CHILDHOOD/ADOLESCENT ANXIETY DISORDERS: EVALUATION AND TREATMENT

PHILIP L. BAESE, MD
ASSISTANT PROFESSOR OF PSYCHIATRY
CHIEF, DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
UNIVERSITY OF UTAH, SCHOOL OF MEDICINE
DEPARTMENT OF PSYCHIATRY

DESCRIPTIVE TERMS

‘Fear’ – Adaptive Anxiety:

- Rational response to a real/perceived danger or threat
- Fight or Flight sympathetic activation
- CNS on alert > problem-solving and survival
- Accurate cognitive processing and coping

DESCRIPTIVE TERMS

Maladaptive 'Anxiety':

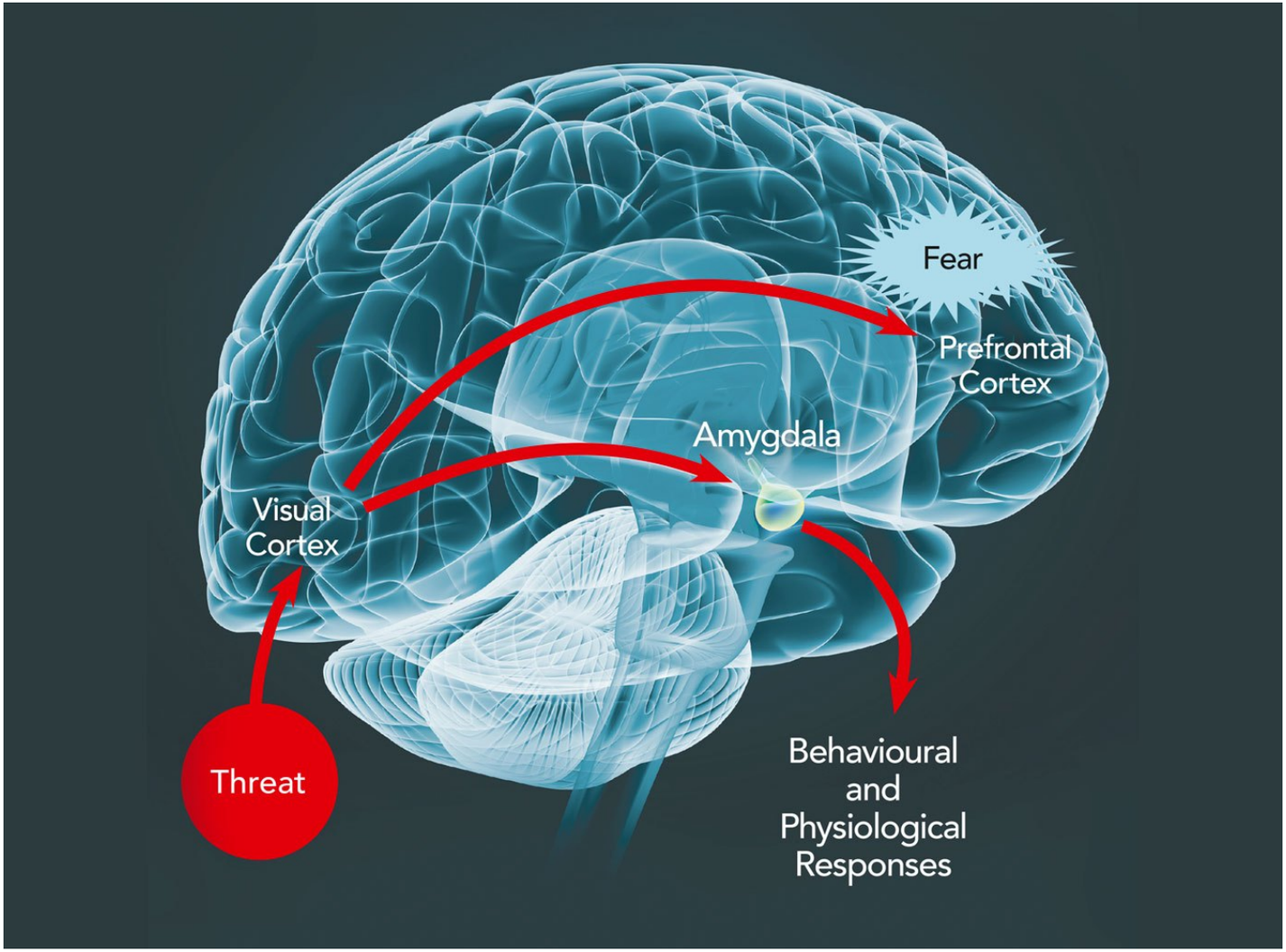
- Irrational response in an actual absence of danger or threat
- Fight or flight sympathetic activation (excessive)
- CNS on alert > distress/dysfunction
- Distorted cognitive processing that impairs function

