Emotional disorders with onset specific to childhood

Emotional disorders with onset specific to childhood - F93 (Clinical term: Emotional disorders with onset specific to childhood Eu93)

Introduction

Children may experience a number of different emotional disorders. This guideline concerns anxiety disorders and symptoms that are specific to childhood, and is intended for use with children aged 10 years and younger. For anxious adolescents and adult-type emotional disorders that may also be seen in childhood (including obsessive-compulsive disorder and post-traumatic stress disorder), see adult guidelines: Obsessive compulsive disorder, and Post-traumatic stress disorder).

Presenting complaints

Anxiety symptoms in childhood can take a number of forms. Most children experiencing anxiety difficulties will demonstrate behavioural, cognitive or somatic features.

Behavioural features

- Avoidance of feared activities, eg reluctance to go to school or to go swimming; feared objects, eg animals.
- Clinginess or reluctance to separate from trusted adults. This can include refusal to sleep alone.
- Withdrawal. This can take the form of shyness in the presence of strangers or large groups of people. In some cases, a more general withdrawal from people and situations is seen, and in severe cases, children may become mute
- Tantrums/tearfulness/other outward displays of distress, when asked to engage in a feared activity or to separate from a parent
- General irritability.

Cognitive features

Many children, especially those of school age, will be able to report cognitive symptoms of anxiety. In particular, they (or more often their parents) report that they worry about feared catastrophes. These worries are often unrealistic, but the child may not recognize this.

Somatic features.

Many anxious children report a range of somatic symptoms, including:

- palpitations
- stomach aches, headaches, other aches and pains with no obvious organic cause
- breathlessness
- difficultly getting to sleep
- nausea

- feeling wobbly or 'jelly legs'
- 'butterflies'.

Some may present their anxiety in an entirely physical form, although with further sensitive questioning, evidence of behavioural and cognitive symptoms of anxiety is usually also present.

Differential diagnosis and co-existing conditions

- Depressive disorder - F32# often co-exists with anxiety and can be very difficult to distinguish in this age group. Marked sleep disturbance, disturbed appetite, dysphoric mood, or tearfulness in the absence of direct anxiety provocation could indicate that a child is depressed.
- Obsessive-compulsive disorder (OCD) - F42 (adult), indicated by the presence of marked rituals or compulsive behaviours. Most children have phases of ritualized behaviour, which can usually be distinguished from OCD by the degree of distress caused if a ritual is interrupted, and the number of rituals present at any one stage.
- Post-traumatic stress disorder - F43.1 (adult) if the onset of anxiety was preceded by an extremely distressing experience.
- Maltreatment - children who have experienced physical, emotional or sexual abuse are at high risk of developing emotional difficulties; this possibility should always be borne in mind. Concern should be raised when anxiety onset occurs over a short period subsequent to relatively normal development and when no other explanation (eg change of school/family circumstances) is apparent.
- Physical illness - it is important to exclude an organic cause for emotional difficulties, particularly where the child presents with mostly physical symptoms. When physical symptoms occur only in specific situations (eg severe headaches on weekdays, but symptom free at weekends and during school holidays), this is a good indication that they might be anxiety-related. It is then usually safe to conclude that symptoms have a psychological origin.
- Normal behaviour - it is often difficult to diagnose anxiety disorder in young children, because a moderate level of anxiety is normative at certain developmental stages. For example, most toddlers show some anxiety when separated from their primary caregiver; a large minority of pre-school and infant school-aged children will express fears of the dark, animals, monsters/ghosts and the like. These worries should not, on their own, raise too much concern, unless they are causing marked distress for the parent or child, or they interfere with the child's ability to engage in developmentally important activities (eg a child who is unable to sleep in their own bed because they are afraid of the dark).

General management and advice to parents and carers

GPs wishing to manage a case themselves should attempt to determine the factors that might be maintaining or causing the anxiety. Multiple factors should be investigated:

- Is an external problem causing the child to be anxious, for example bullying at school or academic difficulties? This should be addressed in the first instance.

- Is the parent anxious? Anxious children very often have an anxious parent. It is thought that children can learn to be anxious from their parents. Advise parents to minimize their own displays of fear or worry when the child is present. A referral to adult mental health services might also be appropriate.

- Does the parent allow the child to avoid feared activities?
  - Gently explain that the child needs to learn to cope with their fear, and should not be allowed to avoid feared activities.
  - Expose a child with a severe phobia to their fear in a number of graded steps; do not suddenly force them to cope with their fear unsupported. If the practitioner does not feel confident in helping the family to develop this 'hierarchy', a referral to specialist services should be made.
  - Encourage parents to display a calm and confident appearance when their child is being exposed to their fear. If they appear upset at their child's distress, the child will pick this up and will then become more distressed.

- How are brave behaviours being encouraged in the family? Encourage parents to praise and give small rewards for displaying brave behaviour, for example a shy child might be told 'If you go into the shop and ask the lady for some sweets, then I will give you the money to pay for them', 'If the child does not approach the assistant, do not provide sweets on that occasion. School-age children respond well to star charts. The rules for using star charts for brave behaviour are as follows:
  - Only focus on one or two behaviours at a time
  - Have one star chart per behaviour
  - Negotiate rules for the star chart, for example 'sleeping in own bed for one night = one star; four stars = trip to the swimming pool'
  - Ignore mistakes and failures – do not ever mark them on the star chart. Simply carry on awarding stars when they are earned.

- Does the parent have good basic parenting skills? Are they consistent and gentle in their use of discipline, or do they shout a lot, or use smacking? Do they use praise and reward to encourage desirable behaviour? There is evidence that many parents of anxious children have impaired parenting skills. If basic advice on these issues is not adequate to change parenting practice (and it is often very difficult for parents to change), attendance at a parenting class may be helpful. Most communities now have access to parenting classes.

- Does the child have a relatively healthy lifestyle? In particular, parents should be encouraged to:
  - monitor their child's caffeine intake
  - make sure that their child eats regularly
  - establish regular daily routines for their child.

The practitioner should do the following:

- Reassure parents that anxiety often passes, and by following the advice given above, there is a strong likelihood of a good outcome.
- Educate parents about their child's anxiety. It is often helpful to explain the fight/flight response and its role in causing distressing physical symptoms. Parents often fail to push their child to expose to their fear, because the physical symptoms that this elicits are so worrying. Strongly emphasize that these symptoms are not harmful to the child.

Medication

Medication is not advised for this age group.

Referral

Referral to specialist mental health services should be considered in the following circumstances:

- When the child has multiple symptoms of anxiety; for example, he/she is very afraid of dogs and distressed by separation from parents.
- When anxiety threatens to interfere with education; for example, the child is very reluctant to go to school, and the parent is not managing to maintain full attendance.
- When symptoms are threatening the achievement of other developmentally important goals; for example, a shy child who is reluctant to mix with other children.
- When the child or parent is very distressed by the symptom(s).
- Where there are co-morbid behaviour problems.
- Where there is felt to be risk of significant harm to the child or other person. Refer to specialist services as an emergency.

Catching anxiety problems early may have long-term benefits. Therefore, where good mental health services are available, the GP should consider referring all cases of anxiety to specialist services, no matter how minor.

Resources for patients and families

Child Anxiety Network (CAN)
http://childhoodanxietynetwork.org
A US-based resource for parents, teachers and health workers regarding childhood anxiety disorders.

Helping your Anxious Child: A Step by Step Guide for Parents by RM Rapee, S Spence, V Cobham and Wignall. New Harbinger Publications, 2000. A self-help book for parents.