

## Position Statement

# Anxiety in children and youth: Part 1—Diagnosis

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### ABSTRACT

Anxiety disorders are the most common mental health concerns affecting Canadian children and adolescents. The Canadian Paediatric Society has developed two position statements that summarize current evidence regarding the diagnosis and management of anxiety disorders. Both statements offer evidence-informed guidance to support paediatric health care providers (HCPs) making decisions around the care of children and adolescents with these conditions. The objectives of Part 1, which focuses on assessment and diagnosis, are to: (1) review the epidemiology and clinical characteristics of anxiety disorders and (2) describe a process for assessment of anxiety disorders. Specific topics are reviewed, including prevalence, differential diagnosis, co-occurring conditions, and the process of assessment. Approaches are offered for standardized screening, history-taking, and observation. Associated features and indicators that distinguish anxiety disorders from developmentally appropriate fears, worries, and anxious feelings are considered. Note that when the word ‘parent’ (singular or plural) is used, it includes any primary caregiver and every configuration of family.

**Keywords:** Adolescents; Anxiety disorders; Children; Mental health.

### BACKGROUND AND PREVALENCE

Anxiety can be a normal emotional and physiological response to potential threats. Fears during childhood and adolescence commonly occur as part of normal development. Anxiety disorders are distinguished from normal anxiety by persistent, disproportionate, or distorted responses leading to impaired functioning (1,2) in everyday life. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) (3) defines seven anxiety disorders: separation anxiety disorder, selective mutism, specific phobia, social anxiety disorder (social phobia), panic disorder, agoraphobia, and generalized anxiety disorder. These diagnoses require a degree of severity, persistence, and associated impairment (3,4) at home or school, or during other developmentally appropriate activities. Anxiety disorders co-occur frequently. For example, a child or adolescent can have both generalized anxiety and social anxiety disorders. The ages of onset for specific anxiety disorders are associated with developmental stages. Anxiety disorders can have a waxing and waning course. They can also remit and relapse, and different anxiety disorders can resolve or emerge in the same child over time. For example, separation

anxiety at preschool age may be followed by generalized or social anxiety at school age or during adolescence (5).

As a group, anxiety disorders are the most common mental disorders affecting children and adolescents in Canada. Until recently, reported rates of anxiety disorder had been comparatively stable for decades, with about 4.0% of youth aged 12 to 19 years self-reporting an anxiety disorder in 2009, for example (6). Ten years later, population survey data began to suggest higher rates of anxiety, with 11% to 19% of adolescents and almost 9% of children self-reporting an anxiety disorder (7). This increase may reflect a true rise in prevalence or be the result of other societal factors such as greater community awareness of anxiety, decreased stigma around mental health issues, increased treatment seeking, or reporting of sub-diagnostic threshold symptoms (8–10). A 2018 study found increasing anxiety across Canada, with professionally diagnosed anxiety disorders in youth 12 to 24 years old doubling from 6.0% in 2011 to 12.9% in 2018 (8). An Ontario study found that between 2006 and 2017, mental health-related emergency room (ER) visits in the province increased from 11.5 to 21.7 per 1,000 population of

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children and youth under 25 years, with anxiety disorders being the most frequent mental health concern (11).

The etiology of anxiety disorders is multifactorial and includes biological factors (e.g., temperament, genetics, and epigenetics), combined often with psychological and social exposures (e.g., adverse childhood experiences). Other factors associated with influencing resiliency (or vulnerability) to anxiety disorders include parenting style, parental modelling of responses to stress, and family accommodation of child stress (1,3,9,12).

## ASSESSING ANXIETY

Along with identifying the presence of anxiety symptoms, other salient components of a mental health assessment should include developmental levels of function, any problematic mental health signs or symptoms, observing parent-child interactions, and taking a medical history (Box 1). The psychosocial inventory should include family composition and background, social stressors, supports, and risk factors (e.g., parental anxiety disorder, recent parental separation, and a recent educational placement change) as well as personal factors, such as interests and preferences. Diagnostic formulation can lead to individualized psychoeducation, environmental or behavioural strategies (e.g., counselling healthier routines and limit-setting, modelling positive self-talk by caregivers, school advocacy), psychotherapy, and medication management options.

