

Anxiety Disorders of Childhood or Adolescence

DSM-IV-TR Diagnostic Code: 309.21 Separation Anxiety Disorder
300.02 Generalized Anxiety Disorder
300.0 Anxiety Disorder NOS
300.01 Social Panic Disorder without Agoraphobia
300.21 Social Panic Disorder with Agoraphobia
300.23 Social Phobia
300.29 Specific Phobia
309.24 Adjustment Disorder with Anxiety

Diagnostic Guidelines

1. Establish diagnostic accuracy as defined in DSM-IV TR.
2. The assessment should consider differential diagnosis of other physical conditions and psychiatric disorders that may mimic anxiety symptoms.
3. Assess for psychosocial stressors and possible precipitants, including family conflict or recent changes in family composition and/or level of functioning.
4. Assess for developmentally appropriate level of separation anxiety.
5. Assess for other co-existing conditions and also treat accompanying depression if present.
6. Assess for substance use/abuse.

Special Considerations during assessment

1. Childcare providers and teachers are effective in identifying anxious children overall and are a resource for clinicians during assessment and treatment. Those children can present with observable fears related to humiliation, rejection and separation. Younger children can manifest their anxiety in fears of separation and panic behaviors, harm avoidance, anxious coping and perfectionism (Glassman, 2003).
2. Assessment of the nature of the parent/child relationship as indicated in the Diagnostic Manual for Children 0-3 is valuable for young children and their families.

Treatment Guidelines

1. Cognitive Behavior Therapy (CBT) is an empirically supported treatment and has received the most empirical support for the treatment of anxiety disorders in youths (Compton et al., 2004) and is recommended by the American Academy of Child and Adolescent Psychiatry. Treatment may include but is not limited to:
 - In-vivo or imaginal exposure (e.g. desensitization)
 - Changing internal cognitions including (1) intolerance of uncertainty; (2) positive beliefs about worry; (3) negative problem orientation; and (4)

- cognitive avoidance. (e.g., explore cognitive messages that trigger anxiety responses and help retrain client in adaptive responses)
- Stress Management (e.g., assertiveness training, implement positive self talk, develop relaxation skills).
2. Play Therapy to help client express fears, relax, and take risks in safe environment. NOTE: This should not constitute the sole treatment modality as child's parents or guardians should be encouraged to participate in family treatment, as well.
 3. Family therapy to work on systemic issues related to client's anxiety:
 - Educate family members that some fears and anxieties are developmentally normal. Provide books to help parents understand and communicate with their child.
 - Develop parents' ability to manage their own anxiety in order to effectively deal with their child's anxiety.
 - Direct family sessions toward positive communication, problem solving, and taking risks in a safe environment.
 - Treat or facilitate obtaining treatment for contributing family dynamics (e.g., substance abuse).
 - If school unable to provide services or support, focus early intervention on prompt identification of any recommended academic accommodations into the child's treatment plan. Consider whether home schooling may have been a response to a child or parent's anxiety and assists the family in re-evaluating that decision.
 4. Group therapy is an important modality for providing a child/adolescent with interpersonal skill development.
 - Teach social skills and assertiveness skills.
 - Role-play social and assertiveness skills.
 - Provide a fun environment through group games (i.e. Thinking, Feeling and Doing) and positive peer experience for the client outside of the home setting.
 5. Community-based resources that may help support the client and the family members include:
 - Day treatment, if necessary (work on school-reintegration in therapeutic setting).
 - Legal support regarding truancy issues.
 - Collaborate with school counselor to provide support in the school setting.
 - Encourage participation in Boys/Girls Club, Boy/Girl Scouts or other supervised recreational activities.
 - Encourage participation in parenting support group, if necessary.
 6. Psychopharmacological Medications
 - Needs to be reserved for significantly impaired children.

- Caution should be used with benzodiazepines as they may worsen symptoms.

Bibliography

Treatment practices for childhood PTSD; Cohen JA et al; *Child Abuse Negl* 2001 Jan;25(1): 123-35

The effect of fluvoxamine and behavior therapy on children and adolescents with obsessive-compulsive disorder; Neziroglu F et al; *Child Adolesc Psychopharmacol* 2000 Winter;10 (4) : 295-306

The treatment of childhood social phobia: the effectiveness of a skills training-based, cognitive-behavioral intervention, with and without parental involvement; Spence SH et al; *J Child Psychol Psychiatry* 2000 Sep;41 (6)713-26

Case series: brief parent-child group therapy for childhood anxiety disorders using a manual-based cognitive-behavioral technique; Toren et al, *J Am Acad Child Adolesc Psychiatry* 2000 Oct;39

Cognitive Therapy: a practical guide; Enright S; *Practitioner* 2000 May; 244(1610): 426-8; 430-1;433

Cognitive behavioral therapy for anxiety and depressive disorders in children and adolescents: an evidence-based medicine review; Compton et al, *J Am Acad Child Adolesc Psychiatry* 2004 43: 930-959

Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders; *J Am Acad Child Adolesc Psychiatry* 2007 Feb, 46:2: 267-283

References

Glassman, R. (2003). New research in depression and anxiety [23 paragraphs]. Medscape Medical News [On-line]. Available: <http://www.medscape.com/viewarticle/464790>

Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. Zero to Three 1997

<http://www.nimh.nih.gov/>: Website of the National Institutes of Mental Health