Team-Based Care Episode: Anxiety and Stress in Children and Adolescents: Part 1

Marcia Slattery: Welcome to this team-based care podcast on anxiety and stress and children and adolescence brought to you by the Office of Continuing Professional Development at the University of Wisconsin School of Medicine and Public Health. I'm Dr. Marcia Slattery, your guest host for this episode. I am a board-certified child and adolescent psychiatrist, a professor of psychiatry and pediatrics at the University of Wisconsin School of Medicine and Public Health. I'm also the director of the UW Pediatric Anxiety Disorders Program. I'm joined today by two esteemed colleagues, Elizabeth Bartholomew and Hannah Koerten.

This two-part podcast will discuss the clinical symptoms and treatment of pediatric anxiety and the impact of stress. Part one will focus on the clinical presentation and assessment of anxiety disorders, and part two will focus on specific treatment interventions for these pediatric anxiety problems, as well as addressing the impact of stress.

At the time of this recording, I, Marcia Slattery, Elizabeth Bartholomew, and Hannah Koerten have no financial relationships to disclose. The three of us have had the pleasure of working together in children's mental health at UW over the years, and we can definitely attest to the importance and positive outcomes associated with using a team-based approach in coordinating care for kids with anxiety disorders. So a very warm welcome to both of you.

Hannah Koerten: Thank you, Marcia.

Liz Bartholomew: Thanks. Glad to join today as well.

Marcia Slattery: It's great. Could each of you please introduce yourself, including highlighting what clinical roles you've had in working with kids with anxiety disorders?

Liz Bartholomew: I'm Liz Bartholomew, licensed clinical social worker. I currently work in a pediatric primary care clinic providing short-term treatment to kids and teens and young adults with anxiety disorders. Previously, I worked in an outpatient psychiatry clinic for over 10 years, treating children and teens with various anxiety disorders.

Hannah Koerten: And I'm Hannah Koerten. I'm a clinical psychologist, and I work primarily with kids and teens in an outpatient setting. I do therapy, psychological testing, and research, and I also get to run a family-based adolescent DBT group in our clinic.

Marcia Slattery: Well, thank you to both of you for being here today and contributing. This is a really important and timely topic. So let's start with some basic clarifying constructs about anxiety, including what we're going to focus on in this podcast, starting with a common question that we often hear that, isn't anxiety normal? And yes, I believe we'd answer that. The answer is anxiety is definitely a normal emotion in kids and adults for that matter too. But what we're going to be focusing on in this podcast is clinical anxiety. Hannah, would you like to start us off by describing to our listeners what we mean by clinical anxiety?

Hannah Koerten: Yeah, I would describe clinical anxiety as something above and beyond typical anxiety that all kids experience with day-to-day stressors. Clinical anxiety will be there more days than not, or in most, if not all, situations related to the anxiety, like a social situation or being separated from parents. The anxiety symptoms also cause a lot of distress for the child or family and will have a negative impact on functioning, which may cause problems at school or with peers. The experience of significant distress or negative impact on functioning is what actually elevates clinical anxiety to the level of an anxiety disorder.

Marcia Slattery: I think it's a great description. Liz, do you have anything to add to what Hannah describes about clinical anxiety?

Liz Bartholomew: I agree. The distress that kids with anxiety experience is very real. I often think about anxiety as not only existing in the child or teen, but living in the whole family because of its impact on the family system. It's also important to remember that kids and teens diagnosed with anxiety disorders are at higher risk for depression, suicide, self-harm such as cutting, and substance abuse compared to other kids. In the primary care clinic where I work, kids with anxiety are also more likely to present for medical problems.

Marcia Slattery: Thanks for pointing that out, Liz. The impact of pediatric anxiety doesn't happen to the child alone. I often use the metaphor of imagining in your mind's eye, if you will, putting a drop of food coloring in a clear bowl of water. Just imagine that for a minute. That's how anxiety can globally color and infiltrate a child's life, including setting the stage for adulthood. I mean, the negative impact of anxiety is so wide ranging. I think we've all seen that and can really impact a child's sense of self, their learning in school, social family relationships, and physical health, to name just a few. And yes, the risks are also very real, including increasing rates of suicidal ideation and suicide attempts. This continues to be an area of significant concern. Most people similarly underestimate the magnitude of the problem.

