by Glenn S. Hirsch, M.D.

# Anxiety Disorders *and* AD/HD

ANXIETY DISORDERS and AD/HD make strange bedfellows. Consider the hallmark of a typical youngster with AD/HD—acting without thinking. In contrast, we might say that a youngster with an anxiety disorder 'thinks too much.' It would seem then that having one of these disorders would "protect" you from having the other one. Unfortunately this is not true. In fact, recent studies suggest that up to 25 percent of children with AD/HD have an anxiety disorder, and 25 percent of children with an anxiety disorder have AD/HD. In order to understand this, it is important to be aware of and able to recognize the symptoms of anxiety disorders.

### The Anxiety Disorders

While anxiety is a normal emotion experienced by everyone, a child or adolescent with an anxiety disorder experiences this symptom more often, more readily and often more intensely than other youngsters. In addition, the symptoms must cause significant distress or interfere with their functioning in at least one aspect of their lives. It is important to be aware that excessive anxiety can result in impaired concentration and restlessness, some of the same symptoms that are seen in children with AD/HD. In addition, these disorders can result in their being excessively tired, on-edge, irritable, tense and having difficulty sleeping.

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What follows is a brief review of each of these disorders.

### Separation Anxiety Disorder (SAD)

Most infants go through a normal phase of separation anxiety that usually peaks at eighteen months of age and rapidly diminishes thereafter. Separation anxiety is not a normal feature of school-aged or teenage children.

Youngsters with this anxiety disorder have an extreme fear of being away from home or from the people who routinely care for them. These children can show distress when separating or even when separation is anticipated. They may worry that a parent may be lost, harmed or that they (the children) may be lost or kidnapped. As a result of these fears, they may refuse to go to school, sleep alone and they may cling to and "shadow" their parents around the home. Often they may have nightmares with themes of separation. Many times these children will end up in the school nurse's office with complaints, headaches or stomachaches, and a wish to call home.

### Generalized Anxiety Disorder (GAD)

Children with this disorder are classic worriers. An older term for this disorder is *overanxious disorder*. These kids tend to be anxious about any number of things in their lives. They can have excessive and unrealistic worries about future events, school, their health, safety at home, natural disasters such as storms, hurricanes or earthquakes, being on time for appointments and family issues. Unlike children with social anxiety, the anxiety persists even if they are not being judged or observed by others. They may worry about doing well in school, including homework and exams, even if they have always done well. They have a tendency to ask parents and teachers for reassurance about how they are performing.

### Social Phobia

These children are painfully shy and feel intense discomfort in social situations. They are especially fearful of situations where they need to perform and are under scrutiny. These situations can include talking in front of the class, starting or joining conversations, eating in public and making friends. They often are concerned that they will do or say something that will result in their feeling humiliated or embarrassed. Often their anxiety extends to their anticipating events where they may have to perform. Younger children may not recognize that their fear is excessive.

The emotional aspects of anxiety may produce physical symptoms such as blushing, tremors, sweating, feeling faint, muscle tension and sometimes even heart palpitations.

When the symptoms are intense, these youngsters may begin to avoid school and all social activities. A form of social phobia that can start in young children, but remain through the school years is *selective mutism*. This disorder is characterized by an inability to speak in many social situations. Often these children will only speak at home to parents and siblings. At times their behavior may seem oppositional, but in fact, the symptom is driven by intense anxiety.

### Obsessive-Compulsive Disorder (OCD)

This disorder is characterized by intrusive and inappropriate recurrent thoughts, images or impulses and/or repetitive behaviors. The thoughts are called obsessions, while the behaviors are called compulsions. Typical compulsions include excessive hand washing, cleaning rituals, checking behaviors such as making sure that windows or doors are locked, or the faucets are shut off, hoarding (the inability to throw anything away) and arranging or ordering things such as books or clothes. Typical obsessions include impulses to harm or kill a family member; incessant worries about dirt, germs, contamination or religion; recurrent thoughts that something has not been done properly; feelings that certain things must always be in a certain place; as well as thoughts of nonsense words, sounds, pictures or numbers.

### Post-traumatic Stress Disorder (PTSD)

In the face of the World Trade Center and Pentagon attacks and tragedies, this disorder takes on renewed significance. PTSD can develop after a youngster is





exposed to an extreme trauma. The diagnosis requires that the child be directly exposed to an extremely traumatic situation involving an actual or threatened death or serious injury, witnessing such an event, or hearing about such an event with regard to a family member. These youngsters will often relive the trauma by having recurrent intrusive thoughts, images, dreams and flashbacks. At times, they will avoid activities, thoughts, places or people who are associated with the trauma. Symptoms of increased arousal such as difficulty concentrating, hyper vigilance and an exaggerated startle response will often accompany the other symptoms. Since many of these symptoms are not unusual immediately after a trauma, in order for this diagnosis to be made the child must experience these symptoms for at least one month.

