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RESEARCH ARTICLE

ANXIETY RELATED EMOTIONAL DISORDERS IN PRIMARY SCHOOL CHILDREN

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ABSTRACT

Children differ from adolescents and adults in their interpretation and ability to express their experience. They simply know that something is going wrong and that they are very afraid. Children can only describe the physical symptoms. They have not yet developed the constructs to put these symptoms together and label them as fear. The objective of present study was to understand the prevalence of anxiety related disorders and gender differences among children. The sample size of present research was 200 children. The sample consists of 100 boys and 100 girls between ages 9-11 years. The Screen for Child Anxiety Related Disorders (SCARED) scale by Birmaher *et al*. (1999) was administered individually on all the participants. Results indicated there is significant difference between boys and girls on different anxiety related disorders.

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INTRODUCTION

Children differ from adolescents and adults in their interpretation and ability to express their experience. Like adults, children experience physical symptoms including accelerated heart rate, sweating, trembling or shaking, shortness of breath, nausea or stomach pain, dizziness or light-headedness. In addition children also experience cognitive symptoms like fear of dying, feelings of being detached from oneself, feelings of losing control or going crazy, but they are unable to vocalize these higher order manifestations of fear. They simply know that something is going wrong and that they are very afraid. Children can only describe the physical symptoms. They have not yet developed the constructs to put these symptoms together and label them as fear. Parents often feel helpless when they watch a child suffer. They can help children give a name to their experience, and empower them to overcome the fear they are experiencing (Beidel and Alfano, 2011). Panic disorder is an anxiety disorder characterized by recurring panic attacks. It may also include significant behavioral changes lasting at least a month and of ongoing worry about the implications or concern about having other attacks. The latter are called *anticipatory attacks* (DSM-IVR). Panic disorder is not the same as agoraphobia (fear of public places), although many afflicted with panic disorder also suffer from agoraphobia. Panic attacks cannot be predicted; therefore an individual may become stressed, anxious or worried wondering when the next panic attack will occur (Phil Barker, 2003). Panic disorder may be differentiated as a medical condition, or chemical imbalance. The DSM-IV-TR describes panic disorder and anxiety differently. Whereas anxiety is preceded by chronic stressors which build to reactions of moderate intensity that can last for days, weeks or months, panic attacks are acute events triggered by a sudden, out-of-the-blue cause: duration is short and symptoms are more intense. Panic attacks can occur in children, as well as adults. Panic in young people may be particularly distressing because children tend to have less insight about what is happening, and parents are also likely to experience distress when attacks occur. The anxiety of Panic Disorder is particularly severe and noticeably episodic compared to that from Generalized Anxiety Disorder. Panic attacks may be provoked by exposure to certain stimuli (e.g., seeing a mouse) or settings (e.g., the dentist's office) (Frisch and Frisch, 2006). Other attacks may appear unprovoked. Some individuals deal with these events on a regular basis, sometimes daily or weekly. The outward symptoms of a panic attack often cause negative social experiences (e.g., embarrassment, social stigma, social isolation, etc.). Psychological factors, stressful life events, life transitions, and environment as well as often thinking in a way that exaggerates relatively normal bodily reactions are also believed to play a role in the onset of panic disorder. Often the first attacks are triggered by physical illnesses, major stress, or

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certain medications. People who tend to take on excessive responsibilities may develop a tendency to suffer panic attacks. A retrospective study has shown that 40% of adult panic disorder patients reported that their disorder began before the age of 20 (Moreau and Follet, 1993). In an article examining the phenomenon of panic disorder in youth, Diler *et al*. (2004) found that only a few past studies have examined the occurrence of juvenile panic disorder. They report that these studies have found that the symptoms of juvenile panic disorder almost replicate those found in adults (e.g. heart palpitations, sweating, trembling, hot flashes, nausea, abdominal distress, and chills) (Alessi, Magen, 1988; Biederman, Faraone, Marrs *et al*., 1997; Essau, Conradt, Petermann, 1999; King, Gullone, Tonge, Ollendick, 1993; Macauly, Kleinknecht, 1989). The anxiety disorders co-exist with staggeringly high numbers of other mental disorders in adults. The same comorbid disorders that are seen in adults are also reported in children with juvenile panic disorder. Last and Strauss (1989) examined a sample of 17 adolescents with panic disorder and found high rates of comorbid anxiety disorders, major depressive disorder, and conduct disorders.

