Assessing and Treating Pediatric Anxiety

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OHSU

OHSU MENTAL HEALTH

Oregon Psychiatric Access Line (OPAL)

Available to all prescribing clinicians regardless of patient insurance status

Do you have a mental health, developmental, or behavioral question about your patient? Want immediate access to a psychiatrist or developmental behavioral pediatrician? Call the OPAL Program to consult with a board-certified psychiatrist or developmental behavioral pediatrician. Psychiatry sub-specialists are available in Child and Adolescent Psychiatry, Substance Use Disorders, Women's and Perinatal Mental Health, and Older Adult Mental Health.

Immediate telephone consultation is available to all medical providers in Oregon. No question is too big or too small.

About the OPAL Program

In collaboration with the Oregon Health Authority, OHSU administers the Oregon Psychiatric Access Line (OPAL) Program which offers psychiatric telephone consultation to all prescribing clinicians, regardless of the age or the insurance status of the patient. The OPAL program is funded by the state of Oregon and is available at no cost to all medical providers in Oregon. True to its mission to expand services, OPAL has now expanded our team of consultants to include developmental behavioral pediatricians (DBPs).

The ongoing vision of this program is to expand the availability of high-quality mental health treatment to all Oregonians through the support of their medical home via:

- Timely psychiatric and developmental/behavioral phone consultation...
- Practitioner education
- Primary care treatment algorithms
- Promotion of linkages with private and public community mental health professionals

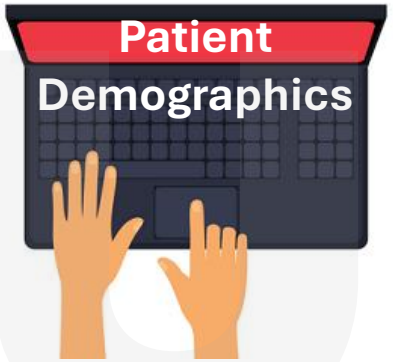
Register online at www.ohsu.edu/OPAL

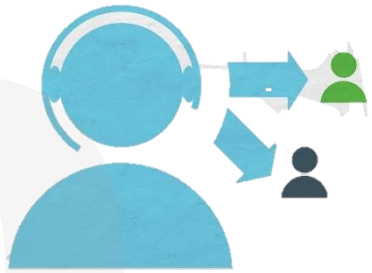
Call toll free at 855-966-7255 Monday to Friday 9 am to 5 pm

How it Works

Open
9 - 5
Excluding most national holidays

Call OPAL





Call is transferred to OPAL consultant

Consultant writes summary

Office staff send summary

I have no disclosures to make

Learning Objectives

Describe the symptoms and behaviors associated with pediatric anxiety disorders.

Review how to assess for anxiety disorders in children and adolescents including commonly used screening instruments.

Review evidence-based treatments for pediatric anxiety disorders.

Anxiety Disorders in Childhood

- Common
- Significant impairment
- Risk factor for other disorders

Screening for Anxiety in Children and Adolescents
US Preventive Services Task Force Recommendation Statement

Summary of Recommendations

Population	Recommendation	Grade
Children and adolescents aged 8 to 18 years	The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years.	B
Children 7 years or younger	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for anxiety in children 7 years or younger.	I

See the Practice Considerations section for additional information regarding the I statement. USPSTF indicates US Preventive Services Task Force.

POPULATION: Children and adolescents 18 years or younger who do not have a diagnosed anxiety disorder or are not showing recognized signs or symptoms of anxiety.

Broad Categories of Anxiety

Broad Categories of Anxiety

- Trauma-Related
  - Acute Stress Disorder
  - Posttraumatic Stress Disorder

- Obsessive Compulsive Disorder

- Non-Trauma or OCD Related Anxiety Disorders

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- Trauma-Related
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Non-Trauma or OCD Related Anxiety Disorders

- Separation Anxiety Disorder
- Social Phobia
  - Selective Mutism
- Generalized Anxiety Disorder
- Specific Phobia
- Panic Disorder with or without Agoraphobia

Manifestation of Anxiety at Different Ages

- Preschool: Defiance, tantrums, crying
- School-age: Somatic complaints, school refusal
- Adolescence: Avoidance

Anxiety Disorders – Age of Onset

Selective mutism - < age 5

Separation anxiety/specific phobias – ~ age 7

School refusal – age 5-6 and 10-11

Generalized anxiety disorder - ~age 7

Social anxiety disorder - early adolescence

Panic disorder - later adolescence

Causative Factors

- Environmental Factors
  - Modeling and competition in the family
  - Critical and over-controlling parenting
- Biological Factors
  - Genetic predisposition
  - Respiratory dysregulation

