic attack and never have another. For those who do have Panic Disorder, it is important to seek treatment. Untreated, the disorder may become much worse. The age of onset for Panic Disorder varies, but is typically between late adolescence and the mid-30’s.

People with Panic Disorder have feelings of terror or panic that strike suddenly and repeatedly without warning. They cannot predict when an attack will occur. Therefore, many experience extreme anxiety between episodes, worrying when and where the next one will occur. They may worry that the next attack could come at anytime.

When a panic attack occurs, the individual may experience **any or all** of the following symptoms. According to the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, DSM-IV), a **panic attack** is a discrete period of intense fear or discomfort, in which **four or more** of the following symptoms develop abruptly and reach a peak within 10 minutes:

- palpitations, pounding heart, or accelerated heart rate
- excessive sweating
- trembling or shaking
- sensations of shortness of breath or smothering
• choking sensation of lump in your throat
• chest pain or discomfort
• nausea or abdominal distress
• feeling dizzy, unsteady, lightheaded, or faint
• feelings of unreality, or being detached from your body
• fear of losing control or going crazy
• fear of dying
• tingling or numbness in parts of your body (usually fingers or lips)
• chills or hot flushes

The frequency and severity of the panic attacks varies from person to person. Some individuals have panic attacks once per week, for months at a time. Others may have short bursts of more frequent attacks everyday for a week, then go for weeks or months without any attacks. Others may have attacks twice per month over many years.

Some people fear that the attacks indicate the presence of an undiagnosed, life-threatening illness, such as cardiac disease and may sometimes undergo several unnecessary medical and laboratory examinations. They may be frequent "visitors" of the hospital emergency room. Despite repeated medical testing and reassurance, they may remain convinced that they do have a life-threatening illness. They may feel misunderstood by their family members. Others fear that the panic attacks are an indication that they are "going crazy." Adolescents who have panic attacks may begin to avoid social situations because they fear they may have a panic attack while among their peers. For example, adolescents who normally enjoyed the mall, may avoid going for the fear of having a panic attack in public. They may stop attending school, for fear of embarrassment of having an attack.

The essential feature of **Panic Disorder** is:

• the presence of recurrent, unexpected panic attacks

• at least one of the panic attacks has been followed by **1 month (or more) of one (or more)** of the following:
  •  persistent concern about having additional attacks
  •  worry about the implications of the attack or its consequences (e.g. losing control, having a heart attack, "going crazy")
  •  a significant change in behavior related to the attacks. Some individuals with Panic Disorder experience associated
symptoms of Agoraphobia, (agoraphobia refers to the fear of being in places outside of the home), while others do not.

The Diagnostic and Statistical Manual of Mental Disorder (Fourth Edition, DSM-IV) defines Agoraphobia as:

Anxiety about being in places or situations from which escape might by difficult or embarrassing or in which help may not be available in the event of having a panic attack or panic-like symptoms. Agoraphobic fears typically involve characteristic clusters of situations that include being outside the home alone; being in a crowd or standing in a line; being on a bridge; tunnel and or traveling in a bus, train, or car.

The situations are avoided or else are endured with marked distress or with anxiety about having a panic attack or panic-like symptoms, or require the presence of a companion.

Panic Disorder can occur with or without Agoraphobia. Some individuals may have occasional episodes separated by years of remission. Others may have continuous, severe symptoms.

Specific Phobia

Although fears are common in the general population, they do not usually result in sufficient impairment or distress to warrant a diagnosis of Specific Phobia. A Specific Phobia is an intense and persistent fear of a particular object or situation. Intense, irrational fears of certain things or situations such as animals, snakes, insects, enclosed places, heights, storms, escalators, tunnels, highway driving, water, flying, and injuries involving blood are a few of the more common ones. Most adolescents and adults with phobias recognize that their fear is excessive or unreasonable.

Most often the object or situation is avoided, although at times it can be endured with extreme distress. Children may not recognize that their fear is excessive or unreasonable. They may express their fear through crying, tantrums, or clinging. The diagnosis is made only if the avoidance, fear, or anxious anticipation of encountering the object or situation interferes significantly with the person’s daily routine or functioning.

Normal Childhood Fear or Phobia

Most phobias first appear in adolescence and adulthood. However, young children can also be diagnosed with a Specific Phobia. Fears of animals and other objects in the environment are particularly common for young children and usually disappear over time. Young children may also experience short-lived fears, such as fear of the dark, strangers, monsters or storms. However, if the
fear persists for at least 6 months and causes impairment in the child's day to day functioning, then a diagnosis of Specific Phobia may be made.

