

ANXIETY DISORDERS IN DEVELOPMENTAL AGE

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ABSTRACT

Anxiety disorders represent the more common psychiatric disorder in developmental age and it is estimated that a third of adolescents satisfy the criteria for an anxiety disorder at the age of 18.

Many researches show that the disorders of anxiety in childhood are associated with anxiety disorders in adulthood, depressive disorders and use of psychoactive substances.

Suffering from anxiety disorders, such as specific phobia, agoraphobia, social anxiety or panic disorder, represents a strong predictor for the development of other psychiatric disorders consequential. In the literature the debate on the weight of environmental factors and genetic factors in determining the development of anxiety disorders is ongoing.

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Introduction

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Many researches show that the disorders of anxiety in childhood are associated with anxiety disorders in adulthood, depressive disorders and use of psychoactive substances.

Suffering from anxiety disorders, such as specific phobia, agoraphobia, social anxiety or a disorder of panic, represents a strong predictor for the development of other psychiatric disorders consequential. In the literature the debate on the weight of

environmental factors and genetic factors in determining the development of anxiety disorders is ongoing.

Some factors can determine the onset and maintenance of anxiety disorders in developmental age such as genetic, temperamental and environmental factors, which include also the parenting and educational styles.

As in adults, anxiety in children is also characterized by specific thoughts, such as thoughts that concern the fear that “bad things” happen to loved ones, or thoughts about the fear of not making it. Anxiety can also find expression in children through the body in the form of somatic symptoms such as headache, vomiting, abdominal pain or limbs, or a

reduction in attention span and appearance may be observed in the child of distraction and listlessness.

The DSM-5 describes anxiety disorders in a specific category, and along the continuum of the life cycle: the same categories refer to infancy, adolescence and age adulthood.

The anxiety disorders in childhood and adolescence are increasingly widespread and afferent to psychology services and child neuropsychiatry, causing discomfort not only in the child, but in the whole family. An excessive load of anxiety interferes with many aspects of life of the child: from the ability to make new friends, to school results, to harmony familiar.

Anxiety disorders are characterized by pervasive feelings of worry or anxiety with obvious physical symptoms that are difficult to control and manifest to most people days for at least 6 months.

In children and adolescents, anxiety manifests itself primarily with concerns relating to school commitments or services in general, such as sports commitments, or social commitments.

There may be a tendency towards perfectionism that generates a state of tension, which it can cause either excessive effort or avoidance behavior. Anxiety, worry, or physical symptoms cause clinically significant distress either impairment of social, educational, or other important areas of functioning. The child anxious, in fact, constantly lives a vague feeling of oppression, "a burden", associated to an attitude of expectation of an event experienced as unpleasant and unexpected⁽¹⁻²³⁾.

Diagnosis and treatment in anxiety disorders

The diagnosis of anxiety disorders is performed using the DSM-5. This manual establishes the criteria for the diagnosis of each of the types of anxiety disorders. If these criteria are satisfied for at least 6 months, the diagnosis can be considered valid. From But when anxiety disorders often coexist with other psychiatric disorders, the diagnosis can be complicated. For example, almost 60% of patients with disorders of generalized anxiety have, accompanied to the latter, also the panic disorder or depressive disorders⁽²⁴⁻³⁹⁾.

The diagnosis therefore presupposes a careful reflection on some concepts such as that of "Continuity and discontinuity of anxiety disorders in children and adults", "border between normal and pathological anxiety, such as the need to turn to anxiety as a continuum which expresses itself with varying degrees of functional, cognitive, somatic and

attainment and behavior that varies according to the various evolutionary phases", and a detailed anamnesis with respect to the "presence and influence of risk factors and environmental / relational contexts". In these cases, it is opportune to evaluate the importance and role of the "Temperament and attachment". Temperament can be defined as a precocious and constant behavioral style, able to influence the personality and since it is a genetic part of the personality, it could represent one of the mechanisms through which the transmission of psychopathological vulnerability from one generation to the next takes place for as much discomfort anxious⁽²⁴⁻³⁹⁾.

