

Anxiety Disorders in Children

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Abstract:

The aim of this study was to determine the prevalence of anxiety disorders among children 7-12 years old by purposive sampling of all lecturers (mothers and fathers) who had this group of child's age at second part of Mosul University. The study enrolled that out of 149 children are assessed, 49 had anxiety disorders making a point prevalence of (32.9%) with a female to male ratio of (1.2:1). In age group 7-8 years the highest prevalent disorders are separation anxiety disorders and specific phobia. While at the age group 9-10 years PTSD shows a highest fraction. At the age group 11-12 years the most common disorders is generalized anxiety disorder. The present study revealed that anxiety disorders are significantly influenced by multiple factors from those were; age of the child; parents who had any psychological and organic diseases; stressful life events; negative temperament; any disease in a child him\herself; education of a father and family history of psychiatric illnesses. Whereas education of mother, family types, socioeconomic status, crowding index, unemployed fathers, and working mothers played no significant role in modifying the occurrence of anxiety disorders. The investigator recommends that over anxious child needs special attitude from teachers to avoid the consequences of school refusal and its sequel.

اضطرابات القلق النفسي لدى الأطفال

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ملخص البحث :

إن الأهداف الرئيسية لهذه الدراسة هو تحديد مدى انتشار اضطرابات القلق عند الأطفال بعمر ٧-١٢ سنة بطريقة اخذ عينات قصدية للتدريسيين (الآباء و الأمهات) للمجمع الثاني لجامعة الموصل الذين لديهم طفل أو أكثر بهذا العمر. وقد شملت الدراسة ١٤٩ طفلاً قيمت حالتهم ، ٤٩ طفل منهم كانوا يعانون من اضطرابات القلق و ذلك بمعدل ٣٢.٩% و بنسبة أنثى اذكر ١.٢/١. في مجموعة الأطفال عمر ٧-٨ سنة ، أعلى نسبة سجلت هي اضطرابات القلق الانفصالي ثم الخوف من شيء معين، أما في المجموعة العمرية ٩-١٠ سنة كانت أعلى نسبة هي اضطرابات القلق بعد الضغط النفسي، والأعمار ١١-١٢ سنة فان اضطرابات القلق العام هي الأكثر شيوعاً. لقد أظهرت الدراسة الحالية بأن اضطرابات القلق للأطفال تتأثر بشكل واضح بعوامل عدة من بينها: عمر الطفل، الوالدين الذين لديهم اضطرابات نفسية أو عضوية كذلك الضغط النفسي في العائلة، المزاج السلبي، تاريخ مرض نفسي عند الطفل كل هذا اظهر أهمية عالية متعلقة بحدوث اضطرابات القلق لدى الأطفال والمستوى الثقافي للآباء. أما المستوى الثقافي للأمهات، نوع العائلة، المستوى المعاشي للعائلة، نسبة الازدحام، الآباء العاطلين والأمهات العاملات كل هذه العوامل ليس لها دور في حدوث اضطرابات القلق لدى الأطفال. يوصى بالاطفال المصابين بالقلق النفسي باحتياجهم إلى سلوك خاص من المعلمين لتجنب حدوث حالة رفضهم للمدرسة ونتائجها الوخيمة.

Introduction:

The presence of anxiety is common in children and adolescent. The entire spectrum of anxiety symptoms from typical developmentally appropriate anxiety, to clinical anxiety syndromes which may cause impairment and sever subjective suffering is encountered by most mental health professionals who work with children and adolescents (Kaplan & Sadock's, 2003). Since anxiety can interfere with concentration and can affect school performance and socialization. When persistent there is a risk of depression, suicide attempts and substance abuse in adulthood (Rothe & Castellanos, 2001; James et al, 2006). Anxiety may be broadly defined as the emotional uneasiness associated with the anticipation of

danger. It is usually distinguished from fear, which is regarded as the emotional response to objective danger, although, the physical manifestations are the same. Anxiety is characterized by a subjective feeling of apprehension dread or foreboding, accompanied by a variety of physical symptoms mediated by the autonomic nervous systems (palpitation, shortness of breath, trembling, sweating, with skin pallor and dry mouth). Anxiety is not only a common human experience, but it is also present or may co-exist with many medical or psychiatric disorder such as asthma and ADHD (Halamandaris and Anderson, 1999; Rothe & Castellanos, 2001). The prevalence rates for the different anxiety disorders vary according to the study. In USA study in children 3-13 years old anxiety prevalence were 7.7%. However, there is general agreement among investigators that anxiety disorders are one of the most prevalent categories of child and adolescent psychopathology (Castellanos & Hunter, 1999).

