Practical Solutions to Address Anxiety Disorders with Children and Adolescents

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A Non-12 Step Mental Health Program
Georgia Strait | Women's Clinic

Background

- Most common mental health disorder affecting children and adolescents
- Fears area a part of typical development
- Distinguished from expected anxiety by **persistent**, **disproportionate**, and **distorted** response leading to **impaired functioning**
- Coexist frequently
- Age of onset is associated with development stages

Based on Current DSM-5

9 Mental Disorders Under Anxiety Category

1. Separation Anxiety Disorder
2. Selective Mutism
3. Specific Phobia
4. Social Anxiety Disorder
5. Panic Disorder - Panic Attack
6. Generalized Anxiety Disorder
7. Substance/medication-Induced Anxiety Disorder
8. Anxiety Disorder due to another medical condition

Separation Anxiety

A. Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
7. Repeated nightmares involving the theme of separation.
8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.

DSM-5 Criteria: Specific Phobia

A. Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

B. The phobic object or situation almost always provokes immediate fear or anxiety. The phobic object or situation is actively avoided or endured with intense fear or anxiety.

C. The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.

D. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

E. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social occupational, or other important areas of functioning.

F. The disturbance is not better explained by the symptoms of another mental disorder, including fear, anxiety, and avoidance of situations associated with panic-like symptoms or other incapacitating symptoms (as in agoraphobia); objects or situations related to obsessions (as in OCD); reminders of traumatic events (as in PTSD); separation from home or attachment figures (as in SepAD); or social situations (as in SAD).

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

Social Anxiety Disorder (Social Phobia)

Diagnostic Criteria — 300.23 (F40.10)

A. Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

B. The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).

C. The social situations almost always provoke fear or anxiety.

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

D. The social situations are avoided or endured with intense fear or anxiety.

E. The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.

F. The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.

G. The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

I. The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.

J. If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

Specify if:

Performance only: If the fear is restricted to speaking or performing in public.

DSM-5 Diagnostic Criteria for OCD

A. PRESENCE OF OBSESSIONS, COMPULSIONS, OR BOTH:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and that in most individuals cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

DSM-5 Diagnostic Criteria for OCD

B. THE OBSESSIONS OR COMPULSIONS ARE TIME-CONSUMING (E.G., TAKE MORE THAN 1 HOUR PER DAY) OR CAUSE CLINICALLY SIGNIFICANT DISTRESS OR IMPAIRMENT IN SOCIAL, OCCUPATIONAL, OR OTHER IMPORTANT AREAS OF FUNCTIONING.

C. THE OBSESSIVE-COMPULSIVE SYMPTOMS ARE NOT ATTRIBUTABLE TO THE PHYSIOLOGICAL EFFECTS OF A SUBSTANCE (E.G., A DRUG OF ABUSE, A MEDICATION) OR ANOTHER MEDICAL CONDITION.

D. THE DISTURBANCE IS NOT BETTER EXPLAINED BY THE SYMPTOMS OF ANOTHER MENTAL DISORDER

Specify if:

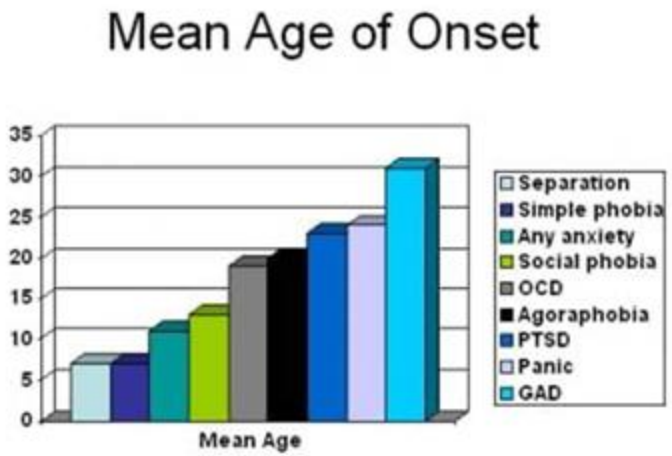
With good or fair insight: The individual recognizes that obsessive-compulsive disorder beliefs are definitely or probably not true or that they may or may not be true.

With poor insight. The individual thinks obsessive-compulsive disorder beliefs are probably true. With absent insight/delusional beliefs: The individual is completely convinced that obsessive-compulsive disorder beliefs are true.

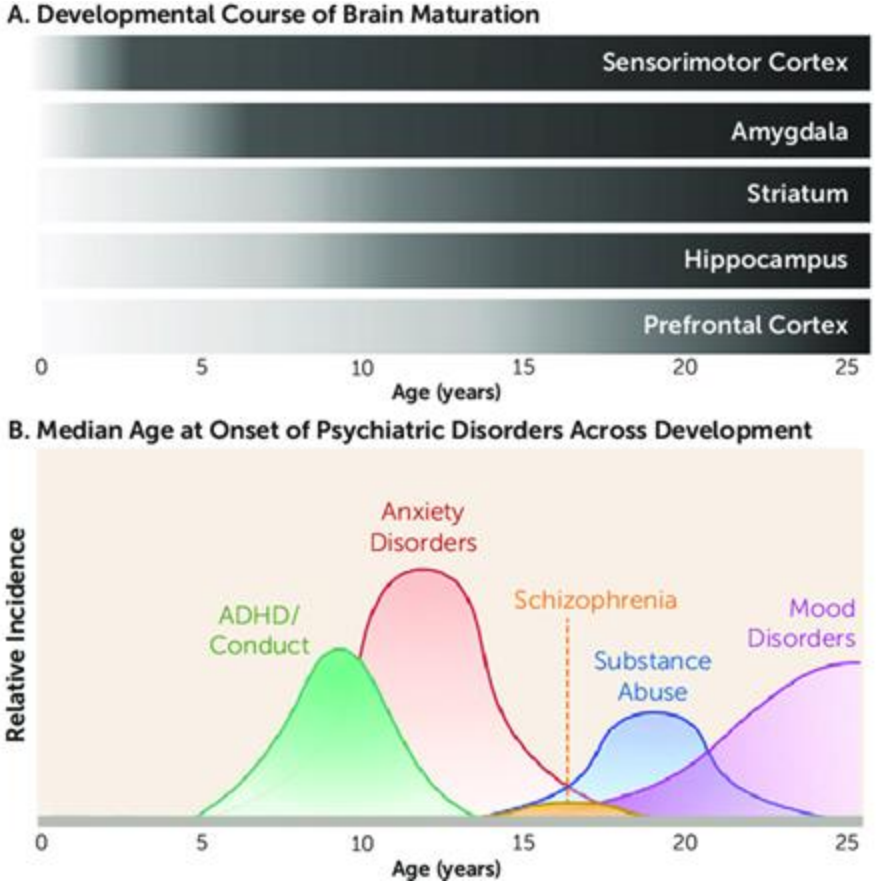
Specify if: Tic-related: The individual has a current or past history of a tic disorder.

