Anxiety Disorders in Children and Adolescents

Written and reviewed, 7/26/2011:

Juan L. Castro, M.D.
D. Alan Bagley, M.D.
Jody L. Brown, M.D.
Gideon Mecum, M.D.

Reviewed and updated, 12/7/2013:

Jody L. Brown, M.D.

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1. **Context**

- 10% to 11% of children have both a mental health disorder and functional impairment.
- There is a prevalence of mental health concerns in pediatric populations.
- Half of adults in the US with a mental health disorder have symptoms by age 14.
- 20% of children receive care for their mental health problems.
- Nearly one in three adolescents (31.9%) meet criteria for an anxiety disorder, with rates for individual disorders ranging from 2.2% for generalized anxiety disorder to 19.3% for specific phobia (Merikangas, 2010).
- Severe anxiety disorders are present in 8.3% of adolescents (Merikangas, 2010).
- Anxiety is a normal part of life and all of us will experience “difficult periods” that are for the most part temporary and usually harmless. Children who suffer from an anxiety disorder experience fear, nervousness, and constant worry, among other symptoms.
- Of note, general data for the prevalence rates of all anxiety disorders in children and adolescents is not currently available strictly using DSM-5 criteria. Therefore, the general prevalence rates listed in this section were acquired using DSM-IV criteria. However, there is available data on prevalence rates for specific disorders using DSM-5 criteria and will be cited below with each specific disorder.

2. **Highlights of Changes in Anxiety Disorders from DSM-IV to DSM-5**

- The chapter on anxiety disorders in DSM-5 no longer includes obsessive-compulsive disorder (which is in the new chapter "Obsessive-Compulsive and Related Disorders") or posttraumatic stress disorder (PTSD) and acute stress disorder (which are in the new chapter "Trauma-and Stressor-Related Disorders").
- Changes in criteria for specific phobia and social anxiety disorder (social phobia) include deletion on the requirement that individuals over age 18 years recognize that their anxiety is excessive or unreasonable. Instead, the anxiety must be out of proportion to the actual danger or threat in the situation, after cultural contextual factors are taken into account. In addition, the 6-month duration is now extended to all ages.
- Panic attacks can now be listed as a specifier that is applicable to all DSM-5 disorders.
- Panic disorder and agoraphobia are unlinked in DSM-5. Thus, the former DSM-IV diagnoses of panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder are now replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria.
- The "generalized" specifier for social anxiety disorder has been deleted and replaced with a "performance only" specifier.
Separation anxiety disorder and selective mutism are now classified as anxiety disorders. The wording of the criteria is modified to more adequately represent the expression of separation anxiety symptoms in adulthood. Also, in contrast to DSM-IV, the diagnostic criteria no longer specify that onset must be before age 18 years, and a duration statement ---"typically lasting for 6 months or more" --- has been added for adults to minimize overdiagnosis of transient fears (APA DSM-5, 2013).

3. Anxiety Disorders in Children, Clinical Cases and Symptomatology

The Major Anxiety Disorders Included in the DSM-5
Clinical Case 1

A child is brought to a physician by his parents because he has been reporting headaches and different physical symptoms in the morning “just before we are to take him to school”. The physical exam and laboratory tests do not reveal any abnormalities. Furthermore, in the clinical interviews, the physician learns that the child is extremely clingy with his parents and becomes very anxious when separated from them.

3.1 Separation Anxiety Disorder

- Children with separation anxiety disorder often have difficulty leaving their parents to attend school or camp, staying at a friend's house, or being alone.

- They often "cling" to parents and have trouble falling asleep.

- Separation anxiety disorder may be accompanied by depression, sadness, withdrawal, or fear that a family member might die.

- Prevalence: The 12-month prevalence of separation anxiety disorder among adults in the United States is 0.9%-1.9%. In children, 6- to 12-month prevalence is estimated to be approximately 4%. In adolescents in the United States, the 12 month prevalence is 1.6%. Separation anxiety disorder decreases in prevalence from childhood through adolescence and adulthood and is the most prevalent anxiety disorder in children younger than 12 years old. In clinical samples of children, the disorder is equally common in males and females. In the community, the disorder is more frequent in females (APA DSM-5, 2013).

- Prevalence: Lifetime prevalence for separation anxiety disorders in U.S. Adolescents (based on DSM-IV criteria): 9.0 % in females and 6.3 % in males (Merikangas, 2010).

Clinical Case 2

A 6-year-old child is brought to the physician because she will not speak outside of the home or in the school setting, even with close friends, grandparents and cousins. However, she is able and willing to speak to her parents and siblings in the home setting and there does not appear to be any expressive or receptive language issues. This refusal to speak at school has led to academic difficulties and social difficulties in the school setting. She has always been described as shy and a bit clingy with her mother and there is a history of anxiety in the family. She is eager to engage in social encounters when speech is not required.

3.2 Selective Mutism

- Children with selective mutism demonstrate a consistent failure to speak in specific social situations in which there is an expectation for speaking (e.g., at school) despite speaking in other situations.

- The failure to speak is not attributable to a lack of knowledge of, or comfort with the spoken language required in a social situation and it interferes with educational or occupational achievement or social communication.

