CME

Rages and refusals

Managing the many faces of adolescent anxiety

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abstract

OBJECTIVE To provide family physicians with a practical approach to recognition, assessment, and treatment of adolescent anxiety disorders complicated by avoidance or oppositional behaviour.

QUALITY OF EVIDENCE Current literature was searched via MEDLINE using the MeSH headings Anxiety and Anxiety Disorders, focusing on epidemiology, clinical presentations in adolescence, and both pharmacologic and nonpharmacologic treatment. In addition, internationally accepted diagnostic criteria, current practice guidelines, and recent textbooks by recognized experts were reviewed. Research evidence and consensus recommendations were integrated with a practical approach developed in a provincial mood and anxiety disorders clinic.

MAIN FINDINGS Anxiety disorders are common in adolescents, with estimated prevalence of at least 10%. Substance abuse and avoiding school are common complications, and irritability with behavioural and rage problems can interfere with effective management. Current controlled research is examining the effectiveness of serotonergic medications known to benefit panic disorder, social phobia, and generalized anxiety in adults. While cognitive and behavioural treatments are effective for some child and adolescent anxiety disorders, they can be difficult to administer, and a supportive and psychoeducational approach could be as effective for those who refuse to go to school.

CONCLUSION Family physicians' awareness of the role of anxiety in adolescent school avoidance and in intense, oppositional emotional reactions at home can lead to more specific assessment and therapeutic intervention. Practical management strategies are recommended.

résumé

OBJECTIF Présenter aux médecins de famille une approche pratique pour reconnaître, évaluer et traiter chez les adolescents les troubles d'anxiété, compliqués par un comportement d'évitement ou de confrontation.

QUALITÉ DES DONNÉES Une recension des ouvrages scientifiques actuels a été effectuée dans MEDLINE au moyen des rubriques MeSH en anglais pour anxiété et troubles de l'anxiété, insistant sur l'épidémiologie, les présentations cliniques chez l'adolescent, ainsi que les traitements pharmacologiques ou non pharmacologiques. De plus, les critères de diagnostic acceptés sur le plan international, les guides de pratique actuels et les manuels récents par des experts reconnus ont fait l'objet d'une revue. Les données probantes de la recherche et les recommandations consensuelles ont été prises en compte et intégrées à une approche pratique mise au point dans une clinique provinciale traitant les troubles de l'humeur et de l'anxiété.

PRINCIPAUX RÉSULTATS Les troubles anxieux sont fréquents chez les adolescents, d'une prévalence estimée à au moins 10%. La toxicomanie et le décrochage scolaire en sont des complications courantes, et l'irritabilité combinée à des problèmes de comportement et de rage peuvent nuire à leur prise en charge efficace. Les recherches contrôlées actuelles examinent l'efficacité de la médication sérotoninergique connue pour ses bienfaits dans le cas du syndrome de la panique, de la phobie sociale et de l'anxiété généralisée chez l'adulte. Si les thérapies cognitives et comportementales sont efficaces pour les troubles d'anxiété chez certains enfants et adolescents, elles peuvent se révéler difficiles à administrer; une approche de soutien et d'ordre psychoéducative pourrait être aussi efficace chez ceux qui refusent d'aller à l'école.

CONCLUSION La sensibilisation des médecins de famille à l'influence de l'anxiété dans les problèmes de décrochage scolaire et les réactions émotionnelles intenses d'opposition chez l'adolescent à la maison peut se traduire par une évaluation et une intervention thérapeutique plus précises. Des stratégies pratiques de prise en charge sont recommandées.