The role of the parent in treatment and intervention for children diagnosed with panic disorder is discussed by McKay and Starch (2011). They point out that there are several levels at which parental involvement should be considered. The first involves the initial assessment. Parents as well as the child should be screened for attitudes and treatment goals, as well as for levels of anxiety or conflict in the home. The second involves the treatment process in which the therapist should meet with the family as a unit as frequently as possible. Ideally all family members should be aware and trained in the process of cognitive behaviour therapy (CBT) in order to encourage the child to rationalize and face fears rather than employ avoidant safety behaviours. McKay and Starch (2011) suggest training/modeling of therapeutic techniques and in session involvement of the parents in the treatment of children to enhance treatment efficacy (Lewin, 2011). Despite the evidence pointing to the existence of early-onset panic disorder, the DSM-IV-TR currently only recognizes six anxiety disorders in children: separation anxiety disorder, generalized anxiety disorder, specific phobia, obsessive-compulsive disorder, social anxiety disorder (social phobia), and post-traumatic stress disorder. Panic disorder is notably excluded from this list. Generalized Anxiety Disorder (GAD) is a neurological anxiety disorder that is characterized by excessive, uncontrollable and often irrational worry. For diagnosis of this disorder, symptoms must last at least six months (Torpy, Janet, Burke, Golub, 2011). This excessive worry often interferes with daily functioning, as individuals suffering GAD typically anticipate disaster, and are overly concerned about everyday matters such as health issues, money, death, family problems, friendship problems, interpersonal relationship problems, or work difficulties. Individuals often exhibit a variety of physical symptoms, including fatigue, fidgeting, headaches, nausea, numbness in hands and feet, muscle tension, muscle aches, difficulty swallowing, bouts of difficulty breathing, difficulty concentrating, trembling, twitching, irritability, agitation, sweating, restlessness, insomnia, hot flashes, and rashes and inability to fully control the anxiety (ICD-10). These symptoms must be consistent and ongoing, persisting at least six months, for a formal diagnosis of GAD to be introduced. Separation Anxiety Disorder (SAD) is a psychological condition in which an individual experiences excessive anxiety regarding separation from home or from people to whom the individual has a strong emotional attachment (e.g. a parent, grandparents, or siblings). According to the American Psychology Association, separation anxiety disorder is the inappropriate and excessive display of fear and distress when faced with situations of separation from the home or from a specific attachment figure. The anxiety that is expressed is categorized as being atypical of the expected developmental level and age (Ehrenreich, Santucci, Weinrer, 2008). The severity of the symptoms ranges from anticipatory uneasiness to full-blown anxiety about separation (Masi, Mucci, Millepiedi, 2001).

In the academic setting

As with other anxiety disorders, children with SAD face more obstacles at school than those without anxiety disorders. Adjustment and relating school functioning have been found to be much more difficult for anxious children (Mychailyszyn *et al*., 2010). In some severe forms of SAD, children may act disruptively in class or may refuse to attend school altogether. It is estimated that nearly 75% of children with SAD exhibit some form of school refusal behavior. Short-term problems resulting from academic refusal include poor academic performance or decline in performance, alienation from peers, and conflict within the family (Ehrenreich, Santucci, Weinrer, 2008). This is a serious problem because, as children fall further behind in coursework, it becomes increasingly difficult for them to return to school (Doobay and Alissa, 2008). Social anxiety disorder (SAD), also known as social phobia, is the most common anxiety disorder (Stein and Stein, 2008).

It is one of the most common psychiatric disorders, with 12% of American adults having experienced it in their lifetime (Kessler *et al*., 2005). It is characterized by intense fear in one or more social situations, causing considerable distress and impaired ability to function in at least some parts of daily life. These fears can be triggered by perceived or actual scrutiny from others. While the fear of social interaction may be recognized by the person as excessive or unreasonable, overcoming it can be quite difficult. Some people suffering from social anxiety disorder fear a wide range of social situations while others may only show anxiety in performance situations. In the latter case, the specifier "performance only" is added to the diagnosis. School refusal is the refusal to attend school due to emotional distress. School refusal differs from truancy in that children with school refusal feel anxiety or fear towards school, whereas truant children generally have no feelings of fear towards school, often feeling angry or bored with it instead. While this was formerly called school phobia, the term *school refusal* was coined to reflect that children have problems attending school for a variety of different reasons and these reasons might not be the expression of a true phobia, such as separation or social anxiety (Wimmer, 2012). The rate is similar within both genders, (American Academy of Family Physicians, 2003) and although it is significantly more prevalent in some urban areas, there are no known socioeconomic differences (Setzer and Salzhauer, 2001).