The following example will distinguish between a normal childhood fear compared to a Specific Phobia: A common example of a normal fear would be one in which a young child is initially fearful of an unfamiliar dog that the she/he encounters at the park. If that child was so extremely fearful of dogs that she/he would not go outside to play or walk to school for the fear of possibly seeing a dog, the child could be experiencing a phobia.

Social Phobia

The essential feature of Social Phobia is an intense and persistent fear of social or performance situations in which embarrassment may occur. Individuals with Social Phobia fear that others will see them as anxious, weak, "crazy" or stupid. The person with Social Phobia typically will avoid the feared situations. The fear or avoidance of the social situation must interfere with the person's normal functioning or cause significant distress to be considered a Social Phobia.

One common Social Phobia is a fear of public speaking. Sometimes Social Phobia involves a general fear of social situations, using public bathrooms, eating out, talking on the phone or writing in front of someone else. Children and/or teens may avoid attending normal activities such as parties. The child may feel lonely and may develop low self-esteem and depression, as they begin to see themselves as inadequate and "different" from other children.

Children and adolescents may avoid attending school due to their anxiety/fear. Anxiety-based school refusal is a clinical problem in which children/adolescents avoid going to school because of their specific fears. In the past, several terms have been used to describe school attendance difficulties, including school anxiety, school phobia, and separation anxiety. Although not a separate psychiatric diagnosis, anxiety-based school refusal often may be related to a variety of associated problems including, symptoms of Separation Anxiety Disorder, Social Phobia, Panic Disorder, Major Depression, conduct problems and/or learning problems. For children, the fear and avoidance of attending school may be associated with separating from their parent, whereas with adolescents the fear may be associated with a specific aspect of the school environment. Up to 80% of children with anxiety-based school refusal meet the criteria for Separation Anxiety Disorder.

Anxiety-based school refusal symptoms may vary in severity, with less severe cases involving complaints of attending school as well as reporting physical complaints. In more serious cases the child may: have bouts of vomiting or diarrhea before or during school, require physical intervention to attend school, or have not attended school for several weeks. In some situations, the anxiety
symptoms may become so severe that the symptoms escalate to the point of panic.

In summary, it is normal for children to be fearful of certain things. This does not mean they are "phobic." If the fear does not significantly interfere with the individual's functioning or cause significant distress, the diagnosis is not made.

**Obsessive-Compulsive Disorder**

Obsessive-Compulsive Disorder is characterized by intrusive, anxious or "strange" thoughts or rituals that the individual feels she/he cannot control. **Obsessions** are persistent, disturbing, intrusive thoughts or impulses that the person finds illogical but irresistible. The obsessions may appear as ideas, words, rhymes, or melodies that annoyingly interrupt normal thoughts and interfere with getting anything accomplished. These obsessions usually lead to compulsions. **Compulsions** are obsessive rituals or actions the person feels urgently compelled to engage in. The rituals are performed to try to prevent or eliminate the obsessions. The obsessions and compulsions are experienced by the individual as irrational. There is no pleasure in carrying out the rituals, only the **temporary** relief from the discomfort caused by the obsession. Obsessive-Compulsive Disorder (OCD) **does** appear in childhood, adolescence, or adulthood, but on average it first shows up in teens or in early adulthood. Obsessive-Compulsive Disorder affects approximately 3% of the child/adolescent population. The course of the illness can vary. Without treatment the symptoms may come and go, they may ease over time, or they may become progressively worse over time.

Individuals with Obsessive-Compulsive Disorder may be obsessed with germs or dirt, so they will wash their hands repeatedly. They may be filled with doubt and feel the need to check things repeatedly (e.g., checking the door locks, household electronic appliances, repeatedly checking that their eyeglasses are straight). They may spend long periods of time touching certain things or counting to certain number; or be preoccupied by order or symmetry, such as needing to follow a precise ritual of washing one arm, then the other arm when taking a shower. If the ritual is interrupted in any way, the person must start over. This may cause interpersonal difficulty for the individual as they may be chronically late for school, work, appointments. Mistakenly, these children are often seen as purposely being late. Getting dressed in the morning can be a frustrating and time-consuming task for the individual with Obsessive Compulsive Disorder (and for their parents). Reading may become difficult, as the individual may be preoccupied with counting the lines of the paragraph or page instead of focusing on the content of the reading material. The individual may become compulsive about making lists. What began as a brief shopping list may go on to become a notebook filled with lists.
Often the individual recognizes that the rituals are excessive, but **without treatment**, may not be able to stop them. The individual may feel ashamed of their thoughts or behaviors and may remain secretive about the symptoms. Children and adolescents with the disorder may **not** realize that their rituals/compulsions are unusual.