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Most cases of generalized anxiety, panic disorder, and social phobia first appear in adolescence or earlier.[1,2] Anxiety develops out of fundamental human survival responses, mediated by the serotonergic and noradrenergic systems, involving avoidance of harm and escape from danger, and ensuring that helpless infants maintain close contact with adults.[3]

When this natural anxiety system is activated inappropriately or responds excessively, or when its signals are misinterpreted, people react with a fight or flight response, instinctive avoidance of danger, and catastrophic worrying. Various anxiety disorders result from this response and are generally well recognized by family physicians. When the symptoms of anxiety disorders in adolescents are behavioural, however, they can be less readily recognizable. Anxious adolescents can be challenging for parents, doctors, and schools to manage because of their unique combination of defiance and avoidance. Common behavioural manifestations of anxiety disorders in adolescents will be reviewed, as well as effective management strategies based on recent pharmacologic and behavioural research.

Quality of evidence and literature search

Current literature (January 1980 to March 2000) was searched via MEDLINE using the MeSH headings Anxiety and Anxiety Disorders focusing on psychology, diagnosis, epidemiology, and both pharmacologic and nonpharmacologic treatment. Articles were selected based on quality of research design and clinical relevance. Official diagnostic criteria based on the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV),[4] current practice parameters from the American Academy of Child and Adolescent Psychiatry,[5] and recent textbooks by recognized experts were reviewed. Experience from clinical assessment, treatment, and outreach programs in the British Columbia Children's Hospital's Mood and Anxiety Disorders Clinic was integrated with research evidence and expert consensus guidelines to provide a practical perspective.

Prevalence of anxiety disorders in adolescents. The core diagnostic criteria for common anxiety disorders in adolescents are the same as for adults.[4] *Panic disorder* is characterized by the occurrence of one or more panic attacks with at least 4 weeks of impairment due to worry about attacks or avoidance of situations that cause panic; as a result, many people become agoraphobic. *Generalized anxiety disorder* is characterized by at least 6 months of worrying about many issues, accompanied by somatic complaints, sleep problems, fatigue, and irritability. *Social phobia* is characterized by tremendous anxiety about scrutiny by others in various situations. The threshold for this disorder has been debated, as anxiety about speaking in public is very common; hence the term "generalized social phobia" is now used to indicate those who have broad social anxieties resulting in seriously impaired function. *Separation anxiety disorder,* characterized by refusal to separate from parents (usually mothers) results in clinging behaviour and school avoidance and often an insistence on sleeping with others. While more common among children, separation anxiety disorder can occur among teenagers in association with panic attacks.[6] *Obsessive compulsive disorder* (OCD) is characterized by either obsessions or compulsions taking up at least 1 hour daily and impairing functioning. The threshold for this diagnosis needs to be carefully applied; subclinical OCD symptoms are present in up to 19% of adolescents.[7]

The prevalence of anxiety disorders in adolescence varies from 5% to 17% in epidemiologic studies,[2] a variation explained by changes in diagnostic criteria for childhood anxiety disorders, multiple comorbid disorders, and method of ascertainment, which can affect the threshold for diagnosis. For example, the reported rate of generalized anxiety disorder (formerly overanxious disorder) ranges from 2.6% to 10.8%.[8] Summarizing more than a dozen epidemiologic studies of the past decade suggests a reasonable estimate for prevalence in adolescence would be 1% for panic disorder, 3% to 4% for generalized anxiety disorder, 3% to 5% for generalized social phobia, and 1% to 2% for OCD.

Presentations of anxiety in adolescence. Diagnostic criteria do not describe what an anxious teen actually looks like. Teenagers sometimes present to family physicians with somatic or insomnia complaints that are readily recognizable as symptoms of anxiety. Frequently, however, it is parents who complain that the adolescent either exhibits uncontrolled behaviour at home or is not attending school. These behavioural manifestations represent aspects

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of the instinctive fight or flight response to the frightening experience of physical and psychological anxiety.[9] Many teenagers have had symptoms of chronic anxiety because an associated lack of effective parental authority develops when parents perpetually avoid upsetting anxious children to prevent emotional and behavioural crises. These children are "demanding, intrusive, and in need of constant attention,… leading to resentment and conflict in the family."[4]

While surprisingly little research has specifically examined relationships between oppositional defiant disorder and anxiety disorders, these features emerge in case studies[10] and textbooks: "conflicts with his parents over school attendance led to tantrums, with screaming, crying, and turning over and breaking furniture."[6] Rates of anxiety disorders in young people with oppositional and conduct disorders are high, and trait anxiety is associated with conduct problems.[11] Extensive research on the problem of school avoidance, in most cases representing an anxiety disorder,[12] reflects a common manifestation of this oppositional quality in anxious teenagers.

