Anxiety Disorders in Youth
Evidence-Based Assessment & Treatment

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Disclosure Statement

• I do not have any conflict of interest, nor will I be discussing any off-label product use.

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Objectives

• Recognize the phenomenology of anxiety disorders among youth from early childhood through teen years.
• List risk and maintenance factors associated with anxiety disorders.
• Summarize evidence-based interventions for anxiety.
• List levels of care and community resources for the purposes of considering referral.
Anxiety: When is it a problem?

- Anxiety is normal, adaptive, and protective
- Anxiety varies in intensity from person to person
- High levels of anxiety are problematic
- **Lowering the volume**, not changing the station

<table>
<thead>
<tr>
<th>Developmental Stage</th>
<th>Common Fears/Worries</th>
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<tbody>
<tr>
<td>Infancy</td>
<td>Loud noises, loss of support, heights, strangers, separation (in the present)</td>
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<tr>
<td>Preschool</td>
<td>Animals, the dark, storms, imaginary creatures, anticipatory anxiety</td>
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<tr>
<td>School-Aged</td>
<td>Specific realistic fears, school achievement, natural events</td>
</tr>
<tr>
<td>Older Children/Adolescents</td>
<td>Fear of fear (ability to think abstractly about fears), school performance, social</td>
</tr>
<tr>
<td></td>
<td>competence, health</td>
</tr>
</tbody>
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Determining Disorder

- Cause significant distress?
- Interference with the child’s daily life, family or social relationships?
- Capable of recovery from distress when the event is not present?
- Duration?
- Is there another potential explanation?
  - Developmentally/culturally appropriate?
  - Medical issue?
  - Are there external stressors/exposure to trauma?
What does anxiety look like?

• AVOIDANCE
• Somatic complaints – body reactions
• Sleep difficulties
• Eating problems
• Excessive reassurance seeking
• Inattention, poor school performance
• School avoidance
• Angry outbursts in effort to avoid
Prevalence and Interference

• Most prevalent mental health disorder among youth
  – 8-12% of youth ages 4-20 suffer from 1+ anxiety disorders
  – More prevalent among females
  – Median age of onset 11 (panic typically latest onset in adolescence)

• Referral practices do not reflect actual prevalence
  – Referred less frequently than those with externalizing problems
  – Less than a third seek treatment; even fewer receive treatment; even fewer receive evidence-based treatment

• If not treated, can lead to...
  – other anxiety disorders, substance abuse, depression, SI, educational underachievement
  – Social, family, academic, medical, school impairments
Anxiety: DSM-5 classifications

Separation Anxiety Disorder
Selective Mutism

Specific Phobia
Social Anxiety Disorder
Panic Disorder
Agoraphobia
Generalized Anxiety Disorder

- Substance/Medication Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition
- Other Specified Anxiety Disorder
- Unspecified Anxiety Disorder
Separation Anxiety Disorder

- Excessive, developmentally inappropriate fear and distress concerning separating from home or significant attachment figure
  - Before or during separation
  - Excessive worry about parents’ safety and health
  - Difficulties sleeping alone
  - Nightmares with themes of separation
  - Somatic complaints
  - School avoidance

**Changes in classification from DSM IV to DSM V**
- Moved from “disorders usually first diagnosed in childhood”
- Age of onset requirement (before 18) and early onset specifier (before 6) removed
- Duration “typically lasting six or more months” (instead of 4 weeks)
Selective Mutism

- Persistent failure to speak, read aloud or sing in specific situations (e.g., school) despite speaking in other situations (e.g., home)
  - Whisper or communicate nonverbally with select individuals
  - Symptoms of social anxiety
  - Important to rule out communication disorder, neurological disorder or developmental disorder

Changes in classification from DSM IV to DSM V

- No longer restricted to childhood
Specific Phobia

• Fear of a particular object or situation that is avoided or endured with great distress
  • Common to present with more than one specific phobia
  • Symptoms must be severe enough to result in extreme distress or impairment related to fear

• Changes in classification from DSM IV to DSM V
  • Clarifying terminology and increasing usability of criteria
  • “excessive or unreasonable” omitted
  • “out of proportion to danger posed” included
Generalized Anxiety Disorder

