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Prevention of Childhood Anxiety Disorders

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1. Introduction

Anxiety disorders consist of excessive and frequent worrying which causes physical and mental distress and impairment in overall functioning (NIH&SAMHSA, 1999). Anxiety disorders are the most common mental health problems reported by children, adolescents and adults (Costello, Angold, & Burns, 1996; Goodman, Ford, Richards, Gatward, & Melzer, 2000; Kessler et al., 2005; Muris, Merckelbach, Mayer, & Prins, 2000). The prevalence of childhood anxiety disorders ranges from 10% to 22% (Dadds, Spence, Holland, Barrett, & Laurens, 1997) with lifetime prevalence estimated to be about 28.8% (Kessler et al., 2005) with ages of onset between 10 to 12 years (Kessler et al., 2005). About one in 6 children have anxiety that causes impairment in their daily lives (Dadds, Spence, Holland, Barrett, & Laurens, 1997). There are many sequelae of anxiety disorders including an elevated risk for later development of mood disorders, other anxiety disorders, substance use as well as physical health concerns (Kessler et al., 2005). In addition, anxiety disorders can result in much psychosocial suffering including higher rates of dropping out of school, lower income levels, difficulties in intimate relationships and difficulty keeping one’s employment (Beidel & Turner, 1998; LeFauve et al., 2004; Lewinsohn & Clarke, 1999; Pine, Cohen, Gurley, Brook, & Ma, 1998; Schatzberg, Samson, & Rothchild, 1998; Woodward & Fergusson, 2001). In addition to the impairment and suffering experienced by children and adolescents, there is a significant cost associated with anxiety disorders. It is estimated that the United States spends more than $42 billion a year on anxiety disorders (Greenberg et al, 1999). In a 2009 Status Report, the Canadian Pediatric Society indicated that mental health problems continue to grow among children and youth and are predicted to increase by 50% by the year 2020 (Children’s Mental Health Ontario Pre-Budget Submission 2010). However, three out of four children who need specialized services do not receive them as access to mental health services continues to be insufficient and in some cases declining (Children’s Mental Health Ontario Pre-Budget Submission, 2010). In clinics, waiting lists are long and no-show and attrition rates sometimes are over 50% (Weist et al,1999). Many children who do receive clinical intervention fail to respond (Barrett, Dadds, & Rapee, 1996; Donovan & Spence, 2000; Weisz et al., 1997) or experience recurrence of symptoms despite receiving treatment (Last et al., 1996). Yet, treating mental health issues in children and youth in a timely way prevent excessive health care costs and ensure productive lives (Children’s Mental Health Ontario Pre-Budget Submission, 2010).
Anxiety disorders are diagnosed in children and adolescents if they begin to interfere in normal daily functioning in three domains i.e. home, school and with peers. Anxiety disorders are listed under the following headings: generalized anxiety disorder, separation anxiety disorder, social anxiety disorder, specific phobia, panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder (DSM-IV, 2000). There are no definitive biological or psychological tests for anxiety disorders and diagnoses are made clinically based on information from multiple sources i.e. teachers, parents or other caregivers in other settings. Anxiety disorders in children often first manifest as physiological symptoms and are misinterpreted as physical illness. Stomach aches are a common physical manifestation of anxiety in younger children. Some young children may manifest temper tantrums when in fact they are having panic attacks. In adolescents headaches mixed in with nausea and stomach aches are more common. These physical symptoms often result in avoidance behavior which often manifests as school refusal. Behaviors resulting from anxiety such as school refusal and temper tantrums are viewed as oppositionality. Due to the avoidance as the end result of anxiety disorders, they are often unrecognized and hence untreated in children. Moreover, these children are usually perfectionistic and want to please so they further go unnoticed especially in a classroom setting. On the other hand, children with disruptive behavior disorders are noticed more and thus are more frequently referred for treatment (Compton et al, 2004, In-Albon & Schneider, 2007).

Currently, the most effective treatment available for anxiety disorders are cognitive-behavioral therapy (CBT) and antidepressant medications specifically the serotonin reuptake inhibitors (SSRIs). Both treatments alone are empirically supported options. For mild to moderate symptoms, usually CBT is offered first. For moderate to severe symptoms, a combination of CBT and SSRI is often helpful. Families, in general, prefer non-medical or psychosocial interventions at initial evaluation (Walker et al, 2001). However, often CBT therapists are in short supply (Andrews et al, 2002).

