"WHERE ARE THE CHILDREN?" - A Look At Childhood Anxiety

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We are all too aware of the high stress levels in the world in which we live today – from financial stress to poverty; from high school costs to constraints in the current education system; child abuse, domestic conflict, family dysfunction and violence; from divorce to single parent and child headed households; alcohol and drug abuse; chronic physical and mental illness; the ravages of ongoing HIV; fear regarding safety in our homes and on our streets; crime; demonstrations and violence in our communities and our universities, as well as xenophobic violence. We live these every day and experience them through the media. Pre-occupied by our own inability to cope in our own daily lives, we rarely ask the crucial question – "Where are the children?"

WHERE ARE THE CHILDREN WHO LIVE IN THESE SPACES AND WHO WE DON'T SEE IN THE FILM CLIPS WE WATCH ON THE NEWS?

The perception is that children remain happy, carefree little people who remain protected from these stressors because they don't understand what is going on and are unaffected by the things we, as adults, are dealing with.

THE REALITY IS THAT THEY ARE RIGHT IN THE MIDDLE OF IT WITH US. THEIR LIVES ARE AN INTEGRAL PART OF OURS. THEY LIVE IN, AND EXPERIENCE ALL OF THE SAME TRAUMA NOT ONLY DIRECTLY BUT THROUGH THE FALLOUT FROM THE IMPACT OF THE STRESS ON THE CAREGIVING SYSTEMS ON WHICH THEY DEPEND FOR THEIR CARE, NURTURE AND PROTECTION. OUR CHILDREN LIVE IN THE STRESS OF OUR WORLD; THEY REACT TO IT LIKE WE DO, AND THEY ARE ANXIOUS.

Stress and anxiety are widespread in children 12 years and under in South Africa. It is important to be aware of the degree to which the incidence of anxiety in our children has been increasing in recent years, across all socio-economic and cultural groupings. Distress in children is most often a reaction to multiple circumstances simultaneously which gives rise to a level of anxiety which impairs the child's capacity to cope and function, and ultimately interferes with development in multiple areas including academic, social, emotional and

personal. Anxiety has to be understood as the product of the interaction of the individual child with their primary caregiver, their family, their school, their community and, through these systems, with the broader society.

ANXIETY IS AN UNCOMFORTABLE, INTENSE, COGNITIVE, EMOTIONAL AND BODILY EXPERIENCE WHICH CONSUMES THE MIND AND THE SELF AND INTERFERES WITH COGNITIVE, EMOTIONAL AND BODY FUNCTIONING. IT IS A SUBJECTIVE SENSE OF DISTRESS - SOMETHING IS NOT RIGHT.

Anxiety is a normal experience and part of everyday life, but it becomes a source of distress when it reaches such an intensity, or persists to such a degree, that it interferes with aspects of normal daily functioning.

ANXIETY MAY BE INHERITED AT A BIOLOGICAL LEVEL THROUGH THE GENES PASSED ON FROM PARENT TO CHILD.

In this case anxiety may be experienced in the absence of significant stressors although this is rarely the case. These children just become increasingly vulnerable to the multiple active stressors in their world. It should be remembered that, in such cases, the child not only inherits the tendency to anxious reactivity, but will also be born into an anxious caregiving and family system which may model anxiety in its dynamics and problem solving style. This may often create an unstable and unpredictable foundation for an already vulnerable child – before taking other stressors into account. Anxiety may present in some form from a very young age, even in babies, whenever nurture, safety and protection structures usually provided by the primary caregiver and family, are threatened or absent. This will occur particularly within the context of a dysfunctional care system.

THE INHERENT CONCERN IS THAT ANXIETY IS OFTEN A DIAGNOSIS THAT IS MISSED AT THE FIRST AND OFTEN SUBSEQUENT APPOINTMENT WITH THE CHILD. OFTEN ANXIETY IS A SILENT PRESENTATION.

This is because it is experienced by the child as an internalised feeling, thought and/or bodily sensation that he or she may not express outwardly.

