



Published in final edited form as:

Arch Pediatr Adolesc Med. 2010 October ; 164(10): 965–972. doi:10.1001/archpediatrics.2010.170.

The Burden of Anxiety Disorders in Pediatric Medical Settings: Prevalence, Phenomenology, and a Research Agend

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Abstract

The current review describes the phenomenology of several common anxiety disorders in children and adolescents as they present in medical settings. Anxiety disorders and associated features in children are described, along with epidemiology, functional impairment, common somatic complaints, medical comorbidity, health care utilization, and presentation in general and specialty pediatric medical settings. Recommendations for clinical management in pediatric settings are presented, and evidence-based interventions are described along with emerging treatments for pediatric anxiety disorders. The review concludes with a discussion of future research directions that may lead to increased recognition and improved management of anxiety disorders in pediatric medical settings.

Overview

Roughly one in four Americans will meet lifetime criteria for an anxiety disorder¹. Anxiety disorders are among the earliest psychiatric conditions to manifest, with a median age of onset of 11 years¹. General population prevalence rates among children under 18 are estimated to be 5.7–12.8%^{2–7}. As such, anxiety disorders are more prevalent in children than either mood disorders or attention deficit hyperactivity disorder^{2–7}, although they often co-occur with these conditions, as well as with other anxiety disorders⁷. Left untreated, anxiety disorders tend to have a chronic and unremitting course^{8,9}. Childhood anxiety disorders also increase risk for adult psychiatric disorders, including depression and substance use disorders^{10,11}.

Anxiety disorders are associated with considerable functional impairment and economic costs related to lost productivity and treatment. In children, anxiety disorders can be associated with school absenteeism or school refusal, poor academic performance, or grades that are lower than what would be expected based on the child's abilities^{12–14}.

Despite the significant public health burden associated with anxiety disorders, most afflicted individuals do not receive specialty mental health treatment, and are instead managed in the general health sector care^{15,16}. To some extent, this may be due to the prominent somatic complaints that often accompany anxiety disorders, particularly in children, and because medical comorbidity is often associated with these diagnoses. Ambiguity regarding the

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Online resources

Anxiety Disorders Association of America www.adaa.org

American Academy of Child & Adolescent Psychiatry www.aacap.org

Association for Behavioral and Cognitive Therapies www.abct.org

etiology of physical symptoms in these patients could conceivably lead to unnecessary medical visits and medical testing, and incomplete resolution of symptoms. In the case of children with verified medical illness, their psychiatric symptoms may go untreated in medical settings, leading to increased distress and loss of productivity. Increased recognition of anxiety disorders and awareness of recommended treatment approaches may lead to improved management in pediatric medical settings.

The primary aims of the current review are as follows:

1. To increase recognition among pediatric medical providers of the signs and symptoms of common childhood anxiety disorders, particularly those diagnoses that may come to their attention due to an association with somatic complaints and medical comorbidity. As there are specific issues concerning childhood trauma and posttraumatic stress disorder that have been covered in several recent reviews^{16;17}, this topic is not reviewed here.
2. To increase awareness of the prevalence of anxiety disorders in pediatric medical settings, including both primary care and specialty clinics such as gastroenterology and cardiology where pediatric patients with anxiety disorders may present.
3. To acquaint clinicians with recommended approaches for managing anxiety disorders in clinical practice.

The review concludes with suggestions for future research.

Key features of pediatric anxiety disorders

Although there are common features among the anxiety disorders, they are differentiated by the focus of the child's fears. In *separation anxiety disorder*, children's fears center on anticipated or actual separation from their parent(s)/caregiver. Children with separation anxiety disorder are often clingy, have difficulty sleeping alone, may have school refusal, and may also exhibit or report somatic symptoms prior to or upon separation. Children with *generalized anxiety disorder* may also express fears about harm befalling family members, but this is not the primary focus of their concern—they also experience excessive and uncontrollable worry about a number of other domains (e.g., being on time, academic performance, friendships). The more worry domains that are present, the more likely the diagnosis of generalized anxiety disorder. Children with *social anxiety disorder* (also known as *social phobia*) may present as shy and in severe cases may refuse to speak to unfamiliar people, particularly adults. They may be overly anxious about a number of social situations in which they feel awkward or uncomfortable, or in which they worry about negative evaluation by others. These children may attempt to avoid situations in which social fears arise (e.g., school). *Panic disorder* is characterized by *unexpected* panic attacks (not triggered by an identifiable stimulus) and typically onsets in post-pubertal children and adolescents. Panic attacks typically feature a sudden onset of various somatic sensations including tachycardia, sweating, tremors, difficulty breathing, and other symptoms. Panic symptoms often result in frequent trips to their pediatrician's office, emergency department, and even specialty settings such as cardiology or neurology for evaluation. Children with panic disorder may avoid, or endure with considerable distress, situations in which panic symptoms have occurred or are feared, such as the classroom, driving, or enclosed spaces, in which case the diagnosis of *panic disorder with agoraphobia* is warranted. *Obsessive compulsive disorder* is characterized by obsessions and/or compulsions. *Obsessions* are thoughts, images, or impulses that tend to "pop up" unbidden in the child's mind, and are experienced as unwanted and difficult to get rid of. Common obsessions include thoughts about contamination; doubts about completion of an activity (e.g., locking the front door); aggressive or violent impulses; religious or sexual thoughts or images; a desire for