- The failure to speak is not better explained by a communication disorder and is not exclusively occurred during the course of autism spectrum disorder, schizophrenia, or another psychotic disorder.
Individuals often have excessive shyness, anxiety (social phobia), fear of social embarrassment, social isolation and withdrawal, clinging, compulsive traits, temper tantrums or mild oppositional behavior.

Prevalence: Selective mutism is a relatively rare disorder with a point prevalence between 0.03% and 1% depending upon the setting (e.g., clinic versus school versus general population) and ages of the individual. The prevalence of the disorder does not seem to vary by sex or race/ethnicity. The disorder is more likely to manifest in young children than in adolescents and adults (APA DSM-5, 2013).

Clinical Case 3
A 7 year old girl is brought to the nurse’s office at school because she started screaming uncontrollably after seeing a spider. She calms down after reassurance, but asked the nurse to please make sure the spider “is not there anymore”. The nurse calls her parents at home to inform them about the situation and learns that she has an extreme fear of spiders to the point that her parents check the house several times during the week to make sure there are no spiders.

3.3 Specific Phobia

- A specific phobia is the fear of a particular object or situation that is avoided or endured with great distress (e.g., flying, heights, animals, receiving an injection, seeing blood).

- In children, the fear or anxiety may be expressed by crying, tantrums, freezing, or clinging.

- A specific fear can develop into a specific phobia if symptoms are significant enough to result in extreme distress or impairment related to the fear, the fear or anxiety is out of proportion to the actual danger posed by the specific object or situation, and if the fear, anxiety or avoidance is persistent.

- It is common for individuals to have multiple specific phobias. The average individual with specific phobia fears three objects or situations, and approximately 75% of individuals with specific phobia fear more than one situation or object.

- Prevalence: In the United States, the 12-month community prevalence estimate for specific phobia is approximately 7% - 9%. Prevalence rates are approximately 5% in children and are approximately 16% in 13-to 17-year-olds. Prevalence rates are lower in older individuals, about 3% - 5%. Females are more frequently affected than males, at a rate of approximately 2:1, although rates vary across different phobic stimuli (APA DSM-5, 2013).

Clinical Case 4
While in a regular medical checkup with a 10 year-old boy, it is brought to a physician’s attention that he becomes very stressed in the classroom when performing oral presentations. Furthermore, he usually avoids going to the playground for fear of meeting peers. His mother reports that he is always thinking that his peers are going to make fun of him. He often refuses social activities. When the physician asked him about this situation, he reports that he becomes very scared and does not know what to do.
3.4 Social Anxiety Disorder (Social Phobia)

- Social phobia is characterized by feeling fearful, anxious or uncomfortable in one or more social settings (discomfort with unfamiliar peers or with adults) or performance situations (e.g., music, sports), which causes significant clinical distress or impairment in social, occupational or other important areas of functioning.

- In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking for failing to speak in social situations.

- The discomfort is associated with social scrutiny and fear of doing something embarrassing or being humiliated in social settings such as classrooms, restaurants, and extracurricular activities.

- Prevalence: The 12-month prevalence estimate of social anxiety disorder for the United States is approximately 7%. The 12-month prevalence rates in children and adolescents are comparable to those in adults. Prevalence rates decrease with age. The 12-month prevalence for older adults ranges from 2% to 5%. In general, higher rates of social anxiety disorder are found in females than in males in the general population (with odds ratios ranging from 1.5 to 2.2), and the gender difference in prevalence is more pronounced in adolescents and young adults (APA DSM-5, 2013).

Clinical Case 5

A 16 year-old adolescent girl is brought to a physician for an urgent medical checkup. She has been complaining of circumscribed episodes of chest pain, dizziness, numbness of her upper extremities and palpitations. These symptoms occur at least once a day and usually last for approximately 10 minutes. She reports that during these episodes she feels as if she is dying. The physical exam did not reveal any abnormalities.

3.5 Panic Disorder

- Panic disorder is characterized by recurrent unexpected panic attacks.

- A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time 4 (or more) of the following symptoms occur:
  
  o Palpitations, pounding heart, or accelerated heart rate, sweating, trembling or shaking, shortness of breath or smothering, feelings of choking, chest pain or discomfort, nausea or abdominal distress, chills, dizziness, unsteadiness, lightheadedness, or faintness, chills or heat sensations, paresthesias (numbness or tingling sensations), derealization (feelings of unreality) or depersonalization (being detached from oneself), fear of losing control or "going crazy", or fear of dying.

- The panic attacks are followed by persisting concern or worry about additional panic attacks or their consequences or there is a significant change in behavior related to the attacks, such as avoidance behaviors designed to avoid having future panic attacks.

- Remember, panic attacks can now be listed as a specifier that is applicable to all DSM-5 disorders.
• Panic disorder and agoraphobia are unlinked in DSM-5. Thus, the former DSM-IV diagnoses of panic disorder with agoraphobia, panic disorder without agoraphobia, and agoraphobia without history of panic disorder are now replaced by two diagnoses, panic disorder and agoraphobia, each with separate criteria.

• Panic disorder is frequently comorbid with other psychiatric disorders, particularly other anxiety disorders (and especially agoraphobia), major depression, bipolar disorder, and possibly mild alcohol use disorder.