Etiology

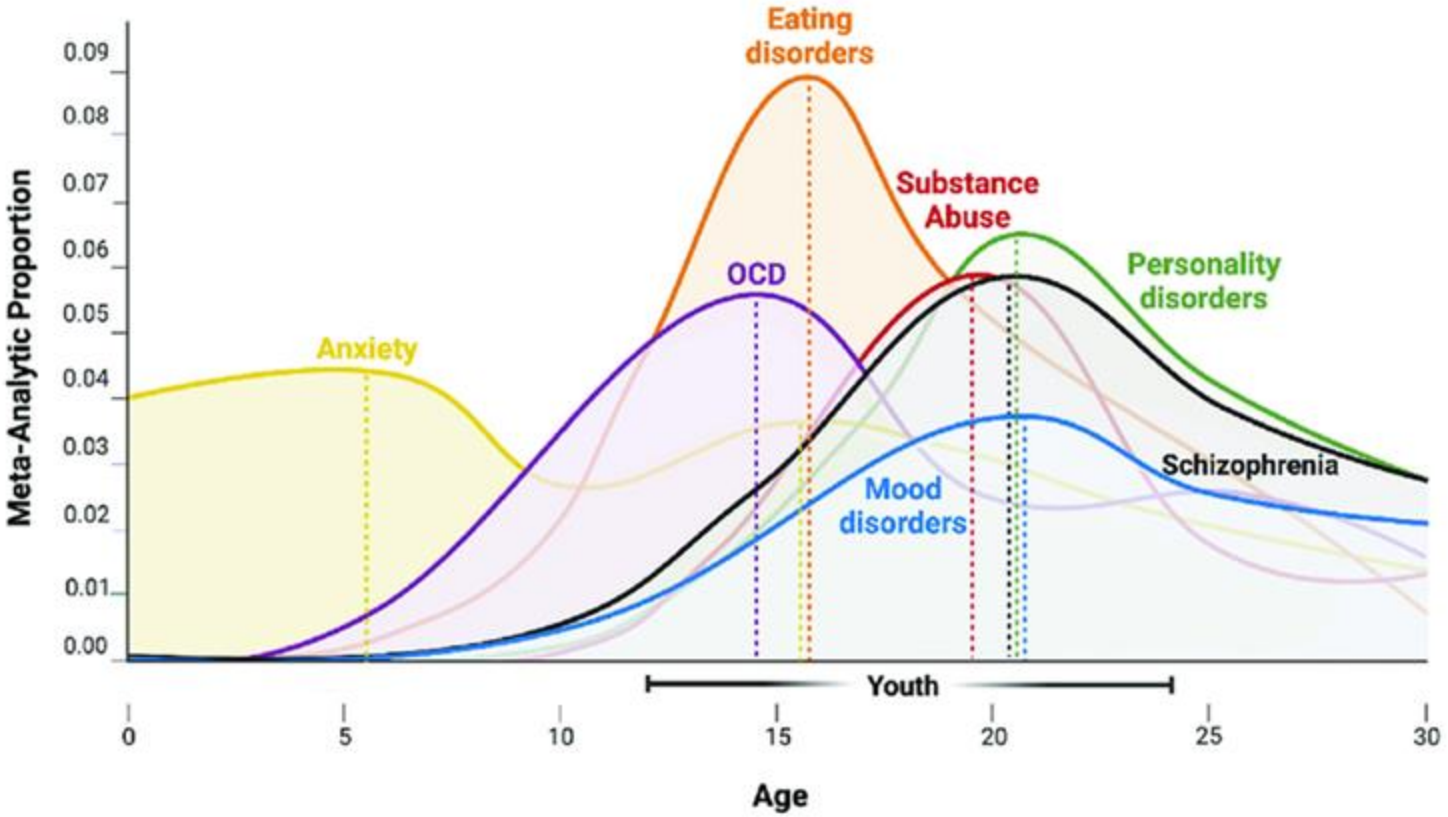
- Biological
  - Temperament, genetics, epigenetics
- Psychological and social
  - Adverse childhood experiences
- Additional factors
  - Parenting style, modelling of stress response
- High levels of anxiety symptoms are related to delayed development of neural circuits including the prefrontal cortex in children and adolescents
(Xie et al., 2021)