symmetry; and nonsensical thoughts related to certain numbers, letters, songs or phrases. The child will typically engage in mental or behavioral rituals, known as *compulsions*, in order to reduce or suppress obsessions. Common compulsions include frequent hand-washing, checking, ordering, and counting. A *specific phobia* refers to a particular stimulus which almost invariably triggers a strong fear response; common phobias in children include fears of animals (e.g., dogs, insects), blood-injection-injury (i.e., “needle phobia”), darkness, and thunderstorms.

Distinguishing anxiety disorders from normal, age-appropriate worries & fears

Many children have transient worries and fears, particularly at certain developmental stages, which should not be viewed as pathological. Anxiety disorders are characterized by greater persistence and severity, and by clinically significant impairment or distress. Derived from information in the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV)* diagnostic criteria¹⁸ and the collective clinical experience of the authors, Table 1 presents considerations for distinguishing normal, developmentally appropriate fears and worries from those that may indicate a need further screening.

Somatic complaints associated with anxiety disorders

Pediatric anxiety disorders are particularly likely to occur in association with somatic complaints (i.e., physical symptoms occurring in the absence of a verified medical condition, or symptoms in excess of what would typically be expected for a given medical illness). In fact, the diagnostic criteria for several anxiety disorders common in children include somatic symptoms. For example, the *DSM-IV* criteria for separation anxiety disorder indicates that “repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting)...” may be present in children with the diagnosis¹⁸. The burden associated with somatic symptoms is considerable—one recent study from the adult literature suggests that somatization is associated with higher costs and healthcare use, even when adjusting for medical and psychiatric comorbidity¹⁹. The pediatric literature bears this out, in that the presence of somatic complaints in children is correlated with increased anxiety disorder severity^{20;21} and functional impairment, including poorer academic performance and increased incidence of school refusal^{20;22;23}.

Somatic symptoms in children with anxiety disorders can include complaints of chest pain, tachycardia, shortness of breath, dizziness, nausea, and vomiting^{20;22;24;25}. Although symptoms may vary, one of the most consistently reported and debilitating symptoms in anxious children is abdominal pain^{20;22;26}. A study by Campo and colleagues investigated psychiatric comorbidity in 42 pediatric patients with functional recurrent abdominal pain (RAP), defined as three or more episodes of abdominal pain within at least a three-month period that are sufficiently severe to disrupt the activities or function of the child, and are not accounted for by identifiable biomedical factors²¹. While 43% of the sample met criteria for a depressive disorder, 79% were found to meet criteria for one or more anxiety disorders. Separation anxiety disorder (42.9%), generalized anxiety disorder (31.0%), and social phobia (21.4%) were the most common anxiety disorder diagnoses in the sample. Although other RAP studies have yielded somewhat lower estimates of anxiety disorders, in the range of 42–67%^{27–29}, these rates were still significantly higher than in control groups, and higher than the prevalence of other psychiatric disorders in the samples. Pediatric RAP has also been associated with increased risk for anxiety and other psychiatric disorders in adulthood³⁰.

Anxiety disorders and medical comorbidity

Anxiety disorders and medical conditions often co-occur, and while the precise nature of the temporal relationship is currently unclear, it is likely bidirectional. For example, the presence of asthma or gastrointestinal illness could conceivably lead to increased anxiety and catastrophic thoughts about physiological sensations, or fears about suffering a medical emergency when separated from parents, in a vulnerable child or adolescent. Conversely, it is possible that anxiety and stress contribute directly—for instance, through decreased immune function³¹—or indirectly (by way of maladaptive health behaviors like poor sleep habits, alcohol or substance use, and decreased compliance with medical treatment regimen) to increase susceptibility to certain medical conditions. Anxiety and medical disorders may also share certain environmental (e.g., parental smoking, low socioeconomic status, or childhood adversity) and biological (e.g., shared neural pathways) risk factors³².

