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Chapter 1: The Rise of Childhood Anxiety

Although it's impossible to pinpoint the moment with certainty, research indicates that the capacity for conscious fear in its most basic sense first develops when a baby is less than 6 months old (Sussex Publishers, 2023). By the time they are 2 years old, they will have developed the cognitive skills necessary for anxiety, or fear regarding a hypothetical scenario, rather than an actual one. Children will spend the formative years of their upbringing confronting a number of new scenarios that can be fear-inducing for their young brain. Their emotional reservoir will expand with maturity and they will gain access to a wide range of emotions; of all of these, however, there is a statistical likelihood that they will develop a unique relationship with the emotion of fear.

Growing up in the 21st century means that these children will see fear expressed in a variety of media forms. They will see fear constantly 'overcome' in the films and programs they are shown, and the heroes in their stories will almost always show great bravery and a willingness to overcome the things that scare them. The child will be told time and time again, whether for a doctor's visit, a first day of school, a first bike ride, or a number of other things: 'don't be afraid.'

Some of the greatest historical quotations and remarks of all time have been comments on the subject of fear. From Star Wars one-liners to the iconic addresses of Presidents like FDR, fear is a topic that unites us because fear is arguably the most primal of all emotional experiences. We are incredibly familiar with the experience, and yet fear captures the human imagination like little else. It's ideal to believe that children are protected, in some ways, from the unpleasant emotions related to fear, at least at a chronic level; that the naiveté of childhood lends itself to a lack of serious concerns, worries, stressors, and

especially anxieties. In an ideal world, children might be entirely immune to such things. But while it's likely that this has never been the case, it is less so today than ever before.

There is compelling evidence to suggest that children today are experiencing higher levels of anxiety than at any point in recorded history. This is perhaps most clearly reflected in the official reported numbers of pediatric anxiety disorders. The most up-to-date reports from the Center for Disease Control and Prevention (CDC) indicate that in the United States alone, between 2016 and 2019, there were 5.8 million children between the ages of 3 and 17 clinically diagnosed with a pediatric anxiety disorder. This is a figure nearly doubled since the 2003 report (Bitsko, 2022). These anxiety disorders come in all shapes and sizes with a wide variety of unique symptoms and challenges; they are classified as the most prevalent of all childhood emotional disorders in the United States, affecting anywhere from "10% - 21% of children" depending on the study (McLoone et al., 2006, p. 220). This alarming statistic implies the potential of one in five children living with a clinically significant level of abnormal, stress-inducing anxiety on a daily basis.

There are a number of factors to consider when asking why we are seeing this clear rise in the prevalence of anxiety- within the general population, but most particularly among young children. No single one of these factors can be held entirely accountable, but studies and educators who cross-examine patterns of mental health across the past few decades seem to have reached a few general consensus: Firstly, one has to note the rise of the 24-hour news cycle, which ensures that no opportunity to be informed of a catastrophe is spared. Gone are the days when news of disaster on the other side of the world might take days, or even weeks, to reach your own ears. Just as adults are now swarmed with a constant, overwhelming flow of alarming notifications, children are often there to absorb the impact as well. In the same vein, the current generation of students is the first in world history to be literally "raised on the internet and social media," and the impacts of that are not yet fully understood (Scheffler

et al., 2018, p. 1). What is known is that this ‘rise of the screen,’ has inarguably reduced or even eliminated many children's primary outlets for decompression through physical activity (Sussex Publishers, 2023). Down-time that was once spent playing outside with friends is now spent on screen-based activities like gaming or streaming films and TV. The anxious energy that has always been naturally released in children through their time in physical play or creativity is now often left confined, as their free time is spent on screens. It certainly doesn’t help that much of the potential content on those screens can be hugely anxiety-inducing, explicitly designed to hook the user and cause them to crave more (Sussex Publishers, 2023).

One also has to consider the global state of political unrest that students are currently living in. Economic, social and political stressors all press harshly on many families in the current climate, and children are far from immune to sensing this. Children are observant by nature. High levels of social turbulence becomes very apparent to them when they begin to observe that the adults in their lives have chronic stressors that appear beyond their control. (Scheffer et al., 2018). This can stir up a sense of uncertainty, enhanced vulnerability and helplessness from very early points in a child's life and an increased sense of powerlessness that may be so subconscious the child themself can’t even truly identify its source. This is made worse by the fact that “in response to an array of economic and cultural shifts, parents today commonly put significantly more pressure on their children to achieve than did parents of a generation or two ago, and many children, carrying the burden of outsize expectations, worry about meeting them” (Sussex Publishers, 2023, pp. 1-2). Although this is most often unintentional - particularly in the earliest years of a child's life - it can have equally unintentional consequences. One of these is a drastic spike in a child's general anxiety.

But the rise of technology and of socioeconomic stress, while perhaps heightened in recent years, are not unfamiliar phenomena. What is entirely new, however, is the final factor

worth examining: The COVID-19 Pandemic turned the world upside down for everyone, and children were highly affected. Some educational and psychological experts with decades of experience working with children are convinced that the effect of COVID-19 on children's mental and emotional wellbeing is “absolutely unprecedented,” and stress further that the full extent of its impact is yet to be seen in the coming years (Morris, 2023).

While each of these factors is critical to consider in their own right, the purpose of this project is not to dwell on them. Each of these phenomena are complicated and multifaceted, with global impacts and implications that extend far beyond a rise in pediatric anxiety disorders. Most importantly, however, they are simply far beyond the control of a parent or educator. Our time and energy are much better suited to studying the new reality of these disorders, and best equipping ourselves to actually help the children they affect.

Before that is possible, we must first be convinced of the gravity of the situation; if it is going to be addressed with urgency, it first needs to be understood as an urgent matter of public importance, rather than simply an issue of ‘nervous kids.’ While the statistics and quantitative data certainly demonstrate the scale of the dramatic increase in anxiety levels, they fail to capture the real heart of the issue: the child behind each statistic. The family behind each diagnosis. The personal battle, struggle and devastation behind each and every case represented in the numbers. A proper understanding of this crisis is only possible when we examine the depth of the impact a pediatric anxiety disorder (PAD) inflicts at the personal level. A breakdown of the most common immediate and long-term impacts quickly reveal the severity not just for the affected child, but for their family, their peers, and ultimately the society they will one day join.

When thinking of the impact of PADs, it can be helpful to picture an earthquake: There is no way of predicting the duration, the severity, or the impact of such an event when it happens. This is dangerous on its own. But often the most dangerous part of an earthquake

is the aftermath: any number of other natural disasters may be triggered as a result- wildfires, tsunamis, avalanches and flash floods, etc. Damage continues long after the initial desire has ceased. PADs work in much the same way. While the disorder itself is chaotic and unpredictable for the child and those surrounding them, some of the greatest, most dangerous impacts are often delayed in the wake of everything "shaken up" by the anxiety. In other words, long after the primary bout of anxiety may have ceased, its impact will likely continue to be felt. "Anxiety disorders," for example, are very "often comorbid with other emotional disorders," and may foster a number of difficulties including, but not limited to, issues with attention and concentration, lower levels of self-esteem, lower achievement levels (academic and otherwise,) illicit drug dependence, progressive social impairments, trouble with peer relationships, ADHD, and most often, depression (McLoone et al., 2006, p. 220). In fact, the 2016-2019 CDC report indicated that of the 5.8 million children observed with registered anxiety disorders, more than 1 in 4 also exhibited some form of behavioral problems, while about one-third showed signs of clinical depression (Bitsko, 2022). A struggle with anxiety does not often occur in isolation; there are likely to be secondary issues involved that require attention.