• Prevalence: Although panic attacks occur in children, the overall prevalence of panic disorder is low before age 14 years (<0.4%). The rates of panic disorder show a gradual increase during adolescence, particularly in females, and possibly following the onset of puberty, and peak during adulthood. The prevalence rates decline in older individuals (i.e., 0.7% in adults over the age of 64). In the general population, the 12 month prevalence estimate for panic disorder across the United States and several European countries is about 2%-3% in adults and adolescents. Females are more frequently affected than males, at a rate of approximately 2:1 and the gender differentiation is observable before age 14 years (APA DSM-5, 2013).

Clinical Case 6

A 17 year-old adolescent girl was taken to her pediatrician by her parents because she has been very resistant to go places with her family over the past year and this has been negatively impacting the family schedule and family dynamics. She does not want to ride in the family’s car, go shopping, go to the movies, or go to events where there will be a lot of people. She describes persistent fears “about something terrible happening” in these situations and not being able to escape from them, so she avoids these and similar situations.

3.6 Agoraphobia

• Agoraphobia is characterized by marked, or intense, fear or anxiety triggered by the real or anticipated exposure to a wide range of situations such as using public transportation, being in the open spaces, being and enclosed places, standing in line, being in a crowd, being outside of the home alone, etc.

• Individuals with agoraphobia tend to avoid these types of situations because of thoughts that escape might be difficult or help might not be available if they developed panic symptoms or other incapacitating or embarrassing symptoms.

• The fear or anxiety is persistent and out of proportion to the actual danger posed by the situation.

• In DSM-5, Agoraphobia is diagnosed irrespective of the presence of panic disorder. If an individual’s presentation meets criteria for panic disorder and agoraphobia, both diagnoses should be assigned.

• Prevalence: Every year approximately 1.7% of adolescents and adults have a diagnosis of agoraphobia. Females are twice as likely as males to experience agoraphobia. Agoraphobia may occur in childhood, but incidence peaks in late adolescence and early adulthood. Prevalence rates do not appear to vary systematically across cultural/racial groups (APA DSM-5, 2013).
Clinical Case 7
A 13 year-old male student is brought to a physician because he is restless and scared about not passing this academic year, despite no evidence of poor performance at school. After being reassured, he reports that he is constantly worrying about school work and has trouble falling sleep. His mother adds that he is complaining constantly of stomach aches, headaches and fatigue. His physical exam is normal.

3.7 Generalized Anxiety Disorder (GAD)
- GAD is characterized by chronic, excessive worrying in a number of areas such as schoolwork, social interactions, family, health/safety, world events, and even natural disasters.
- At least one associated symptom is present, which could be restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension or sleep disturbance.
- Somatic symptoms such as headaches, stomach aches, fatigue and autonomic hyperarousal can occur as well.
- Children with GAD have trouble controlling their worries, and it is usually evident to caregivers that the worrying is exaggerated.
- Prevalence: The 12-month prevalence of GAD is 0.9% among adolescents and 2.9% among adults in the general community of the United States. The lifetime morbid risk is 9.0%. Females are twice as likely as males to experience GAD. The prevalence of the diagnosis peaks in middle age and declines across the later years of life (APA DSM-5, 2013).

Clinical Case 8
A 14 year-old adolescent male began experiencing panic attacks and some generalized anxiety symptoms that impacted his academic and interpersonal functioning and which precipitated a visit to his primary care physician. Upon questioning with his parents out of the room, the adolescent eventually acknowledged use of marijuana but did not correlate its use with the anxiety symptoms. However, through further questioning, there appears to be a pattern of anxiety symptom development soon after use. There is no evidence to support an independent anxiety disorder.

3.8 Substance/Medication-Induced Anxiety Disorder
- Panic attacks or anxiety are predominant in the clinical picture and develop during or soon after substance intoxication or withdrawal or after exposure to a medication.
- The anxiety symptoms are not better explained by an anxiety disorder that is not substance/medication induced.
- Once the substance is discontinued, the panic or anxiety symptoms will usually improve or remit within days to a month, depending on the half-life of the substance/medication and the presence of withdrawal.
• This diagnosis should be made instead of a diagnosis of substance intoxication or substance withdrawal only when the symptoms (panic attacks or anxiety) are sufficiently severe to warrant clinical attention.

• Panic attacks or anxiety can occur in association with intoxication from: alcohol, caffeine, cannabis, phencyclidine, other hallucinogens, inhalants, stimulants (including cocaine), and other substances.

• Panic attacks or anxiety can occur in association with withdrawal from: alcohol, opioids, sedatives, hypnotics, anxiolytics, stimulants (including cocaine) and other substances.

• Medications that can evoke anxiety symptoms include: anesthetics, analgesics, sympathomimetics or other bronchodilators, anticholinergics, insulin, thyroid preparations, oral contraceptives, antihistamines, anti-Parkinsonian medications, corticosteroids, antihypertensive and cardiovascular medications, anticonvulsants, lithium carbonate, antipsychotic medications and antidepressant medications.

• Heavy metals and toxins (e.g., organophosphate insecticides, nerve gases, carbon monoxide, carbon dioxide, volatile substances such as gasoline and paint) may also cause panic or anxiety symptoms.

• Prevalence: the prevalence of substance/medication-induced anxiety disorder is not clear. General population data suggests that it may be rare with a 12 month prevalence of approximately 0.002%. However, in clinical populations, prevalence is likely higher (APA DSM-5, 2013).

