

Anxiety Disorders of Children and Adolescents

Anxiety disorders are common in children and adolescents and can impact many aspects of healthy functioning and development. Anxiety disorders in children also impact parents and family.

Key points in this chapter:

- The prevalence and course of anxiety disorders.
- The different anxiety disorders and the criteria for their diagnosis.
- The impact these disorders can have on the child and the family.
- The role of primary care providers.

COMMON ANXIETY DISORDERS OF CHILDHOOD AND ADOLESCENCE

Anxiety disorders are the most frequent disorders of childhood, and likely of adulthood as well (Kessler, Chiu, Demler, & Walters, 2005). Lifetime and point prevalence estimates of their occurrence range quite widely, with the lowest estimates indicating a rate of around 3% for at least one anxiety disorder at any given time and the highest estimates indicating that upward of 30% (Costello, Egger, & Angold; Merikangas et al., 2010) of people will suffer from an anxiety disorder at some point in their lives. The differences in estimates reported likely stem from the

different populations studied, the different tools used for screening and assessment, the variability in criteria and procedures for establishing diagnoses (for instance, *child only* versus *child or parent* report), the quality of sampling in different studies, and other methodological variables. In any event, there can be little doubt that anxiety disorders are common among children.

Suffering from anxiety can have a devastating and widespread impact on a child and on the family. Anxiety disorders tend to be chronic (Keller et al., 1992), rarely “just going away” on their own with spontaneous remission in only a minority of cases. But the impact of the anxiety extends beyond the specific criteria used for establishing a diagnosis (Angold et al., 1998). Physical and mental health, social functioning, academic achievement, family relationships, and overall quality of life can all be negatively affected by anxiety (Woodward & Fergusson, 2001).

The current version of the *Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-IV-TR)* (American Psychiatric Association, 2000) recognizes the existence of a number of discrete patterns of anxiety-related symptoms and this is to be the case in the upcoming *DSM-V* as well, despite some changes (e.g., excluding obsessive-compulsive disorder from the anxiety disorders group). In this book, however, we have chosen to discuss the anxiety disorders as a group, including OCD, for a number of reasons.

First, the categorization of anxiety disorders into separate entities relies primarily on identifying different stimuli or situations that provoke the anxiety and classifying the disorder accordingly. For example, those who respond with anxiety to social situations are likely to meet criteria for social phobia whereas children who have a fear of separation from their parents would better be described as having separation anxiety disorder. Although such a classification serves a number of important purposes, such as comparing the prevalence or treatment responsiveness of particular patterns of fear, it also creates a certain illusion—the idea that the problem is actually closely tied to the particular stimulus the individual fears. In this book we take the approach that anxiety disorders are more closely connected to how a child manages fear and the experience of anxiety than it is to the specific things that trigger the anxiety.

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Additionally, the high rates of comorbidity between anxiety disorders support the idea that an underlying difficulty in regulating anxiety is a helpful way of conceptualizing the problem. Clinical experience, epidemiological studies, and the multitude of clinical samples reported on in papers about anxiety point to the conclusion that having one anxiety disorder is a powerful predictor of actually meeting criteria for at least one more (Rapee, Schniering, & Hudson, 2009). Both longitudinal and retrospective studies show that although anxiety tends to be chronic within disorders, having one anxiety disorder today also predicts having another different one in the future (Bittner, 2007). Although the theoretical implications of the high rates of comorbidity are equivocal (see Curry, March, & Hervey, 2004), they support considering all the sub-categories of anxiety as a group.

Another reason for treating anxiety disorders as a group rather than as separate entities is the similarity in proven effective treatments. Using the statistical methodology of analysis of variance as a metaphor, one might say that the within group differences in treating anxiety are rather more pronounced than between group differences. In other words, treating a child or adolescent with anxiety is similar across disorders, although it may vary significantly between specific children. Two children suffering from social phobia might be no more similar in the course of therapy than a child with social phobia and one with a specific phobia, although some details of the treatment will naturally vary.