### How are the anxiety disorders treated?

For SAD, GAD, social phobia and OCD, two treatments have been utilized. A form of therapy called Cognitive-Behavioral Therapy (CBT) and medication, specifically the selective serotonin reuptake inhibitors (SSRI's). A number of studies have shown these medications are helpful in treating OCD. A large multi-site study sponsored by the National Institute of Mental Health (NIMH) showed that fluvoxamine was efficacious in treating SAD, GAD and social phobia.

For children suffering from PTSD, specific treatments have been developed that include cognitive and behavioral techniques, in addition to making changes to the environment to ensure ongoing safety.

What are the differences between children with AD/HD alone and those with AD/HD combined with an anxiety disorder? Children with the combined disorder are often referred for treatment at a later age than those without anxiety. Some speculate that this may be due to the fact that for some children the anxiety symptoms may inhibit the hyperactive-impulsive behaviors that are so often the trigger for a referral for evaluation.

Anxious children with AD/HD may be at a lower risk for developing a conduct disorder. Children with AD/HD plus anxiety may exhibit more social difficulties, but no difference in school performance.

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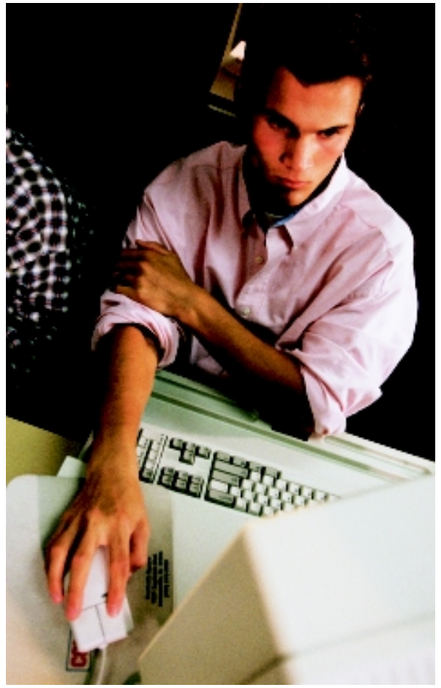
### Treatment of the Combined Disorders

The presence of an anxiety disorder may influence how children respond to medication treatment. Some studies have found that these children do not respond as well to stimulant treatment. In some youngsters there appeared to be an increase in side effects, including tics and sadness. In addition, there have been clinical suggestions that in some children stimulant treatment may worsen symptoms of anxiety. One study, however, found no difference in treatment response between children with anxiety and those without. In contrast, the NIMH Multimodal Treatment of Children with AD/HD[1] looked at a subgroup of children who had anxiety symptoms at the beginning of the study and found that methylphenidate did not exacerbate anxiety symptoms and some children showed a reduction in anxiety symptoms following treatment. Some clinical studies have looked at children with both conditions and have found that the addition of a selective serotonin reuptake inhibitor (SSRI) to stimulant treatment has been helpful.





In order to better evaluate the best treatment for youngsters with AD/HD and anxiety disorder, the NIMH has sponsored a multi-site trial. The study will examine the benefits of the stimulant medication methylphenidate both alone and in combination with fluvoxamine, an SSRI for treating these co-occurring disorders in youngsters ages 6–17.

Five clinical sites across the U.S. are participating in this study. A diagnostic evaluation will be provided at no cost for all eligible participants, and families will be reimbursed for travel expenses. Weekly clinic visits will be required of all participants for the duration of the study (6–22 weeks, depending on response).

The sites and their contacts are listed below:

**Duke University Medical Center**, Durham, NC. Contact: Pat Gammon, Phone: (919) 416-2406, E-Mail: gammo002@mc.duke.edu

**Johns Hopkins School of Medicine**, Baltimore, MD. Contact: Sam Walford, Phone (410) 955-1542, E-Mail: swalford@jhmi.edu

**New York State Psychiatric Institute** (168th St. & Riverside Dr.), New York, NY. Contact: Lisa Capasso, Phone: (212) 543-5952, E-Mail: capassol@child.cpmc.columbia.edu

**New York University Child Study Center** (33rd St. & First Ave), New York, NY. Contact: Pat Rentas, Phone: (212) 263-7779, E-mail: patricia.rentas@med.nyu.edu

**University of California**, Los Angeles, Los Angeles, CA. Contact: Kim Jeter, Phone: (310) 825-6527, E-mail: kjeter@mednet.ucla.edu

A website sponsored by the NYU Child Study Center, **www.aboutourkids.org**, provides information about development and mental health in children and adolescents, and also has an extensive library of articles dealing with the trauma related to the recent attacks on our nation. ■

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### Reference

[1] MTA Cooperative Group. (1999) A 14-month randomized clinical trial of treatment strategies for attention-deficit/hyperactivity disorder. *Archives of General Psychiatry,* 56, 12.

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