Common medical conditions reported in individuals with anxiety disorders include migraine, gastrointestinal disorders, and especially asthma and other atopic conditions like allergic rhinitis, atopic dermatitis, and urticaria^{26;33–37}. One recent study by Chavira and colleagues found that approximately half of the children in their sample with anxiety disorders had a comorbid medical disorder, with allergies or asthma being the most common physical ailment; in comparison, approximately 1 in 4 children *without* anxiety disorders had a medical illness³⁸.

Comorbid anxiety and medical disorders appear to interact synergistically, producing greater impairment in children than what would be expected for either disorder alone^{35;38;39}. In one study of adolescents with asthma, those with comorbid anxiety or depressive disorders reported significantly more days with asthma symptoms (5.4 vs. 3.1 days; $p < .001$) in the last two weeks relative to adolescents without this psychiatric comorbidity, even after adjusting for asthma severity³⁹.

Healthcare utilization

Individuals with anxiety disorders have increased rates of healthcare service use. Across multiple studies and settings, anxiety disorders in adults are associated with frequent medical visits^{40–45}. The findings for pediatric studies on anxiety disorders and health care utilization are less definitive. Few such studies in children have been conducted to date, and those that have been conducted often feature small sample sizes and jointly examine child anxiety and depressive disorders, making it difficult to discern any independent association of anxiety disorders and healthcare use^{46–49}. Nonetheless, overall the extant literature suggests that individuals with anxiety disorders have increased rates of healthcare utilization, particularly when they occur in the context of comorbid medical conditions⁴¹.

Pediatric anxiety disorders in medical settings

Pediatric primary care settings

While the adult literature suggests that anxiety disorders are more common in primary care settings than in the general population, data from pediatric studies are just beginning to emerge. Earlier studies generally produce lower estimates^{50;51}, but a more recent investigation that utilized DSM-IV criteria and semi-structured diagnostic interviews with parents suggests that at least 17% of pediatric patients meet criteria for one or more anxiety disorder diagnoses⁵². In addition, up to 4 out of 5 pediatric patients who meet strict criteria for RAP have an anxiety disorder diagnosis²¹. RAP accounts for 2–4% of pediatric primary care visits annually⁵³.

Pediatric medical specialty settings

Anxiety disorders may be over-represented in pediatric specialty settings such as gastroenterology, cardiology, and pulmonology clinics. Higher prevalence of anxiety disorders in these settings might be expected given the types of somatic complaints (e.g., abdominal pain, chest pain) and medical comorbidity (e.g., asthma) commonly associated with pediatric anxiety disorders. In one study of consecutive pediatric patients receiving services at an inner-city asthma clinic, approximately one in four were found to have an anxiety disorder diagnosis⁴⁷. While overall estimates of anxiety disorders in specialty settings are lacking, several investigations have focused on patients who present to clinics with specific symptoms for which no medical etiology has been found. For example, in a small study of patients with non-cardiac chest pain (i.e., chest pain with no established cardiac etiology) in a pediatric cardiology practice, it was determined that 59% of these children had a psychiatric disorder; all but one of these patients met criteria for an anxiety disorder⁵⁴. Among patients with RAP seeking care in pediatric gastroenterology clinics, 42–67% have one or more anxiety diagnoses^{29–31}. Thus, the available evidence suggests that anxiety disorders are also common in pediatric medical specialty settings, particularly when a clear medical etiology has not been found.

Pediatric emergency department settings

With EDs increasingly serving as *de facto* primary care clinics for many patients, particularly those without health insurance or with inadequate access to healthcare, ED patients may also be at high risk for anxiety and other mental health difficulties. The available data do indicate high rates of anxiety disorders in acute care settings—up to 23% of adult emergency department (ED) patients screen positive for anxiety disorders^{55–59}. However, we could find only one investigation of anxiety disorders in pediatric ED settings. In this study, 45% of 411 randomly selected “non-acute” pediatric ED patients had a probable mental disorder by parent report⁶⁰. Although it is unclear what the prevalence of anxiety disorders would be if the sample were not limited to non-acute visits, this investigation suggests that anxiety disorders may be a fairly common occurrence in pediatric ED settings.