Finally, much of the work with anxious children requires addressing the whole family's needs and roles. Parents of anxious children are faced with similar dilemmas, challenges, and questions although their children may experience the fear in different situations (Lebowitz, Woolston, et al., 2012). The questions that are raised by parents, such as "Should I give in or demand that he does it?"; "When is accommodation a good thing and when is it a problem?"; or "Is this a serious problem or simply attention-seeking behavior?" cut across the spectrum of anxiety disorders, ignoring nosological categories.

The following section describes the different anxiety disorders diagnosable under *DSM-IV-TR* and the way they affect the child and family. Later chapters focus on individual and family models and treatment strategies that can be applied across the range of disorders. Though there are many specific manuals for various disorders, and new ones are

likely to appear, here we draw from the best-known techniques to date to help clinicians, parents, and children facing any of these disorders.

Separation Anxiety Disorder

This is the only anxiety disorder still classified in *DSM-IV* as a disorder of childhood, indicating the acknowledgment that anxiety is generally quite similar in its manifestations at different ages, although specific criteria can vary for diagnosing children in other disorders as well. Indeed, in the upcoming *DSM-V*, separation anxiety disorder is to be moved from the section on disorders of childhood and placed with all other anxiety disorders.

Separation anxiety is characterized by a child's fear of separation from the home or caretakers. Children with separation anxiety usually worry about bad things that could happen to them or to their parents during times of separation. For example, children might fear being kidnapped or getting hurt when a parent is not there to help them. Children who worry about things that could happen to their parents might imagine them getting into a car accident or some such disaster. For some children the fear will be that the parents might simply disappear and never return, and they might spend time fantasizing about being reunited with their parents, even during minor separations.

Children with separation anxiety will often object to or try to avoid even small periods of separation, and some might strive to maintain direct contact with parents whenever possible. Many children with separation anxiety will even follow their parents from room to room around the house. A special focus for many children with separation anxiety is bedtime, when they may feel afraid of being left alone in their room and prefer to sleep next to a parent, either in their own bed or in the parents'. Some children will report having nightmares in which they are separated from their parents. Another night-related separation fear is that of being awake after parents are asleep. Many children try to avoid this either by going to bed first or by demanding that their parents stay up until they are asleep.

Many children will exhibit manifest anxiety by begging not to be left alone, clinging to a parent's legs or even trying to block the door of the house when parents want to leave. Some might repeatedly try to make

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contact with the parents during times of separation, for example, by phoning them endlessly through the day. A major concern for some children with separation anxiety is the separation caused by the need to go to school and school avoidance is a common outcome of the fear. Others may go to school but find it hard to focus on classwork because of their persistent worrying.

Not surprisingly, separation anxiety is most common in younger children and tends to decrease in prevalence as children enter and pass through adolescence, although separation anxiety in young adults is also encountered. When a child with separation anxiety is absent from school for extended periods of time, the likelihood that they will continue to suffer from the disorder in adulthood increases. Early onset is specified in the diagnosis if the disorder appears before age 6, but the natural tendency of young children to proximity with their parents must be taken into account.

Separation anxiety has the clear potential to disrupt both the child's individual functioning; for example, by limiting school attendance and performance or by curtailing social activities (e.g., avoiding sleepovers or visits to peers), as well as family functioning. Siblings may find themselves accommodating the child's anxiety; for example, by spending less time with parents because of their need to be with the anxious child. Parents often adapt to the child's anxiety by limiting their own departures from the home, returning earlier than they otherwise would from work, or sleeping alongside the child.

Panic Disorder and Agoraphobia

Panic attacks are brief periods of time during which a child, despite the absence of immediate danger, experiences intense anxious arousal. The panic attack can be primarily physiological in nature, including symptoms such as sweating, racing heart, shortness of breath, trembling, chest pain, or feelings of choking. In other cases the panic attacks have a more cognitive focus, including terrifying thoughts about losing control or going crazy, fear of dying, or feeling like reality has "shifted" (derealization), or that they have become detached from themselves (depersonalization). For many children the attack includes both cognitive and physiological symptoms.