Unfortunately the damage from an unaddressed childhood anxiety disorder does not stop after childhood. Several longitudinal studies indicate a significant increase in the likelihood of conduct and behavioral issues as an adult. These include elevated risks of substance abuse, unresolved emotional and psychological trauma, and even moderate to severe delays in the transition to independent living, (McLoone et al., 2006). These disorders tend to be "chronic in nature," as well, particularly if they remain untreated;" some data indicates that up to "50-70% of children who meet criteria for an anxiety disorder" will retain this diagnosis at least two years later, meaning that for many children and families, this is not

likely to be a short-term issue and certainly should not be dismissed as a ‘phase’ (McLoone et al., 2006, p. 220).

This is only a brief snapshot of the risks involved with an unaddressed pediatric anxiety disorder. Considering their magnitude, it is not surprising that they “have been named as one of the greatest health problems (exceeding most physical health problems) in terms of global burden” (McLoone et al., 2006, p. 221). It is this idea of global burden that lends the topic a true sense of urgency. These are the children that in just a few short years will begin to take up positions in society. When so many of them are at such risk, it is in fact nothing less than a matter of “profound public health significance” (Strawn et al., 2014, p. 154).

But on a much more intimate level, this is a topic of extreme personal importance on which any teacher, parent or caregiver should be well informed on. Anyone “involved in the supervision, emotional growth and well-being of children and adolescents” should be well-equipped to not only recognise an anxiety disorder, but to take action and provide help whenever possible, whether through assessment, classroom accommodation, referral in cases of need, or just through understanding and empathy (McLoone et al., 2006, p. 219). The vast majority of homes and classrooms are stocked with a basic first aid kit, ready to help when unexpected physical problems arise. Why then should every classroom and home not be equipped with another sort of aid kit? A toolbox of information and practices for children's emotional pain, struggles, and problems?

Some may argue that this sort of awareness is not the responsibility of a teacher. But we must understand that because school plays such an incredibly significant role in a child's identity development, teachers are actually in a unique position to become ‘first responders’ of a sort- recognizing and providing essential support for their students as they see them arise. And in fact, many who take on this profession do so out of care for their students, and a desire to help them in much more than just academic achievement. One study conducted

across five U.S. school districts, involving 292 teachers, reported that “89% of teachers agreed that schools should be involved in addressing the mental health needs of children" (Moran, 2015, p. 27). In this same study, however, the teachers admitted that they were not adequately equipped to help as effectively as they would like. They needed additional knowledge and skill sets, including the ability to know what to look for as a sign of mental health concerns, and strategies for working with students exhibiting such signs (Moran, 2015).

To return to the analogy of the earthquake (or of any natural disaster,) it would be foolish to wait until you’re in the middle of said disaster to try and figure out the right way to handle it. This is why we educate ourselves about the risks, carefully construct plans of action, listen to expert research and input while balancing it for our personal context, and keep appropriate supplies or physical refuge nearby. All of this is best done preemptively so that when those disasters come, we know what to do. It should be no different with our students in crisis. They look to us as a source of safety when fighting something they do not understand and cannot control. It is our responsibility to be that safety. They deserve nothing less.

Chapter 2: Identifying and Understanding Pediatric Anxiety Disorders

In order to develop the best practices for accommodating pediatric anxiety disorders, it's important that we first understand them at a basic technical level. The more information we are equipped with, the more 'visible' this 'invisible monster' can become, and the better fit we are to not only tackle it, but to equip our students with the tools for tackling it themselves.

Fear is a fundamental human emotion, and it plays a vital role in our survival. It serves as our brain's main protective agent, triggering physical signals that keep us alert and cautious in the face of danger. This instinctive sense of fear prevents us from, for instance, reaching into a fireplace or approaching a precarious ledge. As a child grows and develops physically, there is a logical progression of cognitive and emotional development that involves the evolution of their fears. Only as this development continues do they gain the capacity for anxiety.

Anxiety is a distinct subset of fear. It is fear specifically of a hypothetical threat rather than a clear-and-present one. In non-technical terms, anxiety can be described by using "a simple formula: add up all the things that cause us stress, and then subtract all of our abilities to cope. The net result is our anxiety level" (Moran, 2015, p. 27). This definition has two key components: the first is the collection "things that cause us stress" and the second is "our ability to cope." These are the pivot points between normal and abnormal in the discussion of anxiety. When there is an amplified range of things causing stress, and a minimized feeling of ability to cope (or a minimized sense of control,) we may begin to see greater, more abnormal degrees of anxiety. This is particularly true in children, who may often be less equipped to discern whether a sense of fear is justified. This excessive, unbalanced and abnormal anxiety level is not only unhealthy, but can be detrimental to a child's overall wellbeing and stages of development (Schoenfeld, 2008).

While anxiety is a very primitive emotion, clinical pediatric anxiety disorders were only first described and documented in pediatric patients just over a century ago. They have steadily risen in documented frequency since then and today, they are among the most prevalent disorders in children and adolescents (Strawn et. al., 2014). Whether this is because of an actual increase in their prevalence or merely an increase in awareness towards the disorders is difficult to say. It is likely a combination of both.

Research supports the notion that there is a standard progression for the development of most children's anxieties, at least in the modern world. In early childhood, for example, children will almost universally experience a spike in distress when separated from their caregiver. Toddlers often have fears of the dark, of 'monsters,' or of certain animals. By the time children reach early elementary age, they may begin to be fearful of natural disasters or concerned about injury or death of themselves or a loved one. Adolescents, finally, most often worry about how they are perceived by their peers, and their level of success in school or other activities (Thompson et. al., 2013). The very important progression to note here is this: as children grow, their fears are increasingly centered around hypothetical or potential dangers rather than real and present ones. Their mind begins to ponder the possible, not just the current. This falls in line with the precise definition of anxiety- a fear response dispatched by the brain without a clear and present danger. So, literally, anxiety is a skill that children will grow into.

These examples represent the wide variety of childhood anxieties that can be considered normal, or even expected. Because anxiety of so many kinds can be regarded as a very normal part of childhood and adolescence, it can be difficult for caretakers and educators to determine whether their child's anxious behavior is 'normal' or not. The larger, more significant question behind this, is whether there may be a problem to investigate (Schoenfeld, 2008). The key to the difference is interference. The level of interference in

daily life and functioning is the greatest indicator that a child's anxiety has crossed into abnormal territory. When anxiety begins to regularly interfere with functioning in the daily aspects of a child's life, especially in school and social relationships, it is time to investigate further (Moran, 2015).

Neuroscience

The average educator does not necessarily need a deep understanding of the neuroscience involved in an anxiety disorder. A working understanding, however, of what is defecting in the brain of a child struggling with one can be extremely helpful. Understanding that there is an active physical malfunction occurring in the brains of these children equips us with a new perspective; it allows us to step away from the emotional aspect of this topic and instead observe the disorder, and the behavior that results, from an objective standpoint.

It's often tempting to picture the human brain as a single supercomputer of sorts. But a far more accurate representation of our brain might be a sports team or a troupe of actors. There are many individual roles to be filled, each with different responsibilities, and all are hugely reliant on one another to succeed.