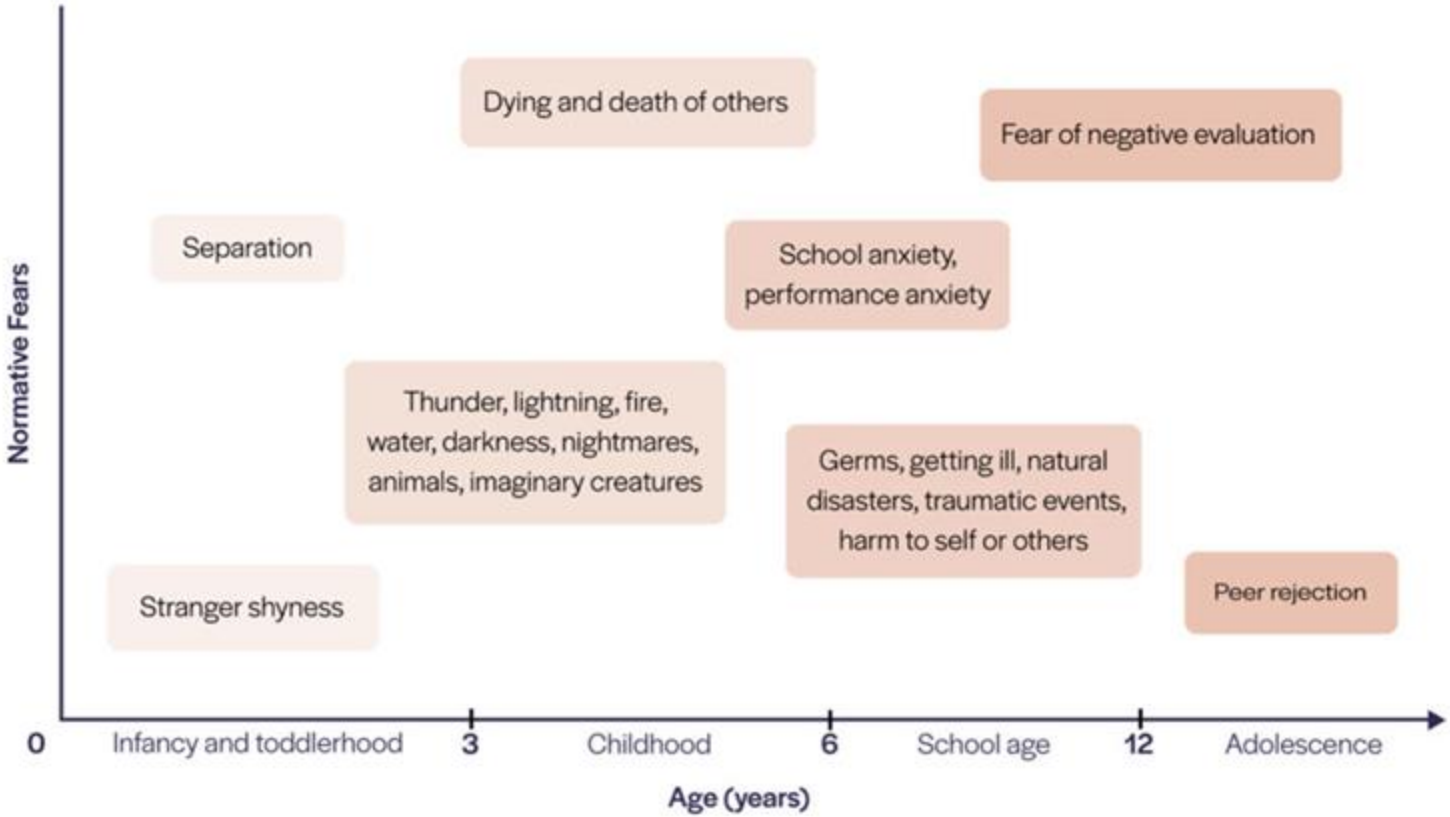


Bhatt et al., 2024



Meyer & Lee, 2019


Eating disorders
Substance Abuse
Personality disorders
OCD
Anxiety
Schizophrenia
Mood disorders
Youth
Meta-Analytic Proportion
0.09
0.08
0.07
0.06
0.05
0.04
0.03
0.02
0.01
0.00
0
5
10
15
20
25
30
Age



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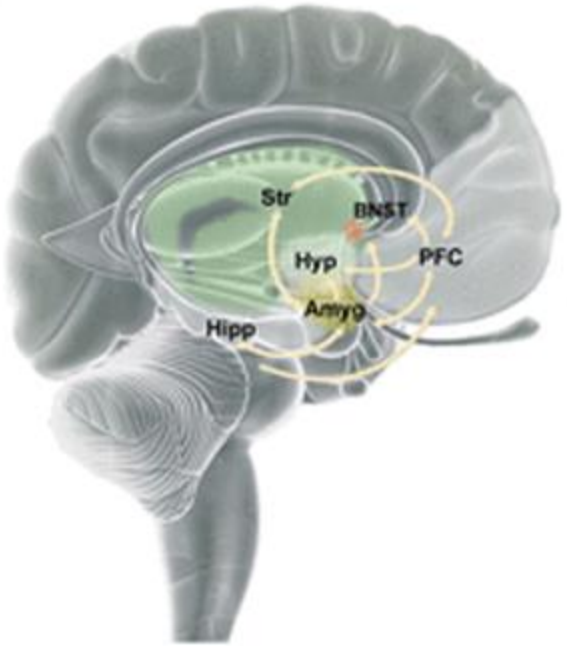
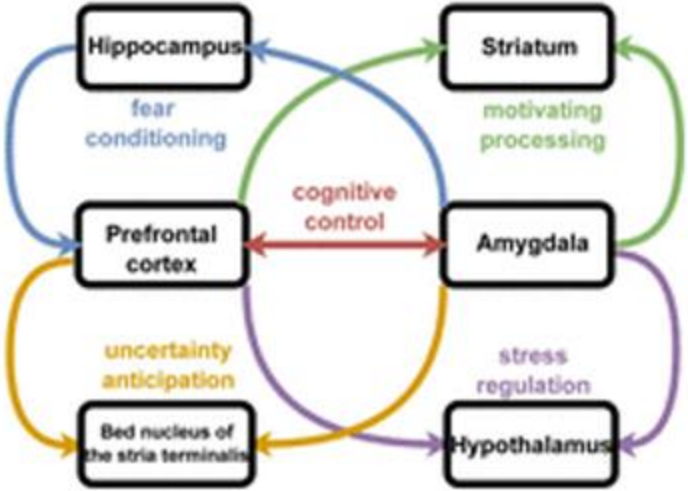
https://tcmhcc.utsystem.edu/resources/anxiety