Anxiety disorders are the most common psychiatric problem for kids of all ages, affecting 20 to 25% of all kids. So up to one in four kids. To put it in perspective, the prevalence of ADHD is around 8 to 10%, yet this is often what most people will guess is the most common psychiatric problem for kids. And interestingly, despite how common anxiety disorders are, they very often are not identified in the healthcare or other settings unless providers know what symptoms to look for and actively ask about. And that's an important piece. It's not that these kids are going to come in and just tell you exactly what the problems are.

Anxiety is very often quiet or secretive, and kids may not talk about what they're thinking or experiencing. In fact, kids with anxiety are often referred to as silent sufferers. In addition, one thing I've found over the years, the symptoms and the behaviors associated with anxiety have usually been present for quite some time, often months or years, before coming to the attention of a healthcare professional, typically their primary care provider. The kids and parents will often say they didn't recognize these behaviors as anxiety, but instead will say, I just thought that's who my kid was. And over the years, they adjust their lifestyle and activities accordingly with the anxiety really behind the wheel. So with that in mind, what I'd like us to really focus on in this podcast is helping healthcare professionals identify common symptoms and behaviors of pediatric anxiety, including how these symptoms may differ in different settings.

In order to make accurate diagnoses while also avoiding common pitfalls leading to misdiagnoses. As we all know, accurate diagnosis sets the stage for accurate treatments, which we'll talk about in part two of the podcast. So with that in mind, let's start with talking about three very common types of pediatric anxiety disorders and what clinical symptoms to look for in each.

Separation anxiety disorder, social anxiety disorder, and generalized anxiety disorder. And one additional caveat, keep in mind that all anxiety is also strongly characterized by avoidance. Our brain tells us to avoid situations that are anxiety-provoking. And so it's also important to ask if kids are avoiding specific situations we'd expect them to be engaging in, in addition to what is reported.

So let's start with separation anxiety disorder. Kids with this anxiety disorder are very anxious when they're separated from their parent or caregiver. This type of anxiety is more commonly seen in younger kids, but it can occur in older kids as well. I wonder, Hannah, if you could start us out talking about some of the common symptoms of separation anxiety disorder that health care providers should look for in kids.

Hannah Koerten: Absolutely. These kids strongly resist any type of separation from their parents or caregivers. This can show up in different ways like meltdowns, maybe screaming, crying, yelling, or physical aggression when parents or caregivers try to leave the home, refusing to leave the home themselves, or even needing to be in the same room as a parent and following them around the home. These kids are often worrying that something terrible might happen to them or their parents because of the separation, like maybe getting into a car accident, getting sick and dying, or being kidnapped. These kids may also have nightmares about something bad happening to them or their parents or refuse to go to sleep on their own.

Marcia Slattery: Liz, I'm sure you see a lot of kids in the primary care clinic with separation anxiety disorder. Any other separation anxiety symptoms you've seen in the kids you've treated?

Liz Bartholomew: Yes, not only do these kids resist separating from their parents, but they also present to the primary care clinic or their school nurse with stomach aches, nausea or headaches. The physical symptoms often occur primarily on school days, so it's really important to ask when and where symptoms show up.

Marcia Slattery: And Liz, we talked earlier about avoidance being a big part of anxiety and that asking about usual activities that are being avoided is often as important as asking about what the anxiety symptoms are that are present. Can you give us some examples of common situations that kids with separation anxiety disorder avoid that health care providers should ask about.

Liz Bartholomew: For school-age kids, parents often describe avoidance of playdates, birthday parties, or sleepovers. I often hear that the only way parents can get their child to attend these activities is if they go with them and stay the entire time. That example highlights a very common parental response to anxiety. Accommodation, and it is a topic we will discuss in greater detail in part two. Parents often share that their child is no longer able to sleep in their own room or be in different parts of the house without them. School mornings can be really challenging, with kids often not wanting to get out of the car or onto the school bus to go to school.

Marcia Slattery: I think those are great points. I think we've all seen kids where the separation resistance can be quite pronounced and quite loud, if you will, in getting parents' attention and can be quite controlling within the family. So in summary, kids with separation anxiety disorder are very anxious when separated from their parents or caregivers, and therefore, behaviors largely reflect resistance to separate from them, both at home and away from home.