Clinical Case 9

A 12 year old male began experiencing panic attacks and some generalized anxiety symptoms that impacted his academic and interpersonal functioning and which precipitated a visit to his primary care physician. Both the patient and his parents deny any substance or medication use that could be precipitating the anxiety symptoms. There are no known anxiety disorders in the family history. A comprehensive evaluation, including a physical examination and laboratory findings identifies the presence of hyperthyroidism.

3.9 Anxiety Disorder Due to Another Medical Condition

• Panic attacks or anxiety are predominant in the clinical picture and there is evidence from history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.

• It must be established that the anxiety symptoms can be etiologically related to the medical condition through a physiological mechanism before making a judgment that this is the best explanation for the symptoms of a specific individual.

• The symptoms are best explained by the physical condition and are not better accounted for by another mental disorder, in particular, adjustment disorder, with anxiety, in which the stressor is the medical condition. The presence of a clear temporal association between the onset, exacerbation, or remission of the medical condition and the anxiety symptoms can be helpful in making this diagnosis.

• A number of medical conditions are known to include anxiety as a symptomatic manifestation including endocrine disease (e.g., hyperthyroidism, pheochromocytoma, hypoglycemia, hyperadrenocortisolism), cardiovascular disorders (e.g., congestive heart failure, pulmonary embolism, arrhythmia such as atrial fibrillation), respiratory illness (e.g., chronic obstructive pulmonary disease, asthma, pneumonia),
metabolic disturbances (e.g., vitamin B12 deficiency, porphyria), and neurological illness (e.g., neoplasms, vestibular dysfunction, encephalitis, seizure disorders).

- Prevalence: the prevalence of anxiety disorder due to another medical condition is unclear. There appears to be an elevated prevalence of anxiety disorders among individuals with a variety of medical conditions, including asthma, hypertension, ulcers and arthritis. However, this increased prevalence may be due to reasons other than the anxiety disorder directly causing the medical condition.
### Symptomatology According to Developmental Stage

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Infant</th>
<th>Early Childhood</th>
<th>Middle Childhood</th>
<th>Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Separation Anxiety Disorder</strong></td>
<td>Separation anxiety is developmentally normal</td>
<td>Separation from parents leads to</td>
<td>Fearfulness (e.g., fear of animals,</td>
<td>Feels anxious but may deny it; engages in only limited independent activity</td>
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<td>social withdrawal, apathy, sadness,</td>
<td>monsters, the dark, murderers,</td>
<td>and is reluctant to leave the home (e.g., avoids school; refers to</td>
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<td></td>
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<td>difficulty concentrating</td>
<td>kidnappers, burglars, car crashes)</td>
<td>participate in sleepover camps or parties, take trips without family, or</td>
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<td>on work or play, reluctance to</td>
<td>Concerns about death and dying</td>
<td>take part in activities requiring extended periods away from home)</td>
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<td></td>
<td></td>
<td>engage in outside activities (e.g.,</td>
<td>Concerns about harm coming to</td>
<td>Concerns about death and dying</td>
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<td>school or preschool avoidance,</td>
<td>themselves or loved ones</td>
<td>Concerns harms coming to themselves or loved ones</td>
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<td>refusing to attend parties or</td>
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<td>sleepovers)</td>
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<td><strong>Selective Mutism</strong></td>
<td>Not diagnosed</td>
<td>Speaking only at home and in the</td>
<td>Inability/refusal to speak outside</td>
<td>Inability/refusal to speak at school</td>
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<td>presence of immediate family members</td>
<td>the home (e.g., at school)</td>
<td>Inability/refusal to read aloud at school</td>
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<td>but often not even in front of close</td>
<td>Inability/refusal to read aloud at</td>
<td>Academic difficulties due to difficulty with assessment of communication/</td>
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<td>friends or second-degree relatives,</td>
<td>school</td>
<td>reading skills</td>
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<td>such as grandparents or cousins at</td>
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<td>Interpersonal difficulties due to interference with social communication</td>
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<td>home</td>
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<td>May use nonverbal means (e.g., grunting, pointing, writing) to communicate</td>
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<td>Inability/refusal to speak or read</td>
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<td>May be willing or eager to perform or engage in social encounters when</td>
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<td>aloud at school/inside the home</td>
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<td>speech is not required (e.g., nonverbal parts in school plays)</td>
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<td><strong>Specific Phobia</strong></td>
<td>Not diagnosed</td>
<td>Specific fears are particularly</td>
<td>In children and adolescents,</td>
<td>In children and adolescents, specific phobia is diagnosed only if symptoms</td>
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<td>common in childhood and are</td>
<td>specific phobia is diagnosed only</td>
<td>persist for more than 6 months</td>
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<td>usually transient during this period</td>
<td>if symptoms persist for more than</td>
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<td>**Social Anxiety Disorder (Social</td>
<td>Not diagnosed</td>
<td>The child fears that he or she will</td>
<td>The child fears that he or she</td>
<td>The adolescent fears that he or she will act in a humiliating or embarrassing</td>
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<td>Phobia)**</td>
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<td>act in a humiliating or embarrassing</td>
<td>will act in a humiliating or</td>
<td>way. The physical symptoms of social phobia may approach the intensity of</td>
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<td>way.</td>
<td>embarrassing way. The physical</td>
<td>panic when the adolescent is in a social situation. These symptoms may lead</td>
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<td>symptoms of social phobia may</td>
<td>to school avoidance of age-appropriate social activities (e.g.,</td>
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<td>approach the intensity of panic</td>
<td>sleepovers, school dances).</td>
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<td>Infant</td>
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<td><strong>Panic Disorder</strong></td>
<td>• Not diagnosed</td>
<td>• “Fearful spells” is the typical manifestation of panic disorder in early childhood but they are very rarely a function of panic disorder.</td>
<td>• For a child, perhaps the only thing more fearful than the actual panic episode is the thought of it happening again. After experiencing a panic attack, a child goes to almost any length to avoid another one. This means they may refuse to go to school, or even refuse to leave the home.</td>
<td>• As in adults, panic disorder in adolescents tends to have a chronic course and no significant differences in the clinical presentation between adolescents and adults have been found. However, adolescents may be less worried about additional panic attacks than are young adults.</td>
</tr>
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<td><strong>Agoraphobia</strong></td>
<td>• Not diagnosed</td>
<td>• First onset of agoraphobia in early childhood is rare. • Fear being outside of the home alone. • Fear becoming lost.</td>
<td>• The clinical features of agoraphobia are relatively consistent across the lifespan, although the type of agoraphobic situations triggering fear, anxiety, or avoidance, as well as the type of cognitions may vary. • For example, in children, being outside of the home alone is the most frequent situation feared. Also, cognitions often pertain to becoming lost.</td>
<td>• Similar to adults in clinical presentation but again, situations triggering fear, anxiety, or avoidance, as well as the type of cognitions vary. • Adolescents will avoid normal routine activities for fear they will trigger another panic attack. This could lead to avoidance of school, extracurricular school activities, social events, etc.</td>
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<td><strong>Generalized Anxiety Disorder</strong></td>
<td>• Not diagnosed</td>
<td>• Symptoms of excessive worry and anxiety may occur early in life and manifested as an &quot;anxious temperament&quot;.</td>
<td>• Onset of generalized anxiety disorder rarely occurs prior to adolescence. The clinical expression of GAD relatively consistent across the lifespan. The content of the worry is the primary difference. • Children tend to worry about school issues, punctuality, and catastrophic events (earthquakes, nuclear war). • Children may be overly conforming, perfectionistic, unsure of themselves, tendency to redo tasks because of excessive dissatisfaction with less-than-perfect performance. • Children can be overzealous in seeking reassurance and approval and require excessive reassurance about their performance and other things they are worried about.</td>
<td>• Adolescents who suffer from GAD tend to excessively worry about school and sporting performances, as well as social interactions/relationships. • Adolescents tend to worry about school issues, punctuality, and catastrophic events (earthquakes, nuclear war). • Adolescents may be overly conforming, perfectionistic, unsure of themselves, tendency to redo tasks because of excessive dissatisfaction with less-than-perfect performance. • Adolescents can be overzealous in seeking reassurance and approval and require excessive reassurance about their performance and other things they are worried about.</td>
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</tbody>
</table>
4. Epidemiology