DESCRIPTIVE TERMS

Avoidance:

- Coping strategy to avoid threat or danger > adaptive
- Coping strategy to avoid ‘anxiety’ > maladaptive

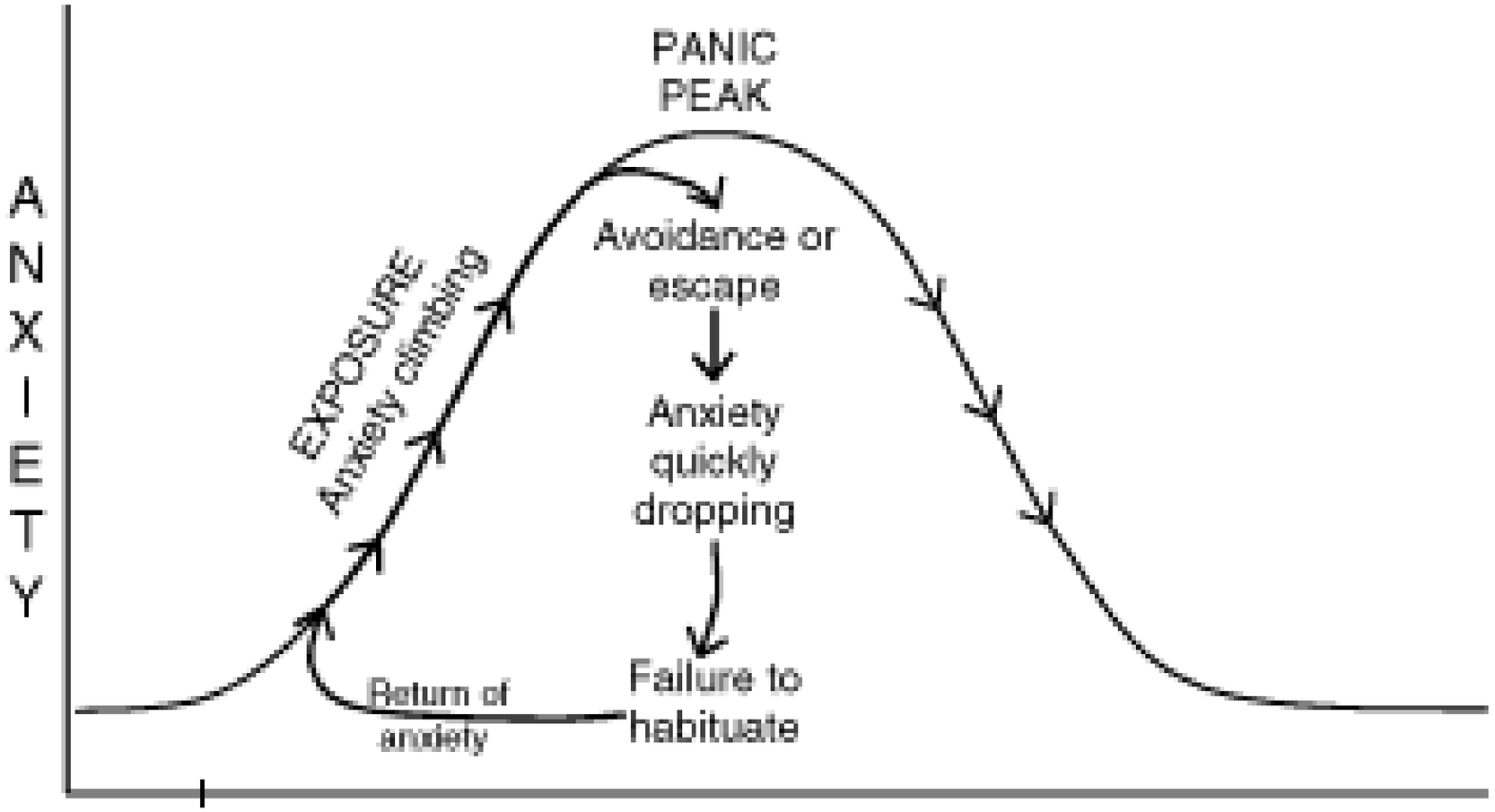
NEUROANATOMY



FEAR/ANXIETY IN HUMANS

- Well functioning anxiety/fear responses are adaptive/protective
- Anxiety heightens cognitive alertness and focuses attention on environmental cues that indicate possible threats
- Excessive anxiety response that over-attributes danger/threat when none exists leads to dysfunction – acute or chronic distress/paralysis/withdrawal and functional impairment