One of the problems with this, though, that I find is that kids gradually need to engage in activities away from parents to become more independent and learn how to navigate experiences with others and to learn about themselves, this is a really important part of development. These experiences are really important for brain development as well as just the global psychosocial development for a growing child. So keep in mind that not only are these symptoms distressing in the moment, both for the child as well as for the parent, it can have some deeper and broader developmental consequences as well that we need to ask about and consider.

So let's move on to social anxiety disorder. Kids with social anxiety worry about situations if possible, scrutiny or judgment, and they worry about doing something that will embarrass them in front of others. Think of it as like more severe shyness. Avoidance is a big component of social anxiety disorder. And I know, Liz, you've worked with a lot of kids with social anxiety disorder. Can you talk about anxiety symptoms you commonly see in these kids? And as with separation anxiety disorder, what situations are often avoided in order to decrease or avoid the anxiety?

Liz Bartholomew: Yes, I tend to hear kids and teens express worry about embarrassing themselves or certainty that they will be judged by their peers as weird. Avoidance comes in many forms for middle and high schoolers I work with. Many avoid classes where there's an expectation to give verbal presentations. For these students, standing up alone in front of the class is terrifying because they are certain they will make a mistake or will appear nervous or anxious. In fact, just today, before I came, I talked with a middle schooler who was certain that they would trip and fall on their way up to give a presentation. Other students I've worked with might skip classes where there's an expectation to participate, such as in small group discussions or foreign language classes. Kids and teens with social anxiety might avoid spending time with peers outside of school, so it is important to listen for what a student is doing both in and outside of school.

I also find it helpful to think about usual situations in which kids need to interact with other kids like the lunchroom, recess, the dreaded gym class, small group projects, birthday parties, and school dances. It's really important to ask if they go or are they more likely to stay home.

Hannah Koerten: I would also add that an important part of this diagnosis of social anxiety disorder is that the fear of judgment of others is out of proportion to the actual social threat. So if a kid shows up in our office describing worries like these, we can ask questions about their actual interactions with peers and assess for kind of appropriate fears related to things like bullying or really negative peer interactions versus some of these social

anxiety fears like that example that Liz shared that are kind of blown out of proportion to the situation.

Marcia Slattery: These are all really great points and really great examples in real life that we hear about. So let's move on to generalized anxiety disorder. Generalized anxiety disorder, or GAD, as it is often referred to, can be more challenging to diagnose if the healthcare team does not ask about specific symptoms. The cardinal feature of generalized anxiety disorder is having multiple worries. I often tell kids it's like having a worry holder in our brain. When one worry exits, a new one takes its place right away. And it's interesting because I don't know about you guys, but the types of worries I've heard kids tell me about over the years has been fascinating, including a lot of worries about doing good in school or whatever they're involved in. A lot of worries about the future. For example, I have many grade school kids that tell me they worry about getting into a good college because they need to get good grades, they need to get a good job, and they need to be prepared for all these grown-up responsibilities. And then when I ask them, like, what do you worry about for a grown-up responsibility? You'd be surprised how many of them tell me, I worry that, how will I pay my taxes? Which I think we all have to laugh about. We may worry that as well, but kids will often worry about stressors that they hear parents talk about. So case in point, parents, whatever you're talking about, your kids are listening.

Kids with generalized anxiety disorder often set the bar high for themselves for example grades. They try very hard to do things right they like rules they love predictability they'd like to know what's going to happen so that they can feel ready I want to be on my game. I'm sure you guys have seen the same as well. And they are often seen as very controlling and the reason be if you think about it from a brain perspective, if you will, with anxiety, if I control things as much as possible, there's less likelihood that something will happen unexpectedly. And therefore, I'm less likely to feel anxious. So I'm going to control my world as much as possible in order to decrease the likelihood of feeling anxious.

An interesting piece also, Liz, that I'd like you to talk about is that kids with generalized anxiety disorder also have difficulty many times with peer relationships, and they will come to us saying they don't have a lot of friends and they have trouble making friends. Can you talk about why this often happens and, in fact, compare it to kids with social anxiety disorder?