Clinical Syndromes:

Separation anxiety disorder: is the most common anxiety disorder in children the essential feature of separation anxiety disorder is excessive anxiety about separation from home or parent or attachment figures. With unrealistic worry about harm to self or parent, repeated nightmares with theme of separation, reluctant to sleep alone or away from parents, school refusal and physical complaint at the time of separation (Rothe & Castellanos, 2001; Kaplan and Sadock's, 2003). Separation anxiety disorder can occur at any age but is seen most often in prepubertal children. The gender ratio is poorly understood some study shown equal number of girls and boys, whereas other epidemiological study report more female with this disorder (Rothe & Castellanos, 2001).

Generalized anxiety disorder: Generalized anxiety disorder involves a worry of general nature. Children with generalized anxiety disorder display excessive anxiety and worry about various aspects of their life. They may worry excessively about their own competence, how they will do on an examination, what they will wear the next day, etc. these children wanting to be excellent at school, athletics, social relation, physical appearance, etc. possibly as a result of excessive worry and self focus. These children often show marked self consciousness. Somatic complaints such as fatigue, difficulties concentrating, restlessness, sleep difficulties and muscle tension. The anxiety produces significant distress for the child or interferes with some aspects of daily functioning. Generalized anxiety disorder present different demographic characteristics compared to children with separation anxiety disorder. Children with generalized anxiety disorder are older at the time of initial intervention. In, addition generalized anxiety disorder is observed more in older, rather than younger children and adolescents (Castellanos & Hunter, 1999).

Panic disorder: The essential feature of panic disorder is the presence of panic attack. Panic attack is characterized by a discrete period of intense fear or discomfort that develops acutely. It is associated with multiple physiological symptoms, such as, palpitation sweating, trembling, choking sensation, feeling short of breath, etc.. Fear of losing control, dying or going crazy are also common during the attack, worries about the consequence of the attack and changes in behaviors related to the attack are typical also.

Spontaneous panic attacks appear to be rare before puberty. The age of onset of the first panic attack in patients with panic disorder peaks between 15 and 19 years of age (Castellanos & Hunter, 1999).

Phobias: In contrast to normal fear, which are developmentally appropriate, phobias are excessive and out of proportion to the demands of the situation, are beyond voluntary control, cannot be reasoned away, lead to avoidance, persist over time and are maladaptive. These stimuli include a variety of specific situations or objects, such as, seeing blood, receiving an injection, animals or heights while social phobias the fear of humiliation and embarrassment is specific to social setting. Several studies have documented that mild fears are common in children of all ages. It appears that girls report fears more than boys (Castellanos & Hunter, 1999).

Obsessive-Compulsive Disorder: Obsessive is recurrent, persistent thoughts that are experienced as intrusive and senseless. Compulsive are repetitive, purposeful behaviors or rituals. The most common reported obsession in children and adolescents are fear of contamination (35%) and thought of harming oneself and familiar figure (30%). The most frequent compulsion are washing and cleaning rituals (75%), checking behavior (40) and straightening (35%). The average age of onset in psychiatrically referred population is between 10 to 12 years (Castellanos & Hunter, 1999)..

Post-traumatic Stress Disorder: In recent years the diagnostic criteria of PTSD were applied to children. The onset can occur at any age, as it is precipitated by an extreme trauma or stresses. The child usually responds with extreme fear or helplessness. Intrusive re-experiencing of the event (such as nightmares, play involving the event), avoidance of factors related to the trauma and chronically increased arousal, disruption in various aspects of their lives (Castellanos & Hunter, 1999).

High anxiety in a child is closely related to frequent negative feedback and parental restriction (behavioral inhibition). This is studied by Castellanos and Hunter (1999), they discovered that children who

remain inhibited throughout childhood would have an increased risk for an anxiety disorder relative to children who were not persistently inhibited so this appears to be a predictor of a predisposition to an anxiety disorder. This is usually associated with tendency to be unusually shy, or to show fear and to withdraw in unfamiliar situations which is called temperamental trait. In a 3 years follow up study, Castellanos and Hunter (1999), found that those children with behavioral inhibition and temperamental trait had higher rate of anxiety disorders than children without this temperamental trait. Evidence also suggests that anxiety disorders are familial, Castellanos and Hunter (1999), a large population based study support the influence and association of genetic factors as risk factors for anxiety disorders and psychopathology in general. In addition, various environmental factors play a prominent role in development of anxiety disorders. Recent reports in the literature demonstrate an association between autoimmune processes and OCD. Some cases of pediatric OCD may be associated with viral and group A B-hemolytic streptococcus infection in children.