One very important subdivision of our brain is known as the limbic system. This is an area mainly focused on the processing of our emotions, and their connection to our memories (Guy-Evans, 2023). Embedded into the very deepest part of this region, literally right in the middle of the brain, is a very important structure known as the amygdala. It is this little almond-shaped player, less than 3 cubic centimeters in size, that is "the most notable and frequently implicated structure in pediatric anxiety disorders" (Strawn et. al., 2014, p.155)

The function of the amygdala is relatively straightforward: it is the "main player in generating the central fear response" (Strawn et al., 2014, p.155). It does this not only through our emotional sense of fear and discomfort, but through triggering key physiological reactions including elevated heart rate and the release of stress hormones (Thompson et. al.,

2013). The amygdala's most unique asset is its link to memory. The amygdala plays a critical role in linking our fear response to the memory of the trigger behind that fear (Guy-Evans, 2023). This structure has the potential, then, to control the hierarchy of anxieties within a brain; it can determine which are minor threats to be mindful of and which are actually cause for a panic response. Its influence on human behavior can be absolutely profound (Schumann, 2011).

Modern imaging technology allows us to examine the brain with an entirely new level of precision. The brain scans of children who struggle with anxiety disorders frequently exhibit certain markers that set them apart from those of the average child. The amygdala in these children's brains often shows a hyperactive, elevated response to stimuli, and consistently heightened cortisol levels. "Findings also indicated a robust correlation between responsiveness of the amygdala and the degree of anxiety symptoms" (Thompson et. al., 2013, pp. 223-224). From this neurological perspective, pediatric anxiety disorders present as "abnormalities in various neural structures that subserve threat appraisal, modulation of fear responses, attachment, and mentalization," and these may be present so early in the course of the disorder that they may even precede any external symptoms the disorder itself (Strawn et al., 2014, p.156).

This is only a shallow glimpse at the disruption occurring in the brain of a child struggling with an anxiety disorder, yet it is more than enough to conclude that these disorders pose a real and present challenge to a child's functioning and wellbeing. A basic grasp of the neuroscience, the 'behind the scenes' happenings of these disorders, can foster empathy for a struggling child.

Causes and Risk factors

There is no single risk factor or individual root cause that can universally account for the development of anxiety in children. The situation is much more complicated. Fortunately,

however, significant, focused research in recent years has allowed us to build a better understanding of the cause of these disorders. For the scope of this project, three of the key subcategories of this research will be emphasized: cognitive, biological, and environmental factors. Each of these, research demonstrates, appears to play at least a moderate role in the development of pediatric anxiety disorders.

The first category of potential causes and/or risk factors is the cognitive factor. This ties in, in many ways, to previous discussion of the neuroscience of abnormal anxiety. Every child's brain is unique, but evidence suggests there are certain cognitive traits that contribute to the development of an anxiety disorder. Among these is a struggle with "emotional dysregulation," which involves "a combination of heightened emotional responding and difficulty regulating emotional reactions" (Thompson et. al., 2013, p. 224). Both "appear to play a pivotal role in" not only the "development" but the long-term "maintenance of anxiety disorders in children" (Thompson et. al., 2013, p. 224). What does this look like practically? It often means that a child seems unable to separate their personal feelings from objective reality. This may mean irrational, frequent outbursts of anger, especially if there is a sudden 'unexplained' change in routine. It may also appear as extreme sensitivity, insistence on seemingly mundane routines or ways of doing things (as an effort to maintain control) or an aversion to crowds or crowded environments. These are all behaviors which may indicate the presence of an anxiety disorder. Cognitive intrapersonal risk factors also include behavioral inhibition (shyness,) heightened physiological responding, negative emotionality, difficulty controlling attention, and trouble with emotional self-efficacy, which is the ability to describe one's own feelings as they occur (Suveg & Zeman, 2004). All of these invisible cognitive symptoms, observable in outward behavior only to the careful eye, can suggest a struggle with an abnormal level of anxiety. They give cause, if nothing else, to investigate further.

Moving on to potential biological risk factors and causes, the evidence becomes more uncertain. Can an emotional disorder truly be linked to a purely physical condition? The research in this area is limited but gradually expanding, as concern grows over the rising prevalence of these disorders. One potentially physiological risk factor is a dysfunctioning hypothalamic–pituitary–adrenal (HPA) axis. This is a critical network of communication that is connected to the central nervous system. "Exposure to stress activates the HPA axis, which results in the secretion of cortisol," a hormone produced in response to stress, and "prolonged secretion of cortisol may up- or down-regulate the HPA axis," essentially throwing it off balance. When this crucial bodily system is off balance, working either excessively or insufficiently, it contributes to the development of anxiety disorders. (Narmandakh et. al., 2021).

Another biological factor of interest is the autonomic nervous system (ANS), which consists of 2 branches: one for stimulating and one for inhibiting the body's responses to stress. The ANS especially controls responses of the heart and the cardiovascular system as a whole, and when this system is, for whatever reason, out of balance in a person, (either with a high level of reactivity to stressors or a low threshold for inhibition), the heart rate and systolic blood pressure of a child can be affected. This idea of an 'unbalanced' or 'wonky' ANS has been proposed as a mechanism "underlying the development of anxiety" in children. The basic implication would be that "Children or adolescents with an anxiety disorder had a higher heart rate and systolic blood pressure than those without an anxiety disorder," an idea that has been supported in both observational and experimental studies, (Narmandakh et. al., 2021)

The final biological risk factor worth mentioning is the genetic factor. Having even one parent with a clinical anxiety disorder has been strongly associated with an "increased risk" of a child, or adolescent, developing one; longitudinal studies, in particular, support this

(Strawn et al., 2021, p. 117). For this reason, it is wise to closely monitor children who come from families with a known history of anxiety or any other struggle with mental health.

The environmental risk factors of anxiety disorders within children are much broader. Among the most frequently noted are parental illness, financial difficulties at home, and conflict within the family, and parental alcohol consumption (Walsh, 2021). All of these contribute to a potentially increased risk for the development of a clinical anxiety disorder. There is also evidence to suggest that the modeling of anxious behavior from parents or caretakers may create risk for the development of an anxiety disorder. When children constantly observe anxious behavior from the people that they know, subconsciously, are meant to care for them, they naturally tend to mirror those behaviors at an increased rate compared to their peers who are less exposed. These behaviors may include, at age-appropriate levels, reluctance to explore novel situations, increased avoidance, and general cautiousness beyond what is developmentally normal for the child's age (Lebowitz et al., 2013). “Children with anxious parents are up to seven times more likely to develop anxiety than children of non-anxious parents,” not only for potential genetic reasons, but also because anxious parents are often more controlling or critical in their tendencies (even unintentionally) and tend to be “selectively focused on negative outcomes than parents who are not anxious” (Strawn, 2021 pp. 224-5). The most explicit environmental risk factor for the development of an anxiety disorder, however, remains exposure to intimate partner violence or domestic violence; this is associated with not only the childhood onset of anxiety disorders, but a tragically wide range of other psychological and developmental concerns (Thompson et. al., 2013).

Finally, there is the risk factor of family accommodation. This is defined as “the degree to which a family changes/adapts behavior to decrease a child’s anxiety or avoid anxiety-provoking stimuli” (Strawn, 2021, p. 117). So, for example, a family who knows that

one child's anxiety increases when going out to a restaurant might stop going out altogether, rather than dealing with the many challenges and stresses of a public episode of intense anxiety. This, in turn, is likely to cement the child's anxious association with the idea of going out, so that if the family attempts to do so at any point in the future, the resulting 'meltdown' is much worse. Overtime, a vicious cycle is created. The family's overall level of energy is drained. Unsurprisingly, this method of accommodation or appeasement of anxiety by families, while understandable, contributes to significantly increased severity and potentiality of anxiety disorders (Strawn, 2021).