• Chronic excessive worry in a number of areas (e.g., school, internal standards with social interactions, family, health/safety, world events, natural disasters) & at least 1 somatic complaint
  • Difficulties controlling worry
  • Often perfectionistic
  • Reassurance seeking
  • May struggle with more internal distress than is evident to parents/teachers
  • Worry is present most of the time
  • Procrastination in behavior or decision making
  • Increased time/effort to avoid anticipated negative outcomes
Social Anxiety Disorder

- **Discomfort or fear in one or more social settings that involves a concern about being judged or evaluated**
  - Discomfort with familiar & unfamiliar peers and/or adults, or performance situations (e.g., music, sports)
  - Associated with social scrutiny, fear of embarrassment
  - Difficulties answering questions in class, reading aloud, initiating conversations, talking with unfamiliar people, attending parties/social events

- **Changes in Classification from DSM IV to DSM V**
  - New title
  - Removed “generalized” specifier; Added “performance only” as specifier
  - Duration and self-recognition criteria matched for children, adolescents and adults
Panic Disorder

Recurrent episodes of intense fear that occur unexpectedly

- Uncued (different than cued panic/anxiety attacks)
- Somatic symptoms (e.g., heart racing, chest pain/pressure)
- Fear recurrent attacks and their consequences
- May avoid particular settings where attacks have occurred

- Agoraphobia (separate disorder)
  - Fear or anxiety about two or more situations (i.e., public transportation; open spaces; enclosed places; lines or crowds; outside of home alone)
  - Panic symptoms/fears that escape will be difficult
  - Onset more likely during adolescence than childhood
Obsessive Compulsive Disorder

• Presence of obsessions and/or compulsions
  • Obsessions: Recurrent and persistent thoughts, impulses, or images that are intrusive and cause marked anxiety or distress; but are not excessive worries about real-life problems
    • Attempts to ignore, suppress or neutralize these thoughts, impulses, or images
    • Awareness that the obsessional thoughts, impulses, or images are a product of his or her own mind, as opposed to delusional in nature.
  • Compulsions: Repetitive behaviors or mental acts that the person feels driven to perform in response to an obsession in order to reduce stress or avoid feared situation
    • These behaviors or mental acts may not always be associated with the content of the obsessional theme
Causes and Maintenance of Anxiety

- Likely caused by a combination of factors
  - Genetic
  - Temperament
    - behavioral inhibition
  - Parenting
    - Reinforcement & Modeling
  - Cognitive Factors
  - Avoidance
  - Environmental/Life stressors

Short Term: Relief

Long Term: More physical symptoms, worry, loss of confidence in coping ability, increased safety behaviors

Increased arousal, emotionality, scanning for danger, physical symptoms intensify, attention narrows and shifts to self

Escape or Avoidance
Approximately 80% of children in treatment for anxiety also meet criteria for one additional disorder, typically another anxiety disorder.

- Mood disorders
- Eating Disorders
- Attention-Deficit Hyperactivity Disorder (ADHD)
- Substance use
- Behavioral problems
- Posttraumatic Stress Disorder (PTSD)

Additional considerations:
- Autism Spectrum Disorders (ASD)
- Learning Disabilities
- Physical Conditions
- Medication Side Effects
- Non-prescription drugs
American Academy of Child & Adolescent Psychiatry (2007) recommends a two-pronged approach for treating anxiety:

- **Cognitive Behavioral Therapy (CBT)**
  - Most studied and empirically supported
  - CBT is the *first line of treatment* for youth with mild-moderate anxiety

- **Medication**
  - SSRIs (e.g., Zoloft/sertraline; Lexapro/escitalopram)

- **CBT & Medication**
  - Acute symptom reduction in moderate – severe cases
  - Comorbid disorder
  - Partial response to psychotherapy
CBT: A Review of the Evidence

• Exposure is the “active” or vital ingredient
  • More exposure practice = better outcomes
  • Anxiety management strategies (e.g., emotion identification, relaxation skills, cognitive strategies)
    • Little direct evidence of added value, may not be necessary for improvement
    • Not sufficient as a stand alone intervention
  • Exposure and Response Prevention (ERP) for pediatric OCD
Child sees dog
Child feels anxious
Child avoids
Adult comforts or rescues
Child's anxiety decreases*

Behavioral model of AVOIDANCE

Child sees dog
Child feels anxious
Child avoids
Adult praises brave behavior
Child learns "I can handle it!"
Child looks at dog in shelter
Child feels anxious

