Table 17-2	Criteria for Diagnosis of a Panic Disorder
A. Both (1) and (2)	
1. Recurrent unexpected panic attacks	
2. At least one attack is followed by ≥1 month of one or more of the following:	
a. Persistent concern about having additional attacks	
b. Worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy")	
c. A significant change in behavior related to the attacks	
B. The presence of agoraphobia	
C. The panic attacks are not due to direct physiologic effects of drugs or abuse or medication or a general medical condition (e.g., hyperthyroidism).	
D. The panic attacks are not better accounted for by another mental disorder, such as social phobia, specific phobia, obsessive-compulsive disorder, posttraumatic stress disorder, or separation anxiety disorder.	

Table 17-3	Criteria for Diagnosis of a Panic Attack
A discrete period of intense fear or discomfort, in which four or more of the following symptoms developed abruptly and reached a peak within 10 minutes:	
Palpitations, pounding heart, or accelerated heart rate	
Sweating	
Trembling or shaking	
Sensations of shortness of breath or smothering	
Feeling of choking	
Chest pain or discomfort	
Nausea or abdominal distress	
Feeling dizzy, unsteady, lightheaded, or faint	
Derealization (feelings of unreality) or depersonalization (being detached from oneself)	
Fear of losing control or going crazy	
Paresthesias (numbness or tingling sensations)	
Chills or hot flashes	

Table 17-4	Criteria for Diagnosis of Generalized Anxiety Disorder
A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about numerous events or activities	
B. The person finds it difficult to control the worry.	
C. The anxiety and worry are associated with three or more of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one symptom is required in children.	
1. Restlessness or feeling keyed up or on edge	
2. Being easily fatigued	
3. Difficulty concentrating or mind going blank	
4. Irritability	
5. Muscle tension	
6. Sleep disturbance (difficulty falling or staying asleep or restless, unsatisfying sleep)	
D. The focus of the anxiety and worry is not confined to features of a disorder (e.g., panic disorder, social phobia, obsessive-compulsive disorder, separation anxiety disorder, anorexia nervosa, somatization disorder, hypochondriasis), and the anxiety and worry do not occur exclusively during posttraumatic stress disorder.	
E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	
F. The disturbance is not due to the direct physiologic effects of a drug or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder.	

including shakiness, trembling, and myalgias. Gastrointestinal symptoms (nausea, vomiting, diarrhea) and autonomic symptoms (tachycardia, shortness of breath) commonly coexist. In children and adolescents, the specific symptoms of autonomic arousal are less prominent, and symptoms are often related to school performance or sports. Children with GAD are often exceedingly self-conscious, exhibit behavioral inhibition, have low self-esteem, and have more sleep disturbance than patients with other kinds of anxiety disorder. Care must be taken to elicit internalizing symptoms of negative cognitions about the self (hopelessness, helplessness, worthlessness, suicidal ideation), as well as those concerning relationships (embarrassment, self-consciousness) and associated with anxieties. Inquiry about eating, weight, energy, and interests should also be carried out to eliminate a mood disorder.

Posttraumatic stress disorder (PTSD) is characterized by re-experiencing a traumatic event in which actual or threatened death or serious injury was possible. The reexperiencing is accompanied by avoidance of stimuli that remind the person of the trauma and by autonomic hyperarousal (Table 17-5). Type, severity, duration, and proximity of the traumatic event are the most likely predictors of PTSD. Presentation often depends on the age group of the child. In preverbal children, there are changes in behavior: regressed clingy behavior, increased aggression, unwillingness to explore the environment, alterations in feeding, sleeping behaviors, and difficulty soothing child. Preschool children may display rapidly changing emotional states like anger, sadness, and excitement and play may have compulsive reenactments linked to the traumatic event. Later symptomatology is more typical of adult PTSD, except that flashbacks are more daydream quality than the sudden intrusive events seen in adults, and complaint of restriction of effect and numbing are less frequent.

Dissociative states lasting a few seconds to many hours, in which the person relives the traumatic event, are referred to as *flashbacks*. Reexperiencing trauma in children may be nonspecific to the trauma (e.g., dreams of monsters). In adolescents anticipation of unwanted visual imagery increases the risk of irritable mood, anger, and voluntary sleep deprivation. When faced with reminders of the original trauma, physical signs of anxiety or increased arousal occur, including difficulty falling or staying asleep, hypervigilance, exaggerated startle response, irritability, angry outbursts, and difficulty concentrating.

Typically an acute stress disorder is present immediately after the trauma. The risk of chronic PTSD increases when symptoms are unresolved by 6 weeks and there are higher premorbid levels of anxiety or depression. PTSD usually begins