Liz Bartholomew: Absolutely. Kids with generalized anxiety disorder and social anxiety might have friendship difficulties. However, these problems present in different ways. Kids and teens with social anxiety disorder have difficulty talking with other kids and being part of usual activities. They tend to stay on the sidelines alone, but would very much like to have friends. Many of the kids I work with generalized anxiety disorder have difficulties in

friendships because of their strong need for control and certainty. Kids with GAD often prefer to direct the play or be in charge of what the group is doing. As kids get older, this can create difficulties and often peers where students will not choose to play with them. Sometimes kids with GAD engage better with younger peers because of the ease of controlling the play.

Marcia Slattery: Thanks, Liz. These are great points. That need to control and not take risks is a common theme for kids with GAD. The problem is, though, as I was mentioning before, their world, unfortunately, becomes increasingly small because they're constantly trying to limit risk, including peer relationships. They don't want to engage in new activities. And because of this, they can often appear more developmentally immature because of just keeping things very small and isolated.

Hannah, kids with anxiety often appear more reserved and quiet, and that's maybe a stereotypic image of kids with anxiety. But I think we all also can attest to the fact that a very common symptom of generalized anxiety disorder is irritability. And these kids can appear very far from quiet and reserved. Can you talk a bit about what symptoms or behaviors healthcare providers should ask in this regard?

Hannah Koerten: Definitely. Some of the most behaviorally dysregulated kids we see in our office actually have generalized anxiety. Parents might describe to us meltdowns or outbursts, yelling, screaming, tantrums. And for some kids, this can quickly escalate to physical aggression, sometimes towards family members, property, peers, or even themselves, like hitting themselves on the head or scratching themselves.

Marcia Slattery: Yeah, it can really become quite violent, which is concerning, obviously, for others and for themselves. And to add to what you're saying, I would also include a very important question to ask when parents describe these behavioral meltdowns is where they occur. Is it only at home or does it occur in other places too? Almost always meltdowns in these outbursts occur at home. And in contrast, what's really interesting, these kids are perfect at school. In fact, teachers describe them to the parents as they're very pleasant, they're engaging, they're helpful. The teachers want a whole classroom of them. And then the parents describe the minute the car door opens, the wheels fall off and they're very irritable and angry. The parents will describe them as like Jekyll and Hyde, just so different at school compared to what they're like at home, which one wouldn't expect. And so important because if you only get that history of the meltdowns, it may impart, as we're going to talk about a little bit later, a misdiagnosis versus this pattern of context-specific expression of these symptoms of irritability and anger, much more at home.

These kids with anxiety, they will often hold it together to look good, if you will, on the outside of home. But once they're in the safety of the home, they unload the stress and tension of the day on family members. As you described, Hannah, a lot of irritability and anger. And as I mentioned, at times can become physically very threatening to family members. So again, really important to ask about. Describe for me what a meltdown looks for. I always ask that a parent. Tell me exactly what it looks like and ask about the physical aggression because the other interesting thing is many parents will be embarrassed to bring that up if their child is hitting them or acting out. So be sure to ask about that as well.

So to summarize thus far, pediatric anxiety disorders are very common, but the clinical symptoms can vary considerably depending on what type of anxiety is present, as well as these developmental differences. For example, grade school kids we know may present with more of these externalizing symptoms like tantrums or outbursts, whereas teens may be more prone to concealing their emotions and instead focusing on avoiding situations that trigger anxiety like social interactions, class engagement, etc.

So moving on a bit, the clinical assessment and diagnoses of pediatric anxiety disorders is definitely the gold standard in the field and hence the importance of informed health care professionals about what to ask. Anxiety and other symptom reading scales can also be used to help provide additional information that may or may not come up in the clinical interviews. And one important caveat to add here that I'm often asked about in the clinic, in talking about any of the screening symptom rating scales we're going to talk about.

The symptoms reported can be very helpful in gaining additional information about specific types of symptoms and severity, but the measures themselves are not diagnostic. In other words, we wouldn't diagnose anxiety, depression, or ADHD from measures alone. The screening tools always augment the central role of the clinical interview. It always comes back to that assessment. So, Liz, can you start us off by talking about some common child anxiety rating skills that our listeners might find to be useful in sorting out these different types of anxiety symptoms that we just talked about?

Liz Bartholomew: Yes. The Screen for Anxiety-Related Disorders, or the SCARED, is the most widely used screening tool for child anxiety. It's in the public domain and can be freely used. Scoring guides are also easy to find. There is a child and parent version available consisting of 41 items that kids and parents are asked to score on a scale of zero, not true about me, to two, very true about me. Example items include, it is hard for me to talk with people I don't know well, and my child worries about being as good as other kids.