- At this time, little epidemiologic data exists for anxiety in children and adolescents using the new DSM-V diagnostic criteria.
- Prevalence for childhood anxiety disorders vary from 6 to 20 percent (Costello et al; 2004)
- 9 to 15 percent of U.S. children and adolescents have anxiety symptoms that interfere with their day-to-day functioning (Bernstein et al., 1996; Bernstein and Shaw, 1997).
- Shy children are at increased risk for developing anxiety disorders (Bernstein et al., 1996; Kagan et al., 1988).
- Up to 15 percent of female and 6 percent of male children and adolescents who experience trauma meet criteria for post-traumatic stress disorder (PTSD).
- The more severe the anxiety disorder and the greater the impairment in functioning, the more likely it is to persist (Dadds et al., 1997, 1999; Manassis and Hood, 1998).
- Children and adolescents with anxiety disorders are at risk for developing new anxiety disorders, depression, and substance abuse.

5. Etiology/Risk Factors

- Biological risk factors include possible genetic predisposition and child temperament.
- Parenting styles (anxious, over-protective, controlling parents) have also been mentioned in some studies as a possible predisposing factor for anxiety disorders.
- Children’s coping skills have been considered to be protective factors in childhood anxiety disorders (Spence, 2001).

6. Untreated Sequelae

- Repeated school absences or an inability to finish school.
- Impaired relations with peers.
- Low self-esteem.
- Alcohol or other drug use.
- Problems adjusting to work situations.
- Anxiety disorder in adulthood.
7. Diagnosis

- Use of diagnostic criteria in the APA’s DSM-V is critical to ensuring validity and reliability in diagnosing anxiety disorders.

- Screening can help to guide the diagnosis of an anxiety disorder and distinguish among anxiety disorders. The screening tool SCARED should be completed by both the parent and child if the child is older than 8 years of age, which can be located at the following websites:
  - Child version:
  - Parent version:

Appendix 1 provides sample SCARED screening tools for both parent and child. Permission to use the scales was obtained from Dr. Boris Birmaher.