Early Indicators and "Warning Signs"

As with many things, the most powerful preventative measure for a child's anxiety disorder is early intervention; at the very least, the earlier a disorder can be identified, the earlier appropriate action can begin to be taken, such as equipping the child with coping mechanisms, soliciting the help of a licensed counselor or therapist, and implementing accommodations if necessary. It's important for educators to be aware of what the earliest indicators of a developing anxiety disorder are, in order to begin addressing them as soon as possible.

Every child is unique, and so their symptoms will likely be just as unique. But there are significantly common threads in the symptoms and behaviors of children whose anxiety levels are beginning to be abnormal. One of the most frequent is constant somatic complaints- that is, complaints of physical problems or fear that physical problems may soon occur if the child is not 'checked' (by the school nurse, a caretaker, etc) (Walsh, 2021). These are those children that ask to go to the nurse frequently, maybe even multiple times a day, and it is clear that it is not done simply to avoid classwork, but because they legitimately feel something is wrong with them and they express disproportionate concern about it (Morris, 2023). Stomach ache, headache, sore throat are very common, but more vague symptoms like

“I can’t breathe” or “I can’t swallow” or “I just don’t feel right”are often tell-tale signs of a high-anxiety child.

Other common external symptoms might include insomnia (or other sleep difficulties such as a refusal to sleep away from a parent), bedwetting, and sudden emotional changes that involve displays of anger, bouncing between withdrawal and intense clinginess, and a general expressed fear of being left alone or abandoned (Walsh, 2021). Because anxiety, more than plain fear, deals with hypothetical or potential dangers, rather than real ones, a child in the early stages of a disorder might frequently express ‘what-if’ concerns to justify or explain their behaviors when questioned. Because this is not typical of children, it may be a clear indicator of elevated levels of anxiety.

It’s key for us to understand the intended function of these external behaviors, which even the child themself may not be able to fully articulate. A student's anxiety related behavior is most often motivated by a desire to find escape or avoidance. Sometimes this is obvious, and other times, less so (Minahan, 2012). The behaviors may be driven by a desire to escape a physical space or to somehow attempt to escape the physical symptoms that have overtaken a students body, sometimes for no identifiable reason. When that hyperactive amygdala is triggering an age-old, deeply instinctual fight or flight response, a child is going to attempt to respond, even in situations where, to an observer, there is clearly no danger. Within school hours, unstructured times such as lunch or recess tend to be particularly difficult periods for these students, as well as any sort of novel events or unexpected changes in the regular daily routine. Escape and avoidance behaviors may flare up particularly strongly during these times (Minahan, 2012).

While these early indicators and external behaviors of pediatric anxiety disorder can be frustrating and disruptive, it's very important to remember that in most situations, children desire to please adults that they know care about them; they desire to behave. When

consistent misbehavior is occurring, it is often because there is some form of need that is not being met, or some necessary skill that hasn't been developed to meet that behavioral requirement (Greene, 1998). Students with anxiety disorders, especially in the early stages, may have the following underdeveloped skills which contribute to their external behaviors:

> "Self-regulation - The ability to calm self and manage frustration. Thought stopping/thought interruption (The ability to short circuit the cycle of negative thinking by refocusing attention on a replacement thought.) Thinking traps - The ability to recognize common patterns of thoughts that can increase anxiety and learn how to manage these thoughts. Social skills executive functioning- the ability to think before acting and to follow sequential steps to complete a task efficiently, and Flexible Thinking" (Greene, P. 36, 1998).

Common Categories of Pediatric Anxiety Disorders

Popular culture, particularly in recent years, has contributed greatly to a general public idea of what anxiety looks like, especially in children and adolescents. But one of the most difficult things about anxiety disorders is that while there are many early indicators, risk factors and 'symptoms' to be discussed, the reality is that anxiety is most often best "understood as a hidden disability" (Minahan, 2012, p. 35). One helpful analogy to think of is that of a shaken soda can. "Unless you see it happen, you have no way of knowing a soda can was shaken just by looking at it. You find out when you open the can and it explodes. The same thing is true with students who have anxiety-related behavior - many times, the student looks fine and then inexplicably explodes" (Minahan, 2012, pp. 35-36). Another helpful analogy is that of an earthquake, where small, gradual amounts of tension are practically unnoticeable until they build up to eventually trigger a great disaster, seemingly 'out of nowhere.'

The DSM-5 identifies a variety of different specific anxiety disorders. It is good to be aware of the most common of these types, in order to know what can most likely be expected in children who are struggling.

Generalized anxiety disorder, often abbreviated GAD, is defined by "a persistent feeling of anxiety or dread," that reaches a level where it frequently interferes with a patient's daily life and activities. The most common indicators of GAD, as they appear in children, may not cause a teacher or a caretaker to immediately consider problems with anxiety. They include general restlessness or seeming "on-edge," as well as constant fatigue, irritability or difficulty with sleeping (U.S. Dept. of Health). Panic disorder, by contrast, is characterized by frequent, unexpected panic attacks and all of their related physical symptoms, which can be particularly frightening for children who have no concept of what is happening to their body. For this reason, they will often simply complain that they feel as though they are 'dying' or that 'everything hurts.' Most problematically children struggling with panic disorder "often worry about when the next attack will happen and actively try to prevent future attacks by avoiding places, situations, or behaviors they associate with panic attacks," including school and any extra-curricular activities, even if they enjoy them (U.S. Dept. of Health, 2023).

Social anxiety disorder is another key subset of pediatric anxiety disorders likely to appear in any given classroom. This is "an intense, persistent fear of being watched and judged by others" which goes beyond what is developmentally normal for children by, again, inhibiting daily life (U.S. Dept. of Health, 2023). These children experience a fear of social situations "so intense that it seems beyond their control," which makes daily functioning in a classroom full of peers a nightmarish situation (U.S. Dept. of Health, 2023).

These are just a select few of the many subsets of pediatric anxiety disorders, and it is clear just between these 3 that the indicators, symptoms, and challenges are of a wide variety and rarely look exactly the same in 2 different students. However they do have one critical thing in common: the necessity for early intervention. Early intervention is critical, and the sooner a problem can be identified, the sooner it can begin to be addressed. Since failure to address these problems can be literally "detrimental" to every area of a child's critical

development, it's vital to begin to take action as soon as you believe there may be an issue (Schoenfeld, 2008, p. 583).