## FOCUSED HISTORY-TAKING AND SCREENING

The core signs or symptoms defining anxiety as a disorder are *hyperarousal* (e.g., being nervous, scared, irritable, or agitated), *avoidance* (e.g., clinging to avoid separation, avoiding places where the focus of fear may be encountered), and thought content reflecting *cognitive distortions* (e.g., repeatedly asking worried questions, seeking reassurance, or making 'what if' statements). History may reveal inciting events such as an environmental stressor (e.g., parental illness) or disturbing exposure (e.g., news, video, injury). The course of symptoms can be progressive, persistent, or recurrent (5). Anxiety disorders may also present with physical (i.e., somatic) symptoms, such as muscle

tension and stomach-aches, that can interfere with school attendance or lead to ER visits (14). Children or adolescents who experience panic attacks (e.g., sweating, feeling short of breath, choking sensations, chest discomfort, nausea, dizziness) may fear future attacks and subsequently avoid situations they associate with them (15).

Approaches to taking an anxiety history include focusing on presenting concerns (e.g., school avoidance, sleep problems), expanding on data obtained from standardized measures, and a review of daily activities. Inquiry into daily routines, such as hygiene, dressing, meals, family and peer interactions, recreation, school, and bedtime, not only screen for signs of anxiety but should be part of any paediatric assessment. Parents may be unaware that behaviours such as picky eating, sleep problems, and substance use can be driven by anxiety. Asking for specific examples when parents express concerns about child anxiety can help distinguish episodes of behavioural dysregulation from nonspecific emotional stressors (such as tantrums). Similarly, a parent expressing concern about their child's behavioural dysregulation or 'outbursts' requires screening for anxiety.

Conducting a confidential, non-judgmental interview with adolescents is an essential part of history-taking. The verbal child or adolescent should be asked to describe situations they avoid or do not enjoy, along with associated thoughts and feelings. Evidence of ability to think about thoughts and feelings (i.e., metacognition) helps inform the individual's potential for cognitive behaviour therapy. For adolescents, the opportunity to interact with the physician independently can facilitate identification of anxiety symptoms, psychosocial stressors, past traumatic events such as violence or abuse, and co-occurring mental illnesses such as substance use, depression, or suicidality. The use of a history-taking tool such as the SSHADESS (Strengths, School, Home, Activities, Drugs, Emotion, Eating, Depression, Sexuality, Safety) may enhance rapport and completion of information gathering (16).

Anxiety questionnaires (e.g., SCARED) completed by parents, children, or youth can be used to screen for severity of symptoms (i.e., whether an individual is in a high-risk category for anxiety) before conducting an interview or as part of diagnostic and treatment processes (17–19). Questionnaires are available at the Canadian Paediatric Society website (13). HCPs should bear in mind that questionnaires can be subjective, while the validity of rating scales can vary for patient age and demographics, general or clinical populations, global anxiety versus specific anxiety disorders, and for screening, diagnosis, and treatment effects. Information gathered from questionnaires must be interpreted in context with the whole assessment of a child's or adolescent's presentation.

## PARENT-CHILD INTERACTIONAL HISTORY AND STYLE

Observing and exploring parent-child interactional history and style can inform both the diagnosis and management of an anxiety disorder, specifically regarding how parents respond to their child's emotions. Parent-child interactions include household routines and rules, expressions of positive regard and negativity, and calming or nurturing responses when a child or adolescent

### Box 1. Five essential components of an anxiety-focused assessment

1. Patient history and parent-reported symptoms and functioning
2. Focused medical, developmental, and mental health history
3. Results from standardized rating scales (13), which can be downloaded at the Canadian Paediatric Society website at no cost
4. Review past assessments (e.g., reports from allied HCPs, early child care, or school settings)
5. Direct observation of the child and parent-child interactions

is dysregulated or distressed. For example, a young child with separation anxiety may routinely be allowed to follow a parent into the bathroom. An adolescent with separation anxiety may text a parent repeatedly throughout the day seeking reassurance, with symptoms increasing if parental response is delayed. Clingy behaviour (e.g., following a parent or texting repeatedly) may lead to parental affect dysregulation (e.g., irritability or rejection), thereby increasing child distress and, potentially, exacerbating anxiety symptoms. Child avoidance may be reinforced by overprotectiveness, or cognitive distortions may become more entrenched with parental expressions of anxiety (e.g., “You’ll only get yourself hurt!”) (20). Parents may themselves be experiencing anxiety, other mental health conditions, or emotional stressors (e.g., financial, personal, or work-related), which can disrupt family routines and exacerbate anxiety and other problems in children.

Parental concerns on history surrounding unlikely ‘worst case’ scenarios for their child (e.g., failing school, delinquency) may suggest anxiety features *in the parent*. Creating a safe space for parents to disclose their own histories of anxiety disorder is crucial, because they may feel embarrassed or blame themselves for a child’s anxiety. Asking about the child’s emotional state and reactions when under stress, and about how stressful family situations or interactions (including parental response) commonly play out, can bring interactional factors to light. Questions may be directed to parents, children (or both) depending on the age and developmental stage of children involved (Table 1).