Screening and management by the pediatric provider

Medical providers may be reluctant to discuss with parents the possibility of a psychiatric or emotional component to their child’s physical symptoms for several reasons, including time constraints associated with work in a busy clinical practice, discomfort with diagnosing and managing psychiatric disorders, belief that psychiatric issues are outside of their purview, or concerns that the child will be stigmatized or parents will not be amenable to such a conversation. However, parents may be more receptive if they perceive that their child’s symptoms are not simply being dismissed as “in his/her head.” A discussion of the association between stress and health, or brain-body connections, if appropriate, may open the door for a conversation about a collaborative approach between the family, primary care physician, and behavioral health specialist, if needed.

When an anxiety disorder is suspected, further screening should be undertaken with both child and parent to assess for the presence of anxiety symptoms. Assessment may be aided by the use of brief validated screening measures, such as the 10-item Multidimensional Anxiety Scale for Children⁶¹ or the 5-item Screen for Child Anxiety Related Emotional Disorders (SCARED; Tables 2 and 3)⁶². These self-report questionnaires are brief, with child and parent versions available, and high scores (e.g., SCARED \geq 3) may indicate that further evaluation is needed. Family psychiatric history may also be informative, as often parents or other relatives may themselves report anxiety, depression, or other psychiatric

symptoms. Providers should also inquire about recent psychosocial stressors (e.g., academic problems, family discord, teasing or other difficulties with peers). Onset and duration of anxiety symptoms should be determined, as well as the impact of the symptoms on child and family functioning.

Mild anxiety difficulties may be managed with education (particularly parental education), support, and encouraging the child to resume previous activities using a gradual approach. Families should also be encouraged to maintain regular schedules for eating, sleeping, and other activities including exercise; normalization of inconsistent routines may also help to alleviate some of the somatic symptoms associated with child anxiety (e.g., fatigue, difficulty concentrating, abdominal discomfort). Anxiety symptoms should be assessed at future visits, using validated screening measures if possible, to monitor for changes or worsening.

When referral seems appropriate, the pediatric provider may find that this is a gradual process—it may take families some time before deciding to accept referrals to behavioral health specialists. In this case, the possibility of referral for further evaluation should be discussed at future visits, particularly if there is evidence of increasing distress for the child or functional impairment related to anxiety symptoms (e.g., academic difficulties, sleep problems, family dysfunction). Referral for behavioral treatment (see below) can be considered for children with moderate anxiety symptoms, although clinicians with expertise in behavioral treatment methods are not readily available in all regions. When presented with either more severe symptoms or an unclear diagnostic picture, referral to a child psychiatrist or another behavioral health specialist may be appropriate for further assessment and discussion of treatment options (see next section on evidence-based approaches). In some instances, often after consultation with a child psychiatrist, the pediatrician may assume primary responsibility for pharmacotherapeutic management (e.g., with antidepressants).

Treatment of pediatric anxiety disorders

Evidence-based approaches

Recommended first-line treatments for pediatric anxiety disorders cognitive behavioral therapy (CBT), and, especially in more severe cases, pharmacotherapy; these may be used as monotherapies or in combination⁶³. CBT is a set of techniques involving psychoeducation, changing maladaptive thought patterns, and gradual exposure to anxiety-provoking situations. It is thought that more realistic cognitions (and thus reduced anxiety) about feared situations are cultivated by learning effective thought-challenging techniques, as well as via the exposure component of CBT. For example, in exposure therapy a child with separation anxiety disorder may be guided through an individually tailored set of exposure exercises, starting with easier tasks (e.g., sleeping in her own bed with the bedroom door open and hallway light on) and progressing to more anxiety-provoking situations (e.g., sleeping in her own bed with the bedroom door closed and without the hallway light on). Through this process, the child learns that her worst fears (e.g., that she will be kidnapped if she sleeps in her own bed instead of with her parents) are disconfirmed, and she thereby gradually habituates to sleeping alone. CBT typically takes place over 10 to 15 60–90 minute outpatient sessions, and also includes at-home practice of newly acquired skills. Shorter or longer treatment regimens may be recommended depending on the severity of the child's anxiety, the presence of comorbid conditions, and other factors.