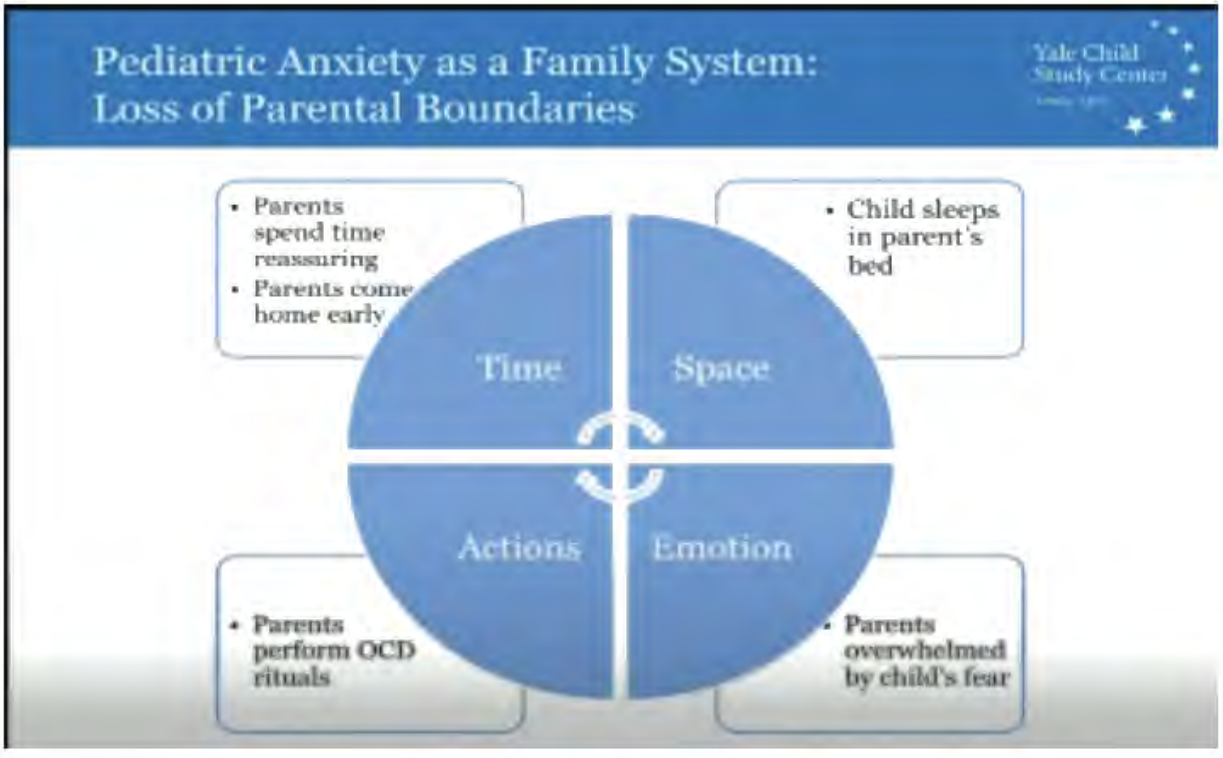
Looking at these disorders from a technical point of view, and attempting to answer the question of what they are and what causes them, allows us greater appreciation for not only their magnitude but their legitimacy. So often, psychological and emotional disorders are dismissed, particularly in children, as mere rebelliousness, laziness, defiance or even manipulation. Breaking these disorders down for study, as we have done in this chapter, grants them a level of legitimacy. We are able to determine that not only is this a legitimate malfunction in a child's brain but that it is a complicated one that they are unequipped to deal with on their own. It is our responsibility, as educators and caretakers, to help them.

Chapter 3: Impact and Accomodation

Anxiety in the Family Unit

One element of what makes pediatric anxiety disorders a uniquely sensitive issue is the degree to which their impact spreads beyond the patient and into the lives of the people around them. We have focused, until now, on the hypothetical potential impacts these disorders may have on the patient throughout the course of their life. But the many impacts of pediatric anxiety disorders inevitably bleed over into the family unit. Parents and siblings alike become drawn into the child's difficulty..

Affected family units may have a hard time defining precisely how their child's disorder is interfering with their daily functioning. It can be complicated to pinpoint the root of such massive impact because, at the most fundamental level, dysfunctional anxiety often actually blurs the boundaries between parent and child (Lebowitz, 2023). There are 4 critical relational domains that exist within all families: these are time, space, actions and emotion, and all of these have the potential to become ‘tangled; by the complications of an anxiety disorder in ways represented by the Yale Child Study Center infographic below. Each domain may be affected in a variety of ways. Routine management of time, for example, is thrown



out of balance when a parent is forced to spend time reassuring the child (often over the same thing again and again). The parent may have to alter their work schedule to collect the child early from school, or return home to avoid leaving them alone. Many parents often become so frustrated and exasperated by their children's anxious tendencies that they simply give in and accommodate to placate the desires of the anxious child in any number of ways (leaving lights on through the night, only eating certain foods, etc). Even the parents' physical space and emotional headspace can become dominated by a child's anxiety disorder. It can happen to such a degree, in fact, that other children in the home may grow to feel neglected or even become resentful of their sibling for the extra attention they receive (Lebowitz, 2023).

It's not just the parents, of course, that need to be considered when discussing the impact that a pediatric anxiety disorder can have on a family unit. Often neglected in these discussions are the siblings of these children. Many studies record finding that "the interactions between siblings and children with an anxiety disorder were characterized by more conflict and control and less warmth as compared with a nonclinical control group," possibly attributable to the fact that "the anxious children [statistically] engaged in more controlling behaviors" (Dia & Harrington, 2006, p. 183). Even more alarmingly, "more than half of the siblings without a mental health diagnosis had at least one elevated scale score suggesting the need for further assessment and possible treatment" (Dia & Harrington, 2006, p. 186).

These are, of course, not exhaustive examples of the impact a child's disorder might have on a family. Parents are often forced to ask themselves: "am I parenting out of my own convictions, or just to constantly accommodate my child's anxiety?" and may experience tremendous self-doubt and their own personal level of anxiety, which can in turn feed into the child's. In fact, they may come to a place where they literally "get swept away by the child's anxiety and reflect their own fear back to the child" in a depressing cyclical manner

(Lebowitz, 2023). Though it's very uncomfortable to acknowledge, there are a number of reasons that parenting a child with an exceptionality may be, at times, more emotionally and cognitively demanding than a neurotypical child. Parenting a child with anxiety is certainly no exception, especially when a parent is determined to maintain a degree of normalcy in the family functioning. Parents of children with PADs face countless situational dilemmas on a potentially daily basis, and questions that may have very complicated answers: do I "give in" or do I demand coping? Is this behavior real or is this just attention-seeking? Who am I allowed to tell about my child's anxiety? What should I tell their school?" (Sufna, 2022) Concern for a child's level of wellbeing and functionality not only presently, but in the future as they grow, can be massively burdensome questions for parents watching their child struggle. These questions can take a massive cognitive toll on parents and caretakers.

With all of these factors considered, it is no surprise that parents of children with anxiety disorders often develop unhealthy tendencies in their search for appropriate coping strategies. At times they fall into the trap of overprotectiveness, offer overly excessive reassurance, or engage in "negative and adverse parent-child interactions, which may affect family functioning and sibling relationships" (Dia & Harrington, 2006, p. 183). All of this does nothing to diminish the resentment of their non-anxious children, who "may perceive more differential treatment by parents" an consciously or subconsciously grow to resent them even further (Dia & Harrington, 2006, p. 183) .

But again, this information is unsurprising. A massive challenge for parenting a child with a PAD is the strain that the disorder often places on collaboration between parents. There are, for example, often widely different perspectives and expectations about the problem itself (disagreement about what is seen as a "big deal," for example) (Sufna, 2022). Its vital to realize that both parents are likely to be reflecting some aspect of the needed help. Dealing with anxiety is a matter of striking a delicate balance between accommodating and

pushing, and it's likely that each parent may naturally lean towards one or the other (Sufna, 2022).

