Anxiety disorders in children and adolescents

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Abstract

Anxiety disorders are among the most common psychiatric disorders in children and adolescents. They commonly interfere with peer relationships, schooling and family life, and persist into adulthood if left untreated. This paper gives an overview of the identification, assessment and treatment of anxiety disorders in children and young people. Identification of anxiety disorders is often poor and many young people with anxiety disorders go untreated. We present a brief review of the evidence base for pharmacological and psychological treatment approaches to the management of anxiety disorders in youth. Both have been found to be effective in the treatment of anxiety disorders, although psychological treatments such as Cognitive Behavioural Therapy (CBT) are considered the first-line treatment due to relative benefits in terms of patient safety and parental preference. Low intensity CBT approaches such as bibliotherapy and online therapies are effective and have the potential to improve access to evidence-based interventions. CBT approaches have also been found to be effective with particular patient groups, such as those with long-term physical health conditions and autism spectrum disorders, who are at an increased risk of anxiety disorders.

Keywords adolescent; anxiety; assessment; child; cognitive behavioural therapy; pharmacological; psychological; SSRIs; treatment

Introduction

Slightly more than one in four people will report an anxiety disorder at some stage of their life. Most begin in younger life and the average age of onset is during childhood. Anxiety disorders are among the most common mental health disorders in youth, with prevalence rates between 9% and 32% during childhood and adolescence.

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Classification

Anxiety disorders are characterised by excessive worries, fears and negative beliefs, avoidance of specific situations or objects, and physical symptoms such as increased heart rate, quick shallow breathing, sweating, and pain in the stomach or chest. The diagnostic manual DSM-5 specifies a number of anxiety disorders (see Table 1). "Panic attack" (sudden onset of intense fear with cognitive and physical symptoms such as heart palpitations, breathlessness, dizziness, derealisation and fear of dying) is included as a specifier that can be applied across the DSM-5 disorders, as it is recognised that panic attacks can be implicated in a range of disorders. Unlike previous versions, DSM-5 does not classify Obsessive Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD) as Anxiety Disorders.

Although the specifics of each anxiety disorder vary, they share some common features. These include overestimation of the actual threat and danger associated with the feared situation, underestimation of the individual's ability to cope, and significant interference in normal life experiences such as friendships, school and family life.

Impact

Anxiety disorders cause significant interference with the day-to-day functioning of children and young people, affecting school performance, social functioning, family life, leisure activities and sleep. Left untreated, anxiety disorders tend to run a chronic course and often persist into adulthood. Anxiety disorders typically co-occur, are often comorbid with other disorders such as depression, and predict the development of other serious mental health problems in later life such as depression, substance misuse and risk of suicide. Prompt identification and evidence-based treatment ensure optimal outcomes.

Development and maintenance

Many factors have been implicated in the development and maintenance of childhood anxiety disorders: these can be broadly grouped into genetic, environmental and child factors.

Genetic factors

Anxiety disorders tend to run in families, with anxious children more likely to have anxious parents than non-anxious children. Children of parents with an anxiety disorder are seven times more likely to have an anxiety disorder themselves, compared to children of parents with no psychiatric disorder. Twin studies confirm a likely genetic cause. These show that there is ~40% heritability for the variance in anxious symptoms.

Child factors

Child temperament is an important factor in the development of anxiety disorders. An inhibited temperament in early childhood is a risk factor for anxiety disorders in middle childhood and mid-adolescence. Other hypothesised vulnerability factors include information processing biases e.g. interpretation of ambiguous situations as threatening and heightened attention towards potentially threatening environmental cues.

Environmental factors

Environmental factors implicated include adverse life events and exposure to negative information or modelling of anxious

Common anxiety disorders in childhood and adolescence

Disorder	Symptoms	Prevalence (%)[a]	Median age (y) of onset
Separation Anxiety Disorder	Anxiety when apart from (usually) a primary caregiver due to the fear that something bad will happen to either themselves or the attachment figure.	1.17	7
Specific Phobia	Intense fear of a particular object or situation e.g. having injections.	1	7
Social Anxiety Disorder	Anxiety in everyday social situations and social interactions due to a fear of negative evaluation by others.	0.32	13
Generalised Anxiety Disorder (GAD)	Excessive and uncontrollable worry about a range of things that may or may not happen or have happened.	0.65	31
Panic Disorder	Involves recurrent panic attacks, which are feelings of terror that occur suddenly and without warning, accompanied by physical symptoms such as chest pain, palpitations, sweating and feeling of choking.	0.14	24
Agoraphobia	The fear of actual and anticipated places or situations that might result in a panic attack and often involves a belief that there is no easy way to escape or seek help.	0.07	20
Selective mutism	Someone who is capable of speech and understanding language but does not speak in specific situations or to specific people.	0.50[b]	Mean range = 2.7 to 4.1

[a] Figures represent point prevalence (proportion who meet criteria for a diagnosis at a specific point in time).
[b] This figure is taken from a different study to the other disorders. It is higher than might be expected, possibly due to methodological differences between the studies.

Table 1

responses. Recent studies have shown that anxious children are more likely to be particularly attuned to this information. Furthermore, child characteristics can elicit certain parental behaviours such as overprotection, which although well intended and understandable, may serve to maintain anxiety as they may allow the child to avoid anxiety-provoking situations. The main takeaway message from all of this is that the development of anxiety disorders in youth is typically underpinned by a complex interplay of several factors.

Management of anxiety disorders in children and young people

Seeking help

Children and adolescents with anxiety problems do not usually seek help from medical professionals themselves. Instead, concerns are more likely to be raised by their parents, for example to their General Practitioner (GP) or other professionals (e.g. school staff). Rates of help seeking for anxiety disorders appear to be lower than for other mental health problems in childhood and the reasons for this are not well understood. Common barriers that prevent parents from seeking help for their child in relation to mental health concerns more generally include:

- lack of knowledge/understanding of mental health problems and how to access services
- family circumstances (e.g. limited time and competing commitments)
- negative attitudes towards service providers and treatments
- perceived difficulties with the mental health system (e.g. long waiting times and a lack of appointment flexibility)

Identification of potential anxiety disorders in children and young people

In the UK, GPs (alongside Common/Single Point of Entry services) have a gatekeeper role in relation to Child and Adolescent Mental Health Services (CAMHS) and therefore recognition and appropriate management within the GP consultation is key for the timely detection of anxiety disorders and access to effective interventions. Despite this, studies have found that GPs are often poor at recognising mental health problems in young people, especially if parents do not raise concerns.

Anxiety can often present as somatic complaints in children (e.g. stomach aches and headaches), and young people may not be as forthcoming as adults in bringing up mental health issues, making anxiety all the more difficult to identify. In addition, GPs report that a lack of confidence, knowledge, time, providers and resources also reduce their ability to detect anxiety and their willingness to refer children and young people for treatment.

Once anxiety is identified as a potential area of concern, assessment of (i) the severity and duration of symptoms and (ii)