Research suggests that both CBT^{64;65} and selective serotonin reuptake inhibitors^{66;67} are effective in treatment of pediatric anxiety disorders. Some recent studies suggest that CBT and SSRIs are equally efficacious for children with anxiety disorders^{65;68}, although one of

these studies found CBT to be superior to pharmacotherapy on some indices⁶⁵. Combination treatment may be more efficacious than either treatment alone--a recent randomized controlled trial found that 81% of children with anxiety disorders receiving both sertraline and CBT were classified as responders, vs. 60% for CBT alone, 55% for sertraline alone, and 23% for pill placebo⁶⁸. For a more comprehensive discussion of the treatment outcome literature, interested readers are referred to recent reviews on this topic^{69;70}.

Emerging treatments

There are several emerging pharmacological and behavioral treatment approaches that may be particularly suited for anxiety disorders in pediatric medical settings. In a 12-week, flexible-dose, open-label trial of citalopram for children aged 7–18 with functional RAP (N = 25), 84% were classified as treatment responders and evidenced significant improvement on both pain ratings and anxiety symptoms throughout the course of the study.⁷¹ In another development, youths (N = 7) recruited from a gastroenterology clinic with anxiety disorders and abdominal pain or discomfort were treated with a 12-week modified CBT intervention that targeted both anxiety symptoms and physical symptoms⁷². Following treatment, all participants were classified as treatment responders, with significant reductions in both anxiety and physical discomfort ratings. Brief, evidence-based behavioral interventions targeting pediatric anxiety are also being transported directly into the primary care setting. One treatment currently being developed by our group is based on a collaborative care model, whereby pediatricians are trained to identify and refer children with anxiety disorders, and mental health professionals deliver the behavioral intervention in the primary care clinic or by telephone. Another treatment model being tested involves brief CBT targeting pediatric anxiety and depression in primary care settings carried out “in house” by master’s level clinicians (i.e., nurse practitioner, clinical social worker)⁷³. Provision of mental health services in pediatric medical settings may enhance both the feasibility and dissemination of evidence-based interventions.

Recommendations for future research

Investigation of anxiety disorders in pediatric medical settings is currently in the early stages and often features small sample sizes, but would benefit from several future research directions. First and foremost, further investigation of the overall prevalence and correlates of anxiety disorders in pediatric medical settings, including specialty settings such as cardiology, gastroenterology, and EDs, is warranted to elucidate the burden associated with pediatric anxiety disorders on the health care system. This is imperative given that most children with anxiety disorders are not treated in mental health specialty settings, those seen in medical settings typically do not receive adequate mental health care, and mental health variables contribute to frequent, costly, and in some cases unnecessary health care visits. Second, future health service research efforts should make use of validated screening measures for assessment of anxiety disorders as opposed to sole reliance on chart review, as clinicians in busy clinical practices routinely miss these diagnoses⁷⁴. Third, screening tools should be developed that are appropriate for pediatric medical settings. The utility of a 5-item version of the SCARED has recently been demonstrated in pediatric primary care settings⁵². Fourth, future research efforts should focus on designing interventions that can be deployed “in house” to effectively identify and treat youths with anxiety disorders; those that do not rely on extensive, specialized training are particularly desirable. One large treatment study of anxiety disorders in adult primary care settings, in which patients are given a choice of medication, computer-assisted CBT with master’s level clinicians, or combination treatment (compared with treatment-as-usual) via a stepped care model, has shown considerable promise⁷⁵. Similar treatment innovations should be developed for pediatric patients in order to improve access to evidence-based care for anxiety disorders.

Acknowledgments

Funding/Support: This research was supported by the following funding sources: National Institute of Mental Health (NIMH) T32 MH018399 (HJR); NIMH K01 MH072952 (DAC); NIMH K24 MH064122 (MBS).

We wish to thank P. Jamil Madati, MD (Department of Pediatrics, University of California San Diego) for helpful editorial comments.

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Table 1
 Considerations when determining whether further screening for anxiety disorders is warranted