It is no new knowledge to educators that the involvement of families is critical in a students' success in their classroom. At times, it may be *the* defining factor in that student's success. There is a valuable partnership and collaboration that exists (or should exist) between the child's school and their family. These striking facts about the realities of the ways that a pediatric anxiety disorder can bleed deeply into the fabric of a home and family absolutely "reiterate the importance of focusing on the family rather than just on the individual child" when working to address such a personal issue with a student (Dia & Harrington, 2006, p. 187). It is always safe to assume that "from an ecological perspective," the issue is likely broader than the school is even aware of and is likely affecting the family as a whole; "assessing the need and potentially intervening at the family level may be more effective and efficient" than an approach that is contained to just the individual student (Dia & Harrington, 2006, p. 187).

Anxiety in the Classroom

When we begin to take what we understand about the nature of pediatric anxiety disorders and we consider it in the traditional classroom setting, it is not difficult to imagine the challenges for everyone involved, beginning with the student, all the way up to the administrators. The traditional classroom has a level of structure and rigidity to which students are expected to conform - a level of control to which they are simply expected to surrender- and this becomes extremely difficult when a child's brain is in full-blown revolt against this idea.

We have observed that many of the symptoms related to anxiety exist across three domains: cognition, behavior, and physiology. Most of the symptoms that a teacher might notice can often be categorized into one of the three, whether it be constant, incessant worries

presented to the teacher (cognition,) or physical flushing of the skin (physiology). But no matter the manifestation of the behavior, one should always remember that consciously or subconsciously, it is a reflection of an attempt on the students' part to either control the anxiety or, at the very least, minimize its effects (Killu, 2016). This idea of attempting to control the effects of one's own anxiety is especially important for an onlooker to understand. Children affected by these disorders often might grow to be just as afraid of the literal feeling of anxiety, or even moreso, as they are of its supposed triggers. Practically, this may look like a child who is asked "why are you anxious?" and responds with "because I might get anxious" or even "because I don't know why I feel anxious," although at times a child may struggle to articulate this. The reality that this intense physical feeling of dread, helplessness and panic could wash over them at any time is a terrible thing to experience, and can make anyone, especially children, paranoid. It can be made worse when it occurs outside of the home, and certainly at school. Being required to spend the day in a semi-confined setting where they may not easily be able to immediately 'escape' should these scary physical symptoms arise can be nightmarish for children, even in the earliest grades.

Each of the three domains may present in unique ways within a classroom or school setting- some easily noticed by faculty, and others more subtle. Within the cognitive domain, anxiety could easily manifest as several problematic classroom manifestations, including a lack of concentration, issues with memory, attention problems, over-sensitivity, difficulty with general troubleshooting and problem solving ('freezing') and incessant worry. In the behavioral domain anxiety might produce a wide spectrum of behaviors, some very disruptive: "restlessness, fidgeting, task avoidance, overly-rapid speed on tasks, irritability, erratic behavior, withdrawal, lack of participation, perfectionism, and a failure to complete tasks" are all major indications of some level of clinical anxiety (Killu, 2016, p. 31). Finally, within the physiological domain, anxiety may present in students as muscle ticks, a

consistently rapid heart rate at inappropriate times, flushing of the skin, perspiration, headaches, muscle tension, nausea, and vomiting, all occurring without clear cause and on a fairly consistent basis (Killu, 2016). Some students will suffer specifically from panic disorder, characterized by repeated episodes of panic attacks with little or no known stimulus; since a student cannot predict when a panic attack is likely to occur, they are on constant guard for every bodily sensation that may signal it's beginning, making it very difficult to concentrate. These attacks can cause "sheer terror in students, often producing physical symptoms such as feeling weak, faint, dizzy, chilled, and having a pounding heart" and naturally "the automatic reaction" is generally "the need to escape, fueling many of the behaviors we've previously discussed" (Moran, 2015, p. 28). This non-exhaustive list of potential symptoms and behaviors clearly demonstrate that clinical pediatric anxiety affects the entirety of the child. Their mind, body and behavior are all, to some degree, hijacked by this powerful level of fear that they likely do not fully understand, and the school setting is unfortunately a common place for this hijacking to occur.

With the wide variety of school-related symptoms that may occur, it's important to remember that while some students with anxiety "can show consistent and recognizable signs," the actual anxiety may simmer under the surface long before any outward expression takes place (Minahan, 2012, p. 35). A student with anxiety will likely increase their insistence on routines and sameness, pushing back against any changes in the school schedule, and we may see easily explosive aggression that seems to appear out of nowhere. Since often we don't know a student is feeling anxious until we see behavioral signs, it is vital to remember that the outward behavior or symptom we are seeing is only a glimpse at the strong emotions that have been boiling up under the surface for a period of time (Minahan, 2012)

In some ways, it is almost as if the very nature of the traditional schooling system is rigged against children with exceptionalities, including pediatric anxiety disorders. In the traditional approach, for example,

> school personnel often identify a desirable target behavior and try to reinforce it through rewards (stickers, praise, etc.), which usually doesn't work. When educators don't recognize how anxiety prompts some behaviors, such as meltdowns or withdrawal, their responses can unintentionally exacerbate the students' inappropriate behavior and their anxiety (Minahan, 2012, p. 34).

If educators are not carefully aware of the unique nature of clinical pediatric anxiety disorders, they may make the mistake of looking at these outward manifestations and simply assuming that a student, who is seemingly healthy and capable, is simply being combative, oppositional, or lazy, when the reality couldn't be further from the truth. In fact, research consistently demonstrates that anxious students will often have to actually exert *more* effort than their peers simply to perform well because they are multitasking at all times, attempting to manage their internal and external manifestations of feelings of anxiety while executing a task (Minahan, 2012). Becoming fully informed of the extreme invisible burden these students are carrying can completely transform how we view them.

Each student is unique and will experience their anxiety in a unique way, but there are some documented patterns in the times of a traditional school day that, according to research, generally seem to be more difficult times for most students with an anxiety disorder. "These include unstructured times such as lunch or recess" where routines may be thrown off, "transitions" in between classes or blocks where there may be increased noise or activity in the space, along with "writing demands, social demands, and novel events or unexpected changes" in the typical school day (Minahan, 2012, p. 36). Awareness of these points in the day, and mindfulness of students that may be struggling through them, can be a simple but major asset for an educator attempting to understand the behavior of their anxious students,

and help them through it. Best practices for how to do so will be discussed later in the chapter.

Impact on Academic Performance

Given that the already intensive impacts of clinical anxiety are generally magnified even more in a traditional school setting, it should come as no surprise that pediatric anxiety disorders can often greatly weaken students' academic performance. This occurs as the natural neurological byproducts of anxiety adversely influence "concentration, memory, attention, organization of work, and performance on tests and other evaluative tasks" (Killu, 2016, p. 31).

These neurological challenges act as metaphorical 'hurdles' in a students academic performance, and as the student experiences the added burden of jumping those hurdles to perform nearly any simple task, they are often aware that other students are not experiencing the same difficulties. This can result in bitterness towards peers, steep plummets in already weakened self-esteem, and sadly, an entirely new source of anxiety as students attempt to conceal their anxious behaviors as much as possible. "As a result of this negative cycle, many students with anxiety based disorders develop a sense of learned helplessness" which can often "result in avoidance of tasks they judge to be difficult" (Killu, 2016, p. 31). These behaviors (sudden refusal of mundane tasks like classwork or peer collaboration, for example) may not be acts of rebellion but actually, at their most primal root, are motivated by a desire to escape the situation at hand (Minahan, 2012). The brain is hijacked to go into a very self-centered, irrational mode for the purpose of self-preservation against a perceived threat, even if that perceived threat, for whatever reason, is the idea of sitting still at a desk for an hour-long class period.