Adolescents with generalized anxiety or persistent panic disorder tend to have a long-standing history of anxiety and chronic irritability.[4,6] Acute rage can occur in the context of spontaneous panic attacks, but more often occurs when stresses build up. Triggers can be social pressures, life changes, new situations, or performance demands, usually related to school.

Often there is a "perfectionism, procrastination, paralysis" pattern. A perfectionist cannot stand "losing face"; hence facing discipline, disappointing others, or any kind of embarrassment leads to a crisis. Excessively high expectations lead to procrastination, as it is no use starting something if it is not going to be good enough. As the work piles up, it becomes harder and harder to start, and paralysis sets in. As a deadline looms or a parent pushes for action, there is a crisis and a "meltdown" with extreme rage or inability to function. Parents become frustrated and angry with the teenager's refusal to cooperate with expectations. At this point the teenager sometimes expresses feelings of hopelessness and thoughts of suicide. Some more explosively express their anxiety and frustration through verbal or physical aggression toward family members. It is necessary to distinguish anxious teenagers from those having primary conduct or defiance problems. The latter are more likely to be truant in the company of friends and to be violating other rules, such as curfews, while anxious teenagers remain at home when absent from school and are often socially isolated.

Temperamentally avoidant and socially phobic teenagers can present a more low-key chronic avoidance pattern that gradually worsens in adolescence. Avoidant teenagers withdraw from stressful activities, such as homework or school, and even from recreational activities and peers. Prolonged absence from school has secondary consequences for academic and social development. These teenagers are often emotionally dependent, with many somatic complaints. When teenagers become housebound, they sometimes develop a fear of being alone, forcing a parent to become housebound with them. Socially phobic teenagers often complain of chronic symptoms of fatigue or develop secondary depression. Often, symptoms improve dramatically over the summer when social pressure is off. Social phobia can be hard to detect without more information from parents because teenagers sometimes appear quite confident in one-to-one situations with adults while being reluctant to admit that they cannot tolerate peer scrutiny, rejection, or judgment. Boys, especially, tend to deny anxiety because it is too embarrassing.

Comorbidity and complications. Anxiety disorders are highly comorbid and frequently complicated by the time they are seen for assessment (**Table 1**).[1,2,8] Many teenagers have multiple anxiety disorders. Others also have learning-related problems that can promote school avoidance. Eventually one third to half of anxious adolescents develop a major depressive episode or the chronic minor depression known as dysthymia. A very common complication of anxiety disorders is school failure due to poor concentration, incomplete work, and not attending school. Finally, adolescent girls' eating disorders are associated with anxiety, as controlling eating can be a way of controlling an overwhelming world.

Unfortunately, anxious teenagers often become substance abusers, usually, it seems, as a form of self-medication. Alcohol abuse can occur, as it does in adults,[13] but cannabis abuse and dependence are