8. Differential Diagnosis

8.1 Psychiatric Conditions that Resemble Anxiety Disorders

- Attention-Deficit/Hyperactivity Disorder (ADHD; restlessness, inattention)
- Psychotic disorders (restlessness and/or social withdrawal)
- Autism spectrum disorders
- Learning disabilities
- Bipolar Disorder (restlessness, irritability, insomnia).
- Depression (poor concentration, sleep difficulty, somatic complaints; Manassis, 2000)

8.2 Comorbidities

- Anxiety disorders often occur with depressive and ADHD symptoms.
- 30–70 percent of children and adolescents with anxiety disorders have a depressive disorder.
- 15–25 percent of children and adolescents with anxiety disorders meet the criteria for ADHD.

8.3 Comorbid/Confounding Disorders

- **Anxiety and ADHD**
  Children with anxiety can present symptoms resembling those of attention deficit hyperactivity disorder. It is not uncommon for both conditions to be present in a patient.

- **Anxiety and Bipolar Disorder**
  Since teens with Bipolar Disorder may experience significant adverse effects when treated with antidepressants, obtaining any history of past or current bipolar symptoms is critical. Look for a family history of Anxiety and/or Bipolar Disorders.
• **Bipolar Disorder**
  
  o **Middle Childhood**
    - Persistently irritable mood is described more often than a euphoric mood.
    - Aggressive and uncontrollable outbursts, agitated behaviors (may look like Attention Deficit Hyperactivity Disorder [ADHD] with severe hyperactivity and impulsivity).
    - Extreme fluctuations in mood that can occur on the same day or over the course of days or weeks.
    - Reckless behaviors, dangerous play, and inappropriate sexual behaviors
  
  o **Adolescence**
    - Markedly labile mood
    - Agitated behaviors, pressured speech, racing thoughts, sleep disturbances
    - Reckless behaviors (e.g., dangerous driving, substance abuse, sexual indiscretions)
    - Illicit activities (e.g., impulsive stealing, fighting), spending sprees.
    - Psychotic symptoms (e.g., hallucinations, delusions, irrational thoughts)

8.4 **Medical Conditions that Resemble Anxiety Disorders**

- Hyperthyroidism
- Caffeinism
- Migraine
- Asthma
- Seizure disorders
- Lead intoxication
- Less common conditions: Hypoglycemia, pheochromocytoma, CNS disorder, and cardiac arrhythmias
- Prescription drugs: antiasthmatics, sympathomimetics, steroids, selective serotonin reuptake inhibitors (SSRIs), typical antipsychotics such as haloperidol and pimozide, and atypical antipsychotics
- Nonprescription drugs with side effects that may mimic anxiety include diet pills, antihistamines, and cold medicines

8.5 **Red Flags**

- Suicidal ideation, suicidal gestures, and suicide attempts
- Comorbid substance abuse
- Auditory or visual hallucinations
- Poor parental supervision and poor family support
- Abuse (physical, sexual or emotional)

9. **Treatment**

9.1 **Treatment of Anxiety Disorders**

- Studies have shown that Cognitive Behavioral Therapy (CBT) is effective for the treatment of anxiety disorders in children.
- SSRI’s have been shown to be effective as well for the treatment of anxiety disorders.
- Studies have shown that a combination of both medication and CBT is more effective in reducing and treating symptoms of anxiety disorders.
9.2 *Assessment Recommendations*

- **Recommendation I**: Patients with anxiety risk factors (family history, other psychiatric disorders, substance abuse, trauma, psychosocial adversity, etc.) should be identified and monitored.
- **Recommendation II**: Assessment for anxiety should include interviews with the patients and families and should include an assessment of functional impairment in different domains.

9.3 *Initial Management Recommendations*

- **Recommendation I**: Clinicians should educate and counsel families and patients about anxiety and options for the management of the disorder.
- **Recommendation II**: Clinicians should develop a treatment plan with patients and families and set specific treatment goals in key areas of functioning including home, peer, and school settings.
- **Recommendation III**: Establish links with community mental health resources, which may include patients and families who have dealt with anxiety.
- **Recommendation IV**: Establish a safety plan, which includes restricting access to lethal means, engaging a concerned third-party, and an emergency communication mechanism.

9.4 *Treatment Recommendations*

- **Recommendation I**: In cases of *mild* anxiety, consider a period of active support and monitoring before starting other evidence-based treatment.
- **Recommendation II**: If a Primary Care (PC) clinician identifies an adolescent with moderate or severe anxiety or complicating factors such as co-existing substance abuse, consultation with a mental health specialist should be considered.
- **Recommendation III**: Consider Cognitive Behavioral Therapy for mild cases and antidepressant treatment such as SSRI’s for moderate cases.
- **Recommendation IV**: PC clinicians should actively support anxious adolescents who are referred to mental health. Consider sharing care with mental health agencies/professionals when possible.

9.5 *Working with Mental Health Liaisons*

- Appropriate roles and responsibilities for ongoing management by the PC clinician and mental health clinicians should be explicitly communicated and agreed upon.
- The patient and family should be consulted and approve the roles of the PC clinician and mental health professionals.

9.6 *FDA Approved Antidepressants in Children with Anxiety*

- Fluoxetine: ≥ 8 y/o
- Sertraline: ≥ 6 y/o
- Fluvoxamine: ≥ 8 y/o
- Doxepin: ≥ 12 y/o
- Imipramine: ≥ 6 y/o
- Clomipramine: ≥ 10 y/o (Clomipramine and imipramine not used often due to their side effect profile.)
9.7 Medication Doses

It is our recommendation to consult a child psychiatrist, when prescribing these medications.