DEVELOPMENTAL AND MEDICAL HISTORY

Questions surrounding a child’s temperament, likes, and dislikes can be pathways to broader issues. A child with anxiety might be described by a parent or caregiver as ‘too serious’, ‘a worrier’, an ‘old soul’, ‘uptight’, ‘a perfectionist’, ‘quiet’, or ‘eager to please’. Adolescents might be ‘over-emotional’, ‘dependent’, ‘shy’, ‘introverted’, or ‘overly sensitive’. One temperamental trait, behavioural inhibition, which is the tendency to withdraw from new environments and transitions from an early age, has been associated with anxiety disorders (5). Behavioural difficulties in unfamiliar situations, which might be described as oppositional, rigid, or aggressive, or as a ‘temper tantrum’, are all possible indicators of anxiety. For example, a child or youth may become angry or aggressive in response to an anxiety-provoking stimulus (i.e., the ‘fight-or-flight’ response) without being able to identify or articulate the cause.

Understanding a child’s functioning across a range of developmental domains (e.g., cognitive, language, social, motor) is required for accurate assessment. One area of delay or disability may contribute to symptoms by impacting participation in various activities (e.g., a learning disorder and fearfulness of school). A child’s cognitive and language levels may preclude the ability to articulate worry or fear, which may necessitate more detailed history-taking from a parent regarding behavioural tendencies across situations. Other conditions can mimic or overlap with anxiety symptoms, such as difficulty participating in social environments or hyperarousal due to sensory processing features in autism spectrum disorder. When a child’s developmental functioning is in question, further developmental assessment is required.

Table 1. Sample questions to ask when exploring anxiety symptoms

|                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Screening questions                  | “Does [name] worry a lot or seem nervous?”<br>“What do other adults say about [her/his] temperament or behaviour?”<br>“Does [name] avoid any activities or situations, or hold back from them because of worry, nervousness, or a belief that things will go wrong?”<br>“What makes [name] worried or scared?”                                                                                                                                                                                                                                                                                                                                                                                        |
| Specific triggers                    | “Does [name] get worried about or avoid certain activities or situations? Does [she/he] ask lots of questions about disasters, being alone, being hurt by animals, car crashes, peers not liking them, or doing poorly in school?”<br>“Does [name] have a hard time being away from a parent?”<br>“Does [name] ever feel panicky or frightened for no apparent reason?”<br>“Does [name] often find it hard to relax, or fall asleep?”<br>“Does [name] ever have trouble breathing, experience a racing heart, sweat heavily, or feel shaky or faint in crowded rooms, big places, or social situations?”<br>“How does your body tell you that you are worried or anxious? What signals does it send?” |
| Speech and behavioural features      | “Does [name] frequently ask ‘what if’ questions?”<br>“Does [name] talk repetitively about bad things happening?”<br>“Does [name] appear nervous in new or unpredictable situations, or seem over-prepared for some social situations?”<br>“Does [name] say that peers don’t like [her/him] or feel rejected by them?”                                                                                                                                                                                                                                                                                                                                                                                 |
| Interactional features (for parents) | “What do you as a parent tend to say and do when your child has anxiety? How does your child usually react to your response?”                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

Adolescents also have key developmental milestones to attain, and understanding the tasks involved is important for contextualizing normal worries (e.g., around peer acceptance, job interviews, and dating). A confidential adolescent history-taking tool such as SSHADESS or HEEADSSS (Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Mental Health, Safety) (21) is useful for gauging development and determining whether worries have become more problematic over time and require intervention.

Medication and dietary histories should be obtained for sympathomimetics. For example, stimulant medications for attention-deficit hyperactivity disorder, caffeine, decongestants, and bronchodilators can cause effects that mimic the anxiety symptoms. For older children and adolescents, consider the possible use of nicotine, amphetamines, alcohol, or cannabis to ‘self-medicate’ by reducing symptoms of an anxiety disorder (1). Fear or preoccupation around eating or food may indicate a comorbid eating disorder.