Table 1. Comorbidity and complications of adolescent anxiety

One third to half develop major depression
One third have attention deficit hyperactivity disorder; one quarter have learning disorders
Substance abuse is common, especially cannabis dependence
School failure is caused by incomplete work or failure to attend
Eating disorders are common

more common among teenagers in school.[14] Many of these teenagers report that marijuana makes them feel calmer and more able to be around other people, so they are prone to use it daily, even during school hours. Being anxious, they are also sensitive to somatic and psychological withdrawal symptoms, such as nausea, irritability, and nervousness (which themselves resemble anxiety disorders),[15,16] and tend to use drugs more frequently to control these symptoms as well.[17] Daily use profoundly affects school performance through well-documented impairment of attention and memory[18-20]; school failure becomes another stressful complication. Marijuana use produces resistance to treatment with some medications as well as adverse drug interactions. In addition to viewing substance abuse as a complication of anxiety disorders, differential diagnosis when evaluating anxiety symptoms must include substance-induced anxiety disorder due to cannabis, caffeine, amphetamines, and other drugs.[4]

Assessment approach

Family physicians might have to assess patients over several appointments. Anxiety problems are complex and usually subacute or chronic. Taking some time will result in more accurate assessment and effective interventions. Taking time also helps build rapport with an adolescent. Begin with a medical history and examination to ensure anxiety symptoms are not caused by some easily identifiable factor, such as medication effects due to bronchodilators, a general medical condition (such as hyperthyroidism), common substances (such as caffeine), or simply sleep deprivation. Acute stressors should be identified, including changes, losses, family conflict, and crises in peer relationships.

Specific symptoms to be clarified include panic attacks, obsessions, compulsions, depressed mood, insomnia, changes in appetite, impaired daily functioning, and suicidal thoughts or attempts. After assuring teenagers of confidentiality, detailed substance use histories must be obtained. While this part of the interview should be done with the teenager alone, parents also need to be interviewed at some point for behavioural observations, school history, past history, and family history. A longitudinal history should emphasize such features as anxious or shy temperament, prior symptoms, perfectionism, obsessive traits, and a history of learning or attention problems. In taking a family history, probe beyond diagnosed psychiatric disorders to include family members with undiagnosed chronic anxiety, avoidance, agoraphobia, or transient panic attacks. A strong family history of multiple anxiety disorders gives a valuable clue that behavioural problems are driven by anxiety.

Managing adolescent anxiety

The essential first step is to gain teenagers' cooperation through developing rapport. This is difficult at first, as anxious teenagers are practised at resistance, but the fact that you have taken time to listen through the assessment has a remarkable effect. Before engaging in more specific treatments (**Table 2**), such factors as sleep routines, regular eating patterns, exercise, and a balance of activities should be addressed. Most teenagers can accept that anxiety symptoms will be worsened by sleep deprivation and lack of fuel. Convincing them to exercise can be challenging, but you can emphasize that simply taking a break and walking the dog can help produce physical relaxation.

Table 2. Management of adolescent anxiety

Basics: sleep, eating, exercise, schedule
Avoid alcohol and drugs
Parent or family counseling
Individual or group counseling
Learning supports
Mandatory attendance at school
Develop areas of success
Cognitive behavioural therapy: education, examination, experimentation, exposure
Medications: primarily selective serotonin reuptake inhibitors
Coping rather than cure

Patterns of avoidance through excessive TV watching, video games, or staying up late take some creativity to manage. Rather than becoming yet another adult insisting on compliance, engage teenagers' interest by suggesting that they try some "experiments." A similar approach should be taken with substance abuse. If you insist that they stop, they could simply stop telling you that they are using. You can encourage them to observe the effects for themselves and let you know what they find out. In other words, keep this discussion open.

Psychoeducation. Psychoeducation regarding the pathogenesis of anxiety symptoms is crucial. Excessive anxiety, especially if it is likely to be a lifelong tendency,

cannot and should not be entirely eliminated by avoidance or even by medications. Anxiety needs to be understood and mastered. Teenagers will be quite interested in an explanation of the physiologic mechanism of specific anxiety symptoms and in how the mind elaborates on these symptoms to produce cycles of avoidance or phobias.[21] Discussing the perfectionism, procrastination, paralysis pattern, or how chronic anxiety is physically exhausting and produces irritability, will demonstrate to teenagers that you have some understanding of what is going on. If they simply begin to observe some of these patterns, they will be on the way to making changes.

