Helping anxious child

Recognise what anxiety may look like

Anxiety is an anticipatory threat response: the brain and body prepare for danger even when the danger is uncertain, remote, or not present. In children, the emotional experience may be expressed through behaviour or physical complaints rather than through the words "I feel anxious." A child may become unusually quiet, angry, tearful, restless, perfectionistic, or reluctant to separate from a caregiver. They may repeatedly ask the same questions, seek constant reassurance, avoid unfamiliar activities, or have difficulty falling asleep.

Physical manifestations can include nausea, abdominal pain, headache, dizziness, muscle tension, sweating, palpitations, trembling, rapid breathing, or an urgent need to use the toilet. These symptoms are real, even when anxiety is contributing to them. Do not assume every physical symptom is psychological; new, severe, recurrent, or unexplained symptoms deserve medical assessment.

Fear is part of normal development. The key issue is impact and persistence. Consider whether the reaction is much stronger or longer-lasting than would be expected, whether the child cannot recover after reassurance, and whether anxiety is limiting learning, friendships, family activities, sleep, or

independence. Developmentally expected fear can still be distressing, but it often fluctuates and gradually improves with support. Persistent impairment is a reason to discuss the situation with a GP, paediatrician, or qualified mental-health professional.

Start with connection and careful listening

Choose a calm moment rather than questioning the child in the middle of intense distress. Sit at the child’s level, use a steady voice, and invite them to describe what happens before, during, and after the worry. Open questions such as "What feels hardest about that situation?" or "What does your body notice first?" can reveal triggers and maintaining factors. Younger children may communicate more easily through drawing, play, stories, or a simple feelings scale.

Validation is not the same as agreement with the feared prediction. Say, "I can see that this feels frightening, and I am here with you," rather than promising that nothing bad could ever happen. Absolute reassurance can become part of a reassurance-seeking cycle, in which the child briefly feels better but soon needs the same answer again. A more useful response acknowledges uncertainty and builds confidence: "We cannot know exactly what will happen, but we can make a plan and handle the next step together."

Try to identify patterns without blaming the child or caregiver. Note situations, times of day, transitions, school demands, social experiences, online activity, sleep, illness, and family stressors. A brief record can help clinicians distinguish triggers from consequences and can identify whether avoidance or repeated checking is maintaining the anxiety.

Build a predictable and supportive daily environment

Predictability reduces the number of decisions and surprises a worried child must manage. Keep regular times for waking, meals, school preparation, homework, relaxation, and sleep. Give advance notice of changes using concrete language and a short sequence of steps. For example, explain who will collect the child, what the first activity will be, and when the child can contact a trusted adult. Visual schedules, calendars, and written plans may be useful for children who find verbal instructions difficult to hold in mind.

Support the foundations of emotional regulation. Adequate sleep, regular nutrition, hydration, physical activity, and time away from stimulating media influence arousal and coping capacity. These measures do not replace treatment, but they can make therapeutic strategies easier to use. Avoid using caffeine or unregulated supplements to manage anxiety without medical advice, particularly in children and adolescents.

Caregivers should also examine accommodation: changes adults make to prevent a child's distress, such as answering endless reassurance questions, completing avoided tasks, allowing repeated checking, or routinely staying away from work and social activities. Compassion is essential, but extensive accommodation can unintentionally communicate that the child cannot cope. Reduce accommodations gradually, collaboratively, and with professional guidance when anxiety is substantial.

Teach coping skills before anxiety peaks

Practise coping skills during neutral periods so they are familiar during stress. A slow breathing exercise can help reduce hyperventilation and sympathetic arousal. One simple approach is to breathe in gently and make the exhalation slightly longer, without forcing deep breaths or using breath-holding if that feels uncomfortable. Practise for a few minutes, then stop if the child becomes light-headed or more distressed.

Grounding directs attention toward present sensory information. Ask the child to name several things they can see, a few sounds they can hear, and sensations such as feet on the floor or the chair supporting them. Muscle relaxation, stretching, rhythmic movement, drawing, music, and a quiet place may also help. Let the child choose from a small coping menu rather than presenting techniques as a test they can fail.