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)	– Clinging or closely following aparent – Inconsolable distress, somatization during transitions – Unfounded worries about parent injury, illness, or death
Selective mutism (Preschool)	Taking time to 'warm up' in social situations	– Being unable to speak in specific situations (e.g., in school)
Specific phobia (Preschool to school age)	Time-limited fear of new objects or situations (e.g., dogs, noise, or high places)	– Fears persist and appear out of proportion to actual risk, leading to avoidance and diminishing quality of life or function
Social anxiety disorder (social phobia) (Late school age, early adolescence)	Discomfort or hesitation around social events or requests to 'perform'	– Excessive, persistent fear of scrutiny – Avoidance (e.g., of school, social events) or compromised involvement in family or community activities – Somatization with social interactions or performance
Panic disorder (Adolescence, young adulthood)	Transient concerns about physiological symptoms (e.g., worrying about recurrence after an episode of vertigo)	– Recurrent panic attacks (feeling out of control, with somatic symptoms) – Fear of panic attacks and avoidance of associated situations – Worries about associated health risks(e.g., for heart attack)
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	– Persistent avoidance of two or more locations based on fears of not being able to escape or summon help
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	– Constant, excessive worry about risk that impairs participation in multiple events or activities – Trouble sleeping, physical restlessness, irritability, trouble concentrating, muscle tension





- Adolescence = peak period for anxiety
- Immaturity of the neural networks underlying emotional regulation
- In adolescence, emotional control system is hypoactivated, fear conditioning system is immature while reward and stress response systems are hypersensitive

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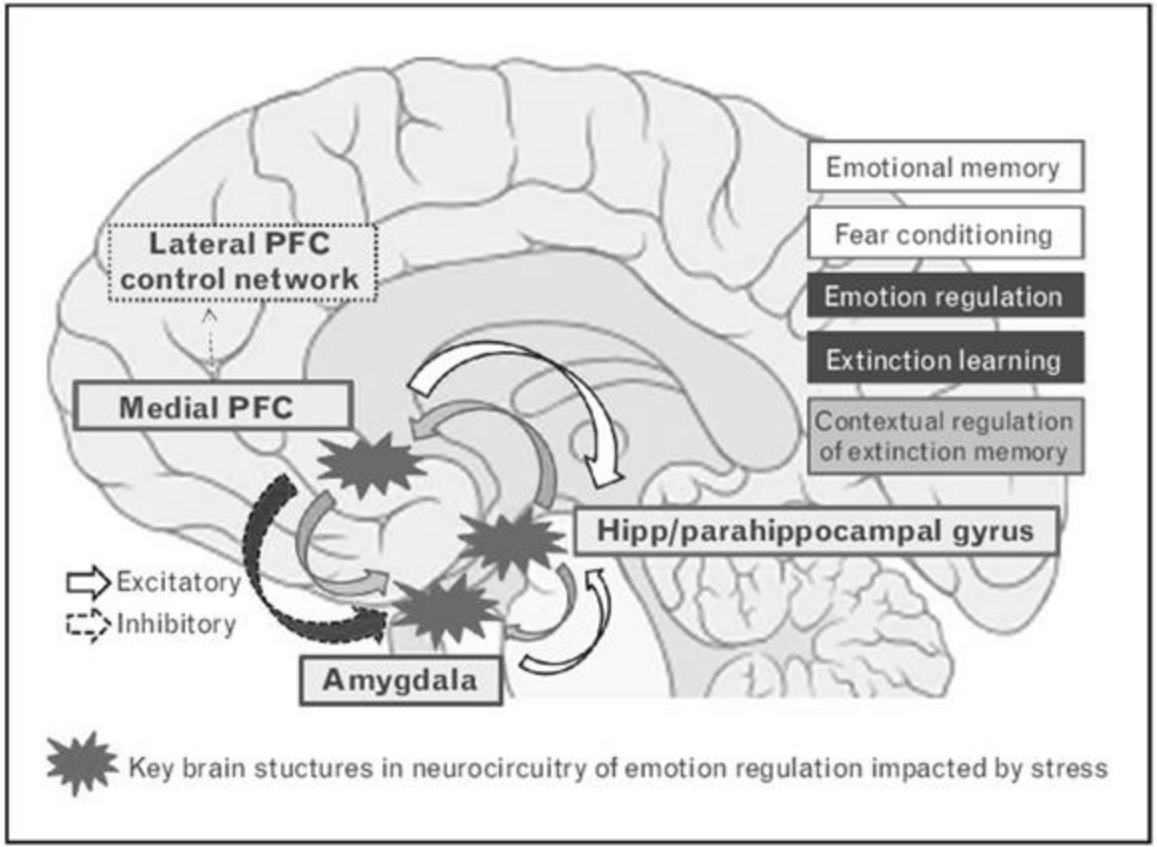
Xie et al., 2021


Emotional memory
Fear conditioning
Emotion regulation
Extinction learning
Contextual regulation of extinction memory
Lateral PFC control network
Medial PFC
Hipp/parahippocampal gyrus
Excitatory
Inhibitory
Amygdala
Key brain stuctures in neurocircuitry of emotion regulation impacted by stress

Assessing Anxiety

- Core signs
  - Hyper-arousal (being nervous, scared, irritable, agitated)
  - Avoidance (clinging to avoid separation, avoiding fears)
  - Cognitive distortions (repeatedly asking worried questions, seeking reassurance, asking “what if…”)
- May present as physical symptoms (stomach aches, nausea)
- Behaviours such as picky eating, sleep problems, and substance use can be driven by anxiety
- Stimulant medications for ADHD, caffeine, decongestants, and bronchodilators can mimic symptoms of anxiety

- Other symptomatology that overlap with anxiety (fatigue, heart rate differences, chest pain)
  - Cardiac disorders
  - Respiratory Disease
  - Adrenal insufficiency or anemia
  - Hyperthyroidism
- Any medical conditions causing pain or discomfort can increase anxiety

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

Canadian Pediatric Society (2023)

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.