Similarly, parents need education about behavioural aspects of anxiety, including rages and avoidance, as they are often also caught up in ineffective cycles of anger and frustration. There is a need for consistent, calm, and structured parenting; conflict resolution strategies; and communication with their teenagers. It is also important to address other family stresses, such as marital conflict, to which teenagers could be responding. At times, a family therapy approach is most helpful to re-establish calm, effective communication and healthier parenting strategies. Further, it is likely that at least one of the parents also suffers from anxiety. Addressing the parent's coping skills or anxiety symptoms will usually improve teenagers' functioning. Encourage parents to check the local library for books or websites to better understand and manage anxiety.

Specific psychosocial treatments. Individual or group counseling for teenagers should focus on skills development, including social skills, structuring time, handling homework, and learning specific cognitive and behavioural strategies for preventing catastrophic thinking and avoidance. Cognitive behavioural therapy (CBT) strategies are effective,[21-24] are easy to learn,[21] and can be taught in small doses by family physicians during frequent short visits. These strategies are harder to practise, however, and teenagers should be approached with an attitude of curiosity and humour to encourage new attitudes and behaviours. The CBT therapist is primarily a coach, taking an active role familiar to physicians trying to change other health behaviours.

Key words are education, examination, experimentation, and exposure. Cognitive behavioural therapy requires *education* about physiologic anxiety, cognitive catastrophization, and avoidance; *examination* of one's own habits in these routines; some *experiments* with new ways of thinking and behaving; and *exposure* to anxiety-provoking situations to practise and reinforce these strategies. An example would be an adolescent who is avoiding school because of anxiety about rejection by peers leading to physical anxiety symptoms and angry irritability with parents. Education includes pointing out the connection between worry and physical symptoms, and how avoidance perpetuates this by making it worse the next time. Some distraction or relaxation strategies can be suggested. Examination of unjustified negative predictions about social contacts can be followed by suggested experiments, such as making eye contact or making a friendly comment. Teenagers should be reminded of the need to practise exposure to feared situations between appointments.

Casually encouraging language should be used: "find out which things work best for you"; "what's so bad about taking a risk; it can't be worse than you've already imagined it…."; "maybe it won't work, but what's to lose in trying?" Tap into teenagers' creativity and sense of humour. Stress and anxiety management books can be recommended for those who like to read.[25,26] School counselors, local health departments, and mental health agencies often run groups for teenagers to help develop these skills. Teenagers who have a fixed pattern of negative thoughts and avoidance will need referral to psychologists or psychiatrists for more intensive treatment.

Role of family physicians. To what degree can family physicians manage these problems? Family physicians are essential in evaluating potential medical factors, in undertaking psychoeducation, in initiating pharmacotherapy when indicated, and in referring patients to specialized resources. While family physicians are often frustrated with the difficulty of accessing mental health resources and specific CBT treatments, they should be reassured that a recent study of school avoidance showed a supportive psychoeducational approach was as effective as CBT and more accepted by young people.[12]

Strategies listed in **Table 2** reflect common sense and can be reinforced by many adults in teenagers' support networks. Support networks can be strengthened by involving extended family members, mental health workers, family services, or a youth worker. When resources are scarce, supportive counseling could be available through a parent's employee assistance program, an ethnic community, or a religious organization. Referral to a psychologist or psychiatrist for further assessment and treatment should be arranged if no progress occurs after several sessions of intervention. Finally, consider having a community health nurse or mental health outreach

worker visit at home to assess very resistant teenagers who are inaccessible because they are refusing to attend appointments.