VICIOUS CYCLE OF AVOIDANCE



AGE NORMATIVE FEARS

- Infants: fears of being dropped/normal separation anxiety 8-14 months
- Toddlers: fears of imaginary creatures/darkness
- Early School Age (5-6 y/o): worries about physical well being (injury/kidnapping)
- School Age: worries about school performance, behavioral competence, peer rejection, health, illness
- Adolescence and beyond: worries about social competence, social evaluation, psychological well-being

ANXIETY DISORDERS IN CHILDREN

- 'Internalizing' Disorders – meaning difficult to consistently observe - 'tip of the iceberg' is observable
- Most common class of mental disorders
- Underdiagnosed
- Difficult to quantify degree of dysfunction, but can be substantially impairing across key environments – home/school/peers

PREVALENCE OF CHILDHOOD ANXIETY DISORDERS

- 5-18% of under 18 year olds with 10% having 'severe' functional impairment – school absenteeism/family disruption/etc.
- Age differences in types of anxiety
- Younger Children (<10 years): Separation Anxiety Disorder/Specific Phobia/Selective Mutism
- Adolescents: Social Phobia/Panic Disorder
- Young Adult onward: Generalized Anxiety

DSM-V DISORDER CLASSIFICATION

- Lifespan grouping plus specifiers; OCD and PTSD are excluded
- Panic attacks are now a specifier for any DSM-V diagnosis...
  - Separation Anxiety Disorder
  - Selective Mutism
  - Specific Phobia
  - Social Anxiety Disorder
  - Panic Disorder
  - Agoraphobia
  - Generalized Anxiety Disorder
  - Substance/Medication Induced Anxiety Disorder
  - Anxiety Disorder due to another Medical Condition

OTHER WAYS TO CATEGORIZE ANXIETY…

- **Stimulus-provoked (situational) anxiety**
  - Specific phobias
  - Social anxiety disorder
  - Separation anxiety disorder

- **Stimulus-unprovoked anxiety**
  - Panic disorder
  - Generalized anxiety disorder

- **Other with prominent anxiety**
  - Obsessive Compulsive Disorder
  - Post-traumatic Stress Disorder