Brain imaging studies indicate that OCD may result from alterations in circuits involving the basal ganglia, which are brain centers involved with complex movements and behaviors. Also, a small subgroup of patients with OCD may develop symptoms after an acute streptococcal infection (Allen AJ et al, 1995)

**Personality Style or Obsessive-Compulsive Disorder**

Many people can relate to having some of the symptoms of OCD, such as checking the stove several times before leaving the house. But the disorder is diagnosed only when such activities consume at least an hour a day, are very distressing and interfere with daily life.

Being "obsessive" or "compulsive" is **not** the same as having "obsessions" or "compulsions." Many people who have personality styles or preferences for neatness or organization may refer to themselves as being "obsessive" or "compulsive." These are personality styles only and should not be confused with "obsessions" or "compulsions" which are features of an emotional disorder that is often extremely impairing. Superstitions and repetitive checking behaviors are common in everyday life. A diagnosis of Obsessive-Compulsive Disorder would not be considered unless the superstitions or checking behaviors consume a great deal of time or result in major impairment/distress.

**Post-Traumatic Stress Disorder**

Post-Traumatic Stress Disorder (PTSD) is a type of anxiety disorder that may develop following exposure to an extreme traumatic event. Often, people with PTSD have persistent frightening thoughts and memories of the traumatic event. PTSD, once referred to as "shell shock" or "battle fatigue," was first brought to public awareness by war veterans, but it can result from any traumatic incident. These may include kidnapping, serious accidents such as car, train, or plane wrecks, natural disasters such as floods, earthquakes or hurricanes, violent attacks such as mugging, rape, or torture or being abused. The event that triggers it may be something that threatened the person directly or threatened someone else close to him or her. Or it could be an event witnessed such as mass destruction after a plane crash, finding the body of a victim of homicide or completed suicide, or witnessing a violent act against another person.

According to the **Diagnostic and Statistical Manual of Mental Disorders** (Fourth Edition, DSM-IV), Post-traumatic Stress Disorder is defined as a disorder in which:
The person has been exposed to a traumatic event in which both of the following were present:

- The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
- the person’s response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.

The traumatic event is persistently re-experienced in one (or more) of the following ways:

- recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
- recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
- acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
- intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- efforts to avoid thoughts, feelings, or conversations associated with the trauma
- efforts to avoid activities, places, or people that arouse recollections of the trauma
- inability to recall an important aspect of the trauma
- markedly diminished interest or participation in significant activities
- feelings of detachment or estrangement from others
- restricted range of affect (e.g., unable to have loving feelings)
- sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)

Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- difficulty falling or staying asleep
- irritability or outbursts of anger
- difficulty concentrating
- hypervigilance
- easily startled

According to the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition, DSM-IV), PTSD is diagnosed only if these symptoms persist more than one month.

PTSD can occur at any age, including childhood. The disorder can be accompanied by depression, substance abuse, or other types of anxiety disorders. The person's symptoms may be mild or severe. In severe cases, the person may have difficulty returning to their normal socializing habits.

In summary, the person with PTSD may experience sleep problems, depression, feeling detached or numb, or being easily startled. They may lose interest in things that they usually enjoyed and have difficulty feeling affectionate. People may sometime become extremely irritable or have violent outbursts. Going places or seeing things that remind them of the traumatic event may be very troubling, and so they may avoid those places or situations. Anniversaries of the traumatic event are often very difficult. Some individuals with PTSD repeatedly "relive" the trauma in the form of nightmares, disturbing memories, experience "flashbacks," or intrusive images of the traumatic event. Regular everyday events may trigger the flashback. The "flashback" may come in the form of images, sounds, smells, or feelings. The person experiencing a flashback may lose touch with reality for brief or longer periods of time (dissociation). The person may experience dissociation that lasts from a few seconds to several hours, or even days, during which the components of the event are relived and the person may believe the traumatic event is happening all over again. Not every individual who experiences a traumatic event will go on to develop full symptoms of Post-Traumatic Stress Disorder. Some individuals will
have no symptoms at all. The likelihood of developing this disorder may increase as the intensity of and physical proximity to the stressor increases.
Causes of Anxiety Disorders