The SCARED is very useful in sorting out different types of anxiety symptoms, including somatic and panic, separation, social, and generalized anxiety symptoms, as well as

school avoidance questions. It's also useful because you can use it for a wide range of ages, 8 to 18 years old. Personally, I try to get a SCARED completed at all intake appointments because it helps guide my own assessment questions. I've also noticed that when I administer both the GAD-7 and the SCARED, a teen can score low on the GAD-7, but higher on the SCARED.

Marcia Slattery: Thanks, Liz. You just mentioned the GAD-7, which is another commonly used anxiety reading skill to clarify about. The GAD-7, or the Generalized Anxiety Disorder 7, screening questionnaire is widely used in medical settings. The advantages of why it's used so often is that it's very short and quick, seven items, and can provide an initial gauge of the anxiety symptoms and severity, and therefore it's also very useful in tracking treatment. The disadvantages are that it's more limited in scope of anxiety as the name implies it primarily taps into generalized anxiety symptoms and the scale is validated for age 12 and up so it's not a good choice for grade school age kids. You mentioned in your practice list that kids may score low on the GAD-7 but higher on the SCARED can you give us some examples of what kinds of other symptoms kids might report on the SCARED that the GAD-7 may not capture. In other words why is it worth the while of getting the SCARED which is a little bit longer relative to this short screener.

Liz Bartholomew: Absolutely. The SCARED is better at bringing out different types of physical symptoms associated with anxiety, as well as symptoms of social anxiety and separation anxiety. It also really draws out symptoms of generalized anxiety in much more detail.

Marcia Slattery: I agree. So I think we all agree the SCARED is strongly preferred as the initial tool of assessment for pediatric anxiety for kids of all ages. It's, again, worth the time to complete it. The GAD-7, on the other hand, may be more useful for serial follow-up appointments and monitoring progress. The SCARED can be obtained at different intervals of time. It would not be something I would give at every appointment, whereas the GAD-7 may be useful to get at each appointment to track.

Hannah Koerten: Another advantage of the SCARED is that there is this parent version so that they can report on symptoms they observe in their child. The GAD-7 does not have a parent report version, so you're just getting the kid's report. It can be really helpful to compare how kids and parents or caregivers are describing the anxiety symptoms. Sometimes the child report reflects more what the kids are thinking and feeling internally, whereas the parent report can kind of show their observations of outside or symptoms you'd see from the outside.

Marcia Slattery: I think it's a great point. Getting information from parents is critical both in the clinical interview when we're assessing these kids and by using measures such as the SCARED Parent Report. I mentioned also at the beginning that many kids with anxiety disorders may have symptoms that are either silent or misleading for the health care team. And let's spend a few minutes on how anxiety disorders are commonly misdiagnosed as other disorders. This happens a lot. A few that come to mind are ADHD, depression, or oppositional defiant disorder.

Anxiety is commonly misdiagnosed when the child and or the parent presents with specific concerns that don't sound like anxiety. For example many kids with anxiety disorders have variability in their ability to sustain attention. This is a very common symptom of anxiety. So parents and kids feel like they'd likely have ADHD so they present to their primary care clinic requesting treatment for ADHD. And to add yet another twist, although anxiety disorders might be misdiagnosed as another disorder, anxiety disorders can also co-occur with other psychiatric disorders. And in fact, this happens frequently. Kids may have anxiety and other psychiatric disorders as well.

So primarily assessing the anxiety, but considering these other manifestations of symptoms that might be suggestive of other symptoms and disorders as well. Hannah, can you talk about how clinicians might consider ways to sort out concerns of inattention, like what might be due to anxiety and or whether there might also be ADHD? What should they ask and what screening measures might be helpful?

Hannah Koerten: Yeah, a great place to start is getting some ADHD symptom rating forms. For example, the parent and teacher Vanderbilt ADHD assessment scale, which is used in the kids ages 6 to 12. This will give us information about ADHD symptoms in the school and home setting. When I'm trying to tease apart anxiety and ADHD on these forms, I often ask the kids follow-up questions like, you know, when your mind wanders at school, what are you usually thinking about? Or does your body need to move and fidget all the time? Or are you more likely to fidget in certain situations.

