

screening for anxiety disorders in children and adolescents. However, in primary care, school, or other child-serving settings, freely available general social–emotional screening instruments (eg, Pediatric Symptom Checklist [<https://www.massgeneral.org/psychiatry/treatments-and-services/pediatric-symptom-checklist/>]⁶⁸; Strengths and Difficulties Questionnaire [<http://www.sdqinfo.com>]⁶⁹) can be deployed systematically to standardize identification of anxiety concerns. Early identification of an anxiety concern, if confirmed as a problem upon follow-up assessment, can facilitate early intervention, including guided self-management and focused intervention for subclinical and mild presentations.

In the context of a psychiatric evaluation, symptoms of anxiety typically are identified through spontaneous youth or parent report (the presenting problem or chief complaint), during the clinician's review of psychiatric symptoms, the conduct of the mental status examination, or through input from referral sources. However, because of the variability inherent in nonsystematic methods of identification, a more standardized approach may be useful. As one option, the American Psychiatric Association (APA) developed the freely available parent- and self-rated Level 1 Cross-Cutting Symptom Measures (<https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures>)⁷⁰ to screen for multiple psychiatric disorders including anxiety. These instruments could be included in intake packets to systematically and efficiently gather information about presenting problems prior to the evaluation. The parent and self-rated versions of the Level 1 Cross-Cutting measure have demonstrated good reliability in the *DSM-5* field trials conducted in pediatric clinical samples across the United States.⁷¹

Evaluation

Clinically significant anxiety (ie, an anxiety disorder) must be distinguished from everyday worries and fears, which are common to the human experience and normative (even when exaggerated) in specific developmental stages (eg, being startled and exposure to strangers in infants, separation from caregiver in toddlers, supernatural creatures in preschoolers, physical well-being and natural disasters in school-aged children, and social and existential concerns in adolescents). In *DSM-5*,¹ mental disorders are defined as “a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.” By *DSM* convention, a mental disorder is diagnosed if all or a threshold of diagnostic criteria for the given disorder are met. Included in most diagnostic criteria

sets is the requirement for a specific frequency and duration of symptoms as well as clinically significant distress and functional impairment, along with the caveat that alternative mental, medical, and substance-related explanations for the symptom presentation must have been ruled out before the diagnosis is applied.

In *DSM-5*,¹ diagnostic criteria are provided for 11 anxiety disorders (one with 8 subcategories).^a Although the boundaries between psychiatric disorders are now recognized as porous, such that different disorders within and across categories may share similar symptoms, risk factors, and neural substrates, diagnostic precision nonetheless is key for understanding disorder course and prognosis and for guiding empirically based treatment recommendations.

According to *DSM-5*,¹ separation anxiety is characterized by developmentally inappropriate, excessive worry or distress associated with separation from a primary caregiver or major attachment figure. Selective mutism is characterized by absence of speech in certain social situations despite the presence of speech in other situations (usually at home). Specific phobia is characterized by excessive fear or worry about a specific object or situation. Social anxiety is characterized by excessive fear or worry about being negatively evaluated by others in social situations. Panic (ie, abrupt surge of intense fear or discomfort) is characterized by recurrent unexpected panic attacks with physical and cognitive manifestations. Agoraphobia is characterized by excessive fear or worry about being in situations (eg, crowds, enclosed spaces) in which the individual may be unable to escape or get help should panic-like or other overwhelming or embarrassing symptoms occur. Generalized anxiety is characterized by excessive, uncontrollable worries regarding numerous everyday situations or activities. Substance/medication-induced anxiety and anxiety due to another medical condition are characterized by anxiety occurring in the context of substance/medication use or a physical illness. When diagnostic criteria are not fully met for a given anxiety disorder or if a precise diagnosis is not possible due to limited information or other factors, *DSM-5* includes “other specified” and “unspecified” diagnoses to be applied in these circumstances. The “unspecified” diagnosis may be the best diagnostic choice for nonbehavioral health

^a*DSM-5 Anxiety Disorders with International Classification of Diseases–10 code: Separation Anxiety Disorder (ICD F93.0); Selective Mutism (ICD F94.0); Specific Phobia (Animal: ICD F40.218, Natural environment: ICD F40.228, Fear of blood: ICD F40.230, Fear of injections and transfusions: F40.231, Fear of other medical care: F40.232, Fear of injury: F40.233, Situational: F40.248, Other: F40.298); Social Anxiety Disorder (F40.10); Panic Disorder (F41.0); Agoraphobia (F40.00); Generalized Anxiety Disorder (F41.1); Substance/Medication-Induced Anxiety Disorder (see substance-specific codes), Anxiety Disorder Due to Another Medical Condition (F06.4); Other Specified Anxiety Disorder (F41.8); and Unspecified Anxiety Disorder (F41.9).*