There is no single cause for anxiety disorders. Rather, there are a variety of factors involved. Among these factors are genetic predisposition, personality characteristics, learned behavior or thought patterns, and stressful life events. Some children/teens are born with behavioral inhibitions. This tends to run in families and is controlled by centers in the brain called "amygdala", which is like an alarm box in the brain that sets the threshold for physiological activation to threat. All these factors appear to contribute to the development of anxiety disorders.
Treatment for Anxiety Disorders

The anxiety disorders are often responsive to treatment. Treatment usually involves psychotherapy, medications or a combination of both.

Psychotherapy involves the presence of an interested, but objective person (therapist) and the use of talking to define and resolve problems. There are many types of psychotherapy, but only a few are designed to specifically treat anxiety disorders. Studies have shown that cognitive-behavioral therapy can be effective for treating several of the anxiety disorders. Providing the individual and family with psychoeducation about the illness is also an essential step toward recovery. Effective treatments are already available, even though there is much to be learned about the causes and treatments of anxiety.

If you or a member of your family are experiencing symptoms of anxiety, it is important to seek treatment. Once you seek treatment, we recommend that you inquire about the specialization of the therapy. There are many effective types of therapy. It is your right as a consumer to know the type of therapy you will be receiving. The following will provide a brief overview of the most effective therapies in treating the anxiety disorders.

Cognitive-Behavioral Therapy

Cognitive-behavioral therapy is a type of psychotherapy that focuses on identifying and changing the anxious person's thinking patterns and behaviors. Cognitive-behavioral therapy assumes that negative thought patterns and irrational beliefs lead to anxious feelings and that the way to change the person's anxious feelings is to change the thoughts that lead to the feelings.

It is often a characteristic of the anxious person to engage in negative "self-talk". "Self-talk" is a term that describes "what we say to ourselves in our own mind," in response to any particular situation. Cognitive-behavioral therapists believe that our "self-talk" influences our mood and behavior. Cognitive-behavioral therapy teaches the patient to identify their "self-talk" and automatic thoughts, and to react differently to the situations and bodily sensations that seem to trigger panic attacks and other anxiety symptoms. Patients learn how their "self-talk" and thinking patterns contribute to their symptoms as well as how to change their thoughts so the symptoms are less likely to occur. This new awareness of one's own thinking patterns is combined with exposure and other behavioral techniques to help confront the feared situations. The therapist also may demonstrate ways to reduce anxiety by using breathing exercises or techniques to refocus attention.

Successful treatment for Panic Attacks, Phobias and Generalized Anxiety usually involves a type of cognitive-behavioral therapy called desensitization or exposure
therapy in which the patients are **gradually** and safely exposed to what frightens them until the fear begins to fade. Relaxation and breathing exercises can also be helpful at reducing the anxiety symptoms.

**Behavioral Therapy**

Behavioral therapy is a type of psychotherapy in which the therapist helps the individual focus on changing specific behaviors or actions. The behavioral therapist uses several techniques to help the individual decrease or stop unwanted behavior (this is particularly helpful for treating Obsessive-Compulsive Disorder). This type of therapy assumes that anxious behaviors are learned and reinforced in the environment. Parents are also taught to be aware of their own behaviors that may be reinforcing the child’s/adolescent’s anxious behavior. The person learns to monitor their behavior and events with the goal to increase positive events. Specific social skills are taught and self-reward after positive behavior is encouraged.

**Family Management**

Working with the entire family is an especially helpful model of treatment when the anxious individual is a younger child. Parents and family are taught how to manage the child when s/he is experiencing symptoms of Separation Anxiety Disorder. Separation Anxiety symptoms can be extremely impairing for the child and may lead to frustrating interactions between the child and parents. Helping the parents with management skills for the anxious child may be helpful for younger children.

**Medications**

Medications can be very effective in relieving anxiety symptoms. Currently, there are many choices of medications found to be effective. If one medication does not work for the individual, there are others to try. In the following section we will highlight some of the most effective medications that are currently used to treat anxiety disorders.