Panic disorder is characterized by the presence of repeated panic attacks and a persistent worry about the possibility of having more such attacks in the future. Although the attacks themselves are brief, typically peaking within 10 or 15 minutes and even though some children experience only few actual attacks, they can be severely impaired by the fear of the experience being repeated. In addition, many children suffering from panic disorder report having frequent physical signs of anxiety that do not reach the level of a panic attack but cause discomfort or make them worry that an attack is imminent. This may be due to a tendency to constantly monitor their own inner physiological state (Schmidt, Lerew, & Trakowski, 1997), leading them to focus on transient normal changes that would otherwise not receive any attention.

Another theory proposes that the symptoms of panic are caused by an unnecessary triggering of the body system usually active during potential suffocation, as happens during overexposure to carbon dioxide (Klein, 1993). Children who have panic disorder may also interpret normal physical discomfort such as a headache or stomachache as the sign of something catastrophic, such as a life-threatening illness. This kind of monitoring and misinterpretation can lead to a vicious cycle in which focusing on their body causes them to recognize any changes, which in turn heightens anxiety. This can lead to a panic attack and causes even more inner focus and monitoring. Children may ask their parents to check their pulse, listen to their hearts, or provide reassurance that they are well. A related fear in children exists when a child is very afraid of vomiting and begins to focus on internal gastrointestinal signs, searching for clues of impending need to vomit (although this would be diagnosed as a specific phobia rather than panic disorder).

In many cases panic disorder will be associated with *agoraphobia*, which describes the fear or avoidance of situations in which they think they may experience symptoms of panic. A child who has had a panic attack in school, for example, may be afraid to go to school because of a fear of having another panic attack while there. In severe cases the avoidance will be generalized to any place outside of the home and the child may refuse to go out at all or need to be accompanied by a parent who can “rescue” them should an attack begin. This pattern increases the potential of even few and brief panic attacks to severely impair a child’s well-being and development for lengthy periods of time.

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Panic disorder and agoraphobia are more common in adolescents than in children and only a relatively small number of cases are reported in younger children. The diagnosis, however, relies on the existence of at least two episodes that meet criteria for a full-blown panic attack, including at least 4 of the 13 possible symptoms listed by the *DSM-IV-TR*. Episodes including less than four such symptoms (dubbed *limited-symptom attacks*) may be significantly more common in the younger population.

The effect of panic disorder and agoraphobia on the family's and parents' functioning is caused by the need to provide reassurance to a child or even to arrange for repeated medical examinations. These may serve to alleviate parental worry about the child's health but can also be triggered by the child's need of professional medical confirmation that he or she is not at risk. The dramatic manifestation of anxiety, accompanied by terrible thoughts and extreme physical agitation, can cause parents to panic and be overwhelmed by their own fear for the child's health. Parents are often much at a loss regarding how to respond to a child during an attack. The child, seeing how upset and worried the parents are, may take this as confirmation that something is indeed terribly wrong. Agoraphobia can impact the family by limiting the child's ability to function independently, requiring parental accompaniment to locations and activities that would otherwise be done without them.

Specific Phobia

Specific phobias are fears of particular things or situations that cause a child to avoid contact with the feared stimulus or to be distressed when contact must be endured. There is no real limit on the objects that can become the focus of a child's phobia but some common groups of phobias include fear of animals such as snakes, bugs, dogs, or bats; fear of natural phenomena including heights, darkness, storms, and water; fear of blood, injections, and medical procedures; and fears relating to particular situations such as riding in a car, plane, or elevator or of being in closed places. Other common fears in childhood include the fears of clowns, loud noises, or the things that make them such as balloons and the fear of throwing up. Some children will explain their fear as relating

to a thought of harm that might come to them through exposure to the phobic object. For example, children might think they would be bitten if they were to approach a dog. Other children will have a fear of their own reaction to the stimulus. For example, the level of horror and revulsion that many children experience when confronted by a spider can be enough to cause the phobia even if they do not believe the spider is dangerous.

