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CPS Position Statement on Anxiety Disorders (Part 1: Epidemiology & Diagnosis)

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Hi my name is Luke MacDonald and I'm a 2nd year medical student from Dalhousie University in Saint John, NB, working with Dr. Benjamin Klein, a developmental pediatrician at McMaster University in Hamilton, Ontario Today we will review Part 1 of the CPS anxiety position statements which focuses on the epidemiology, clinical characteristics, and assessment of anxiety disorders in the pediatric patient population.

Anxiety in the pediatric population is a common issue that primary care providers, teachers, parents, and mental health professionals are often faced with. In response to increasing demand for education on this topic, the Canadian Pediatric Society has developed two position statements to summarize evidence and provide recommendations for the diagnosis and management of anxiety disorders in children and adolescents.

The objectives of this podcast series are to identify the key points of the position statements so that listeners can:

1. Understand the epidemiology of anxiety disorders.
2. Review how to diagnosis anxiety disorders.
3. Understand management, and follow-up care for patients presenting with anxiety.

Let's go ahead and get started. First, it is important to recognize the difference between anxiety, fear, and anxiety disorders. **Anxiety** and **fear** in isolation can be normal emotional experiences for developing youth, and commonly they are in response to a potential threat or stressor. **Anxiety disorders** should be considered when fears or anxieties become pathological; this can be characterized by responses that are pervasive and not consistent with the expected response to certain situations. Anxiety disorders are also characterized by an impairment in functioning in one or more aspects of the child's life.

There is a great deal of variability between the different anxiety disorders, and the Diagnostic and Statistical Manual of Mental disorders outlines seven that can all be observed in children or adolescents: these include separation anxiety disorder, selective mutism, specific phobias, social anxiety disorder, panic disorder, agoraphobia, and generalized anxiety disorder. It is also important to know that while there are categorically seven anxiety disorders, the presentation may vary widely from patient to

patient, and often times anxiety disorders will co-occur. Some anxiety disorders, like separation anxiety disorder, are observed more frequently in preschool age children, but may manifest as others such as social anxiety or generalized anxiety as the child progresses through developmental stages.

Anxiety disorders are the most common mental disorders affecting children and adolescents in Canada, and rates are continuing to climb. The most recent data demonstrates that roughly 9% of Canadian children report having an anxiety disorder, and 11-19% of adolescents. Increasing prevalence may be attributed to a number of factors, some of which are positive – including more treatment-seeking from children and parents in response to decreased stigma and greater awareness in society. The number of clinically-diagnosed anxiety disorders as well as mental health-related emergency department visits have doubled since 2011.

Physicians and other health professionals may often be faced with the question of why and how a parent's child developed an anxiety disorder – and the answer is that anxiety disorders are a multifactorial condition. This means that there are biological, psychological, and social factors that may all play a part in the etiology of an anxiety disorder. Some examples of factors to take into account when assessing anxiety include genetics/family history, temperament, adverse childhood experiences, resiliency, and parenting styles.

ASSESSMENT

While it is important to identify the presence of anxiety disorders, there are some other critical components of the healthcare visit to take into account when working with these patients. There are five essential components of the anxiety-focused assessment as outlined by the CPS position statement:

1. patient history and parent-reported symptoms and functioning
2. focused medical, developmental, and mental health history
3. results from standardized rating scales
4. review of past assessments, including those from early childcare or school settings
5. direct observation of parent-child interactions

Three of the core symptoms to include in your history-taking include hyperarousal (signs of nervousness, irritability, or agitation), avoidance behaviors (such as clinging and avoiding certain environments or situations), and cognitive distortions (which may manifest as repeatedly asking questions and requiring reassurance). An example of a child exhibiting cognitive distortion symptoms would be a child who repeatedly asks their parent or teacher if something is 'safe', and needing to be told multiple times in order to feel reassured. It is also important to ask about potential stressors in the patient's life, and details about the symptom onset and duration. It is not uncommon for children and adolescents to experience physical symptoms in relation to anxiety, such as muscle tension, headaches, and GI discomfort, so be sure to ask about these and inquire about interference with school attendance. While not all individuals with anxiety disorders will experience panic attacks, it will be important to ask about this and identify what a panic attack looks like for the patient in question.

There are standardized rating scales, which are available for free on the CPS website, that may help to characterize anxiety and aid in the diagnostic process. Some of these include questionnaires for parents or youth to fill out to screen for the severity of symptoms. While these are useful tools to use in the assessment process, it is important to use them in collaboration with other components of the anxiety assessment to ensure accuracy and patient-centred care.