Canadian Pediatric Society (2023)

Psychoeducation

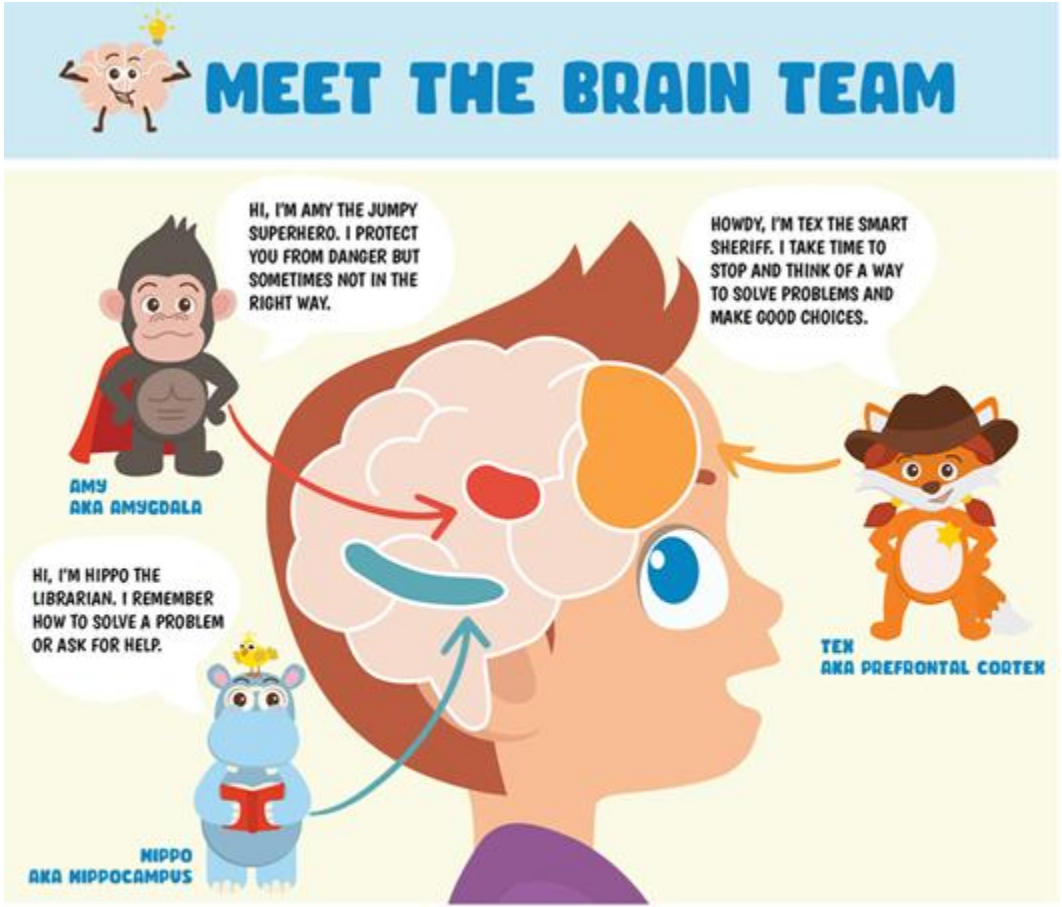
- Normalizing and labelling experiences of uneasiness
- Explaining symptoms of anxiety
- Balancing facing fears and having empathetic responses
- Modelling and supporting adaptive coping (avoid avoidance)
- Healthy routines
  - Regular exercise
  - Limited screen time
  - Limited Caffeine

Box 1. Positive parenting tips for managing anxiety

1. Help children and adolescents recognize, acknowledge, and name feelings, including how they feel physically, and label them (e.g., as worrisome, anxiety-provoking, or scary).
2. Avoid avoidance by using gentle but firm encouragement. Take time to talk about strong emotions and sensitive topics, try *"You look worried. Is something on your mind?"*, or *"It sounds like you're really angry. Would you like to talk about that?"*
3. Empathize and validate anxieties, but try not to reinforce them (*"I know you're feeling scared, AND I know you're brave to do this"*).
4. Connect and maintain secure attachment by engaging in child-led, free play with younger children, and staying aware of, and involved with, adolescents (14,17):
   - Spend one-on-one time together,
   - Know and show interest in who their friends are, and
   - Encourage community and extra-curricular activities.
5. Foster self-confidence (positive affect) through effective praise:
   - Start statements of praise with 'You …' instead of 'I….'
   - Be specific about how they've earned your special notice.
   - Recognize brave, helpful, or kind acts as soon as possible after they happen. For younger children, notice brave behaviours—no matter how small and (ideally) every day.
6. Encourage opinions and choices. Acknowledge growing independence in older children, and promote and celebrate sound decision-making and problem-solving (17).
7. To make anxiety more manageable, break the task of facing it into small, practical steps (if possible), and positively reinforce each one.
8. Reward attempts and approximations, and compliment process as much as end results. Focus on strengths rather than shortcomings.
9. Model coping skills and techniques such as deep breathing, muscle tension relaxation, imagery, mindfulness, distraction, and positive self-talk.

10. Be involved with schooling. For a child or teen with anxiety, help teachers understand its sources and related behaviours. For example, explain that when your child avoids classroom tasks or appears oppositional, that this is likely due to anxiety, and ensure that necessary supports or accommodations are in place.
11. For young children showing signs of child care or school avoidance:
    - Prepare the night before so mornings are not rushed and stressful.
    - Encourage bringing a favoured toy from home to ease transition.
    - Take time to say a warm goodbye but avoid repeated goodbyes.
12. Model positive ways of handling conflict or distress when managing anxiety by:
    - Slowing down speech.
    - Taking time to calm down.
    - Being respectful of others' beliefs and feelings.
    - Being assertive rather than aggressive (18).