Objectives

- To assess the symptoms of anxiety related disorders in primary school children.
- To assess the gender related differences between boys and girls on anxiety related disorders.

Hypothesis of the study

1) There will be no difference in children on different anxiety disorders.
2) There will be gender related differences in anxiety related disorders between boys and girls.

Variables

Independent Variable- Gender i.e. boys and girls
Dependent Variable – Different anxiety related disorders.

MATERIALS AND METHODS

Sample

The total 200 subjects were taken. The 100 boys and 100 girls were randomly selected from different schools of Jodhpur. Age range of the subjects is 9-11 years.

Tools

Screen for Child Anxiety Related Disorders (SCARED) Scale by Birmaher *et al*. (1999). It measures five anxiety related emotional disorders i.e. panic disorder or significant somatic symptoms, generalized anxiety disorder, separation anxiety disorder, social anxiety disorder and significant school avoidance.

Statistical Analysis

After scoring each data was analyzed in terms of significant of mean differences using‘t’ test between boys and girls.

RESULTS

Table 1 shows that there are significant gender differences between boys and girls on three anxiety related disorders i.e. panic disorder or significant somatic symptoms, separation anxiety disorder, and significant school avoidance but not significant on generalized anxiety disorder and social anxiety disorder. This shows that boys are less suffers from anxiety related disorder in comparison of girls. Girls are most sufferers because they are confined to home, family orientation and more restrictions, due to this they develop many somatic symptoms which are related to different anxiety disorders. Separation anxiety disorder may cause significant negative effects within a child's everyday life, as well. These effects can be seen in areas of social and emotional functioning, family life, physical health, and within the academic context (Ehrenreich, Santucci, Weinrer, 2008). To examine whether there were gender differences in the number of anxiety symptoms within each of the diagnostic groups, analysis of variance (ANOVA) was conducted. This analysis yielded significant main effects for both group, $F(2,1215)= 485.48$, $p<.001$ and gender, $F(l,1215) =12.19$, $p<.001$, as well as a significant Group X Gender interaction, $F(2,1215)= 19.22$, $p<.001$.Whereas boys and girls in the no-disorder group did not differ with respect to their anxiety symptom scores, $F(l,1215)= 3.04$, $p>.05$, girls had a significantly higher number of anxiety symptoms than boys within both the current cases, $F(1,1215)= 306.16$, $p<.001$, and recovered cases, $F(l,1215)=74.50$, $p<.001$, groups (Peter *et al*., 1998). Table 2 shows that there are significant gender differences between boys and girls on overall anxiety related disorders. High scores revealed that girls exhibit more anxiety disorders in comparison of boys. Table 3 shows the graphical presentation of gender differences of anxiety related disorders in children. It is clearly indicate that girls are more prone to anxiety disorders. Eassau *et al*. (1999) also found a high number of comorbid disorders in a community-based sample of adolescents with panic attacks or juvenile panic disorder. Within the sample, adolescents were found to have the following comorbid disorders: major depressive disorder (80%), dysthymic disorder (40%), generalized anxiety disorder (40%), somatoform disorders (40%), substance abuse (40%), and specific phobia (20%). Consistent with this previous work, Diler *et al*. (2004) found similar results in their study in which 42 youths with juvenile panic disorder were examined. Compared to non-panic anxiety disordered youths, children with panic disorder had higher rates of comorbid major depressive disorder and bipolar disorder. Two broad, but not mutually exclusive, frame works can be offered to explain the observed gender differences in anxiety disorders. The first suggests that the female preponderance in anxiety disorders is due to genetically or biologically determined differences between the sexes. The second assumes that gender differences in anxiety are linked to differences in the experiences and social roles of men and women in this culture. The results revealed that female participants were significantly more likely than male participants, $(N=1,221) =20.99$, $p<.001$, to be diagnosed as a current case (74%) or are covered case (65%); the difference in the gender distribution of the no-disorder control group (48%female) was not significant. Paralleling this gender difference in diagnostic group composition, female adolescents also obtained significantly higher anxiety symptom scores than did male adolescents (M=1.9 and 0.9, respectively), $(1,707) = 6.30$, $p<.001$ (Peter *et al*., 1998).