Thorough medical history-taking and physical examination are required to identify disease symptoms that may mimic anxiety, with further investigations as appropriate. Fear or avoidance of eating may relate in part to problems swallowing caused by, or secondary to, oral motor dysfunction, esophageal mucosal inflammation, esophageal dysmotility, or an anatomical abnormality. Other conditions with symptomatology that overlaps with anxiety include cardiac disorders (involving tachycardia and chest discomfort), respiratory disease (e.g., with dyspnea from asthma), adrenal insufficiency or anemia (with fatigue and tachycardia), and hyperthyroidism (with tremulousness and tachycardia). Furthermore, any medical condition that causes pain, discomfort, or functional impairment can compound anxiety. Stressful medical events such as prolonged hospitalization, a medical procedure, or anaphylaxis can cause or contribute to anxiety.

### FAMILY AND SOCIAL HISTORY

An inventory of past and present psychosocial stressors and supports, along with a family history of medical and mental health, can inform level of risk for anxiety and other mental health conditions in children and youth (22). Ongoing environmental stressors may affect the provision of services (e.g., to address housing or food insecurity) or immediate intervention (e.g., in cases of maltreatment or exposure to domestic violence). Parental medical or mental health conditions, or family experience of racism, violence, poverty, grief, or other adversities, each confer risk for a broad range of developmental and mental health disorders in children. Parental anxiety disorder is a specific risk factor for child anxiety (5).

### IN-OFFICE OBSERVATIONS

When a child or youth appears withdrawn, avoids eye contact, or refuses to speak, or when a younger child exhibits clinginess, hypervigilance, and fearful questioning or behaviours, the HCP should consider these possible signs of anxiety. The parent should be asked about frequency, context, and impact of these behaviours on function at home, in school, or when socializing in community. Furthermore, a child's affect, speech, and behaviour should be observed when sources of anxiety are discussed to gauge child response. Behaviours consistent with anxiety, though not fully sensitive or specific (1), can help with correlating clinical features obtained on history, past assessment review, or checklists, and should be documented as part of the assessment. Parental anxiety behaviours, including nervous affect, a tendency to catastrophize, and worried questions, also may be noted.

### DIFFERENTIAL DIAGNOSIS AND COMORBIDITIES

Both the differential diagnosis and range of factors contributing to anxiety are broad, and the co-occurrence of anxiety with other conditions is common. The relationships among anxiety, other mental health conditions, and developmental and psychosocial factors are complex and not well understood (23). Table 2 shows how common it is that anxiety co-exists with, or contributes to, developmental or mental health conditions (and vice-versa).

## ASSESSMENT FOR SPECIFIC ANXIETY DISORDERS

A key diagnostic criterion for anxiety disorders is that the symptoms experienced fall well beyond 'normal' fears and inhibitions expected for a child or youth's developmental age and stage, causing clinically significant distress or impairment in social or school life, and possibly in other important areas of functioning (3,8). Table 3 describes physiological, anxiety-related behaviours, and features consistent with anxiety disorders, along with common age of onset for specific anxiety disorders.

### RECOMMENDATIONS

Assessments for anxiety in children and adolescents must be comprehensive due to the broad range of possible clinical presentations, comorbidities, and differential diagnoses. Specific recommendations for paediatric health care providers are as follows:

- Consider using an anxiety questionnaire (e.g., SCARED) to screen for severity of symptoms before conducting an interview.
- Focus on the following factors when history-taking for anxiety symptoms:
  - Presenting concerns (e.g., fears, avoidance, school difficulties, sleep problems),
  - Inciting events, exposures, and timing of episodes,
  - A review of daily activities and parent-child interactions,
  - Data obtained from standardized screening tools, with more measures when indicated, and
  - Symptoms of possible comorbid conditions.
- Inquire specifically about the child or youth's developmental functioning.
- Take a focused medical history, including medications, sleep, and diet.
- Conduct one-on-one, confidential, non-judgmental interviews with adolescents, utilizing a history-taking tool (e.g., HEEADSSS).
- Obtain a family history, including social information such as:
  - Composition and background
  - Social stressors, supports, and risk factors (e.g., housing and food insecurity, parental separation)
- Obtain a history of personal factors (e.g., the child's or youth's interests, strengths, and preferences).
- Create a safe space for parents to disclose their own history of anxiety or mental health that may be affecting relational responses and coping strategies.
- Consider the following as possible signs of anxiety when they are directly observed:
  - A child or youth appears withdrawn, avoids eye contact, or refuses to speak.
  - A younger child exhibits clinginess, hypervigilance, and fearful questioning or behaviour.
- When potential signs of anxiety are reported, ask parents about frequency, intensity, context, and impact on their child or youth's participation in home, school, and community.