Aim and Specific Objectives of the study are:

1. To determine point prevalence of anxiety disorders among study sample.
2. To calculate type specific point prevalence of anxiety disorders among study sample.
3. To compute gender and age specific point prevalence of anxiety disorders among study sample.
4. To specify the possible risk factors for the development of anxiety disorders among study population, which include child temperament, familial tendency, stressful life events and diseases in a child.

Method:

Selection of the children and their families was done by using purposive sampling technique of all lecturers of second part of Mosul University which is located in hai-Al-Shurta in Mosul city in left bank of River Tigris. This part of Mosul University is include five colleges: College of Fine Arts, College of Low, College of Political Since, College of Basic Education and College of Nursing. The unit of the present study was lecturers who had children (7-12 years of age) were considered in the interview. The information was collected by direct interview with either mother or father in all children, while child interview and family interview done when the investigator suspected the diagnosis of anxiety disorders. All the information needed to evaluate the different risk factors for anxiety disorders in children are collected through use of questionnaire form prepared by the investigator. The diagnosis is depending on the diagnostic criteria from DSM- IV- TR, 2000 scale published by American Psychiatric Association.

Calculation of socioeconomic status scored by three parameters related to the head of the family were considered (i.e. educational level, job and ownership of the house) each parameter is scored as follows:

Educational level: (0 = illiterate, 1 =primary and secondary, 2 =university). Job: (0 =unemployed, 1=unskilled, 2= skilled, 3= professional). Ownership of the house: (0= rent, 1=owned).

Scores of the three parameters were added together, then the socioeconomic level was stratified into: Low=0-3. Intermediat=4-6. High=6. (Abdul-Majeed, 2002).

Data collection was conducted during November and December 2005. Statistical analysis was carried out by using SPSS software, Chi-square (X^2) test computed for contingency tables to find the statistical

association or differences between diseased and not diseased children. For the presence or absence of the significance, p-value as < 0.05 was considered to be significant throughout the analysis (Kirkwood, 1988).

Results:

During the two months period spent on data collection (202) number of either mothers or fathers were included, which yielded a total 149 children (7-12 years).

Table (1) portrays the demographic characteristic of the study population. Almost (34.9%) were children 7-8 years of age and (35.6%) were among the age group 9-10 years, and (29.5%) were 11-12 years of age. Regarding sex distribution the same table depicts that there are 49.7% males and 50.3% females. The table also indicates that the largest number had 6 or more family members (47%).

Table (1): Demographic characteristic of study sample

Demographic criteria		No. of children	%
Age	7-8	52	34.9
	9-10	53	35.6
	11-12	44	29.5
Gender	Male	74	49.7
	Female	75	50.3
Number of family members	3	1	0.7
	4	45	30.2
	5	33	22.1
	6 or more	70	47

Table (2) depicts the family characteristic of study sample. About the occupation of both mothers and fathers, the results showed that

majorities of mothers are housewives (69.1%) and the majority of fathers are employed (87.9%). The general educational level for both mothers and fathers is shown in the same table same number of mothers fall in the primary and secondary level (29.5% & 18.8%) as in college level. About fathers' educational level, almost nine-tenth (87.9%) had university educational certificates compared to almost half (51.7%) of mothers. The lowest distribution of study sample fall in low crowding index (14.8%), children who lived in an overcrowded homes (>4 person/room) had a (38.9%) in study population. Other characteristic of study population is socioeconomic status (SES), it is clear in same table that two third had intermediate SES (60.4%).

Distribution of study population (children) according to presence or absence of diseases among mothers and fathers were almost the same in fathers and mothers who had no disease (71.1% & 71.8% respectively). On the other hand more than one quarter of mothers had psychiatric conditions (27.5%) & more than one tenth of fathers had organic diseases (11.4%). About family type almost three quarters of children lived in nuclear family (75.2%).