DISCUSSION

Approximately 1 to 5% of school-aged children have school refusal (Fremont, 2003), though it is most common in 5- and 6-year olds and in 10- and 11-year olds, (American Academy of Family Physicians, 2003) it occurs more frequently during major changes in a child’s life, such as entrance to Kindergarten, changing from elementary to middle school, or changing from middle to high school (Wimmer, 2012). The problem may start following vacations, school holidays, summer vacation, or brief illness, after the child has been home for some time, and usually ends prior to vacations, school holidays, or summer vacation, before the child will be out of school for some time. School refusal can also occur after a stressful event, such as moving to a new house, or the death of a pet or relative (American Academy of Family Physicians, 2003). Anxiety disorders are the most common type of

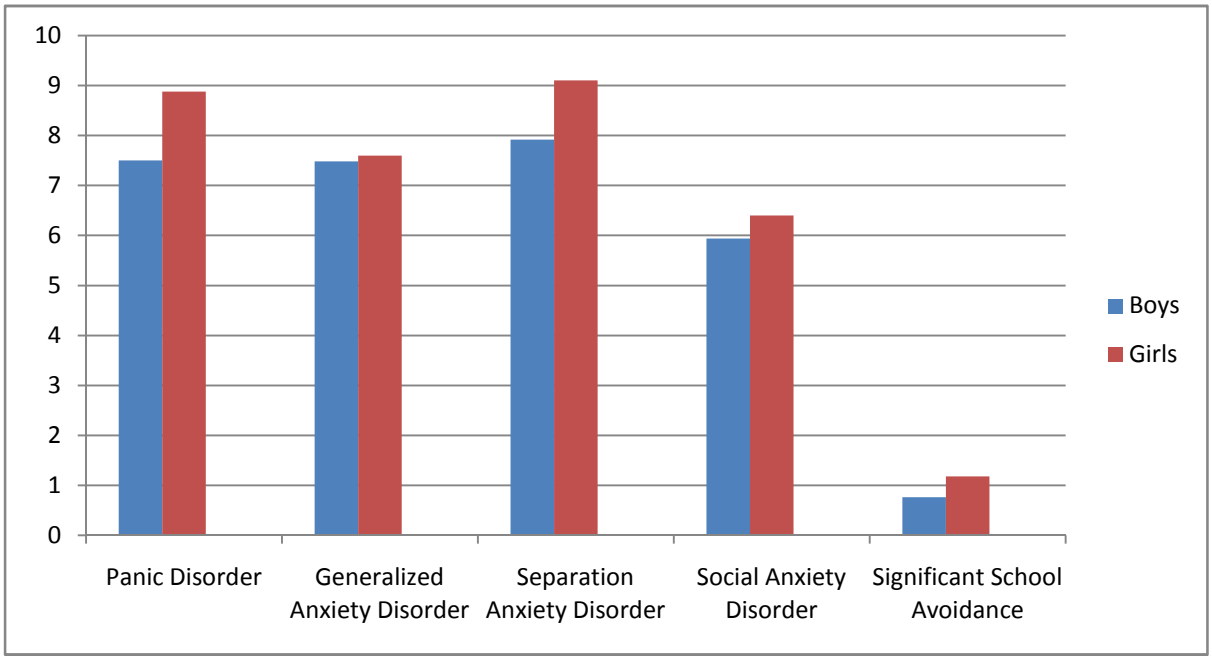
Table 1. Mean, S.D. and 't' value of gender differences i.e. boys and girls on different anxiety related disorders