**Antidepressants**

Antidepressant medications are effective in treating anxiety disorders as well as treating depressive disorders. There are different types of anti-depressant medications:

**Selective Serotonin Reuptake Inhibitor (SSRI’s)**

Examples of these medications are Prozac (fluoxetine), Zoloft (sertraline), Paxil (paroxetine) and Luvox (fluvoxamine). These medications work by functionally
increasing the brain's supply of the neurotransmitter called serotonin. SSRI's are among the "newer" anti-depressant medications and have become quite popular over the past few years. These medications tend to cause fewer of the side effects such as drowsiness and dry mouth, seen with some other antidepressants. The most common side effect of the SSRI's include nausea, stomach ache, insomnia or, in some individuals, sleepiness and lack of appetite. Although more studies are needed, the SSRI's have been found to be effective in treating the symptoms of Panic Disorder (including panic attacks), Separation Anxiety, Agoraphobia, Social Phobia, Obsessive-Compulsive Disorder, as well as for individuals experiencing coexisting anxiety disorder and depressive disorder.

Cyclic Antidepressants

Some examples of the cyclic antidepressants used to effectively treat anxiety disorders are Tofranil (imipramine), Pamelor (nortriptyline), Norpramine (desipramine), and Anafranil (clomipramine).

All cyclic antidepressants work similarly but differ in their side effects. They may alter different neurotransmitters. Each individual responds differently to the various antidepressant medications, and sometimes several must be tried before the right one is found. A person may tolerate one medication but not another. The most common side effects of the cyclic antidepressants are dry mouth, constipation, dizziness, drowsiness, low or high blood pressure, rapid heart beat and problems with the electric conduction of the heart. Due to these side effects, the person taking this type of medication needs frequent monitoring of blood pressure, heart rate and electrocardiograms. If these side effects do occur, they tend to generally lessen and disappear as treatment continues. **Immediately inform your physician of any side effects.**

Cyclic antidepressant medications are frequently used to treat Panic Disorder (including panic attacks), Agoraphobia, as well as for individuals experiencing coexisting anxiety disorder and depressive disorder. Although more studies are needed, Anafranil (clomipramine) has been shown to be effective in treating Obsessive-Compulsive Disorder and other conditions such as depression.

Benzodiazepines

Only high potency benzodiazepines have been found helpful for the treatment of Generalized Anxiety and Panic Disorder. They may also be used as "adjunct" treatment with other medications. Benzodiazepines include Xanax (alprazolam).

All benzodiazepine drugs tend to depress the activity of the central nervous system, thereby decreasing the anxiety quickly, more "quickly" than other medications. Therefore, they may be prescribed temporarily while the other medications are "kicking in". These medications work effectively, but **unlike** the
other types of medications we have already described, the benzodiazepines have the potential for the side effect of physical dependence, especially when taken in high doses over a long period of time.

These medications are most appropriate when treating short-term, acute anxiety or stress, rather than long-lasting conditions. However, these medications may still be used in the treatment of the longer-lasting conditions when other types of medications have been ineffective. Some individuals can take a benzodiazepine like Xanax or Klonopin long term, at a low dose, in a responsible and effective way.

**Beta-Blockers**

When treating anxiety disorders symptoms, the two most commonly used beta-adrenergic blocking drugs (beta blockers) are Inderal (propranolol) and Tenormin (atenolol). These medications are used mainly for cardiovascular illness, but may be effective for blocking physical symptoms of anxiety, such as heart palpitations. Beta-blockers are not effective for the ongoing treatment of anxiety disorders, but given in a single dose they do relieve severe physical symptoms of anxiety before a high performance situation, such as public speaking.

Potential side effects of beta blockers are lowering of blood pressure, which can cause light-headedness or dizziness, fatigue and drowsiness. Unlike the benzodiazepines, the medications do not cause physical dependence.

**Buspirone**

Buspirone (buspar) is frequently used in the treatment of anxiety disorders. This medication has been found to be effective in diminishing symptoms of Generalized Anxiety. Many physicians prefer it over Xanax (and other benzodiazepines) for treating Generalized Anxiety because it does not cause sedation and does not lead to physical dependence.