Table (2): Family characteristic of the study sample

Family characteristic		No. of children	%
Occupation of mother	Housewife	103	69.1
	Working	46	30.9
Occupation of father	Working	131	87.9
	Not working	18	12.1
Educational level of mother	Primary or less	44	29.5
	Secondary	28	18.8
	University	77	51.7
Educational level of father	Primary or less	6	4
	Secondary	14	9.4
	University	129	86.6
Crowding index	High	58	38.9
	Intermediate	69	46.3
	Low	22	14.8
Socioeconomic state	Intermediate	90	60.4
	High	59	39.6
Mothers disease	Psychological	41	27.5
	Organic	1	0.7
	No Disease	107	71.8
Fathers disease	Psychological	26	17.4
	Organic	17	11.4
	No Disease	106	71.1
Family type	Nuclear	112	75.2
	Extended	37	24.8

Table (3) provides quantitative estimates of point prevalence of anxiety disorders among study children. At the time of the survey there were 49 diseased children out of 149 children examined. The overall point prevalence of anxiety disorders in children was 32.9%. The prevalence breaks down according to the specific psychiatric disorder is documented in same table. The prevalence rate was (10.7%) in generalized anxiety disorders GAD. The prevalence of specific phobia SP is (8.1%), the same figure was reported for posttraumatic stress disorder PTSD (8.1%), separation anxiety disorder (4.7%), obsessive compulsive disorder OCD and panic disorder PD is (0.7%) in each.

Table (3): Type specific point prevalence (%) of anxiety disorders

Disorders	No. of children	%
GAD	16	10.7
SP	12	8.1
PTSD	12	8.1
SAD	7	4.7
OCD	1	0.7
PD	1	0.7
Total Diseased	49	32.9
No Disease	100	67.1
Total	149	100.0

Table (4) shows gender specific point prevalence of anxiety disorders. Almost all gender specific prevalence rates were higher in females than in males except in SAD (2.7% versus 2%). This difference is of no significant value.

Table (4): Gender specific point prevalence of anxiety disorders

Disorders	Male		Female		Total	
	No.	%	No.	%	No.	%
GAD	7	4.7	9	6	16	10.7
SP	5	3.4	7	4.7	12	8.1
PTSD	6	4	6	4	12	8.1
SAD	4	2.7	3	2	7	4.7
OCD	0	0.0	1	0.7	1	0.7
PD	0	0.0	1	0.7	1	0.7
Total diseased	22	14.8	27	18.1	49	32.9
No disease	52	34.9	48	32.2	100	67.1
Total	74	49.7	75	50.3	149	100

$\chi^2 = 2.880, P \text{ NS}$

Table (5) depicts the age specific point prevalence of anxiety disorders among study population. Overall the highest prevalence is shown among the age group 7-8 years (14.8%). While the lowest one was among 11-12 years (6%). Considering the older children i.e. age group 11-12 years, GAD were in top of the list (5.4%) while for the age 9-10 years PTSD and GAD had the highest fraction (4.7% and 4% respectively). SAD were the highest prevalence in the age group 7-8 years (4.7%) followed by SP (4%). The difference according to the age is highly significant.

Table (5): Age specific point prevalence of anxiety disorders

Disorders	7-8		9-10		11-12		Total	
	No.	%	No.	%	No.	%	No.	%
GAD	2	1.3	6	4	8	5.4	16	10.7
SP	6	4	5	3.4	1	0.7	12	8.1
PTSD	5	3.4	7	4.7	0	0.0	12	8.1
SAD	7	4.7	0	0.0	0	0.0	7	4.7
OCD	1	0.7	0	0.0	0	0.0	1	0.7
PD	1	0.7	0	0.0	0	0.0	1	0.7
Total diseased	22	14.8	18	12.1	9	6	49	32.9
No disease	30	20.1	35	23.5	35	23.5	100	67.1
Total	52	34.9	53	35.6	44	29.5	149	100

$\chi^2 = 31.270$, P is 0.01-

Table (6) clarifies social background. An intermediate socioeconomic state and high crowding index carried no significant association with anxiety disorders and also there is no an evident effect ($P \leq 0.093$) of the family type with anxiety disorders.

Table (6): Social background component of parent in anxiety disorders

Social background	Not Diseased n=100		Diseased n=49		Total n=149		X ²	P-value
	No.	%	No.	%	No.	%		
Socioeconomic state								
Intermediate	59	39.6	31	20.8	90	60.4	0.250	0.617
High	41	27.5	18	12.1	59	39.6		
Crowding index								
High	34	22.8	24	16.1	58	38.9	4.239	0.120
Intermediate	48	32.2	21	14.1	69	46.3		
Low	18	12.1	4	2.7	22	14.8		
Family type								
Nuclear	71	47.7	41	27.5	112	75.2	2.830	0.093
Extended	29	19.5	8	5.4	37	24.8		

Table (7) shows no significant association of mother's and father's job and the development of anxiety disorders. Education of mothers has no significant association with the development of anxiety disorders ($P=0.347$). Furthermore comparing education of father with occurrence of anxiety disorders revealed significant association ($p=0.034$). The same table shows the distribution of the study population according to the presence of any psychological or organic diseases of fathers and mothers. A child who had a diseased mother and father were more prone to develop anxiety disorders ($p=0.001$ & $p=0.000$ respectively).