Factor	Boys			Girls			't'	p
	N	M	SD	N	M	SD		
Panic Disorder	100	7.50	4.64	100	8.88	3.69	2.32*	0.05*
Generalized Anxiety	100	7.48	3.50	100	7.60	2.77	0.26	No Sig.
Separation Anxiety	100	7.92	3.63	100	9.10	3.12	2.46*	0.05*
Social Anxiety	100	5.94	3.20	100	6.40	1.92	1.23	No Sig.
Significant School Avoidance	100	0.76	0.86	100	1.18	1.05	3.07**	0.01**

Table 2. Mean, S.D. and 't' value of gender differences i.e. boys and girls on overall SCARED scale

Gender	N	M	SD	t	p
Boys	100	29.42	12.66	2.38*	0.05*
Girls	100	33.16	9.30		

Table 3. Graphical presentation of boys and girls on different anxiety related disorders



psychopathology to occur in today's youth, affecting from 5–25% of children world-wide. Of these anxiety disorders, SAD accounts for a large proportion of diagnoses. SAD may account for up to 50% of the anxiety disorders as recorded in referrals for mental health treatment (Ehrenreich, Santucci, Weinrer, 2008). SAD is noted as one of the earliest-occurring of all anxiety disorders (Beesdo, Katja; Knappe, Susanne; Pine, Daniel, 2009). Adult separation anxiety disorder affects roughly 7% of adults. Research suggests that 4.1% of children will experience a clinical level of separation anxiety. Of that 4.1% it is calculated that nearly a third of all cases will persist into adulthood if left untreated (Ehrenreich, Santucci, Weinrer, 2008). Research continues to explore the implications that early dispositions of SAD in childhood may serve as risk factors for the development of mental disorders throughout adolescence and adulthood (Lewinsohn, Holm-Denoma, Small, Seely, 2008). It is presumed that a much higher percentage of children suffer from a small amount of separation anxiety, and are not actually diagnosed. Multiple studies have found higher rates of SAD in girls than in boys, and that paternal absence may increase the chances of SAD in girls (Cronk, Slutske, Madden, Bucholz, Heath, 2004). To clarify whether gender was associated with early anxiety disorder onset in addition to being associated with a higher rate of occurrence, we compared the mean age at onset for female and male anxiety cases (current and recovered).The mean onset ages for male and female cases did not differ (girls: n=97, M=8.0 years, SD=3.9; boys: n= 45, M=8.5years, SD=3.8), r(141)=0.77, p>.05 .In addition, no significant gender differences were obtained for mean onset ages for any of the specific anxiety disorders (Peter *et al*., 1998). Social anxiety disorder is known to appear at an early age in most cases. Fifty percent of those who develop this disorder have developed it by the age of 11 and 80% have developed it by age 20. This early age of onset may lead to people with social anxiety disorder being particularly vulnerable to depressive illnesses, drug abuse and other psychological conflicts (Stein and Stein, 2008). Physical symptoms often accompanying social anxiety disorder include excessive blushing, sweating, trembling, palpitations and nausea. Stammering may be present, along with rapid speech. Panic attacks can also occur under intense fear and discomfort. An early diagnosis may help minimize the symptoms and the

development of additional problems, such as depression. Some sufferers may use alcohol or other drugs to reduce fears and inhibitions at social events. It is common for sufferers of social phobia to self-medicate in this fashion, especially if they are undiagnosed, untreated, or both; this can lead to alcoholism, eating disorders or other kinds of substance abuse. SAD is sometimes referred to as an 'illness of lost opportunities' where 'individuals make major life choices to accommodate their illness' (Stein, Murray; Gorman, Jack, 2001; Shields and Margot, 2004).

CONCLUSION

The study shows that there is difference between boys and girls on overall anxiety related disorders. Children are our future generation and before entering in adolescent stage which is consider as transition stage or turning point of life then how could they deal with this stage if they already suffer from anxiety related disorders. Psychologists can play an effective role in educational and social settings to help in treatment and intervention for children diagnosed with anxiety disorders. Parents as well as the child should be screened for attitudes and treatment goals, as well as for levels of anxiety or conflict in the home. Educational system should be such that in which initial assessment of the children for anxiety related disorders should be conducted. The therapist should meet with the family as a unit as frequently as possible. Ideally all family members should be aware and trained in the process of cognitive behaviour therapy (CBT) in order to encourage the child to rationalize and face fears rather than employ avoidant safety behaviours. In this way the future of the children as well as nation can be save by our educational system.

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