Although adults must recognize that their fear is irrational and extreme in order for the diagnosis to be conferred, this requirement does not exist for children. Many children, however, do display this kind of insight and acknowledge that the degree of fear or avoidance is not warranted by the realistic risk. Having insight can facilitate treatment of the phobia as children are more likely to engage in a process meant to reduce the fear if they realize it is not actually protecting them from harm.

Children with phobias will try to avoid any exposure to the feared stimulus. Often they will generalize the fear and avoidance to a wide array of situations, beyond direct contact with the object of their fear. For example, a child with a fear of dogs may be afraid to walk down entire streets because of a fear of seeing a dog or hearing one bark. Or the child might attempt to avoid any contact with pictures, toys, or stories that involve dogs. This pattern of generalization can cause the phobia to have a much wider impact on a child's functioning than might otherwise have been expected. A child with a phobia of sharks might never encounter a shark but be terrified at any contact with water, even in the shower.

Phobias are common across all ages and tend to appear relatively early in childhood (Kessler, Berglund, et al., 2005). However, often the phobias are diagnosed as a comorbid condition while another anxiety disorder was the actual trigger for treatment. This is likely because, unless the phobia is having a particularly detrimental effect on a child's life, many parents assume that phobias are normal and do not require treatment. However, treating a phobia relatively early on can serve both to minimize its impact and the opportunities for greater generalization of avoidance and to provide the child with a model of overcoming fear—replacing coping strategies for avoidance as the response to anxiety.

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A child's phobia can impact the family in various ways, including by creating avoidance that the entire family adheres to. For example, one child who had a fear of dogs insisted that the family not rent any movie that featured dogs and would vet (excuse the pun) any selection before allowing it to be rented from a video library. A child with a fear of driving or of traveling over bridges might curtail family activities, or one with a fear of loud noises may be unable to tolerate parties being held at home, even for siblings. Some children become so afraid of insects that they object to any windows being opened in the home, creating a potentially stifling environment.

Social Phobia

Social phobia, also known as *social anxiety disorder*, is characterized by marked and persistent fear of social situations in which the child will be subject to potential scrutiny by others. Children may fear acting in an embarrassing or humiliating way or showing overt symptoms of anxiety such as stammering, blushing, or trembling. The thoughts that are triggered by social situations may include the idea of being perceived as anxious, weak, stupid, or "crazy." Physical symptoms are almost always associated with the anxiety-provoking situations and can include racing heart, tremors, sweating, blushing, gastrointestinal discomfort, and muscle tension. As a consequence, the child may avoid social situations like eating or speaking in public. When children must confront these situations, they usually do so with considerable distress. The avoidance of such situations or the distress they cause can interfere significantly with the normal routine of the individual, their occupational or academic functioning, or their social activities and relationships. Because transient periods of shyness or social awkwardness are normal, particularly in adolescence, children are only diagnosed with social phobia if their symptoms have persisted for at least 6 months.

In some cases the social phobia will be limited to particular situations such as attending parties, speaking in class, or talking to girls. In other cases, however, almost any social interaction can be the trigger for intense fear and the avoidance is very broad. In these cases, termed *generalized social phobia*, the disorder has tremendous potential to disrupt normal development. Some children retreat into almost complete

self-isolation, making every effort to avoid all contact with others. This can lead to school avoidance as well as to negative impact on the child's mood and self-esteem. Social phobia, however, does not necessarily indicate a lack of social awareness or of social interest (Brown, Silvia, Myin-Germeys, & Kwapil, 2007; Coplan, Prakash, O'Neil, & Armer, 2004). Many children with even severe social phobia long for friendship or for the ability to interact more confidently with others, even while they may make every effort to avoid doing so.