2. Prevention

Due to these concerns, it seems logical to move toward services that provide prevention of anxiety disorders. The benefits of prevention are that a large number of people can be targeted over a short period of time, it is more cost effective and there is reduced distress for children due to earlier intervention (Lowry-Webster, 2001). Preventive mental health programs serve two purposes. From a health care perspective, they address and identify risk and protective factors in individuals, providing for better long-term prognoses. In addition, these programs accrue economic benefits because prevention is often less expensive than the economic and societal costs once an illness has manifested (Beardslee et al, 2011). For implementation of prevention programs, it is important to consider the risk factors, protective factors and strategies for prevention. There is a complex interplay of biological, psychological and environmental factors in the development of childhood anxiety disorders (Donovan et al, 2000). In the development of childhood anxiety the following risk factors have been implicated.

3. Risks and protective factors in childhood anxiety disorders

Puberty results in maturational changes not only physically but also emotionally. Puberty may increase risk factors for many psychiatric disorders including anxiety disorders.
According to Leen-Feldner et al, adolescents with advanced pubertal status and greater reactivity to a hyperventilation challenge were at increased risk for panic symptoms (Leen-Feldner et al, 2007).

Fear conditioning is known to be linked to the genesis of anxiety. In a study by Otto et al, 2007, risk factors for fear conditioning were examined in a nonclinical sample. Those in the sample that had higher levels of anxiety sensitivity (increased anxiety symptoms) predicted increased tendency towards fear conditioning (Otto et al, 2007).

The quality of attachment between an infant and the primary caregiver is an important indicator of future development of anxiety disorders (Erickson et al, 1985; Lewis et al, 1984; Sroufe et al, 1990). In a study by Warren et al, 1997, the role of attachment style on the later development of anxiety disorders was studied in 172 children at 12 months and then later at 17.5 years of age. At 12 months a pattern of anxious resistant attachment predicted later anxiety disorders, even after controlling for infant temperament and maternal anxiety.

Parental anxiety is a risk factor for childhood anxiety disorders both through the mechanism of heritability and parent’s modeling of anxious behaviors (Rosenbaum et al., 1988; Turner et al, 1987; Weissman et al, 1984). It is estimated that heritability accounts for about 40-50% of anxiety symptoms in children (Thapar et al, 1995).


Other risk factors for childhood anxiety disorders are traumatic and stressful life events following which children have higher levels of fears. Higher rates of anxiety disorders are present in children following major natural disasters (Dollinger et al, 1984). Moreover, parenting behaviors have been identified to interact with other risk factors in the development of childhood anxiety. Parents of anxious children often model, prompt, and reinforce anxious behavior in their children (Barrett et al, 1996). Other parental characteristics that contribute to risk factors for childhood anxiety are being overly controlling, critical and, overprotective (Krohne et al, 1991).

Protective factors either promote positive development or protect against risk factors. A person’s temperament, cognitive ability and social competence can all serve as protective factors against developing anxiety disorders (Farrell et al, 2007). Other protective factors include parental monitoring of child’s behaviors (Jessor et al., 1995), peers and adults in a child’s life who are good role models (Hawkins et al, 1992) and acceptance and support by peers (Jessor et al, 1991; Quinton et al., 1993). In addition, a positive connection with the school with parental monitoring in both school and home setting and parents’ having a positive relationship with the school (Greenberg et al, 2001) all contribute towards protection from risks of anxiety disorders. Lastly, the type of responses children use to cope with stressful experiences influence how much anxiety and distress they experience (Spence et al, 2001).

4. Prevention strategies

In the past few years school personnel have become interested in programming to address the social and emotional needs of children due to the resultant deleterious effects of difficulties in these areas on their academic and social functioning. In this regard, there has
Prevention and treatment exist on a spectrum and both are required to reduce the distress and impairment associated with anxiety disorders in children. Historically, however, most public investments have been made in treatment services (Waddell et al, 2004) whereas prevention efforts are often neglected. In the future, the availability of a balance between both prevention and treatment services would be ideal. Both risk and protective factors should be targeted by prevention programs to be more effective.

8. References


Prevention of Childhood Anxiety Disorders


Anxiety disorders are one of the most common psychiatric disorders worldwide and many aspects of anxiety can be observed. Anxious patients often consult primary care physicians for their treatment, but in most cases they do not accept the diagnosis of anxiety disorder. Anxiety is a symptom that could be seen in many organic disorders and can accompany almost any psychiatric disorder. Anxiety disorders are frequent and are associated with significant distress and dysfunction. Stigmatization is an important factor in insufficient diagnosis. The problems of anxiety cover all fields of life. This book intends to describe the epidemiological aspects and the main co-morbidities and consecutive diseases of the anxiety disorders.

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