THIS MAY BE BECAUSE THEY DO NOT KNOW THEY SHOULD EXPRESS IT OR DO NOT YET HAVE THE VOCABULARY TO DO SO. THEY MAY EVEN EXPERIENCE IT AS A BAD FEELING AND MAY FEEL GUILTY ABOUT IT AND THEREFORE DO NOT BRING IT TO THE ATTENTION OF THE CAREGIVER. THIS IS WHY IT IS SO IMPORTANT TO UNDERSTAND THE DYNAMICS OF THE FAMILY WHEN EVALUATING A CHILD.

In some families children are encouraged to talk about their feelings and are therefore taught the relevant vocabulary. In very stressed families the main goal becomes survival and communication with the children is limited. There is no time to discuss emotions and often not even a real awareness that the child has emotions at all. Another concern is that when children do externalise anxious emotions it is often in the form of behaviours which are interpreted by the caregiver or class teacher as 'bad behaviour' and therefore not responded to in an appropriate manner, which actually increases the level of anxiety in the child.

Given the multiple barriers to the diagnosis of anxiety and the recognition of unacceptable levels of distress in our children, it is crucial that we become increasingly aware of the signals they may be sending out to suggest their distress.

THIS WAY WE CAN ASSIST THEM TO BECOME THE HAPPY, HOPEFUL CHILDREN WE THOUGHT THEY WERE AND OPTIMISE THEIR DEVELOPMENTAL FUNCTIONING AND GROWTH.

THE CLINICAL FEATURES WE WOULD BE LOOKING FOR WOULD FALL INTO THE FOLLOWING CATEGORIES:

Emotional Symptoms or Subjective Feelings

- Sense of fear, distress, edginess, vulnerability
- Sadness, crying
- Anger
- Tantrums
- Irritability, stubbornness, disrespect
- Difficulty expressing distressing emotions
- Blunting of emotion – Less emotionally reactive or not showing emotion

Cognitive Symptoms –Thought Patterns

- Fearfulness
- Chronic excessive worrying
- Repeated questioning
- Needs repeated re-assurance
- Patterns of negative thinking
- Negative expectations of outcome and of the future
- Poor concentration

Specific Fears

- Multiple fears inappropriate for age
- Fear of the dark
- Fear of going to certain places
- Fear of separation from caregivers and of something happening to caregivers
- Fear related to academic performance
- Fear of going to school
- Fear related to the social setting
- Fear of crime
- Fear of natural disasters

Physical or Bodily Symptoms

These are a common presentation in childhood anxiety and often become the focus of intervention. This causes the anxiety to be missed initially or completely.

- Headaches, stomach aches, nausea, vomiting diarrhoea, muscle tension, chest pain, dizziness, fainting, palpitations and breathlessness
- Bedwetting } Physical expression of
- Daytime soiling } subconscious anxiety
- Sleep difficulties and nightmares
- Changes in eating behaviour

Behaviours

- Nail biting
- Fidgeting
- Tremors
- Skin picking
- Head banging
- Hair pulling
- Tantrums
- Aggression
- Impulsivity
- Self-destructive behaviours – cutting, thoughts of death and suicidal ideation – At this stage the child is quite likely also depressed.

Social Integration

- Withdrawal and isolation
- Struggles with friendships
- Become victims of bullying

Personal

- Fear of failure
- Low self esteem
- Attention seeking
- Regression to more childlike behaviour represents need for more supervision and help
- Manipulative - You feel like the child is manipulating you. This is a subconscious mechanism that the child uses to effect control over their world and make it more safe for them.

Trauma Related Anxiety

It is very important to remember that many of our anxious children have experienced one or often multiple traumatic events during their lives and their anxiety experience may be coloured by these experiences.

- Pre-occupation and distress around thoughts and memories of specific traumatic events
- Trauma-specific nightmares
- Avoidance behaviour – Attempt to avoid exposure to reminders of the trauma
- “Flashback” experiences – Not necessarily in children and difficult to elicit – re-experience the trauma at a multisensory level together with the same responses experienced at the time of the original trauma

IN ORDER TO HEAR AND SEE OUR CHILDREN, THE FIRST STEP IS TO BECOME MORE AWARE THAT THERE ARE SO MANY ANXIOUS CHILDREN IN OUR CONSULTING ROOMS, CLASSROOMS AND HOMES. THE SECOND STEP IS TO HEIGHTEN OUR CAPACITY TO DETECT THEM THROUGH CORRECT INTERPRETATION OF THE MANY SIGNALS THEY PUT OUT.