Table (7): Mothers', and fathers' characteristics in anxiety disorders

Variables	Not Diseased n=100		Diseased N=49		Total n=149		X ²	P- value
	No.	%	No.	%	No.	%		
Mother's job								
Working	71	47.7	32	21.5	103	69.1	0.5	0.480
Housewife	29	19.5	17	11.4	46	30.9		
Father's job								
Not working	89	59.7	42	28.2	131	87.9	0.334	0.563
Working	11	7.4	7	4.7	18	12.1		
Education of mother								
Primary	29	19.5	15	10.1	44	29.5	2.116	0.347
Secondary	22	14.8	6	4	28	18.8		
University	49	32.9	28	18.8	77	51.7		
Education of father								
Primary	6	4	0	0.0	6	4	6.743	0.034
Secondary	6	4	8	5.4	14	9.4		
University	88	59.1	41	27.5	129	86.6		
Mother's Diseases								
psychological	18	12.1	23	15.4	41	27.5	14.073	0.001
Organic	1	0.7	0	0.0	1	0.7		
No Disease	81	54.4	26	17.4	107	71.8		
Father's diseases								
psychological	9	6	17	11.4	26	17.4	21.551	0.000
Organic	8	5.4	9	6	17	11.4		
No Disease	83	55.7	23	15.4	106	71.1		

Table (8) shows that positive family history of anxiety disorders among family members increased the risk of developing anxiety disorders in a significant way ($P=0.000$). An important point is recorded in this table that the presence of two and more stress factors in child home increased the risk of developing anxiety disorders in a very highly

significant way ($P=0.000$). The same table shows that negative temperament is seen in almost one quarter (24.8%) of diseased children and (11.4%) of not diseased children had a significant degree ($P=0.000$). While history of diseases in child (psychological & organic) showed also significant difference between diseased and not diseased children.

Table (8): Family history of anxiety, life stress, temperament, and diseases in a child as risk factors in anxiety disorders

Variable	Not Diseased n=100		Diseased n=49		Total n=149		X ²	P- value
	No.	%	No.	%	No.	%		
Family history of same condition								
Present	78	52.3	14	9.4	92	61.7	34.015	0.000
Absent	22	14.8	35	23.5	57	38.3		
Life stress								
Present	59	39.6	7	4.7	66	44.3	26.647	0.000
Absent	41	27.5	42	28.2	83	55.7		
Temperament								
Negative	17	11.4	37	24.8	54	36.2	48.722	0.000
Positive	83	55.7	12	8.1	95	63.8		
Diseases in Child								
Present	16	10.7	26	17.4	42	28.2	22.315	0.000
Absent	84	56.4	23	15.4	107	71.8		

Discussion

Nothing is known about the morbidity of anxiety disorders of children per unit population in our country, since neither a regional nor the national register of these children exists. What is taken for granted in Iraq could not be assumed neither in western countries, higher income countries and more developed countries nor in other developing countries, because of impact of wars, embargo and disasters. Thus, the

findings of the present study may differ if it is compared with other findings taken in another period of time or another place. Therefore, the figure of point prevalence of anxiety disorders is 32.9% in this study which could be quite helpful indicator of the problem of childhood psychiatric disorders in Mosul City. The mental health of children and adolescents is influenced by displacement through war and catastrophe; by stresses on families, economic adversity, the limitation of child rights affording the access of education and health, and by the women in the society who must manage their children. For many children who face uncertain future, including those who are traumatized by disasters, the burden of serious emotional and behavioral disorders afflicts their lives, (World Federation for Mental Health, 2003). All these factors are present in Iraqi society. Furthermore, this may help in planning a preventive strategy to reduce the adverse outcomes of psychiatric disorders in children depending on the facts that the geographical variation in the prevalence of psychiatric disorder in children all over the world suggests the possibility of prevention, if factors that are amenable to change can be identified and dealt with.