Some kids will share that they just daydream in school, get distracted by various things in their environment, or fidget all the time, although usually more when they're bored, while other kids might notice that they're worrying a lot about a test or something that their friend said to them or getting in trouble at school. Some kids also only fidget at school rather than at home and schools where they feel incredibly stressed or anxious for various reasons like maybe social situations or tests or being away from their parents. So asking these types of questions can help us as providers start to understand the why underlying these common behaviors that present to the office and may look like ADHD.

Marcia Slattery: Great points. Liz, I know from our experience in working together that a lot of kids present to their primary care provider with concerns of possible ADHD when in fact the symptoms may reflect other problems such as anxiety. We just talked about that having information from multiple informants is very important in general for assessing mental health problems for kids. But a busy primary care physician provider is also not typically going to be able to reach out to schools and other informants. Can you speak in your setting? How should a pediatric primary care provider go about obtaining additional information, let's say from school staff.

Liz Bartholomew: You're right. Pediatric primary care providers may have 15 to 30 minutes for an appointment. So obtaining additional information from parents and teachers outside of the appointment time is essential. I think the most effective way to collect information and get the ADHD screeners done with school staff is to communicate to the child's parent caregivers that they have the very important role of partnering with school staff. Parents and caregivers often need to be the liaison between school and the health care team. For example, when I need to get teacher Vanderbilt ADHD rating skills completed, I will ask parents and caregivers to reach out directly to a school staff member who can help distribute these scales. Helpful staff members at school are school counselors or school psychologists. Once school has completed these forms, I ask that parents and caregivers return the completed forms directly to the health care team for review. Additionally, the school may have information that the parent caregiver can communicate to the health care team. Parents also have a central role in communicating recommendations from the health care team to the school regarding interventions that may be helpful for their child at school. I'll use that as a teaser until part two of this podcast when we talk about treatments and interventions.

Marcia Slattery: Thanks, Liz. These are excellent points. I think all of us agree that, again, parents are integral member of the team in both reporting information about their child as well as relaying information to and from school. Liz, what about the kids who present with depressive symptoms? This can be another situation in which anxiety is often missed and the kids are misdiagnosed, let's say, with primary depressive disorders. Any symptoms or behavior patterns for these kids that clinicians should be aware of?

Liz Bartholomew: Kids with anxiety may also experience symptoms of depression, such as periods of feeling sad, isolating more, seeming less engaged, or interested in their usual activities. For many of these kids, the depressive symptoms develop secondary to their anxiety. That is, because of the anxiety. I work with many kids and teens who experience persistent anxiety. I often hear them engaging in negative self-evaluation, which sometimes leads to feelings of hopelessness and worthlessness. This can lead to feeling more

demoralized and isolated, which can in turn contribute to feeling more sad, especially when they're alone. Sometimes sadness can also present as increased irritability and negativity.

Marcia Slattery: So there's that irritability again showing up in another form we talked about for anxiety as well as depression potentially. So an important point, the assessment of the anxiety symptoms helps to understand the context of the depressive symptoms that can develop. If clinicians are concerned about symptoms of depression, what screeners would you suggest they consider?

Liz Bartholomew: The Patient Health Questionnaire 9 or PHQ is the most widely used self-report depression scale. The PHQ is a widely used self-report tool for depression screening and monitoring. It consists of nine questions and each question is scored zero to three. Answers range from not at all to nearly every day. Questions ask about interest and pleasure, fatigue, appetite, feeling bad about oneself, and focused concentration. The last question is important because it assesses for suicidal ideation by asking a child or teen if someone has had thoughts of being better off dead or hurting themselves in some way. A limitation for this measure is it's only normed for ages 12 through adulthood.

Marcia Slattery: So to review, while the PHQ-9 is a good self-report screener for depressive symptoms, number one, there is a parent report version, and as you described, it's normed for teens and adults, which brings home the message once again of the importance of the clinical assessment, I think as we've all agreed upon, especially for grade school age kids, asking them and their parents and caregivers about symptoms of depression. Hannah, you also recently described the mood and this pattern of behavior dysregulation that kids with anxiety often have. Can you talk about what these kids are often misdiagnosed as?