The treatment for anxiety involves a work of research and assessment of expectations and habitual cognitive schemes and of a consequent search for alternative and more functional patterns. In recent years, in this field a lot of space has been given to both the cognitive and the cognitive therapies. therapy focused on the intolerance of uncertainty or the standard therapist. The first focuses on the factors contributing to the development of the disorder, including negative beliefs about the danger and uncontrollability of the hemorrhage, the positive metacognitive beliefs about rumination as effective doping mode and some behavioral aspects such as attempts to avoid rumination and control of his own thoughts. The second one, on the other hand, intervenes on the reduction of anxiety and rumination, helping the patients to improve their ability to tolerate, face and accept the inevitable uncertainty of everyday life. The strategies and techniques used include, for example, training awareness of one's anxiety states, in vivo and imaginative exposures, the cognitive structuring of irrational beliefs and problem-solving exercises⁽²⁴⁻³⁹⁾.

Generalized anxiety Disorder (GAD)

With regard to Generalized Anxiety Disorder (DAG), it is characterized for anxiety and worry (excessive waiting), which are manifested by the most days for at least 6 months, related to a number of events or of activity (such as work performance or scholastic), generalized precisely. The individual has difficulty controlling the worry and anxiety, yes considers excessive by intensity, duration or frequency with respect to the real probability or impact of the feared event. This disorder is associated with three or more of the following symptoms: restlessness (feeling thesis, with nerves a skin), fatigue, difficulty concentrating or memory lapses, irritability, muscle tension and changes in sleep (difficulty falling asleep or

maintaining sleep, or restless and unsatisfactory sleep). What makes it possible to draw a border between pathological and not, is the excessive dimension concerns and negative impact on psychosocial functioning individual. In addition to Panic Disorder, moreover, Generalized Anxiety Disorder is characterized by anxious symptoms sweetened in their intensity but protracted over time and, therefore equally debilitating. According to the World Health Organization suffers of generalized anxiety disorder 5% of the world population, especially women. Only a third of those who suffer from it, however, turn to a mental health specialist, in as the physical symptoms of anxiety often lead patients to turn to other figures professionals (eg primary care physician, internist, cardiologist, pulmonologist, gastroenterologist)⁽⁴⁰⁻⁴⁸⁾.

Separation anxiety

The main feature of Separation Anxiety Disorder is excessive anxiety manifested by the child when he must separate from someone in the family he is deeply tied (usually the figure maternal). This state of anxiety must be inadequate at the level of development and appear for the first time in the first six years of life. THE subjects suffering from separation anxiety have of usually a normal behavior as long as they are in presence of the parent or primary figure of attachment, but they manifest intense anxiety in the when they are separated from it. Furthermore they tend to express unrealistic fears and persistent with regard to the occurrence of catastrophic events that can separate them forever from parents. Children with separation anxiety disorder are afraid of being killed or kidnapped or to incur some serious accident or illness if they are far from the parents, or that to parents can happen something bad when they are far away⁽⁴⁹⁻⁵²⁾.

They usually avoid staying alone even for a few minutes. They can manifest an intense reluctance to go to school, as this involves a separation from the mother or, more generally, from the primary attachment figure. Children with separation anxiety often have difficulty at bedtime and may insist for someone to stay with them until they fall asleep. When they find themselves to be separated from the parents can manifest physical symptoms such as headache, vomiting; ask to call the parents and be brought home. The anxiety disorder of separation can sometimes develop after some stressful life event (for example, the death of a relative or of a pet, a disease of the child or of a relative, a change of school, a move to another area, or an immigration)⁽⁵³⁻⁶⁰⁾.