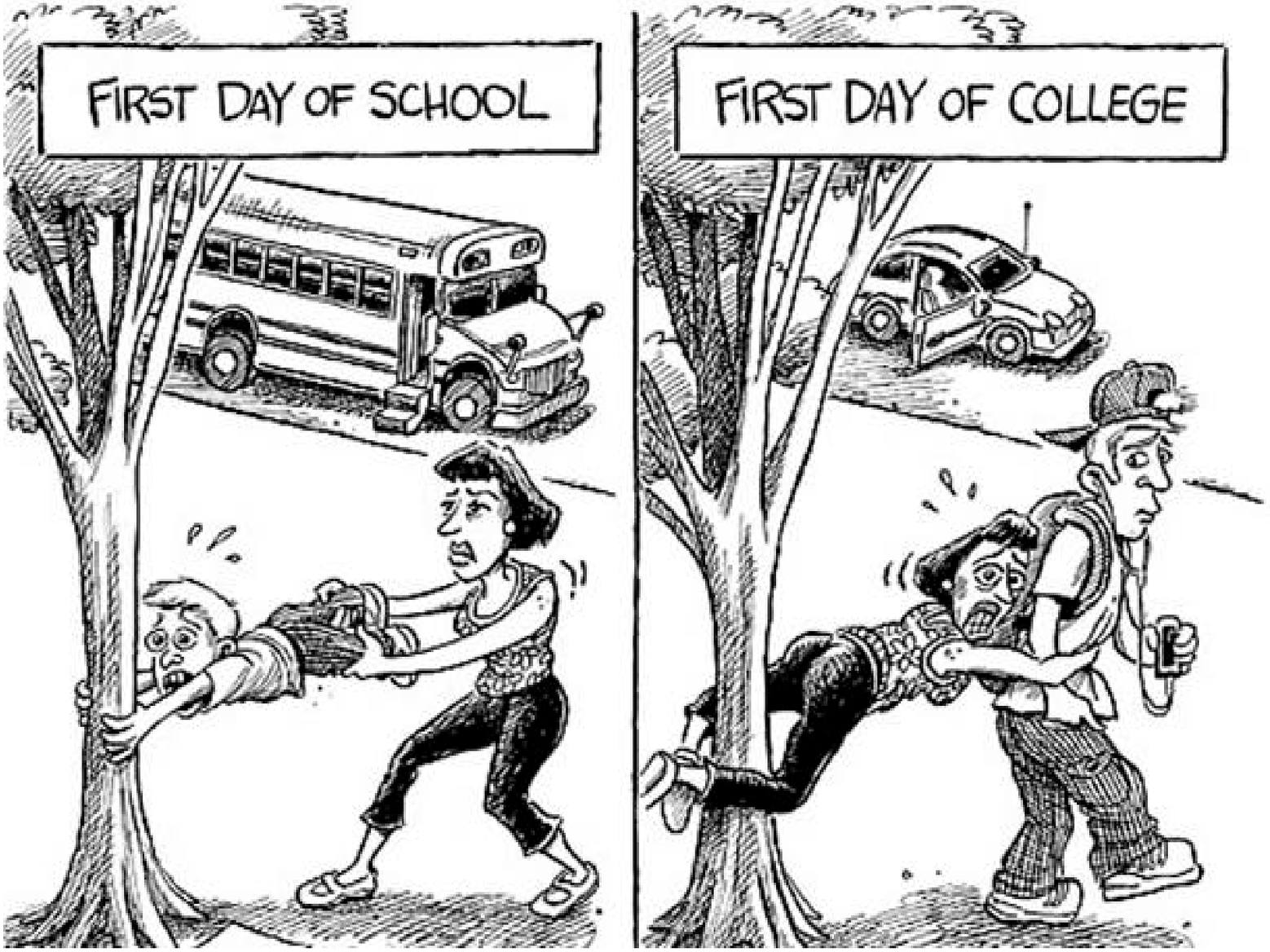
MULTIFACTORIAL ETIOLOGY

Individual models/Family models

- Genetic (familial aggregation)
- Fear circuitry aberration (physiologic reactivity)
- Cognitive processing (temperament)
- Defense mechanisms (psychodynamic)
- Familial genetic stress diatheses
- Trauma exposure/threat-vigilance

SEPARATION ANXIETY DISORDER

- Constant thoughts/intense fears about the safety of parents/caretakers
- Refusing to go to school
- Frequent stomach aches or other physical complaints
- Extreme worries about sleeping away from home
- Being overly clingy
- Panic or tantrums at times of separation from parents
- Trouble sleeping or nightmares



OTHER KEY DIAGNOSTIC CRITERIA

B. The duration of the disturbance is at least 4 weeks.

C. The onset is before age 18 years.

D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

SOCIAL ANXIETY DISORDER
(PREVIOUSLY SOCIAL PHOBIA)

- Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation), being observed (e.g., eating or drinking), or performing in front of others (e.g., giving a speech).
- The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (e.g., be humiliated, embarrassed, or rejected) or will offend others.
- Avoidance of social situations
- Few friends outside of family

SCREENING TOOLS FOR CHILDHOOD ANXIETY

- **Beck Anxiety Inventory**
  - 21 items on a 0-3 Likert scale
  - 0-21 (low anxiety)
  - 22-35 (moderate anxiety)
  - >36 (cause for concern)
- Free
- Not specific for anxiety disorder type