Hannah Koerten: Yeah, kids who present with more externalizing symptoms of anxiety might get labeled as having a primary behavior disorder, for example, oppositional defiant disorder. When kids are holding in anxiety and don't have ways to cope, anxiety can come out in some pretty explosive ways. Digging deeper to find out whether certain anxieties or stressors are triggering the behavior, for example physical aggression when a parent is about to leave the home, can help identify the cause of the behavior to give a more accurate diagnosis and treatment recommendations. I found it incredibly helpful to coordinate directly with other members of the team like our primary care providers and psychiatrists when I'm assessing anxiety and these other behaviors that we've been talking about. I personally like to use our electronic medical record to directly message a brief summary or forward my note when I'm considering a new diagnosis. And I've also really appreciated, I've had several PCPs reach out to me directly if they see one of my patients in their office and notice new mental health symptoms or struggles, like for example, if they're

not showing up to school or there's new avoidance behaviors. This type of communication can be a lot more difficult when members of the treatment team are in another healthcare system. So in those cases, I usually ask the family to fill out a release of information so I can communicate with other providers over the phone, which does take a lot more time out of session, so that can be more complicated. This type of communication, I think, could be really helpful in the primary care setting because sometimes the clinical history is very difficult to clearly sort out. As we mentioned several times, primary care, you have such a short amount of time, and when there are overlapping symptoms or contrasting reports, it can be really tricky to sort this out. So in these cases, having a mental health provider on the team do further assessment could be really useful, or even talking with the family about a referral to psychiatry or psychological testing to help them get an accurate diagnosis when this is available in your area.

Marcia Slattery: These are all really great points. Again, underscoring the importance of the treatment team members really right, communicating with each other, with the child and the parent, the caregiver, and sometimes with additional informants like the school, might be the teachers, the counselors, the nurses, the treatment setting may also dictate who communicates with who. For example, Hannah, you as a psychotherapist might reach out, as you mentioned, to talk with the PCP or the school staff member, whereas, Liz, as you talked about, the PCP primary care provider and the primary care will likely advise the parent to gather and communicate the information back and forth. In any event, the clear communication can help to avoid this confusion over missed information, including this really important piece of coordinating care between primary care, mental health specialty clinics, and the schools.

Well, I don't know about you guys, but I have found this to be an incredibly helpful discussion of anxiety disorders in kids, and I really appreciate your thoughts and your expertise. Some take-home points to summarize for our listeners.

Number one, anxiety disorders are very common. and typically affect multiple domains of the child's life. Number two, all anxiety is not the same. There are different subtypes of anxiety, including separation, social, and generalized anxiety disorders, among the most common types. And three, anxiety symptoms are easily missed, which underscores the importance of healthcare team members being knowledgeable about what to look for, what to ask about, including these avoidant behaviors, and what screening measures to consider to augment the clinical interviews that they conduct.

In part two of this podcast, we'll shift gears and focus on specific treatments and interventions for pediatric anxiety. Today's focus on accurately identifying the symptoms of pediatric anxiety will form the basis for these next discussions in that, as we'll see, different

treatments may be more appropriate for different types of anxiety. And we'll also discuss the important impact of stress on triggering and exacerbating anxiety.

Thank you so much to both of you for your input again and your expertise on today's podcast. It's so rewarding working with both of you in coordinating treatment for so many of these kids with anxiety. And thank you for your dedication to kids and their families. Sincere thanks and gratitude as well to colleagues at the Office of Continuing Professional Development at the UW-Madison School of Medicine and Public Health who made this podcast possible. Reminder, continuing education credit is available for this episode through the Interprofessional Continuing Education Partnership at UW-Madison. To claim credit, you can text this code, V as in Victor, A-P-L-E-V at this number, 608-260-7097. Again, Again, this number is 608-260-7097 and text the code V as in Victor, A-P-L-E-V as in Victor. Your feedback is also really important to us. To complete an evaluation form for this episode, see the show notes. This information is also included on the UW-ICEP website at ce.icep.wisc.edu. We have also attached copies and or links of diagnostic criteria for the three major types of anxiety disorders we discussed today, as well as screening measures, including the SCARED, the GAD-7, the PHQ-9, and Vanderbilt ADHD reading skills on the ICEP website for this podcast. Thank you for listening. We look forward to joining you again soon for part two of this podcast on anxiety and stress in children and adolescents.