Social phobia is commonly diagnosed in mid- to late adolescence but often had its onset in much earlier childhood. Younger children who are described as shy or behaviorally inhibited may be later diagnosed with social phobia. In other cases particular incidents or situations might precipitate the onset of social phobia in a person without a pronounced history of shyness. For example, a teenager who is teased because of acne might develop social phobia and be embarrassed to be seen by others. In some children social anxiety might cause them to be ashamed of the need for glasses or braces, leading them to either avoid being seen or to refuse to wear the corrective apparatus.

A rarer but related disorder most commonly diagnosed in young children is *selective mutism*, which is characterized by the failure to speak in some social situations despite speaking in other ones. Children with selective mutism might speak normally at home but refuse to speak outside of the house, or they might speak with family and other children but not with adults. Although not formally part of the diagnosis, selective mutism is commonly associated with shyness and also accompanied by other manifestations of childish anxiety such as clinging to parents in social situations.

Children with social phobia or selective mutism often make use of parents or siblings as mediators and go-betweens for interacting with the social world. Socially shy children might refuse to talk on the telephone and demand that someone else at home speak for them, or they may be too embarrassed to speak with a stranger and have someone else function as their representative. In older children and adolescents particularly, this pattern can cause them to appear more impaired and can limit many age-appropriate functions. In some cases a child with social anxiety will also attempt to limit the entrance of guests or strangers into the home, imposing limitations on parents and siblings.

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Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is characterized by recurring thoughts, images, or impulses that are intrusive and distressing (obsessions) or by the need to perform repetitive behaviors or adhere to strict behavioral rules (compulsions). Most children with OCD report having both obsessions and compulsions but some will not be able to identify specific thoughts or behaviors. The variety of potential obsessional content or compulsive behaviors is unlimited, but some common obsessions include thoughts about contamination, doubts over whether actions were performed, thoughts relating to distressing aggressive or sexual content, and thoughts about negative things that could happen to the self or to loved ones. Worry about parents dying is a common obsession in children. A particular kind of contamination obsession sometimes seen in children is the fear of being contaminated by another person's personality or by specific traits associated with that person and perceived as undesirable.

Typical compulsions include the need to repeatedly wash hands, the need to perform actions a set number of times, behaviors aimed at producing order or symmetry (in actual objects such as by lining things up on a shelf or in the inner experience such as by touching with the left hand something that was touched with the right hand), and repeatedly checking things (e.g., checking that the water was turned off). The compulsions are usually performed to alleviate distress caused by the obsessions. Although adults must have recognized at some point that the obsessions or compulsions are not reasonable, this kind of insight is not a requirement in children. Insight is associated with age so that younger children often do not display insight whereas adolescents generally do.

Although in many cases the compulsion logically or directly relates to the content of an obsession, for example, when children wash their hands because of an obsession about dirt or germs, this is not always the case. Other children might engage in the same hand-washing behavior because of the thought that if they did not, their parents would suffer a car accident. In many cases the child will attempt to avoid situations that are likely to trigger obsessions or the need to perform compulsions. For example, children with a recurring image of cutting themselves might try to avoid any contact with knives or sharp objects, and others with a fear

of contamination might go to great lengths to avoid contact with potential contaminators. In other cases the child will avoid starting a behavior that is likely to become prolonged because of ritualization, for instance, avoiding showering because it is hard to get out of the shower, or avoiding reading because of the need to repeatedly read the same sentence again and again. This avoidant tendency can greatly exacerbate the negative impact of the disorder on daily life.

The onset of the disorder can occur early in childhood, although a later onset is more common. Symptoms usually appear gradually and gain in severity and frequency over time but sometimes severe symptoms can appear suddenly. This may be triggered by particularly anxiety-provoking incidents, such as exposure to distressing content that the child remains mentally focused on. One possible cause of the sudden appearance of OCD symptoms is the syndrome known as PANS (previously PANDAS; (Swedo et al., 1998)) or Pediatric Acute-onset Neuropsychiatric Syndrome (Swedo, Leckman, & Rose, 2012). This is the sudden appearance of obsessive-compulsive symptoms triggered by antibodies produced in response to infections with Group A beta-hemolytic streptococci. However, the sudden appearance of OCD symptoms, even when preceded by strep infection, are not sufficient to establish a diagnosis of PANS, and ancillary symptoms such as changes in motor functioning, mood, and personality or the appearance of separation anxiety and enuresis need to be considered.