Behavioral model of APPROACH

Child looks at dog in shelter
Child feels anxious
Child continues looking at dog
Child's anxiety decreases
Child learns "I can handle it!"
Adult praises brave behavior
Child avoids
Child sees dog
Child feels anxious
Child’s anxiety decreases*

*Child’s anxiety decreases

CBT: Moving from Avoidance to Approach
Examples of Exposures

- Separation Anxiety
  - Being upstairs alone
  - Going on “quests” in the grocery store
  - Reducing reassurance seeking

- Social Anxiety
  - Dressing up/crabwalking down the hall
  - Doing a survey

- Selective Mutism
  - Doing a survey, gradually increasing # of words and volume

- Phobias
  - All the steps leading up to a shot
  - Touching spider webs

- Generalized Anxiety Disorder
  - Imaginal exposures about the end of the world
  - Getting things wrong on a test

- OCD
  - Licking the bottom of your shoe
  - Touching sticky things and preventing washing
  - Imaginal

- Trauma
  - Narrative of traumatic event
Managing Anxiety: from early intervention to disorder

• Common pitfall: Tendency toward accommodation
  – Not bad but not helpful
    • Relaxation strategies

• Best practices – encourage approach vs. avoidance over time

• What can you do?
  – Encourage families to identify goals, offer opportunities for exposures, and track progress
  – Encourage parenting that emphasizes brave behavior vs. anxious behavior
  – Encourage families to practice facing fears even at subclinical or normative levels of anxiety
    • Build life skill vs. focus on diagnosis

Accepting that the child is anxious + Confidence that they can tolerate that experience = SUPPORT
Community Resources
Anxiety Treatment at Seattle Children’s

• Implementing a stepped care model

Figure 1. Specialty Care Stepped Care Model
Anxiety Groups at SC

- **Anxiety Groups**
  - Ages 6-17, groups divided by age
  - Both parents and youth
- **Early Years Anxiety Group**
  - Parents of youth ages 3-7
- **Selective Mutism Group**
  - Early Years (ages 3-7); Tweens (ages 8-12)
  - Primary diagnosis of selective mutism
  - Both parents and youth
- **School Avoidance Group**
  - Parent only group
  - Youth (any age) avoiding school for >2 weeks and < 2 years
  - Must be enrolled in an in-person school program

- **OCD Intensive Outpatient Program (Bellevue-Overlake)**
  - 3 hours/day, 4 days/week
  - Must have primary diagnosis of OCD (severe or extreme)
  - Have failed course of ERP in typical outpatient setting

  *Coming soon! Anxiety Group for youth (and their parents) with mild-moderate intellectual disability*
Anxiety Resources

- Association of Behavioral and Cognitive Therapies: [www.abct.org](http://www.abct.org)
- Anxiety and Depression Association of America: [www.adda.org](http://www.adda.org)
- Division 53: Society of Clinical Child and Adolescent Psychology: [www.effectivechildtherapy.com](http://www.effectivechildtherapy.com)
- WorryWise Kids: [www.worrywisekids.org](http://www.worrywisekids.org)
- National Child Traumatic Stress Network: [www.nctsnet.org](http://www.nctsnet.org)
- International OCD Foundation: [www.iocdf.org](http://www.iocdf.org)
- Child Anxiety Tales: copingcatparents.com
- Washington's Mental Health Referral Service for Children and Teens (833-303-5437) 
  - [https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/washingtons-mental-health-referral-service-children-teens/](https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/washingtons-mental-health-referral-service-children-teens/)
Anxiety Resources

• Cognitive Therapy Techniques: A Practitioner’s Guide (Leahy)
• Using Homework in Psychotherapy: Strategies, Guidelines, and Forms (Tompkins)
• Treating Anxious Children and Adolescents (Rapee, Spence)
• Helping Your Anxious Child (Rapee, Spence)
• OCD in Children and Adolescents: A Cognitive-Behavioral Treatment Manual (March, Mulle)
• Talking Back to OCD (March, Benton)
• Freeing Your Child from OCD (Chansky)
• Mastery of Anxiety and Panic in Adolescents, Therapist Guide (Pincus)
• Riding the Wave Workbook (Pincus)
• Treating Trauma and Traumatic Grief in Children and Adolescents (Cohen, Mannarino, Deblinger)
• The Explosive Child (Greene)
• Parenting a Child who has Intense Emotions (Harvey)