**Table 2.** Differential diagnosis and common comorbidities for anxiety

|                                                    |                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Child temperament/Emotional regulation development | Behavioural inhibition and low adaptability from a young age are both 'normal' variations of temperament and risk factors for anxiety (24,25). Adolescence is a crucial developmental period for emotion regulation but is also associated with increase in affective instability (26).                                              |
| Environmental adversity                            | ACEs have a cumulative negative association with mental health outcomes, including anxiety (22,27–30).                                                                                                                                                                                                                               |
| School problems                                    | School problems, and learning disabilities specifically, have been strongly associated with later mental health problems, difficult peer and family relationships, and lower quality of life in the longer term (31–33).                                                                                                             |
| ADHD                                               | An estimated 25% of children with ADHD also have anxiety disorders (34), possibly related to effects of ADHD on early development (23).                                                                                                                                                                                              |
| OCD and tics or TS                                 | Anxiety disorders are often comorbid with OCD (in 26–75% of cases (35)) or tic disorders (in 30% of cases (36)). While these conditions overlap phenomenologically, they appear to have distinct mechanisms (36,37).                                                                                                                 |
| ASD                                                | ASD is associated with higher levels of anxiety (38). ASD features, such as sensory over-responsiveness, repetitive behaviours (39), and social skill deficits (40), overlap with anxiety symptoms (41).                                                                                                                             |
| Eating disorders                                   | High rates of comorbidity exist between eating disorders and anxiety disorders. Anorexia nervosa is associated with features of anxiety around body weight or shape perfectionism, and bulimia nervosa is associated with low self-esteem (i.e., social anxiety symptoms) and ineffectiveness (i.e., general anxiety symptoms) (42). |
| Somatic symptom disorders                          | Somatic symptoms vary widely but include anxiety around becoming ill or functional symptoms, and anxious or excessive health-related behaviours (either health promotive or to prevent illness) (43,44).                                                                                                                             |

ACE Adverse childhood experience; ADHD Attention-deficit hyperactivity disorder; ASD Autism spectrum disorder; OCD Obsessive compulsive disorder; TS Tourette syndrome.

**Table 3.** Distinguishing developmentally appropriate anxiety features from symptoms of anxiety disorders

| Anxiety disorders (typical age of onset)                                     | Developmentally appropriate fears and worries                                                                                      | Symptoms suggestive of anxiety disorder                                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Separation anxiety disorder (Preschool)                                      | Self-limiting distress around new separations from parent (e.g., for child care)                                                   | <ul style="list-style-type: none"> <li>– Clinging or closely following parent</li> <li>– Inconsolable distress, somatization during transitions</li> <li>– Unfounded worries about parent injury, illness, or death</li> </ul>                                                |
| Selective mutism (Preschool)                                                 | Taking time to 'warm up' in social situations                                                                                      | <ul style="list-style-type: none"> <li>– Being unable to speak in specific situations (e.g., in school)</li> </ul>                                                                                                                                                            |
| Specific phobia (Preschool to school age)                                    | Time-limited fear of new objects or situations (e.g., dogs, noise, or high places)                                                 | <ul style="list-style-type: none"> <li>– Fears persist and appear out of proportion to actual risk, leading to avoidance and diminishing quality of life or function</li> </ul>                                                                                               |
| Social anxiety disorder (social phobia) (Late school age, early adolescence) | Discomfort or hesitation around social events or requests to 'perform'                                                             | <ul style="list-style-type: none"> <li>– Excessive, persistent fear of scrutiny</li> <li>– Avoidance (e.g., of school, social events) or compromised involvement in family or community activities</li> <li>– Somatization with social interactions or performance</li> </ul> |
| Panic disorder (Adolescence, young adulthood)                                | Transient concerns about physiological symptoms (e.g., worrying about recurrence after an episode of vertigo)                      | <ul style="list-style-type: none"> <li>– Recurrent panic attacks (feeling out of control, with somatic symptoms)</li> <li>– Fear of panic attacks and avoidance of associated situations</li> <li>– Worries about associated health risks (e.g., for heart attack)</li> </ul> |
| Agoraphobia (Late adolescence, young adulthood)                              | Transient reluctance to use public transportation, to be in crowded or enclosed places, crowds, or to be outside of the home alone | <ul style="list-style-type: none"> <li>– Persistent avoidance of two or more locations based on fears of not being able to escape or summon help</li> </ul>                                                                                                                   |
| Generalized anxiety disorder (Late school age through young adulthood)       | Transient worries about grades, health, or world events that do not impair participation in school, family, or community           | <ul style="list-style-type: none"> <li>– Constant, excessive worry about risk that impairs participation in multiple events or activities</li> <li>– Trouble sleeping, physical restlessness, irritability, trouble concentrating, muscle tension</li> </ul>                  |

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