Canadian Pediatric Society (2023)



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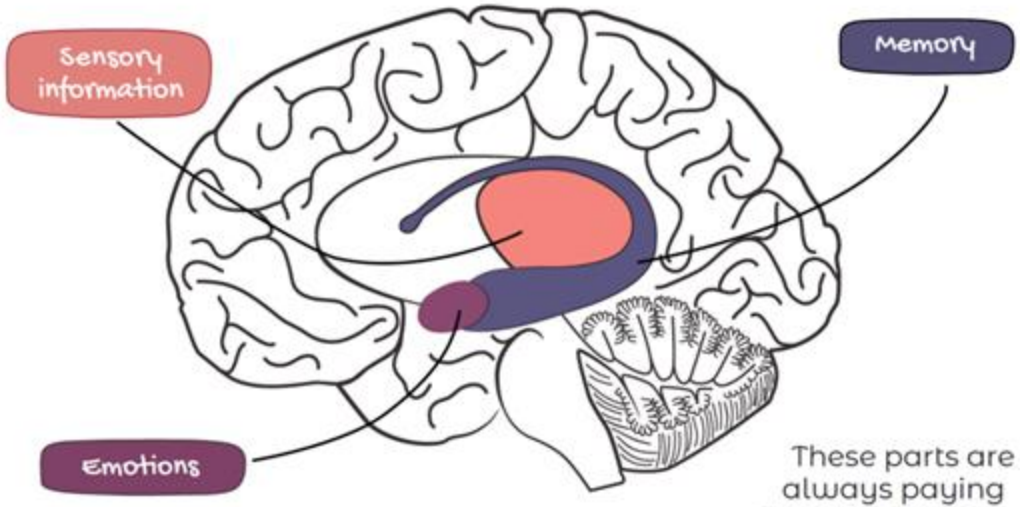
Blissful Kids

In the middle of your brain there are parts in charge of emotions, memory, and getting information from your senses.



These parts are always paying attention to the world around you. They help keep you safe.

CBT

- Recognizing signs of anxiety
- Managing physical symptoms (relaxation, deep breathing, imagery)
- Identify patterns of anxious thinking and replace with more positive thoughts
- Exposure and desensitization to anxiety triggers

Advances in Psychiatric Treatment (2001), vol. 7, pp. 224–232

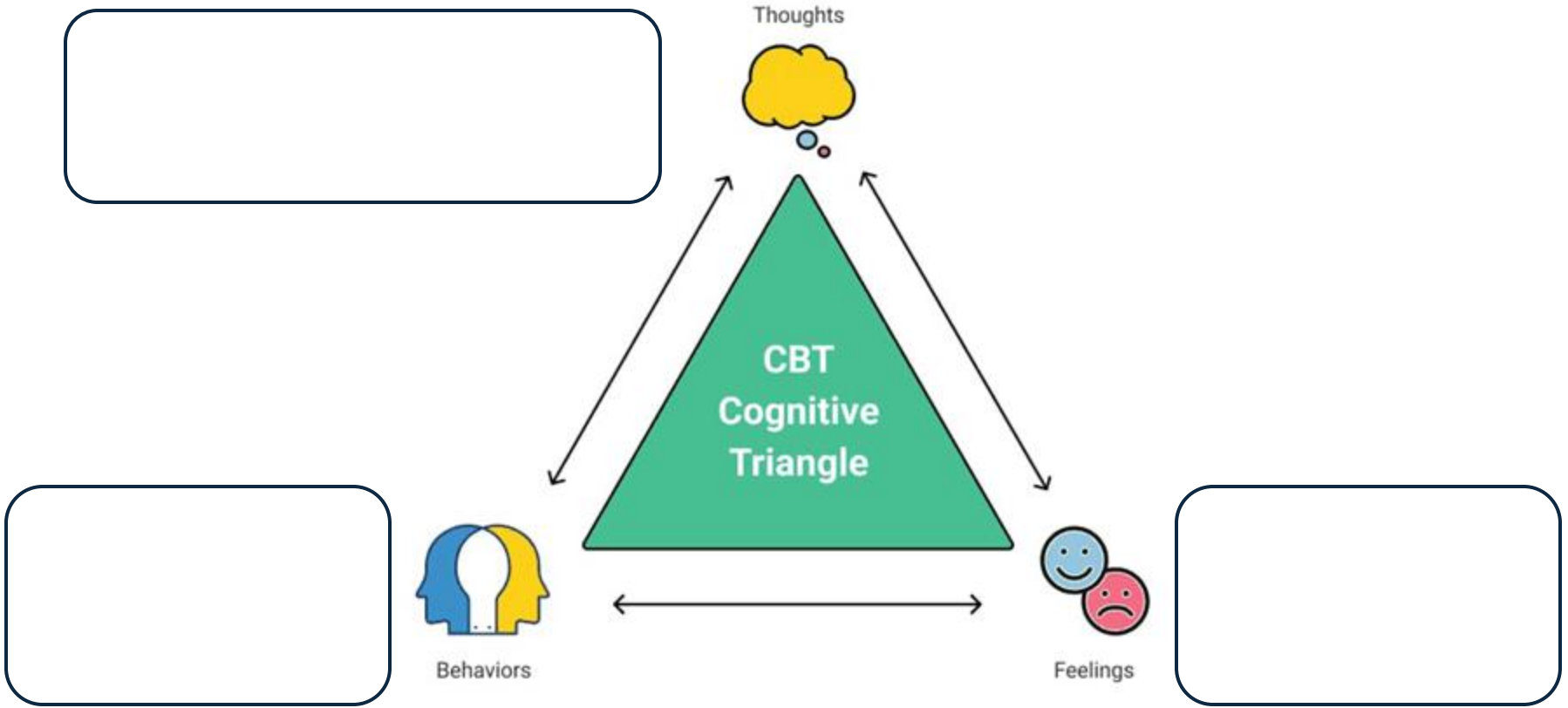
Cognitive–behavioural therapies for children and adolescents