**MAO-Inhibitor Antidepressants (MAOI's)**

Examples of these medications are Nardil (phenelzine), Parnate (tranylcypromine), and Marplan (isocarboxazid). MAOI's are frequently used if a person has not responded positively to the other medications. MAOI's have also shown to be useful for treating Social Phobia and Panic Disorder symptoms that did not respond to other treatments or medications. The greatest problem with using certain types of MAOI's is the diet and drug restrictions a person must follow while using the medication. Only people who are willing to follow the strict restrictions can use MAOI's. For this reason, these medications are not often used to treat children or adolescents. Foods that are prohibited include processed meats, cheese, pickles, and pickled foods, red wines, and sherry,
certain drugs such as amphetamines, barbiturates, some cough medicines, nasal decongestants and certain other antidepressants. The interaction of MAOI's with any of these substances can cause a quick and severe rise in blood pressure, accompanied by severe headaches and other symptoms. If you or anyone in your family is being treated with a MAOI, please consult your physician prior to beginning any additional medication. MAOI medications can be combined with other classes of antidepressants. However, since there are potentially dangerous side effects, you should be closely monitored by your physician.
Comorbidity (Co-Existing Conditions)

Anxiety disorders frequently occur simultaneously with other disorders such as Major Depression. Major Depression is a disorder in which the individual experiences a change in functioning in which they experience pervasive depressed or irritable mood, along with a combination of associated symptoms such as sleep disruption, decrease or increase in appetite, fatigue or loss of energy, loss of interest or pleasure in activities, and diminished ability to concentrate. Recurrent thoughts of death, suicidal thoughts and/or behaviors are among the most serious of the symptoms.

According to the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), Major Depression occurs frequently (50-65%) in individuals with Panic Disorder. In approximately one-third of individuals with both disorders, the depression occurs prior to the onset of the Panic Disorder. In the remaining two-thirds, depression occurs coincident with, or following the onset of Panic Disorder. Two-thirds of depressed children have preexisting anxiety disorders. Comorbidity with other anxiety disorders is also common.

In a recent study with depressed adolescents and their families, it was found that having a untreated, co-existing anxiety disorder was a predictor of poor treatment outcome for the depressed adolescent. Therefore, it is essential for the treatment to target both the depression and anxiety.
The Family and Anxiety

Common Responses and Feelings of Family Members

Many of us at some point in our lives have experienced a stressful life event such as when a family member develops a medical illness, requires hospitalization, or becomes injured. The impact on the family can be felt in a variety of ways. Changes in the family’s daily routine occur. Cleaning the house, working 10 hour days at your job, running errands, or going to Tuesday night bingo, suddenly become routines that you must alter to help your family member.

When someone in your family has an emotional illness like anxiety, it will have an impact on each member of the family. Besides changing routines for the family, the illness may bring out a range of emotional reactions from each family member. Some family members may experience worry and fear, as well as anger and confusion about why the individual is feeling and behaving the way they are. Others may feel ashamed of the individual and may want to avoid him/her all together. Because of misunderstandings about the illness, some family members may feel very angry and refuse to believe that the individual has a real illness. These are all normal feelings and responses that family members may experience.

The family may become frustrated as they may try to help the anxious family member. It is normal for family members to offer common sense suggestions to the individual experiencing anxiety. However, these ordinarily helpful techniques of reassuring someone that there is "nothing to worry about" may be ineffective with an anxious person.

When a family member has a Phobia, family members may try to help by telling the phobic family member that the fear is illogical. This common sense advise will not relieve the individual from the irrational fear. Forcing the individual to "face the fear" will not be effective. Actually, forcing or "tricking" the individual to face the feared object/situation may actually worsen the person's fear and avoidance.

Because anxiety disorders tend to run in families, one or both parents or siblings may also suffer from an anxiety disorder or other psychiatric disorder, especially depression. It is extremely critical that those family members get effective treatment. If no treatment is provided for the additional family member, it may be difficult to effectively treat the child/adolescent. In a recent study of depressed adolescents and their families, it was noted that untreated parental depression and anxiety actually impedes the recovery of the depressed adolescent.

Remembering that anxiety disorders are illnesses with a primary symptom of worry and fear that is not usually based on present circumstances, but rather
upon excessive irrational fears of what "could be", will be a helpful reminder for the entire family.

**Coping Tips for the Family**

The following information is a list of tips that families have found to be helpful reminders as they learn to understand and cope with their family member’s emotional illness:

Learn about your family member’s specific anxiety disorder. Request the name of the specific diagnosis. Understanding the illness is an essential first step toward coping with the illness. Ask for written information. Ask any questions you may have. Direct questions to the treatment team.