- **Fluoxetine:**
  - Children 8 to 12 y/o: 5 to 60 mgs.
  - Adolescents 13 y/o and up: Adult dosing.

- **Sertraline:**
  - Children 6 to 12 y/o: 12.5 to 25 mgs.
  - Adolescents 13 y/o and up: Adult dosing.

- **Fluvoxamine:**
  - Children/Adolescents 8 to 17 y/o: Initial dose of 25 mg at bedtime; increase by 25 mg every week. Max dose: 200 mg. Doses over 50 mg should be divided into 2 doses with the larger dose being administered at bedtime.

9.8 SSRI/SNRI Adverse Effects

- **Serious Adverse Effects**
  - Serotonin Syndrome (muscle rigidity, tremulousness, myoclonus, autonomic instability, agitated confusion, rhabdomyolysis)
  - Akathisia (uncontrollable internal motor restlessness)
  - Hypomania
  - Discontinuation syndromes (nausea, vomiting, headache, tremor, dizziness, fatigue, irritability, palpitations, rebound depression/anxiety)

- **Common Adverse Effects**
  - GI effects (dry mouth, constipation, diarrhea)
  - Sleep disturbance
  - Irritability
  - Disinhibition
  - Agitation/jitteriness
  - Headache

9.9 What to Do After Starting an Antidepressant

- Talk with the child about their worries and fears. Reassure the child that others experience worries and there is help available.

- Encourage the child to pursue natural talents and interests.

- Help the child ease gradually into new situations and provide praise.
9.10 What to Do While Waiting for a Referral

- **Parent Recommendations**
  - Encourage parents to schedule regular play dates with other children with whom their child is compatible. Their child may thus gain confidence in her ability to participate in group activities with other children.
  - Structured group play and activities (church group, boy scouts, team sports, etc.) can help children and adolescents learn social skills.

- **School Recommendations**
  - With permission, involve teachers in assessing function. Determine whether there are any school-related stressors.
  - The school may assess for learning disabilities or special education needs that may be contributing to the child’s distress.
10. Family Resources

- **Anxiety Disorders Association of America (ADAA):**
  11900 Parklawn Drive, Suite 100
  Rockville, MD 20852
  Phone: (301) 231-9350
  Website: [http://www.adaa.org](http://www.adaa.org)

- **American Academy of Child and Adolescent Psychiatry (AACAP) Anxiety Disorders Resource Center:**
  [http://aacap.org/cs/AnxietyDisorders.ResourceCenter](http://aacap.org/cs/AnxietyDisorders.ResourceCenter)

- **PTSD in Children and Teens: Web Resource Link:**

- **Arkansas Teen Crisis Hotline:**
  Teen Crisis Hotline: (888) 798-8336
  Teen Crisis Hotline: (479) 872-8336

10.1 Arkansas Building Effective Services for Trauma

The UAMS Psychiatric Research Institute and the UAMS Department of Pediatrics collaborate to serve children who have experienced abuse.

- **Clinical Care** - Implement evidence-based assessment and treatment practices throughout the state to create a comforting and safe environment for children and adolescents who are traumatized and optimize their physical and mental health outcomes.

- **Training** - Provide state-of-the-art training, supervision and learning environments that will maximize the adoption of quality interventions for traumatized children and adolescents.

- **Advocacy** - Enhance awareness, expand knowledge and promote collaboration among all individuals working with traumatized children and adolescents and their families.

- **Research** - Constantly monitor, assess the effectiveness of, and develop and test new models of interventions for traumatized children and adolescents to provide the safest and most effective care available.

Arkansas Building Effective Services for Trauma (AR BEST) has developed a comprehensive list of the names and contact information of clinicians who are trained to provide treatment for children who had been exposed to severe trauma:

[http://uams.edu/arbest/map.asp](http://uams.edu/arbest/map.asp)

For more information regarding AR BEST: [arbest_info@uams.edu](mailto:arbest_info@uams.edu)
11. Bibliography


Appendix
Appendix 1

Screen for Child Anxiety Related Disorders (SCARED)
Parent Version—Pg 1 of 2 (To be filled out by the PARENT)

Name: _________________________________
Date: _________________________________

Directions:
Below is a list of statements that describe how your child feels. Read each statement carefully and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

<table>
<thead>
<tr>
<th></th>
<th>0 Not True or Hardly Ever True</th>
<th>1 Somewhat True or Sometimes True</th>
<th>2 Very True or Often True</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When my child feels frightened, it is hard for him/her to breathe.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. My child gets headaches when he/she is at school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. My child doesn’t like to be with people he/she doesn’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. My child gets scared if he/she sleeps away from home.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. My child worries about other people liking him/her.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. When my child gets frightened, he/she feels like passing out.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7. My child is nervous.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8. My child follows me wherever I go.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>9. People tell me that my child looks nervous.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>10. My child feels nervous with people he/she doesn’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>11. My child gets stomach aches at school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>12. When my child gets frightened, he/she feels like he/she is going crazy.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>14. My child worries about being as good as other kids.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>15. When he/she gets frightened, he/she feels like things are not real.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>16. My child has nightmares about something bad happening to his/her parents.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>17. My child worries about going to school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>18. When my child gets frightened, his/her heart beats fast.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>19. He/she gets shaky.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>20. My child has nightmares about something bad happening to him/her.</td>
<td>○</td>
<td>○</td>
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</tr>
</tbody>
</table>
### Screen for Child Anxiety Related Disorders (SCARED)