Chronic, clinical anxiety in students can also lead to low levels of persistence, as well as a lack of intrinsic motivation that becomes a tendency to either give up quickly on a task,

or withdraw completely where failure is perceived to be likely (Killu, 2016). Not only do grades suffer, but relationships with teachers and peers can break down as no explanation seems clear for the behavior. Academic performance issues can very quickly breach into the child's personal identity, and "as this pattern escalates, anxious children often engage in self blame and self-deprecation, and worry and ruminate about their own competence" (Killu, 2016, p.31). A child's perception of themself not only as a student but as a person, if not carefully monitored and encouraged, can fall apart under these circumstances. Which is where we begin to see such high rates of comorbidity with other mental health issues, as discussed in Chapter 1.

In the midst of all of this, it's worth noting that research indicates an anxiety disorder does not actually affect the students academic *ability* at all. It is only their actual academic performance that is being hindered, not their innate capacity to perform (Killu, 2016). But too many students lack a well-informed, empathetic team of teachers and administrators equipped to properly support them through this very nuanced, complicated fight against anxiety in the school setting. It can be difficult to know how far is too far to push a student, and how much accommodation becomes enabling. There are, however, many more resources available now than in years past to inform educators of best practices for accommodating these disorders. They are essential pieces of a toolkit that all teachers can benefit from having.

Best Practices for Accomodation

A solid basis for thinking about best practices for accommodation of anxiety disorders is the understanding that these "students would behave if they could," and therefore "if a student can't behave, it's often because he or she hasn't developed the necessary skills" (Minanhan, 2012, p. 36). Students with anxiety may lack development in the areas of self-regulation, thought interruption, social skills, and even executive function, which can affect their academic performance as well as their behavior.

Because the impacts of an anxiety disorder can be so pervasive, the best practice for their accommodation is not simply to wait until symptoms 'flare up' or become obvious during the school day. By that point, the anxiety is likely to have escalated to such a degree that little will help but to allow the symptoms to run their course. Instead, it is recommended that

> a teacher should have anxiety management in place throughout the day in order to avoid overwhelming students and provoking a Behavioral incident. implementing anxiety reducing breaks consistently throughout the day helps to settle students and keep them calm. students should not have to earn breaks nor should breaks be withheld because of behavior (Minahan, 2012, p. 37).

In other words, accommodation for anxiety should not be a stand-alone procedure, but rather a series of choices woven throughout the school day, affecting the schedule, the physical space, the delivery of instruction, etc. "Effective teaching should always attempt to address and quell anxiety as part of learning," not as an entirely separate issue (Minahan, 2012, p. 151). Many of the strategies and best practices for accommodations are highly inclusive and are likely to benefit all students, whether they struggle with clinical levels of anxiety or not (Moran, 2015, p. 30).

Consistent Daily Routine

Because we know that many students with anxiety struggle most during unregulated times such as lunch, recess or transition points, it is good practice to maintain a consistent daily routine in the classroom with a clearly defined schedule and expectations. Many students may find it tremendously helpful to physically display that routine/schedule in the classroom. Subconsciously, this allows their minds a small sense of control and awareness of what to expect throughout the day, which can help to combat feelings of anxiety related to uncertainty (Moran, 2015).

Culture of Cooperative Learning

Allowing students, whenever possible, to work with peer groups in a more fluid manner than traditional direct-instruction is highly beneficial for all students, but can be particularly helpful for those with anxiety. For one, their mind quickly becomes occupied by task-based interaction with classmates. Secondly, they are able to build a connection with others that can combat the isolating feeling anxiety generally produces; it gives them a subconscious sense of 'I am not alone, and if something happens, these people will help me.' The more fluid, informal atmosphere that comes with cooperative learning can relieve some of the pressure students may feel, particularly if they are struggling to hide the physical symptoms of their anxiety during quiet, direct instruction where any disruption might be easily noticed. A teacher can make a critical, game changing difference when they initiate these positive peer interactions, building confidence, developing relationships, and fostering a more comfortable environment for everyone involved, without ever compromising the learning objectives (Moran, 2015).

Culture of Creativity

In any content area, effective teachers can find ways to allow students to express themselves creatively in ways that show their understanding and demonstrate their learning. This is beneficial for all students, allowing them to individualize their work and for the teacher to get to know them on a more personal level. It is of particular benefit to students with anxiety. When the pressure of exact, specific presentational expectations is removed, these students often tend to thrive (Moran, 2015).

Classroom Pass

One less-inclusive but very effective practice that may benefit students with anxiety is the use of a 'classroom pass.' This is a permanent, pre-arranged agreement between the teacher and student which allows a student to exit the classroom if they begin to experience strong symptoms of anxiety, without drawing attention to themselves. The terms of this pass

should be arranged beforehand between the student, teacher, and potentially the parents or administration, but it allows for a student to "access a safe person or safe place for approximately 5 to 10 minutes in order to work through their symptoms," which might include "the school counselor, nurses office, a trusted coach, or an administrator" (Moran, 2015, p. 30). The discreteness of this practice is very important, since the ability to make a subtle, graceful exit is vital to the students' own self-esteem, and to their peer relationships.

The benefits of this particular accommodation are two-fold: Firstly, it allows the student time away from the classroom space to diffuse, work through, or otherwise cope with their oncoming symptoms. Secondly, this is a practice that reflects a clear understanding of how an anxiety disorder actually functions. We know that the anxious thoughts and behaviors a student might experience are rooted most deeply in a feeling of powerlessness or a need for escape (Minahan, 2012). This pass, for a struggling student, provides both some degree of control and escape. They are now able to enter class understanding that if their symptoms flare up, they have the capacity to escape the situation without severe embarrassment, disruption or consequence. It gives them back a small degree of control over their situation when they may feel they have none at all. Just having this pass may comfort them enough that they seldom, if ever, need to use it. Though it is a small practice, it demonstrates a high degree of empathy and compassion on the part of the teacher and school. Naturally, it is important that the teacher provide limits and be sure to consistently monitor the situation to ensure that there is no misuse by the student. But absent deliberate misuse, all involved can be benefited (Moran, 2015).

Testing accommodations

A common element of a students 504 plan, testing accommodations don't necessarily have to be very formal. Research on the actual makeup and proctoring of assessments "suggests some simple ways in which the actual form of the examination can affect anxiety"

levels for students (Rosenfeld, 1978, p. 153). Some factors about the test itself may spike student's nerves, like the order in which questions are presented. When difficult questions are placed at the start of the test, the entire thing can seem impossible and overwhelming, sparking a rush of immediate anxiety that may damage concentration and performance (Rosenfeld, 1978).

But more impactful than test construction seems to be the teachers' attitude towards assessment. In regard to the discussion leading up to the test, for example, attempts to to motivate students by emphasizing its importance will generally work only to the disadvantage of students with high levels of anxiety, especially if the test is difficult. But a teacher also has the power to make the test seem less intimidating. A teacher can do a number of things to "demystify" testing, "decrease uncertainty" about expectations, and "deemphasize the formality and importance of the particular examination" with just a few simple practices (Rosenfeld, 1978, p. 157). To many students, especially those with anxiety, testing can represent "a fearsome, mysterious dragon;" so, "anxiety can sometimes be reduced by encouraging the students to participate in planning the methods by which grades will be assigned ... the dragon seems less threatening if the students have helped determine the system by which they are devoured (or rewarded)" (Rosenfeld, 1978, p. 158). Involving students in the process of creating an assessment (deciding what types of questions to include, how it will be graded, how much time will be given, etc.) can not only lessen student anxiety about the assessment but actually make the assessment more valid and reliable, since it makes sure that all students are aware of expectations.