- **REMAIN HOPEFUL.** Anxiety can be treated.
- Encourage your relative to remain in treatment.
- Encourage person to take medication as prescribed, even if beginning to feel better. Parents should maintain control of the medication supply.
- Take care of yourself, go on with your life. Your relative will need your strength, so don’t let yourself get run down.
- Share general information about the illness with the entire family.
- Be direct and honest in communicating.
- Notice positive changes and tell the person.
- Let the school know what is occurring. They can be helpful to the child/teen. This is especially important if your child/teen is experiencing anxiety related to school attendance. Work with the school to design a gradual re-entry plan for the child. Your child must return to school. You may want to sign a release to allow the school and therapist to share information.
- Look for gradual progress. Recognize small improvements.
- Remember, individuals with anxiety may also have symptoms of other emotional illnesses, like depression. Learn about these illnesses also.
- Always take any type of suicidal talk very seriously. Immediately contact your treatment team.
- Know how to reach your treatment team. Know the appropriate emergency numbers and procedures.
- Set limits, but be sensitive to your child/teen’s mood. Parents need to provide structure and rules for the child/teen, even if the child is experiencing an emotional illness. Recognize when you need help with child management.
How Can Family Members Help?

Continued Functioning of the Family

Family members are long-term support resources for the person experiencing an emotional illness. Therefore, it is essential that the family members take care of themselves and try to go on with their own lives. Obviously, adjustments may need to be made, but it is important to go places, see friends, and enjoy yourselves individually and as a family, even if the individual with anxiety does not want to go along. Although it may be difficult, it is important for the entire family, including the family member with the illness, that the overall family functioning return to normal.

Effective Communication Between Parents and Teenagers

Communication between parents and teenagers can be especially difficult during times of high stress. When the teenager is experiencing an emotional illness like anxiety or depression, this can mean even more stress and arguments for the whole family. Even though it may be difficult, it is during these stressful times that families need to talk with each other in helpful ways.

It is important to speak directly with the child/teenager about the things that concern you. Dealing with matters as they occur, instead of waiting until they build to great tension is recommended. Listening to your teenager is important. Providing clear, simple rules and reasonable expectations will help the child know what is expected. It is important for parents to provide praise and positive remarks to the child/teenager. Criticism and negative remarks are best expressed in a calm tone of voice when you are not angry. How you say something is often as important than what you say.

Involvement in Treatment

Family members are partners in the child/teenager's treatment. It is important for parents to encourage the individual to attend treatment and to work on problems. Learning about the illness will help all family members. Understanding and supporting their involvement in treatment is an essential way for family members to help. Teenagers who are teased or made fun of for attending treatment frequently drop out of treatment and may experience a further decline of their self esteem.

Realistic Expectations

It is important to realize that the anxiety symptoms that your child/teenager is experiencing are real. They are experiencing a legitimate medical illness. Anxiety disorders clearly cause significant distress and impairment. No matter
how unrealistic the child/teen's worries or fears may seem to you, it is crucial to remember that they are real. Emotional illness, no matter what type, can be complicated and difficult to understand. As you notice your family member's symptoms and think to yourself, "Why is s/he so worried about these things? It's really no big deal!", remember that their fears and worries are unrealistic, excessive and chronic. Otherwise, if the individual is experiencing realistic worry in response to a troubling situation and is not experiencing chronic distress or impairment, it would not be considered symptoms of an illness.

Realize that the symptoms of anxiety may limit performance in such areas as schoolwork and interpersonal relationships. The individual is not to blame for his/her situation and neither are you. Adjusting your expectations for your child/teen while they are recovering may be necessary.

Sometimes management and support of anxious children and teens is so challenging that additional help in child management is required. If you feel you are having difficulty coping, speak to your clinician about these. They may be able to help you identify additional support systems for your family and help you develop additional techniques for managing your child's symptoms. Children and adolescents with anxiety disorders can be effectively treated. Although there remains a lot we do not know yet, we look to the promise of continued research. After having read this manual, you will be familiar with the basic features of anxiety disorders. We hope you find this handbook helpful, and we welcome your suggestions for how to improve it.
References


Dulcan, Mina K. Information for Parents and Youth on Psychotropic Medications. Department of Psychiatry, Emory University School of Medicine, Atlanta, GA. 1992.