OCD has the potential to greatly disrupt the life and development of both the child and the family. The avoidance of potential triggers described earlier, the amounts of time spent on compulsions, the cognitive resources usurped by the disorder, and the distress of feeling out of control with regard to one's own mind can wreak havoc on a child's life, affecting school performance, academic achievement, mood, and general well-being. Many children fear that they are crazy or are deeply ashamed or guilt-ridden because of the content of their intrusive thoughts. Although the disorder is not uncommon, the seeming strangeness of thinking unwanted thoughts or behaving in irrational ways leads most children to be reluctant to discuss the problem with others, sometimes including parents. This can serve to delay the time to treatment as well as to increase a child's loneliness or discouragement.

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Parents of children with OCD almost invariably report engaging in accommodating behaviors (see more detail on this in Chapter 3 on family accommodation). Accommodation can include providing reassurance, participating in rituals, providing items needed for compulsions (such as extra soap), modifying schedules, and shaping the family routine in such a way as to minimize the affected child's distress (Lebowitz, Panza, Su, & Bloch, 2012; Storch et al., 2007). For example, parents of a child with contamination fears might engage in ritualized washing of their own hands before handling the child's food. Siblings also report accommodating to the child's anxiety. In one case a brother would regularly lift his older sister in and out of the car because of the fear she had of stepping on the ground in the driveway. This kind of accommodation can cause great distress to the parents or siblings and has been shown to be associated with poorer treatment response as well, with more severe symptoms and greater impairment in the child with OCD.

Generalized Anxiety Disorder

Generalized anxiety disorder (GAD) describes persistent worry, which is difficult to control and is accompanied by tension, restlessness, fatigue, difficulty concentrating, irritability, or sleep disturbance. Although the focus of the worry can vary and may shift or change over time, many children with GAD worry most about their own performance in various domains such as school work or athletic achievement. Other worries that many children report relate to the health of loved ones, being late or making mistakes, or to the family's future, as in worrying about parents getting divorced or about their financial status. Many children with GAD are described by themselves or others as perfectionistic.

Children with GAD typically have somatic symptoms such as complaining about aches or pains, stomach unrest or nausea, or being overly tired. Another feature of GAD is its close association with mood disorders such as depression. In older children generalized anxiety creates a risk for substance abuse, likely as a means of self-medicating the cognitive or physiological symptoms of the chronic stress. The loss of sleep typical of children with GAD can increase the impact of the

disorder on both mood and school functioning, making concentration much more difficult. In children whose anxiety focuses on performance or achievement this can create a vicious cycle where the anxiety impairs the ability to perform optimally, which heightens the anxiety about performance. Some children report lying in bed worrying about the sleep they are losing and how it will affect their performance in school the next day, getting more and more worried and accordingly less able to fall asleep.

Parents can become involved in the need to provide reassurance to a child's constant worry, at times needing to respond to many phone calls throughout the day or to answer endless questions prompted by the anxiety. Some children have their parents check and recheck homework assignments with them because of a fear of making a mistake or submitting less than perfect work.

THE GOOD NEWS AND THE BAD NEWS

As discussed earlier in this chapter the various anxiety disorders, despite the differences between them, seem to have more in common with each other than they do distinguishing them. These shared characteristics include two important pieces of information, which we sometimes call the *good news* and the *bad news* of anxiety disorders. The bad news about anxiety is that in most cases, once a disorder has taken hold—in other words is more than a passing worry or a developmentally appropriate fear—the likelihood that the disorder will spontaneously remit is not high. This pattern is due in part to the nature of avoidance, which we discuss more fully in Chapter 5. As children become accustomed to avoiding a given situation, because of anxiety, they experience fewer opportunities to learn that the stimulus is not actually dangerous. In fact, in many cases, if left untreated anxiety disorders will get progressively more severe and lead to more impairment to child and family functioning.