Conditions under which any test is given are the final factor here, and matter for all students, not only those with clinical anxiety. "The behavior of the instructor (e.g., warm and understanding versus cold and authoritarian), place of examination (e.g regular classroom versus an unfamiliar auditorium), and time of examination (e.g., regular class period versus

evening, or Saturday)" may make a massive difference in a students performance, since they can directly impact levels of cognitively draining anxiety (Rosenfeld, 1978, p. 158).

Classroom Environment

The classroom environment, including both physical setup and teacher-established atmosphere, can have possibly the most continuous and immediate impact on the experience of a student with an anxiety disorder. In most situations, a teacher has at least some degree of control over how their classroom is set up and how it functions, ranging from practical choices like student seating arrangements and lighting sources, to questions of rules such as whether food and drink are allowed during class. Each of these choices is a relatively small detail that contributes to the overall fabric, atmosphere and mood of a classroom. That fabric can be modified with simple choices. Consider, for example, offering flexible seating options, allowing students to have snacks and drinks within class, or making it a habit to play calming music while working. Each of these strategies can help to lower the anxiety levels of a student before a large 'flare-up' occurs, while maintaining a generally positive tone for all students (Moran, 2015).

Physical activity is a proven protective agent against anxiety, so incorporation of physical movement is an excellent, simple method that teachers can use wherever possible in their classroom procedures and instructional methods. "Increased physical activity [is] associated with less anxiety in both the unadjusted model and after adjusting for age, sex, SES and BMI Z score," and this is even true when paired with video games and music (Walsh, 2021). All of these are free, with an unlimited supply of pre-prepared options for classroom incorporation thanks to technology, and teachers would be wise to take advantage of them when possible. .

Apart from what teachers can accomplish within the classroom, there are a number of quality school-wide social-emotional programs that administrations can consider

implementing which address anxiety either directly or indirectly (McLoone et. al., 2006). The FRIENDS program, for example, is a universal "prevention program that is implemented as part of the school curriculum," meant to address child and adolescent mental health and, specifically, to prevent the growth of clinical anxiety in students (McLoone et. al., 2006, p. 229). The Cool Kids Program is another example of an academic success program which also incorporates emphasis on social skills and mental health awareness (McLoone et. al., 2006, p. 230). Schools are, of course, faced with countless demands competing for their budget and attention, so naturally there may be some question as to the validity of programs like these- whether they are truly 'worth it' in the grand scheme of things. But there are a number of great benefits to providing mental health interventions within the school setting . These programs at a school-wide level, for example, often help to "circumvent barriers that are often associated with children accessing services," including a lack of transportation, "the cost of services," and often "lengthy waiting lists" (McLoone et. al., 2006, p. 233).

Schools are in an excellent position to be able to monitor their students for mental and emotional health concerns, including anxiety, depression, and a number of others. They have the capacity to intervene with prevention and early intervention before any major dysfunction is able to develop, stopping a potential problem at its source. Schools are capable of producing real-life settings in which to challenge students, and provide them with real, practical coping skills and chances to use them in a safe environment . Addressing, or even opening up discussions about, severe anxiety in the school or classroom setting can also help to decrease shame and stigma that is often associated with mental health and emotional struggles (McLoone et. al., 2006). It is important, also, that a school always checks in with a family unit when they see a child struggling with anxiety, since we know that clear distress in the child is often a sign of distress within a family (Morris, 2023).

Misconceptions Towards the Anxious Child

We've established that it's critical to support a child struggling with anxiety or any other mental health concern; it naturally follows that it is important to provide support for the family unit where needed, as well. But we must always be sure to consider the idea of support holistically, especially when dealing with such delicate, personal issues as mental health, in a school setting. Support means combining acknowledgement, acceptance, legitimization of anxiety with confidence in a child's ability to cope, and gradual expectations for increased coping (Lebowitz, 2023). In other words, there is a fine balance that has to be struck between providing comfort measures and accommodations for the anxious child, and pushing them beyond their comfort zone so as not to let them regress.

There are a number of common misconceptions related to pediatric anxiety disorders, which can subconsciously influence the actions of well-meaning parents and educators, and keep them from helping to their full potential. It's commonly believed, for example, that anxiety is inherently harmful and that it is the caretaker's job to 'protect' the child from anxiety altogether. This is a very problematic message for the child, as it subconsciously teaches them to be fearful of their own emotion rather than learning to acknowledge, accept and cope with it. After all, "a child who believes they cannot cope with anxiety will continue to fight it" (Sufna, 2022). Parents and educators alike also commonly believe, mistakenly, that if they acknowledge the child's fear, then they are validating it and preventing the child from overcoming it. In their logical, non-anxious mind; this can cause the child to feel that they are not believed by their parents and cause them to feel isolated or even abandoned, which is far from the goal (Sufna, 2022). Acknowledging the fear and actively teaching the child to work *through* it, rather than avoiding it, is a far better strategy,

Conclusion

Though it may be difficult for us to recall now as adults, it is universally true, across all cultures and socioeconomic statuses, that children often believe their caregivers are omnipotent; they often believe that they know all things and have the power to change everything at will. We know, of course, that no matter how much we care for and desire to help a child, this is not the reality. But if we try to remember how we look from their perspective, we can ask ourselves: how might that impact the way they view caregivers during their worst episodes of anxiety? (Sufna, 2022). How would we feel if there was a sense that during our scariest, most vulnerable moments, the person we relied on to take care of us and believed to be all-powerful was suddenly unable, or even unwilling, to 'take away the feelings?'

The point of this somewhat sad consideration is to stress that all children develop within the context of relationships. Young children will always need help in learning to express and regulate strong emotions just as much as they need help with any more tangible skill, like tying their shoes. Even older children into young adulthood will desperately need their parents to reinforce and model positive, healthy coping with all emotions- pleasant and unpleasant alike (Sufna, 2022). Educators and parents alike must work to model these things for all children, and especially for those that are struggling with clinical neurological imbalances that throw their emotions out of whack, including pediatric anxiety disorders.

While we have discussed a number of measures that can be taken to accommodate anxiety within the family and in the classroom, it is critical to remember that no relationship is instantaneous. Rather, "relationships build over thousands of moment-to-moment interactions" (Sufna, 2022). While the most wonderful thing about working with children is that it matters so much, one of the most terrifying things is that it matters every single day.

It may be difficult to believe, when faced with the overwhelming statistics and the difficult realities of the problem, that an educator has any ability at all to make a difference in the life of a child with an anxiety disorder. But nothing could be further from the truth. “Many adults who suffered from PAD actually account that it was someone outside of their immediate family that was most influential for them in their battle with anxiety” (teacher, coach, etc) (Sufna, 2022). Your potential for deep and lasting impact within a child’s life (even beyond their academic education) is unlimited, but it will always run parallel to your willingness to make mistakes, ask difficult questions, and handle the ugly, frustrating everyday moments. Sometimes just a physical presence can help in anchoring a child, or a gentle reassurance that you’re here and you’re not about to leave them. That is a level of care, compassion and love that, if given time, patience and perseverance, trumps any manner of fear.

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