Help the child label the worry and separate it from identity. "My anxious thought says I will definitely be rejected" is different from "Everyone will reject me." Older children may record a prediction, estimate how likely it feels, and later compare it with what occurred. This is a basic cognitive-behavioural strategy, but it should remain curious rather than argumentative. Avoid debating every worry for a long time; acknowledge it, use

the planned coping response, and return attention to the next manageable activity.

Use gradual exposure instead of forced confrontation

Avoidance reduces distress immediately, which makes it very reinforcing. Over time, however, it prevents the child from learning that anxiety can decrease and that feared situations may be manageable. Evidence-based cognitive behavioural therapy commonly addresses this pattern through gradual exposure: planned, repeated contact with a feared situation at a tolerable level, while reducing safety behaviours and allowing new learning to occur.

Exposure should be collaborative and graded, not a sudden demand to face the most frightening situation. Create a sequence from easier to harder steps. A child worried about speaking in class might first practise answering with a caregiver, then speak to one trusted person, then ask a question in a small group, and eventually contribute to the class. The child can rate distress before and after each step, but the goal is not always to reach zero anxiety. The goal is to participate while anxiety is present and discover that it can change without escape.

Do not use exposure to dismiss a legitimate danger. Bullying, abuse, discrimination, unsafe environments, serious medical symptoms, and realistic safeguarding concerns require protection and adult intervention, not habituation practice. A clinician can help design exposure when anxiety is severe, broad, associated with panic, or causing major avoidance.

Coordinate support with school and professionals

School staff may notice attendance changes, reduced participation, perfectionism, concentration problems, social withdrawal, or distress around particular lessons and transitions. With the caregiver’s agreement, share a concise description of triggers, early warning signs, helpful responses, and the agreed plan. The school may be able to provide a predictable arrival routine, a named trusted adult, a quiet reset space, clear instructions, planned breaks, or a staged return after prolonged absence.

School refusal is not simply defiance. It can reflect anxiety, separation

distress, learning difficulties, bullying, neurodevelopmental differences, depression, trauma, sleep problems, or physical illness. The appropriate response depends on the underlying factors. Prolonged absence can make return harder, so seek advice early from the school and healthcare team rather than relying on repeated morning negotiations.

Professional assessment may involve the child's developmental history, medical history, family context, school functioning, mood, sleep, substance exposure in adolescents, and safety. Cognitive behavioural therapy has substantial support for childhood anxiety disorders. Depending on severity, age, diagnosis, comorbidities, response to therapy, and local guidance, a specialist may discuss medication as an adjunct or alternative. Medication decisions require an appropriately qualified prescriber and ongoing monitoring; caregivers should not start, stop, or alter treatment without medical advice.

Know when to seek help

Arrange a routine appointment when anxiety persists, repeatedly disrupts sleep, causes frequent physical complaints, leads to avoidance, affects school attendance or performance, limits friendships and activities, or creates significant family conflict. Also seek assessment when the child has panic-like episodes, compulsive rituals, trauma-related distress, low mood, developmental concerns, or a marked change from their usual behaviour. Bring observations from home and school, a medication and health history, and examples of what the child avoids or needs adults to do.

Ask directly and calmly about safety if the child appears hopeless, withdrawn, or unusually distressed. Urgent help is needed if a child talks about wanting to die, self-harm, harming someone else, cannot be kept safe, is experiencing severe confusion or agitation, or has a medical emergency such as breathing difficulty, fainting, chest pain, or an acute allergic reaction. Contact local emergency services or an urgent crisis service according to your location.

Caregivers should seek support for themselves as well. A calm, consistent adult response is easier when the adult has guidance and rest. The aim is not to eliminate every uncomfortable feeling. It is to help the child understand anxiety, remain connected to ordinary life, develop effective coping skills, and access evidence-based care when needed.