School interventions. For most anxious adolescents, school is a great stressor because of the social environment and performance demands. Ask parents to maintain close contact with the school, and beware of facilitating school avoidance with medical excuses. Learning supports should be put into place to adjust academic workload if indicated, to address specific learning disabilities, and to help teenagers develop schedules, prioritizing work and avoiding procrastination by breaking up projects into small chunks. Parents can help by hiring a tutor. School-based counseling might facilitate attendance. Some teenagers need smaller classes, "support block," or special program placement.

Ideally, because of the exposure principle, school attendance should be mandatory. As this is effectively unenforceable, we have to compromise and be creative. If all else fails, less preferable options include part-time attendance and home schooling so that at least basic academics are completed. Some young people with social phobias bypass the social complexities of high school through home schooling, but go on to attend post-secondary programs—so be patient.

Pharmacotherapy. What is the role of medication? Medication options (**Table 3**) should be considered by family physicians when anxiety impairs adolescents' psychosocial and academic functioning. Pharmacotherapy with selective serotonin reuptake inhibitors (SSRIs) is increasingly used for anxiety disorders due to demonstrated efficacy in controlled trials involving anxious adults and open trials involving teenagers. Several controlled trials are currently under way in children and adolescents. In adults, we have level 1 evidence for the efficacy of SSRIs in panic disorder, social phobia, OCD, and even generalized anxiety disorder.[27] Imipramine and buspirone are also effective for generalized anxiety in adults. In children and adolescents, we have level 1 evidence that OCD is responsive to clomipramine, fluvoxamine, and sertraline[28] and that fluoxetine is also effective in selective mutism, thought to be variant of social phobia.[29]

Clonazepam has been shown to be superior to placebo in adolescent panic disorder but is associated with problems of irritability and disinhibition at doses of 2 mg or more daily.[30,31] We also have level 2 evidence from open trials involving young people for the efficacy of buspirone[32] and fluoxetine[33] in generalized anxiety.

Considering the high comorbidity with depression, the most common medications prescribed for adolescent anxiety are SSRIs, especially paroxetine if getting to sleep is a concern. Initial medication dose should be low (eg, 10 mg of paroxetine or 25 mg of sertraline) to minimize the transient exacerbation of anxiety seen in many of these patients or the effect of anxiety sensitivity, which causes them to overreact to or misinterpret

Table 3. Medications for adolescent anxiety

MEDICATION CLASS	INDICATIONS	ADVANTAGES	DISADVANTAGES
Selective serotonin reuptake inhibitors	Obsessive compulsive disorder (level 1) Social phobia (level 2) Generalized anxiety (level 3) Panic disorder (level 3)	Treats comorbid depression Well tolerated	Sexual side effects Occasional behavioural disinhibition or amotivational state
Imipramine	Attention deficit disorder (level 1) School phobia (level 1) Generalized anxiety disorder (level 2)	Treats comorbid attention deficit hyperactivity disorder Inexpensive	Anticholinergic and cardiac side effects
Buspirone	Generalized anxiety disorder (level 2)	Well tolerated	No effect on depression Subtle effects
Benzodiazepine	Panic disorder (level 1) Generalized anxiety disorder (level 2)	Rapid onset	Behavioural side effects Cognitive impairment

Level of evidence: 1—controlled clinical trials in children and adolescents; 2—controlled trials in adults, open trials in adolescents; 2—evidence in adults, clinical observation in adolescents.

somatic sensations (such as jitteriness, nausea, or dizziness). Dose-finding studies in adult anxiety disorders, however, demonstrate that the effective dose is often at least 40 mg of fluoxetine or paroxetine. In younger people, a limiting factor is dose-related behavioural activation,[34] and in the longer term, the high rate of anorgasmia is definitely upsetting to teenagers. In generalized anxiety, buspirone or venlafaxine are alternatives that could have fewer sexual side effects.