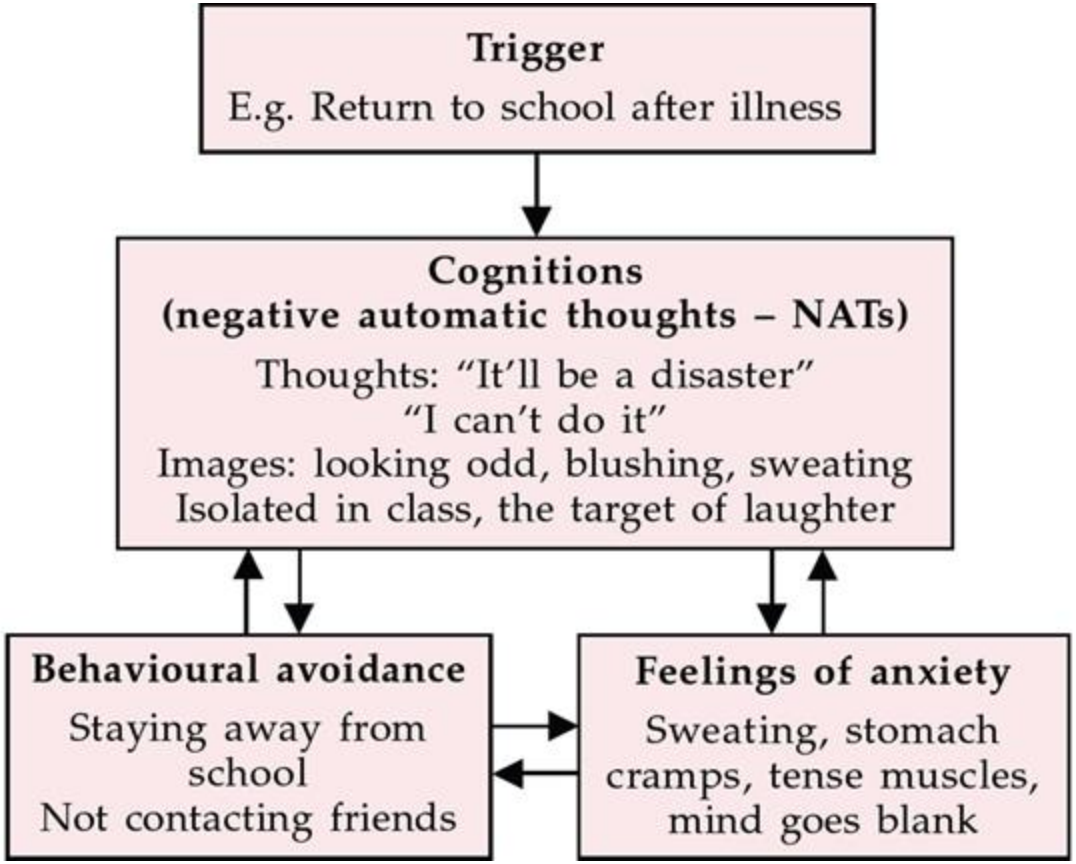
Veira Bailey

- Higher proportion of behavioural activities
- Use developmentally appropriate language

Thought diary

What happened?	Emotions	Automatic thoughts	Behaviour resulting from automatic thoughts	Alternative thoughts/ coping	Behaviour resulting from alternative thoughts	How do you feel now?
What made you upset? Event or situation. Date and time.	Be precise about what you are feeling: sad/ anxious/angry. How much do you feel it? (0–10)	Write down the thoughts that come just before these feelings. How much do you believe these thoughts? (0–10)		Write down your alternative/coping thoughts in response to automatic thoughts. Rate belief 0–10.	What plan of action will you now take?	Re-rate emotions 0–10. Re-rate belief in automatic thoughts 0–10.


Thoughts
CBT
Cognitive
Triangle
Behaviors
Feelings


Trigger
E.g. Return to school after illness
Cognitions
(negative automatic thoughts – NATs)
Thoughts: "It'll be a disaster"
"I can't do it"
Images: looking odd, blushing, sweating
Isolated in class, the target of laughter
Behavioural avoidance
Staying away from school
Not contacting friends
Feelings of anxiety
Sweating, stomach cramps, tense muscles, mind goes blank


with older children

STOP skill

S **Stop**: instead of reacting, stop, freeze, don't move a muscle. Stay in control of your emotional urges.

T **Take a step back** from the situation. Take a break. Take a deep breath and avoid impulsive emotional actions.

O **Observe**: notice what is going on inside and outside you. What is the situation? What are your thoughts/feelings? What are others doing?

P **Proceed mindfully**: act with awareness. Think about your goals. Ask your wise mind what will make this worse or better?

@SHEPERSISTEDPODCAST

TIPP skill

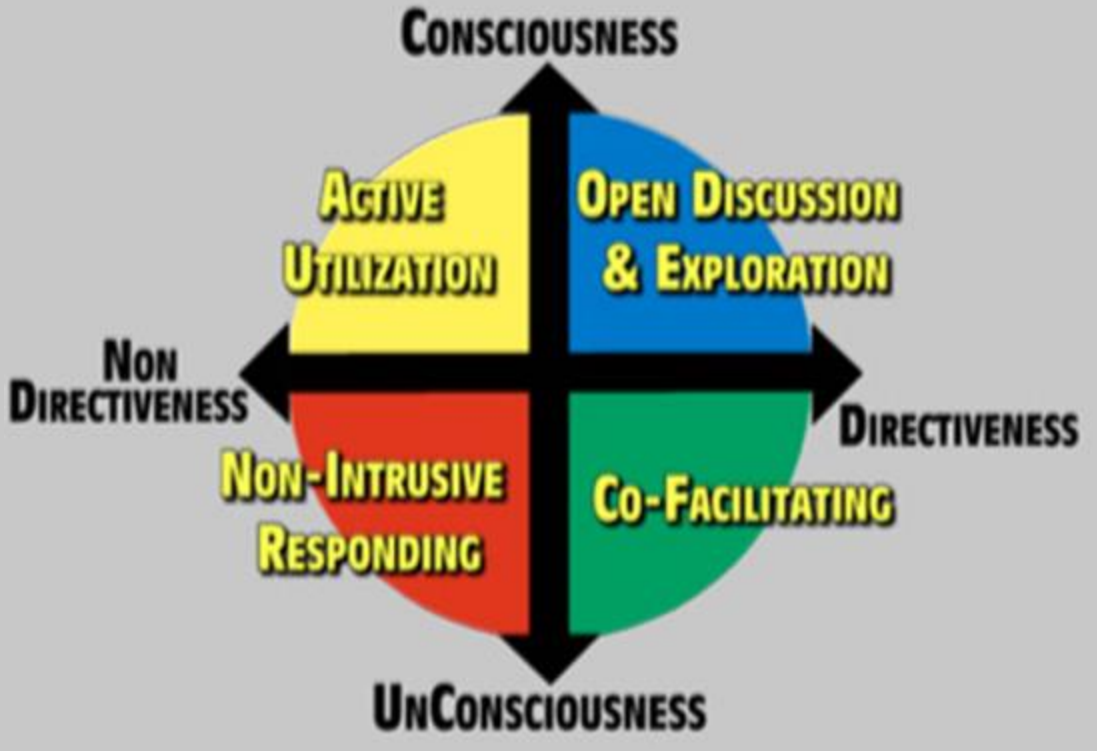
T **Temperature**: submerge your face in ice water or put ice packs under your eyes to stimulate your vagus nerve and lower your HR