SCREENING TOOLS FOR CHILDHOOD ANXIETY

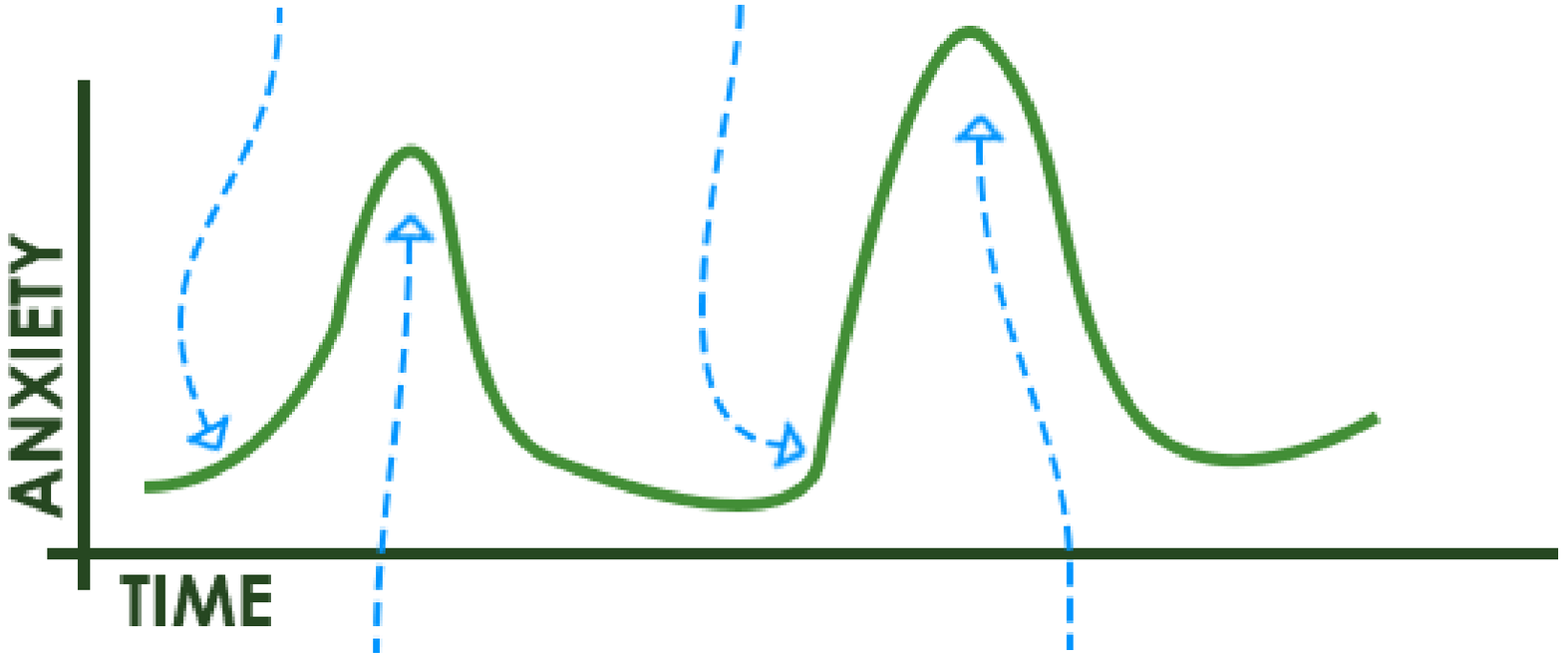
- **SCARED** – Screen for Anxiety Related Disorders (Child and Parent forms)
  - 41 item screen
  - Item specific thresholds for:
    - Panic/Somatic symptoms
    - Generalized Anxiety Disorder
    - Separation Anxiety Disorder
    - Social Anxiety Disorder
    - School Avoidance

TREATMENT OF ANXIETY

- Multimodal approach
  - Parent/child interaction
  - School personnel input
  - Degree of impairment
  - Child participation
- Cognitive Behavioral Therapy
- Medication
- Combination