For those with attention problems as well as anxiety, a combination of SSRIs and stimulants can be considered. Because of demonstrated efficacy in both attention deficit hyperactivity disorder in young people and anxiety in adults, imipramine is an option, although limited by side effects.[35] After conflicting results from several placebo-controlled trials on imipramine's effect on school avoidance, a recent study found imipramine combined with CBT to be significantly more effective than placebo with CBT.[36] Clinical practice suggests that the antidepressant serotonin and noradrenaline reuptake inhibitor (SNRI) venlafaxine is a better tolerated option, although controlled research is lacking at present.

Although SSRIs are becoming valuable in relatively quickly improving symptoms and functioning in anxious young people, several problems remain. First, anxiety tends to be chronic,[1] so symptoms return quickly when medication is tapered, and hence long-term treatment is common. Second, symptoms of avoidance require additional behavioural interventions. Third, an anxious teenager might be returned to school with an SSRI, but if learning disabilities are not addressed, school failure and secondary avoidance will recur. Longer-term studies involving adults with anxiety disorders have clearly shown that the best outcomes are with a combination of CBT and medications, and that medications rarely eliminate anxiety symptoms—even with optimal treatment.[37] Anxious patients need to learn to tolerate physiologic anxiety and to develop skills to overcome avoidance symptoms in order to prevent long-term impairment of social and occupational function.

Conclusion

Anxious teenagers sometimes hide behind aggression or defiant avoidance behaviour, which can be as frustrating for physicians as for families. Although medications can reduce symptoms and hence the intensity of behavioural problems, habitual patterns of avoidance in particular require teenagers' cooperation in practising exposure. It is helpful to follow adolescents' interests to find areas for success—a job,

Editor's key points

- Anxiety disorders are common among adolescents (estimated prevalence 5% to 15%) and can present as substance abuse, somatic or insomnia complaints, out-of-control behaviour, or refusing to go to school.
- Comorbid conditions include attention deficit hyperactivity disorder, learning disorders, depression, and eating disorders.
- Assessment should take place over several appointments, while physicians build rapport, ensure confidentiality, and identify acute stresses and specific symptoms.
- Management should focus on listening to teenagers, educating them about anxiety symptoms, and encouraging them to observe the effects of their actions. The goal is to have them learn to control their anxiety rather than cure it.
- Medications, particularly selective serotonin reuptake inhibitors, have been shown to help control the symptoms of anxiety, but are not a long-term panacea.

Points de repère du rédacteur

- Les troubles anxieux sont fréquents chez les adolescents (la prévalence estimée varie de 5 à 15%) et peuvent se manifester par de la toxicomanie, des plaintes d'ordre somatique ou d'insomnie, un comportement incontrôlable ou le refus d'aller à l'école.
- Au nombre des états de comorbidité figurent l'hyperactivité avec déficit de l'attention, les problèmes d'apprentissage, la dépression et des troubles de l'alimentation.
- Il faudrait procéder à une évaluation s'échelonnant sur quelques rendez-vous, pendant lesquels les médecins établissent la relation, assurent la confidentialité, et identifient les symptômes précis et les manifestations de stress aigu.
- La prise en charge devrait insister sur l'écoute des adolescents, leur éducation concernant les symptômes de l'anxiété et un encouragement à observer les répercussions de leurs actions. Le but est de les amener à apprendre à maîtriser leur anxiété plutôt que de la guérir.
- Il a été démontré que la pharmacothérapie, en particulier certains inhibiteurs de recaptage de la sérotonine, aidait à contrôler les symptômes de l'anxiété, mais elle n'est pas une panacée à long terme.

hobbies, sports, mentoring—to keep them functioning as well as possible. Physicians and families need to maintain a calm and practical approach; it is rare for anxiety to go away completely. Even with optimal medication management and psychotherapeutic supports, longitudinal research in both adults and children indicates that anxiety will be chronic and recurrent. Hence, teaching teenagers to cope effectively is a more realistic goal than attempting to cure anxiety. Fortunately, the skills gained in coping with anxiety as adolescents will better equip patients to manage future symptoms of anxiety.

Competing interests

None declared

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