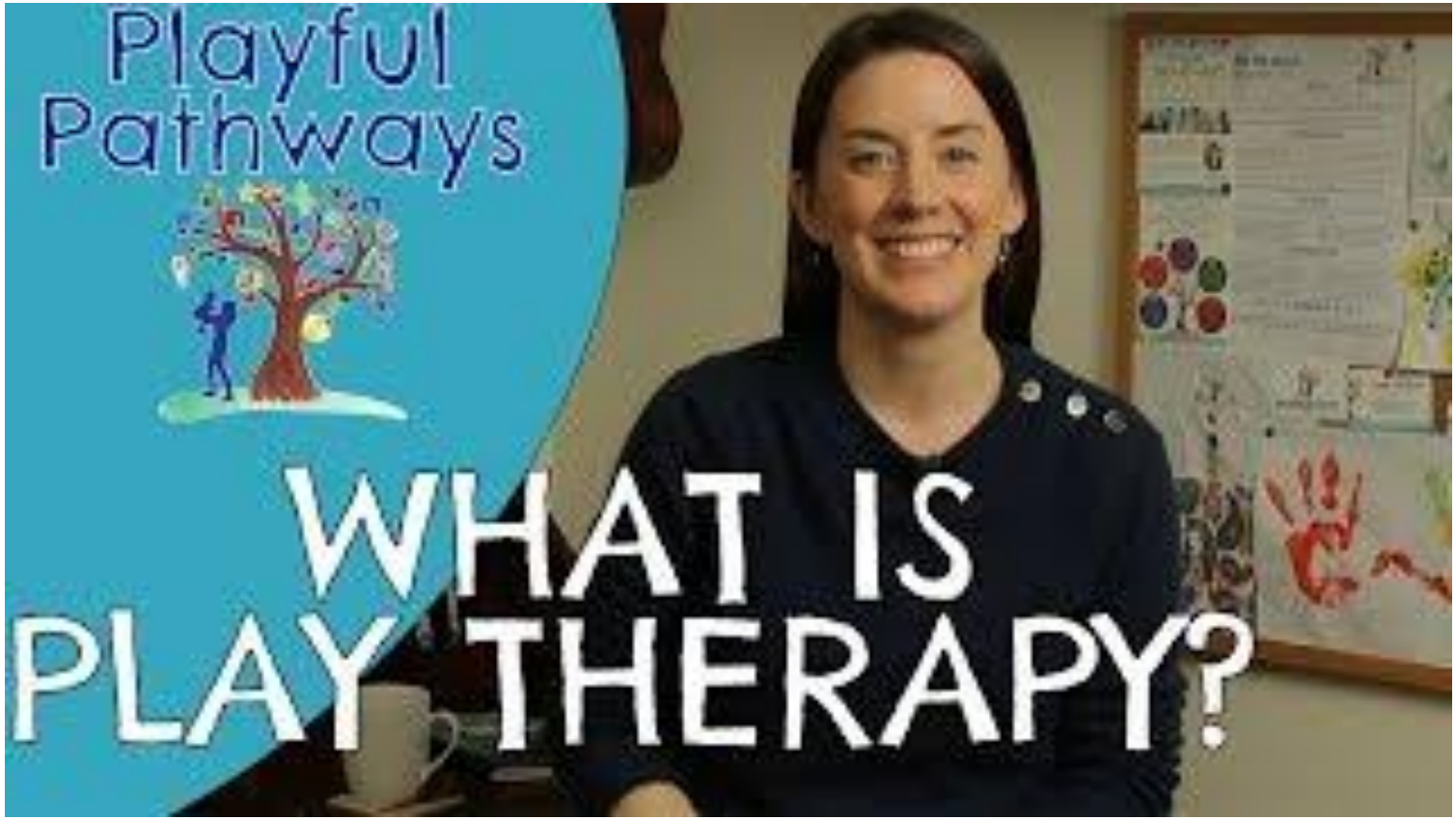
I **Intense exercise**: raise your HR through intense cardio, causing your body to lower your physical arousal + symptoms of anxiety

P **Paced breathing**: breathe in time with counts, making your exhale longer than your inhale

P **Paired muscle relaxation**: clench your muscles on your inhale, release on your exhale, letting go of tension from anxiety

@SHEPERSISTEDPODCAST


CONSCIOUSNESS
ACTIVE UTILIZATION
OPEN DISCUSSION & EXPLORATION
NON DIRECTIVENESS
DIRECTIVENESS
NON-INTRUSIVE RESPONDING
CO-FACILITATING
UNCONSCIOUSNESS


Playful
Pathways
WHAT IS
PLAY THERAPY?

Parents in Session

- Parents as a resource
- Co-regulating
- Enmeshment to Avoidant