Anxiety in Children

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Anxiety disorders are one of the most common mental health problems identified in children. Estimates of lifetime prevalence vary greatly, from 8% to 27% by age 18. Chronic anxiety disorders are associated with increased risk of other serious mental health problems in later life, so early identification and treatment is key.

Normal fears vs anxiety disorder

Fears and worries are a normal part of child development, and the content of fears changes according to the individual's developmental stage. Anxiety disorders occur when the intensity of fear or worry is so high that it starts to impact on the child's functioning and wellbeing, and/or when the anxiety is out of context with their developmental stage.

'Normal' fears by developmental stage:

- **Infancy:** loud noises, heights, loss of physical support.
- **1–2 years:** strangers, toileting activities, being injured.
- **3–5 years:** animals, monsters, the dark, being alone.
- **6–9 years:** animals, lightning and thunder, personal safety, school, death.
- **9–12 years:** tests, personal health.
- **13 years+:** social interactions, personal injury, economics and politics.

Main symptoms

Physiological symptoms:

Anxiety triggers the innate fight-or-flight reaction. In children with anxiety disorders this response is activated in feared situations — for example, being away from a parent (separation anxiety) or having to speak to a teacher (selective mutism). Symptoms include a faster heartbeat, sweating, shortness of breath, muscle tension, shakiness, nausea, and headaches.

Negative thoughts and worries:

- "What if" thoughts about the future and their ability to cope — often extreme and unrealistic.
- Rumination about past events, such as replaying a difficult social interaction.
- Vivid images of the worst thing happening, which can increase physiological arousal.
- Significant time spent on worries, and sometimes worrying about worrying itself.

Avoidance:

- Marked avoidance of feared situations — particular places, people, animals, or objects.
- Avoiding situations they previously enjoyed, such as birthday parties.
- Avoidance can become more generalised over time, leading to significant impact on daily life such as school refusal.

Safety behaviours:

- Routines or rituals that the child feels will keep them safe — for example, always carrying water or mints if fearful of being sick.
- Reassurance-seeking from caregivers is a key safety behaviour in children with anxiety disorders.
- Safety behaviours may give brief relief but in the long term maintain anxiety.
- Children may show increased distress if unable to carry out a safety behaviour.

Prolonged anxiety can often lead to low mood — there is a high comorbidity between anxiety and depression.

Special characteristics in pre-school and school-aged children

Tantrums and behavioural outbursts:

These may be frequent, severe, and appear out of context. The child may find it hard to name what is making them distressed, and may direct aggression towards primary caregivers. Age-appropriate boundaries should still be maintained, as with any child.

Sleep problems:

Bedtime is a common time for worrying, as there are fewer distractions. Children may fear being left alone at night, experience nightmares, or struggle to sleep without a parent nearby or the light on.

Friendships:

Anxiety disorders can make it hard to form and sustain friendships. Children may become clingy and reluctant to separate from caregivers, limiting social opportunities. At school, they may prefer to spend break times with staff rather than peers.

Illness:

Children often confuse the physical symptoms of anxiety with illness — tummy aches are common. They may also cite physical symptoms to avoid school or social situations.

Other common symptoms (also associated with depression):

- Difficulty concentrating.
- Irritability.
- Lacking enjoyment.
- Tearfulness and moodiness.

Risk factors

- **Genetics and temperament:** children may be naturally predisposed to a more anxious temperament, or there may be a family history of anxiety or mental health difficulties.
- **Bullying and peer problems:** isolation or difficult friendships at school can increase risk.
- **Adversity:** parental separation, ill health, bereavement, accidents, or abuse.
- **School difficulties:** falling behind or struggling with schoolwork.
- **Direct experience with feared stimuli:** traumatic events, embarrassing incidents, or negative experiences.
- **Parental or caregiver anxiety:** modelling anxious behaviour, reinforcing avoidance, or communicating that situations are dangerous.

The more risk factors present, the more likely it is that a child could develop an anxiety disorder.

Watchful waiting

If anxiety is mild, it may not be necessary to refer immediately to a healthcare professional. A parent or teacher may keep an eye on the child and offer support. If symptoms persist or worsen, consult with the GP about whether a referral would be beneficial.

How to help a child with anxiety

- Talk to the child about the cause of their anxiety.
- Make links between physical sensations and anxiety — normalise these sensations.
- Gently encourage the child to face the feared situation in a way that feels manageable.

When and where to refer

Consider referring when anxiety persists, gets worse, or impacts on functioning — for example if a child refuses to go to school. Refer to the GP, the Special Educational Needs Coordinator (SENCO), or the school nurse.

Treatment options

Cognitive Behavioural Therapy (CBT) is the main recommended treatment for children and young people with anxiety disorders. It looks at how problems, feelings, thoughts, and behaviours fit together. Research suggests the crucial component in any treatment is exposure to the feared stimulus — either imagined or in real life.

With younger children, treatment should routinely involve parents and caregivers so they can support exposure work outside of sessions.

When symptoms are severe and persist despite psychological treatment, medication may be considered. It should always be used alongside continued psychological support, and can only be prescribed by a psychiatrist specialising in children's mental health.