Disclosures

I have no financial interests to disclose
Learning Objectives

• Identify main clinical presentations of anxiety disorders in youth
• Identify different modalities of intervention in anxiety disorders based on what part of the “cycle of anxiety” they target
• Describe basic components of evidence-based psychotherapy for anxiety and obsessive compulsive disorders in a pediatric population
• Describe first-line pharmacologic treatment of anxiety disorders and obsessive compulsive disorders in a pediatric population
Prevalence of Anxiety Disorders

• 6-20% prevalence of at least one childhood anxiety disorder (Costello et al 2004)

• More severe symptoms / greater impairment in functioning → more likely for anxiety disorder to be persistent
When is anxiety a problem?

- When it causes **functional impairment**
  - Social problems
  - Academic problems
  - Decrease in independent functioning
- When it affects **peer and family relationships**
- When it leads to **self-medication in the form of substance abuse**
Presentation of Anxiety Disorders

- School refusal
- Physical symptoms (stomach ache, headache, difficulty breathing are some examples)
- Rituals
- Reassurance-seeking (asking for reassurance over and over again even after being reassured once or twice)
- Agitation
- Aggression
- Insomnia/refusal to sleep alone
- Perfectionism
Common Anxiety Disorders

- Selective mutism
- Separation anxiety disorder
- Generalized anxiety disorder
- Social anxiety disorder
- Panic disorder
- Specific phobia
- Obsessive compulsive disorder*

Note: in the following slides, there are descriptions of disorders based on DSM-5 criteria, but the purpose of slides is description and not all criteria are included.
Selective Mutism

- Consistent failure to speak in specific social situations in which there is an expectation for speaking despite speaking in other situations
  - Many manifest as:
    - Refusal to speak in school
    - Refusal to speak to adults outside the family

Caveats:

- Not attributable to a lack of knowledge of, or comfort with the spoken language required in the social situation
- Not better explained by a communication disorder or other psychiatric condition
Separation anxiety disorder

• Developmentally inappropriate and excessive fear of separation from those to whom the individual is emotionally attached

• May manifest as:
  o School refusal
  o Refusal to sleep away from parents (not even in own bed)
  o Repeated checking on parents at night, or by phone
  o Tantrums when separating
  o Frequent reassurance seeking
Generalized anxiety disorder

• Excessive anxiety and worry occurring more days than not for at least 6 months, about many different topics

• May manifest as:
  - Frequent reassurance seeking (to peers, parents, teachers)
  - Frequent checking behavior
  - Avoidance of worry-inducing activities/situations (including school)
  - Tantrums / explosiveness in times / situations of uncertainty
  - Irritability
  - Insomnia
Social anxiety disorder

- High fear or anxiety about one or more social situations in which the person may be scrutinized by others
  
  Eb: meeting new people, being observed, or performing in front of others

- May manifest with:
  - School avoidance
  - Panic attacks
  - Worry
  - Excessive preparation for social situations (spending hours choosing clothes, for example)
  - Rumination after the fact
  - Insomnia
Panic disorder

- Recurrent unexpected panic attacks
  - Panic attack: *an abrupt surge of intense fear or discomfort that reaches a peak within minutes* with physical symptoms that can include heart palpitations, sweating, trembling, feeling short of breath, feeling of choking, chest pain, dizziness, nausea, chills or heat sensations, fear of losing control, fear of dying, and others

- Attacks are followed by *persistent concern or worry about having additional panic attacks* or their consequences

- Significant behavior change may occur to avoid attacks
Specific phobia

- Extreme fear or anxiety about a specific object or situation
  (example: flying, heights, animals, injections)
- May be expressed by crying, tantrums, “freezing,” or clinging
- The specific object or situation almost always provokes immediate fear and anxiety
- The specific object or situation is avoided or endured with intense fear and anxiety
- The fear is out of proportion to the actual danger posed by the specific object or situation and to the cultural context
Workup and Assessment

• Medical workup
  o Substance use
  o Hyperthyroidism
  o Hyperglycemia/ hypoglycemia
  o Seizure disorder

• Trauma screen

• Measures
  o SCARED
  o GAD 7
Treatment

• Parental psychoeducation/bibliotherapy (first line)
• CBT (first line)
• Medication (second line, or to start if anxiety is moderate to severe at presentation)
• Combined treatment is best!
Parental psychoeducation

• Anxious kids often have anxious parents!
• This is a disorder for which we have excellent, effective treatments that are generally well-tolerated
• Avoidance
• Reinforcement
• Think of anxiety as a ball in the air
• “What goes up must come down”

Trigger → Anxious reactivity → Escape urge → action → relief
CBT

- Start with CBT rather than medications for mild to moderate anxiety
- Certain models of CBT have shown sustained treatment gains up to 5 years out
CBT - exposure

• Exposure and response prevention
• Habituation
  - Hang in there until anxiety subsides!
• Like scratching an itch – the more you do it, the more you will want to do it
SSRI Use in Anxiety Disorders

- CAMS
  - Multicenter RCT
  - 3 active treatment groups plus placebo group

At 12 weeks:

- CBT > placebo (avg “dose” 171)
- Sertraline > placebo (avg dose 141)
- Combination > all (avg dose 131)
CAMS - Conclusion

- CBT and sertraline both work, combo of the two has superior response rate
Fluoxetine: Mixed Anxiety Disorders

- N = 74 (37 fluoxetine, 37 placebo), ages 7-17
- Diagnoses: Generalized Anxiety Disorder, Social Phobia and/or Separation Anxiety
- Dose = 20 mg, 12 weeks
- 61% of fluoxetine vs. 35% placebo were much improved or very much improved

Birmaher et al, 2003
SSRI use in “anxiety”

• POTS
  o 112 subjects
  o 12 weeks
  o Similar outcomes, with CBT and sertraline superior to placebo in efficacy, and combination superior to all, but rates of clinical remission did not follow these patterns exactly (for remission, combined > CBT > sertraline > placebo)
  o Mean dose in combined treatment arm: 133 mg / day sertraline
  o Mean dose in medication only treatment arm: 170 mg /day

• Conclusion

  Youth with OCD should begin with CBT or CBT plus SSRI
Other Anxiety Medications

• Duloxetine
  o 1 RCT for GAD
  o 272 patients, ages 7-17
  o Showed statistically significant improvement in symptoms compared w/ placebo

MA Rynn et al, 2007; Strawn et al 2015
Medications - anxiolytics

- **Antihistamines**
  - No recent controlled trials in kids
  - Hydroxyzine approved anxiety treatment in adults
  - Use for short term insomnia, anticipatory anxiety

- **Benzodiazepines**
  - Avoid if at all possible – a temporary measure that often leads to dependence
  - If using, limit to 2 weeks or less, at low dose, while getting a more long-term treatment (such as SSRI) started
Medications

- SSRI – best evidentiary support. First line medication
- SNRI – second line
- Hydroxyzine
- Benzodiazepines (use with extreme caution)
Monitoring for response

- Follow up measures
  - SCARED
- Subjective report
- Collateral informants (school, parents)
- Overall functional status
Duration of Treatment

- Obtain relief
- Stability for 1 year
- Consider taper
  - During a low stress period
  - Re-initiate SSRI (or SNRI) if symptoms recur
- Some patients may require chronic treatment

Connelly et al. (2007).
References