A study was done in Palestine by Thabit and Vostanis, (2001) on 959 children from Gaza Strip ages ranged from 6-12 years trying to detect the prevalence of behavioral and emotional problem among Palestinian children, concluded that the incidence in boys was 54.9%, while in girls it was 49.4%. Factor analysis of the study revealed 3 factors; aggressive behavior, anxiety-fearful and school refusal. Other study on American children shows that anxiety disorders occurring in 5-20 of all children and adolescents (James et al, 2006).

In this study PTSD point prevalence was estimated; where more than 10% of children had this disorder. A study done in North of Iraq showed that at the time of trauma children reported PTSD in very high

percentage (87%) while life time PTSD was diagnosed in 12.5% only, (Ahmad et al, 1999; Ahmad and Mohamad, 1999) this may be due to over diagnosis at the time of trauma. This difference may be due to fact that a traumatic exposure interacts with factors in the child and family to contribute to the development of PTSD and these factors are called child vulnerability (Silva et al, 2000). Child vulnerability to trauma may be strong in Iraqi children that resulted in less prevalence rate of this disorder in Mosul City. In this study has been reported that girls had same scores like boys, this was not supported by Ahmad et al, (1999) study in which female had more scores.

Rothe & Castellanos (2001) and Castellanos & Hunter (1999) studied the prevalence of separation anxiety disorder in USA. They found that it was 5-7% in children 9-13years old. They suggested that these children are more likely to come from low socioeconomic state and single parent homes. This is almost similar to the finding of the present study (4.7%).

Wars, embargo and disasters in Iraq are affecting the result of the present study, which revealed an increase in the prevalence of specific phobia (8.1%). This finding is not like a study that has been done by Rothe & Castellanos (2001) on American children aged 8, 12, and 17 years which showed that only 1% met the criteria for this disorder but it is similar to a study done in Spine show the prevalence was 3-13% (Gil & Meca, 2001).

Rothe & Castellanos, (2001) concluded that separation anxiety disorder had an equal gender distribution until adolescent age (18years), after which the disorder appeared to predominate in girls, while specific phobia and PTSD were more in girls. This is correlated with the present study.

Regarding that is no significant statistical association of the present study with male sex that anxiety disorders occur more in female. The present study showed that there was a statistical association of age and anxiety disorders and this is explained that anxiety disorders has a high percent of remission rate. It has been found that remission rate of separation anxiety disorder at 4-5 years follow up, was 77%. While the 8 years follow up of anxiety disordered children suggested that they are relatively well adjusted in young adulthood, (Castellanos & Hunter, 1999). Background of the Parents the result of this study showed that being a working and not working mother and father, poor socioeconomic status, and overcrowded homes carries no risk for children to develop anxiety disorders. In fact most of the study population are from highly educated, and usually good socioeconomic status compared with other people in community.

Earlier, Eapen et al, (2001) in United Arab Emirates showed no significant association between crowding index, socioeconomic state and prevalence of behavioral and emotional problems in children. About extended families a study carried out by Mir et al, (2001) showed that although extended family is provided as a supported structure for children of South Asian communities, in fact extended family has been greatly modified through other factors such as inappropriate housing and low income, which are equally may result in adversity of value system within these communities. These suggestions can be applied to the results of the present study.

Reviewing the results of the present study showed that parents with organic and psychiatric disorders carried a high significant association with development of anxiety disorders. Castellanos & Hunter (1999) reported a higher significant prevalence of anxiety disorders among monozygotic twines than dizygotic twines. Furthermore, Rothe &

Castellanos, (2001) studied the informational transmission of anxiety and fears from parent to children. In their sample the majority of children attributed anxiety and fears to “modeling” their parent behavior (65%) and “informational” transmission (89%).

There is a wide agreement on the importance of life stresses, as a risk factor for anxiety disorders. Regarding the present study a persistent highly significant risk association exists between anxiety disorders and stressful life events. This result simulates two studies carried out in United Arab Emirates showing that behavioral disturbance in children between 6-18 years old and fears were associated with certain unspecified chronic life difficulties and parental distress (Eapen et al, 2001, Mohammed et al, 2001).

Several investigators examined the relationship between early temperamental traits and predisposition to the development of anxiety disorders (Salmon, et al, 1998). The result of a three years follow up study carried out by Castellanos & Hunter (1999) found that children with temperament trait had higher rate of anxiety disorders than those without this temperamental trait.

Rothe & Castellanos (2001) in USA prove that an overanxious child, phobia and substance abuse are common causes of school refusal. So, over anxious child needs special attitude from teachers to avoid the consequences of school refusal and its sequel.

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