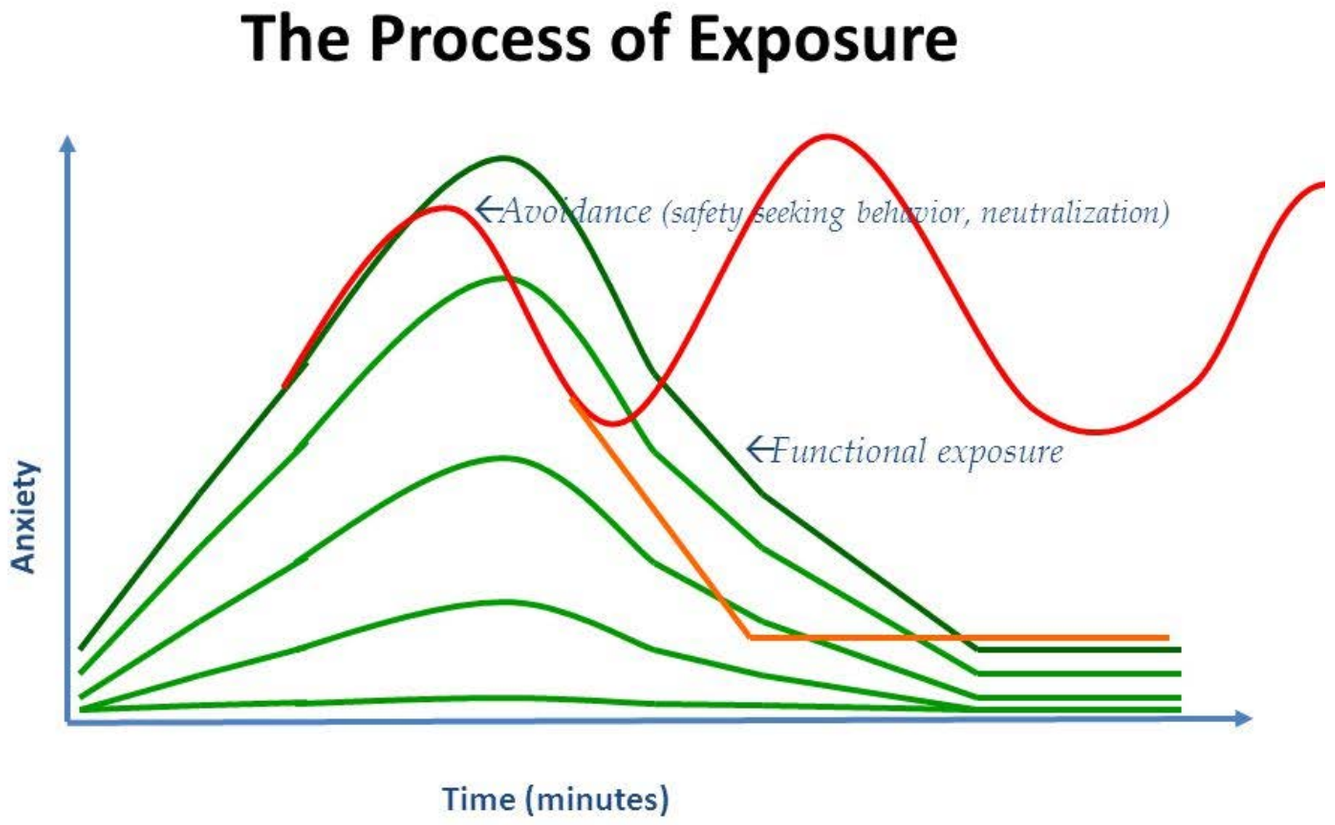
ANXIETY AND AVOIDANCE

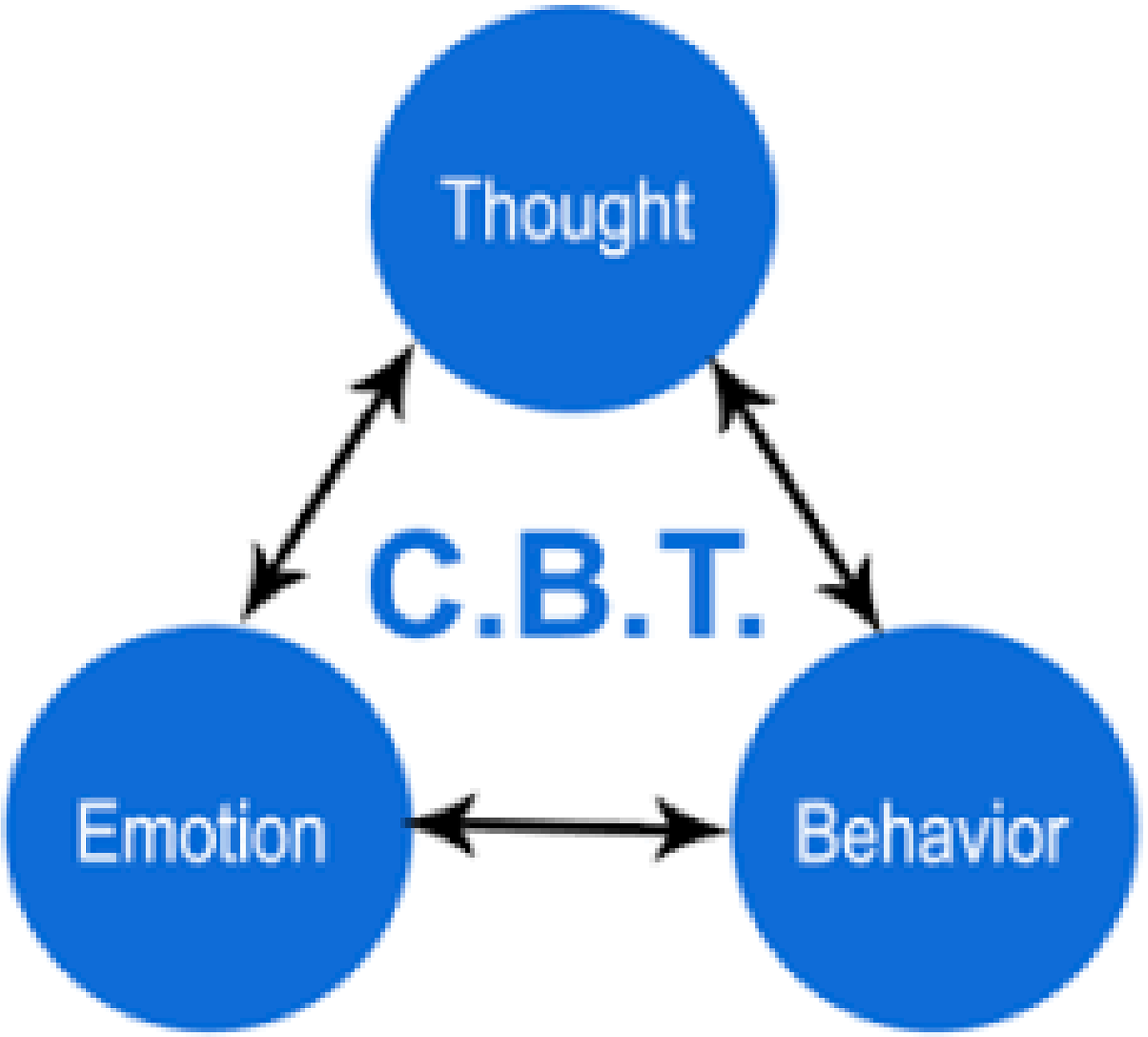
(A person is confronted with an anxiety-producing situation which leads to an uncomfortable sense of worry and agitation.)