**Parent Version—Pg. 2 of 2 (To be filled out by the PARENT)**

<table>
<thead>
<tr>
<th>Item</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. My child worries about things working out for him/her.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. When my child gets frightened, he/she sweats a lot.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. My child is a worrier.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. My child gets really frightened for no reason at all.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. My child is afraid to be alone in the house.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. It is hard for my child to talk with people he/she doesn't know</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. When my child gets frightened, he/she feels like he/she is</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>28. People tell me that my child worries too much.</td>
<td></td>
<td></td>
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<tr>
<td>29. My child doesn't like to be away from his/her family.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. My child is afraid of having anxiety (or panic) attacks.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. My child worries that something bad might happen to his/her</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32. My child feels shy with people he/she doesn't know well.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33. My child worries about what is going to happen in the future.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>34. When my child gets frightened, he/she feels like throwing up.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35. My child worries about how well he/she does things.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. My child is scared to go to school.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. My child worries about things that have already happened.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. When my child gets frightened, he/she feels dizzy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. My child feels nervous when he/she is with other children or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>adults and he/she has to do something while they watch him/her</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(for example: read aloud, speak, play a game, play a sport.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. My child feels nervous when he/she is going to parties, dances,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or any place where there will be people that he/she doesn't know</td>
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<td></td>
</tr>
<tr>
<td>well.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. My child is shy.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SCORING:**
A total score of ≥ 25 may indicate the presence of an Anxiety Disorder. Scores higher than 30 are more specific. A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate Panic Disorder or Significant Somatic Symptoms. A score of 9 for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate Generalized Anxiety Disorder. A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate Separation Anxiety Disorder. A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate Social Anxiety Disorder. A score of 3 for items 2, 11, 17, 36 may indicate Significant School Avoidance.

Developed by Burt Birnbaum, M.D., Sunetra Khetarpal, M.D., Marilyn Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birnbaub@mss.upmc.edu
Screen for Child Anxiety Related Disorders (SCARED)
Child Version—Pg. 1 of 2 (To be filled out by the CHILD)

Name: ________________________________
Date: ________________________________

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

<table>
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</thead>
<tbody>
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<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>2. I get headaches when I am at school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>3. I don’t like to be with people I don’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>4. I get scared if I sleep away from home.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>5. I worry about other people liking me.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>6. When I get frightened, I feel like passing out.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>7. I am nervous.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>8. I follow my mother or father wherever they go.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>9. People tell me that I look nervous.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
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<td>○</td>
<td>○</td>
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</tr>
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<td>11. I get stomachaches at school.</td>
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<td>○</td>
<td>○</td>
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<td>○</td>
<td>○</td>
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<tr>
<td>14. I worry about being as good as other kids.</td>
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<td>○</td>
<td>○</td>
</tr>
<tr>
<td>16. I have nightmares about something bad happening to my parents.</td>
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<td>○</td>
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<td>○</td>
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</tr>
<tr>
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<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>
Screen for Child Anxiety Related Disorders (SCARED)
Child Version—Pg. 2 of 2 (To be filled out by the CHILD)

<table>
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<tr>
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<td>○</td>
<td>○</td>
</tr>
<tr>
<td>22. When I get frightened, I sweat a lot.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>23. I am a worrier.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>24. I get really frightened for no reason at all.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>25. I am afraid to be alone in the house.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>26. It is hard for me to talk with people I don’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>27. When I get frightened, I feel like I am choking.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>28. People tell me that I worry too much.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>29. I don’t like to be away from my family.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>30. I am afraid of having anxiety (or panic) attacks.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>31. I worry that something bad might happen to my parents.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>32. I feel shy with people I don’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>33. I worry about what is going to happen in the future.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>34. When I get frightened, I feel like throwing up.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>35. I worry about how well I do things.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>36. I am scared to go to school.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>37. I worry about things that have already happened.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>38. When I get frightened, I feel dizzy.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example, read aloud, speak, play a game, play a sport.)</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don’t know well.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
<tr>
<td>41. I am shy.</td>
<td>○</td>
<td>○</td>
<td>○</td>
</tr>
</tbody>
</table>

**SCORING:**
A total score of ≥ 25 may indicate the presence of an Anxiety Disorder. Scores higher than 30 are more specific. A score of 7 for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate Panic Disorder or Significant Somatic Symptoms. A score of 9 for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate Generalized Anxiety Disorder. A score of 5 for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate Separation Anxiety Disorder. A score of 8 for items 3, 10, 26, 32, 39, 40, 41 may indicate Social Anxiety Disorder. A score of 3 for items 2, 11, 17, 36 may indicate Significant School Avoidance.

*For children ages 8 to 11, it is recommended that the clinicians explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birnbaumer, M.D., Susana Khaterpal, M.D., Marlene Cully, M.Ed., David Breslau M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh, (1995). E-mail: birnbaume@smeet.pmc.edu