The good news about anxiety disorders, however, is that in the multitude of studies that have been conducted, examining the efficacy of treatment for anxiety disorders, most children have improved dramatically after treatment. Cognitive behavioral therapy (CBT), which is discussed in this book, as well as medication, have been found to be effective ways of treating childhood anxiety. Both of these are now

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widely considered to be well-supported, evidence-based treatments, which work in most cases.

So what is the conclusion to be drawn from considering both the good and the bad news about anxiety? If left untreated the situation is likely not to improve or even to get worse, but treatment can effectively cure or minimize anxiety disorders, so the obvious conclusion is that treatment is well advised. Unfortunately, due to limitations in access to treatment, dissemination of best practices, and delays in correctly identifying the problem, most children will wait a long time before treatment is attempted.

The Role of Primary Care

One important gateway to treatment that needs to be better utilized is identification and referral by primary care providers. Efforts at various levels, from training of new primary care providers to creating more awareness and influencing policy, are being made to address this need. As Lisa Honigfeld, of the Connecticut-Based Child Health and Development Institute points out, pediatricians, family physicians, nurse practitioners, and other primary care medical providers can play a key role in addressing anxiety. These medical professionals care for children over time, within the context of their families and community environments. Approximately 90% of children and youth visit a primary care provider each year (National Survey of Children's Health, 2007). Such visits are required for school entry and camp and sports participation. These visits, along with sick care visits, present valuable opportunities to identify children who have mental health concerns, a role recognized and endorsed by the American Academy of Pediatrics (Committee on Psychosocial Aspects of Child and Family Health, 2009).

Through open communication and dialogue among parents, primary care providers, and mental health professionals, children at risk for—or already suffering from anxiety disorders—can be identified and offered access to treatment resources. One crucial element is that of screening. When providers of primary care take an active role in screening their patients for symptoms of clinically significant anxiety, the problem can be addressed before some of the more insidious effects of anxiety have taken hold.

Screening can be done at multiple levels, such as inquiring about family history of mental conditions, discussing concerns with parents, asking about anxious or avoidant behavior, and having parents or children (of appropriate age) complete standardized screening tools. Many insurers, including both state and commercial insurance companies, will actually compensate primary care providers for every screening done during a child's well visit. For children over the age of 4, pediatricians can use the Pediatric Symptom Checklist to identify children who may have mental health concerns (Jellinek et al., 1999). Other tools such as the Spence Children's Anxiety Scale are specifically aimed at identifying anxiety-related problems (Spence, Barrett, & Turner, 2003).

Another role in which primary care providers are instrumental is in identifying somatic complaints such as stomachache, disordered sleep, loss of appetite, or headache, which are manifestations of an anxiety disorder. As we discuss more fully in Chapter 6, anxiety has both acute and chronic effects on physiological functioning. In children in particular, who may have difficulty verbalizing their anxiety, somatic complaints are a common way of displaying anxiety. In Chapter 14 we discuss the role that anxiety and its somatic component can play in school avoidance and absenteeism.

Although child health-care providers rarely provide psychotherapeutic interventions per se, they can create critical linkages to community services and can ensure that patients follow through on recommendations for evaluation and counseling. Once children are under the care of mental health professionals for treatment of anxiety, the children's health provider's role is to provide ongoing monitoring of the children's progress toward treatment goals and overall health. This requires regular communication to and from the mental health provider and periodic administration of screening tools and assessment tools.

In the next two chapters we discuss two important facets of childhood anxiety disorders in greater detail. First we look at the relevance of emotion regulation for the development and treatment of anxiety and then at the role of family accommodation in these disorders. The following sections of this book focus on treatment of childhood anxiety at the individual and family level. The final section of the book tackles some specific aspects of anxiety such as school phobia and anxiety in adult children and the dependence it can cause.

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