(The anxiety-producing situation is avoided, and the person receives a feeling of relief. However, next time the anxiety will be worse.)

CBT

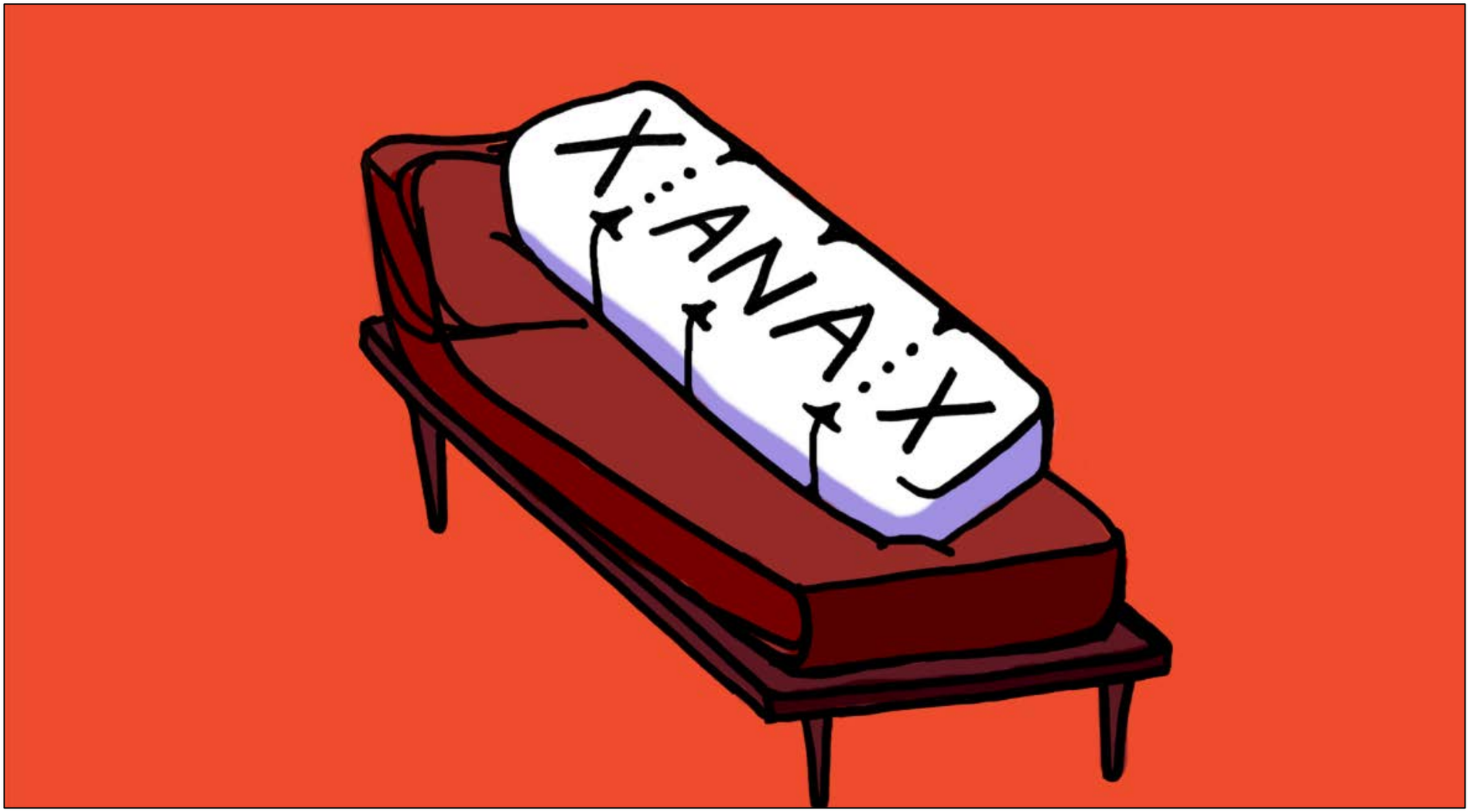




COMPONENTS OF CBT

- Psycho-education
- Skills building
- Exposure therapy
- Adequate exposure to an anxiety inducing stimulus will ultimately lead to reduction of symptoms (the cure to anxiety is through it, not around it)

PSYCHOPHARMACOLOGY



PSYCHOPHARMACOLOGY

- **Acute symptomatic treatment**
  - Antihistamines (diphenhydramine/hydroxyzine) can be helpful – careful of paradoxic responses in young children and habituation
  - Benzodiazepines – with caution
  - Propranolol can be helpful for performance/phobia issues
- **Longer-term treatment**
  - SSRI's/SNRI's for most
  - Other agents in refractory/severe cases (anticonvulsants/atypical antipsychotics

SSRI'S / SNRI'S FOR CHILDHOOD ANXIETY

Medication	FDA Approval	Starting Dose	Usual Dose Range	Maximal Daily Dose
Citalopram	No	5-10 mg/d	20-40 mg/d	40 mg/d
Escitalopram	Yes – 12up/MDD	2.5-5 mg/d	5-20 mg/d	30 mg/d
Fluoxetine	Yes – 8 up/MDD; 7/up OCD	5-10 mg/d	10-40 mg/d	60 mg/d
Fluvoxamine* *bid dosing	Yes – 8 up/OCD	25-50 mg/d	50-200 mg/d	300 mg/d
Sertraline	Yes – 6 up/OCD	12.5-25 mg/d	25-100 mg/d	200 mg/d
Duloxetine	Yes – 7 up/GAD	30 mg/d	30-60 mg/d	120 mg/d

BENZODIAZEPINE USE IN CHILDREN

- Use cautiously for short-term/acute treatment
  - Until SSRI is effective and CBT skills are in place (1- 3 months typical)

- Review side-effect risks
  - Misuse/abuse/diversion
  - Sedation/paradoxic disinhibition
  - Impaired judgment
  - Altered sleep

- What about diazepam (Valium)/alprazolam (Xanax)?
  - Use with caution – more cognitive effects with diazepam
  - Alprazolam helps panic, but is consistently problematic to use

Benzodiazepine	Pediatric Dosing
Clonazepam (Klonopin)	0.25 mg to 4 mg/d divided 2-3X
Lorazepam (Ativan)	0.125 mg to 2 mg/day divided 3-4X

OTHER MEDICATION CONSIDERATIONS…

- Clonidine at low doses prior to sleep can be helpful
- Gabapentin at low doses prior to sleep and judicious daytime use can be helpful
- Avoid use of atypical antipsychotic class as a first line for sleep; d/t metabolic and other SE risks, reserve for the most difficult to treat/refractory situations
- Keep therapy (CBT) ongoing and always in conjunction with medications for most robust response

OTHER POINTS FOR BENZODIAZEPINE USE

- Not approved by FDA for use in children
- Tolerance and withdrawal, including risk of seizure if not tapered slowly
- Drug-drug interactions, especially problematic with recreational drug use – alcohol in adolescents
- Impairment if adolescent who drives
- Can be problematic for work – positive drug screens, etc.

TREATMENT PHASES

- Acute symptom control (panic/sleep disruption)
- Maintenance of response and functional improvement
- Prevention of recurrence
- Termination of treatment
- Monitoring off of treatment