Social phobia

The Social Anxiety Disorder (Social Phobia) is characterized by a fear or marked anxiety about one or more social situations in which the individual is exposed to possible examination of others. Examples include social interactions (eg, having one conversation, meet unknown people), be observed (eg, while eating or drink) and perform a performance in front of others (eg, make a speech)⁽⁶¹⁻⁶⁵⁾.

What really fears the individual is the possibility of act in such a way as to manifest its symptoms of anxiety, which will be evaluated negatively (because embarrassing, humiliating, they will lead to rejection or result offensive to others). As with many anxiety disorders, anxiogenic situations are avoided either endure with discomfort from the patient. Fear, anxiety and avoidance to diagnose social anxiety must last more than 6 months and must be disproportionate to the real threat posed by the situation. Moreover, the subjects who suffer from it can result unassertive or excessively submissive, they can avoid eye contact and speak aloud low; they can also be shy, be less open in conversations and reveal little of themselves⁽⁶⁶⁻⁷⁰⁾.

When we talk about school phobia (or school exertion) we refer to a disorder in which the level of anxiety and fear to go and stay at school are such as to significantly compromise a regular school attendance and cause short and long-term sequelae. The consequences may relate to emotional, social development, acquisitions, difficulties in relationships with the family. Subsequently there may be difficulties in working and may increase the risk of an important impairment of the person's health. School waste should not be confused with the unjustified absence from school, the latter being a behavior in which anxiety and fear are absent. Excessive attendance at school is associated with antisocial behavior and lack of interest in school education.

The boy who suffers from school refusal can be absent from school from the beginning of the day, or can go to school and then, after a few hours, ask to return home. During school hours the child stays at home, a trustworthy and safe environment, can take care of other activities, including tasks, in a serene way. This disorder affects 1-5% of school-age children without gender differences, from the data present in literature seems more frequent in some delicate evolutionary changes such as the inclusion in the elementary school (5-6 years) and the transition to middle school (10 -11 years)⁽⁶⁶⁻⁷⁰⁾.

The disorder is characterized by the following problematic behaviors and somatic symptoms:

- high anxiety reaction when leaving home or arriving in front of the school, to the point of presenting symptoms of panic;

- manifestation of a wide range of somatic symptoms (dizziness, headache, tremors, palpitations, chest pains, abdominal pain, nausea, vomiting, diarrhea, back pain, pain in the limbs)

- level of distress can be raised from the night before and the baby can get off badly, sleep can be disturbed by nightmares or nocturnal awakenings⁽⁶¹⁻⁷⁰⁾.

Other disorders that can be associated with school refusal are separation anxiety, generalized anxiety, social phobia aberration, specific phobia, panic attacks, stress disorder-traumatic stress disorder, depression, conduct/defiant disorder, ADHD, specific learning disorders⁽⁶²⁻⁶⁹⁾.

Among the factors that most affect the predisposition and unleash of the school we find environmental ones. Symptoms can start after life-threatening life events at home or at school, including an illness or family member, separation between parents, transient separation from one of the parents, conflicting relationships in the family, a maladaptive link with one of parents, problems with the group of gods peer or with a teacher, the return to school after a long break or vacation.

Data available in the literature compared to biological factors, derived from family studies and twins, suggesting that there could be a biological vulnerability for the development of emotional problems, including rejection school. The trigger factors can be many but what interests most from the therapeutic point of view it is to correct the maintenance factors of the disturbance. It's clear that through the avoidance or escape from unpleasant events one gets reduction of anxiety, to this is added the positive reinforcement that the child receives in the stay home. In the literature much attention is given to the functioning profile of the child for the clinical and therapeutic implications that have the variables of maintenance⁽⁶⁶⁻⁷⁰⁾.

In conclusion, anxiety disorders are frequent in childhood and adolescents and they may be present in many other neurodevelopmental disorders such as primary headaches, genetic syndromes, mental retardation, autism spectrum disorders, sleep troubles and learning disorders⁽⁶²⁻⁷⁷⁾.

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