DSM-IV Anxiety Disorders	Symptoms indicative of normal/developmentally appropriate fears and worries	Symptoms indicating that threshold for disorder may be met
Separation anxiety disorder	<ul style="list-style-type: none"> mild distress/apprehension regarding separation from primary caregivers (e.g., on the first day of school) 	<ul style="list-style-type: none"> catastrophic thoughts and/or recurrent bad dreams about being kidnapped, lost, or harm befalling parents if separated reluctance or refusal to be separated from parents abdominal pain, chest pain, headaches, nausea or vomiting prior to or upon separation; older children/adolescents may experience panic attacks when separated
Generalized anxiety disorder	<ul style="list-style-type: none"> mild/occasional worries about grades, health, world events, etc. child can be easily consoled/distracted when worried worries are not in excess of what most same-age peers experience 	<ul style="list-style-type: none"> worry is excessive and difficult to control (e.g., constant worrying about grades even when child has straight As) in some cases child may be described as perfectionistic by adults trouble sleeping, restlessness, irritability, trouble concentrating, or muscle tension are present when worrying
Social anxiety disorder	<ul style="list-style-type: none"> shyness or performance fears that do not overly distress the child or interfere with the child's activities 	<ul style="list-style-type: none"> excessive fears of being judged negatively or embarrassed in social situations (e.g., when the center of attention, with adults, when meeting new people) child may attempt to avoid such situations (e.g., refusal to go to school or extracurricular activities, skipping class when a presentation is scheduled) physical symptoms such as flushing or tremor, especially upon exposure to social cues, may be observed
Panic disorder w/or w/o agoraphobia	<ul style="list-style-type: none"> occasional concerns about symptoms of physiological arousal (e.g., transient concern about possible recurrence after an episode of vertigo) 	<ul style="list-style-type: none"> unexpected panic attacks which include symptoms like rapid heart rate, shortness of breath, trembling or shaking, dizziness, lightheadedness, and gastrointestinal discomfort persistent fear of having future attacks or catastrophic thoughts about the consequences of future attacks (e.g., heart attack) avoidance of situations in which panic or panic-like sensations are anticipated (e.g., avoidance of exercise/sports)
Obsessive compulsive disorder	<ul style="list-style-type: none"> mild obsessive thoughts without compulsions (e.g., occasional "germ-phobic" thoughts that are not associated with excessive hand-washing or cleaning) child can easily be distracted from these thoughts/behaviors thoughts and behaviors are not time-consuming 	<ul style="list-style-type: none"> obsessions are persistent and may be distressing to the child child feels driven to perform repetitive or ritualistic behaviors (compulsions) physical evidence of compulsions may be present (e.g., dry, cracked hands due to excessive washing)

DSM-IV Anxiety Disorders	Symptoms indicative of normal/developmentally appropriate fears and worries	Symptoms indicating that threshold for disorder may be met
Specific phobia	<ul style="list-style-type: none"> • mild fear reaction to a particular object or situation (e.g., briefly clinging to parent when confronted with a friend's pet dog) • child very rarely encounters the feared situation and has no need to (e.g., fear of heights when in a tall building, but lives in a rural area with few or no tall buildings) • child does not go out of her way to avoid the situation 	<ul style="list-style-type: none"> • fear significantly impacts the child's life or family function (e.g., family trips avoided due to child's fear of flying; necessary medical evaluations or treatment delayed due to child's fear of needles) • strong affective and behavioral reactions, which may include a panic attack, upon exposure to the feared stimulus (e.g., shaking, crying and hyperventilating at the doctor's office when a vaccination is imminent)

Note. Symptoms which may come to the attention of medical providers are bolded.

Table 25-item Screen for Child Anxiety Related Emotional Disorders, Child Version. (SCARED-C)⁶²

SCARED (Child Version)			
Directions: Below is a list of sentences that describes how people feel. Read each phrase and decide if it is “Not true or hardly ever true” or “Somewhat true or sometimes true” or “Very true or often true” for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for <u>the last 3 months</u>.			
	Not true or hardly ever true	Somewhat true or sometimes true	Very true or often true
I am shy.	0	1	2
People tell me that I worry too much.	0	1	2
I am scared to go to school.	0	1	2
I get really frightened for no reason at all.	0	1	2
I am afraid to be alone in the house.	0	1	2

Note. Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh. (10/95). E-mail: birmaherb@msx.upmc.edu

Table 35-item Screen for Child Anxiety Related Emotional Disorders, Parent Version. (SCARED-P)⁶²

SCARED (Parent Version)			
Directions: Below is a list of statements that describes how people feel. Read each statement carefully and decide if it is “Not true or hardly ever true” or “Somewhat true or sometimes true” or “Very true or often true” for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for <u>the last 3 months</u> . Please respond to all statements as well as you can, even if some do not seem to concern your child.			
	Not true or hardly ever true	Somewhat true or sometimes true	Very true or often true
My child is shy.	0	1	2
People tell me that my child worries too much.	0	1	2
My child is scared to go to school.	0	1	2
My child gets really frightened for no reason at all.	0	1	2
My child is afraid to be alone in the house.	0	1	2

Note. Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh. (10/95). E-mail: birmaherb@msx.upmc.edu