Observing the interactions between parent/guardian and child, as well as the child's behavior in the office, is a useful part of the anxiety disorder assessment. There are many features that clinicians should pay close attention to, including household routines, the parental expression of positivity or negativity, and, most importantly, how the parent responds to the child or adolescent when they become distressed. Is the parent irritable or dismissive in response to their child? Are they overprotective or worrisome? Do the parents themselves seem anxious or emotional? It is just as important to be mindful of the parents as it is to be attentive to the behavior of the child or adolescent; it is important to foster a safe environment so that parents feel comfortable and welcomed to discuss their own concerns and mental health, if necessary. The developmental history of the patient is important, and clinicians are advised to ask about temperament, behavioural concerns, and school performance. Adolescent patients should be screened using a tool like HEEADDSSS, or another targeted way to assess development. Particular attention should be paid to medications or drugs that may mimic anxiety symptoms or be being used as a mode of self-medication – including alcohol, nicotine, cannabis, and stimulants. Medical history is also important, especially in the context of anxiety symptoms with medical conditions on the differential, such as tachycardia, dyspnea, or tremor.

As we discussed, anxiety disorders are multifactorial conditions that may have a genetic component – as such, obtaining family history is relevant and important in the assessment of anxiety. Similarly, appropriate evaluation of any possible situational or environmental stressors should be conducted.

Let's take some time to discuss specific anxiety disorders in the child/adolescent population, and how they may present to care providers. In the clinic setting, youth with anxiety disorders may appear withdrawn, avoid eye contact, or refuse to speak. Younger children in particular may show signs of clinginess, and hypervigilance. Healthcare professionals should make note of these observations as potential signs of an anxiety disorder, but remember to include other possible sources of symptomology on the differential – including environmental stressors, issues at school, learning disabilities, ADHD, OCD, tic disorders, and autism spectrum disorder.

The first anxiety disorder to be familiar with is **separation anxiety disorder**. The typical age of onset of this anxiety disorder is in preschool-age children. It is normal for preschool age children to experience temporary distress when having to separate from their parents for various reasons, but when the child expresses clinginess, inconsolability, and persistent worries about parental illness or death, it is suggestive of an anxiety disorder. Children with separation anxiety may also have somatization, or the onset of physical symptoms, during times of transition from their parents or caregivers.

Next we have **selective mutism**, which also tends to present in younger children. While it is normal for some children to be shy, those with selective mutism are

often unable to speak at all in specific situations and not in others; for example, a child who is able to talk freely at home but refuses to do so in the school environment.

Specific phobias are common, both in the adult and pediatric population. It is normal to be fearful of certain things or situations, but a specific phobia is a fear that is irrational, and the fear that one experiences is out of proportion with the actual threat involved. In the setting of a clinical phobia, the fear often produces avoidance behaviors and interference with day-to-day functioning. An example of a patient with a diagnosable specific phobia would be a child who is so fearful of insects that they refuse to play outside, or a child with a blood/injection/injury phobia that has a degree of severity to the point that it interferes with receiving medical care.

The next anxiety disorder to be aware of is **social anxiety disorder.** Unlike the others, onset of this disorder typically occurs in later childhood or early adolescence. Patients with this condition will experience excessive, persistent, and irrational fear of scrutiny by other people; similar to other anxiety disorders, it will produce avoidance behaviors and may contribute to somatizations, or physical symptoms of anxiety in response to social situations or performance.

Panic disorder and **agoraphobia** are anxiety disorders that are more likely to present in adolescent patients. Panic disorder is characterized by recurrent panic attacks and consequent fear of future panic attacks, while agoraphobia is related to fear and avoidance of situations based on fear of being unable to escape – this may include enclosed spaces, crowds, or in extreme cases, just being outside of the home.

The last anxiety disorder included in the position statement is **generalized anxiety disorder**, or GAD. This condition affects patients of all ages, and in pediatrics it can present anywhere from later childhood onward. It is considered developmentally appropriate for children and adolescents to worry, especially in response to situational stressors. However, when these worries become constant, excessive, and result in a notable impairment in functioning, it should be considered for a diagnosis of GAD.

In summary, it is important to recognize and understand the prevalence of anxiety disorders and how they may manifest in childhood and adolescence. There are many tools and diagnostic aids to help us in the assessment of these disorders, but we must remember to include important aspects like developmental history, medical history, and the mental health of the parents or guardians involved in the patient's care. As a general impression, it is important for professionals to ensure that both DSM-5 criteria are met and that the anxiety is producing significant impairment in functioning, in order to establish a diagnosis. If clinicians are well-equipped to detect and assess for the various anxiety disorders seen in pediatrics, it can help to connect children with appropriate management strategies that will be discussed in part two of this podcast.

Thank you for listening and stay tuned for Part 2 of the CPS statement on anxiety in children and youth which will focus on management of anxiety disorders.

REFERENCES

Klein, B., Rajendram, R., Hrycko, S., Poynter, A., Ortiz-Alvarez, O., Saunders, N., & Andrews, D. (2023). Anxiety in children and youth: Part 1-Diagnosis. *Paediatrics & Child Health*, *28*(1), 37–51. https://doi.org/10.1093/pch/pxac102