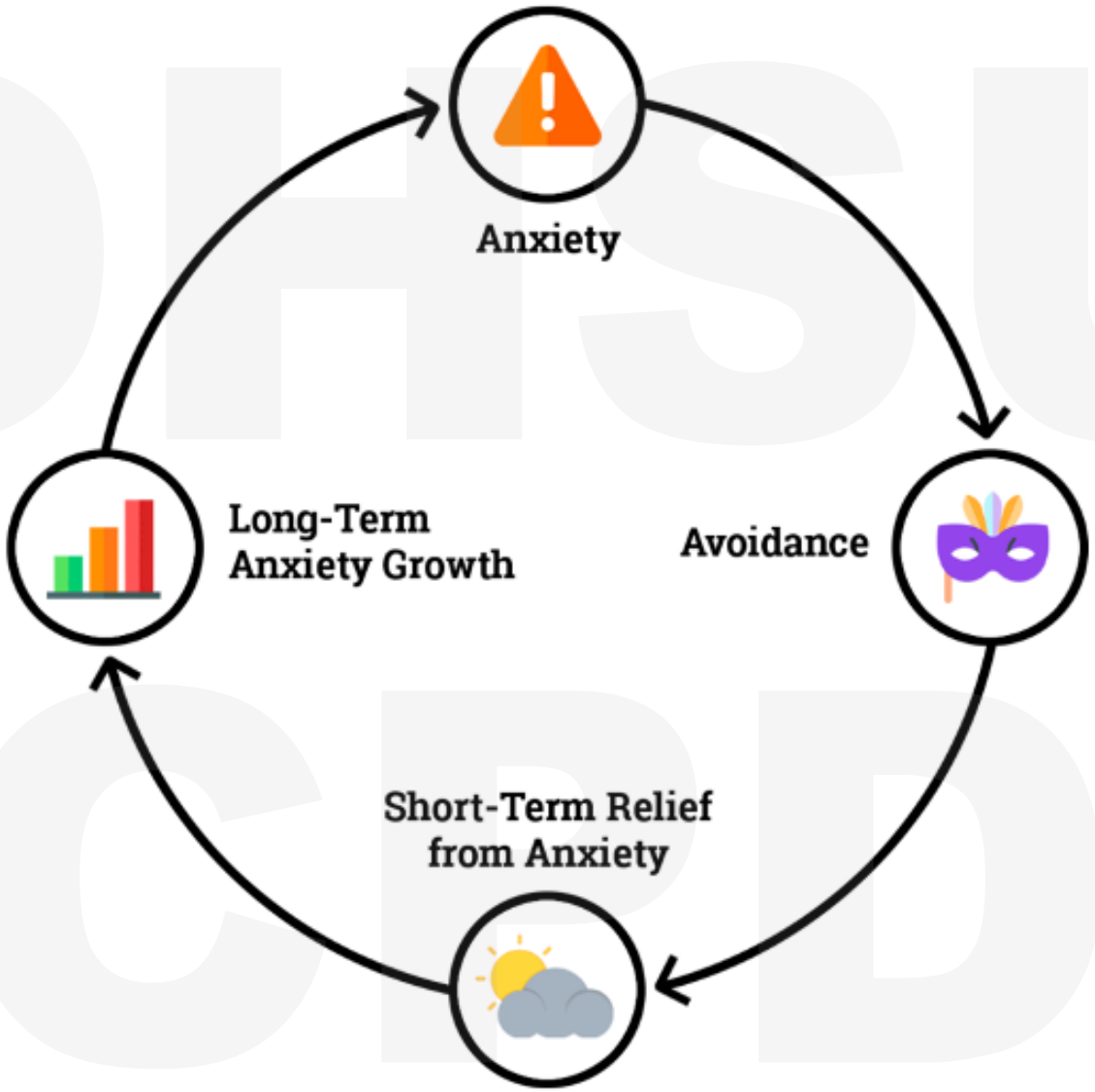
Psychological Factors

Overachiever

Cognitive Biases

- Preferential attention to perceived threatening cues

Conditioning Happens!


Anxiety
Avoidance
Short-Term Relief
from Anxiety
Long-Term
Anxiety Growth

Assessment

- Interview of parents
- Interview of child
- Collateral information from teachers
- Consider co-morbid psychiatric conditions

Assessment

Consider medical conditions

- Substance use disorder in teenagers
- Eating disorder
- Endocrine disorder
- Sleep disorder

Ask about trauma early in the assessment

SCARED (Parent and Child Report)

8 and older

SCORING AND INTERPRETATION

- Total Score ≥ 25 is considered positive

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

Screen for Child Anxiety Related Disorders (SCARED)
Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name: _____

Date: _____

Directions:
Below is a list of statements that describe 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 the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe.	○	○	○
2. My child gets headaches when he/she is at school.	○	○	○
3. My child doesn't like to be with people he/she doesn't know well.	○	○	○
4. My child gets scared if he/she sleeps away from home.	○	○	○
5. My child worries about other people liking him/her.	○	○	○
6. When my child gets frightened, he/she feels like passing out.	○	○	○
7. My child is nervous.	○	○	○
8. My child follows me wherever I go.	○	○	○
9. People tell me that my child looks nervous.	○	○	○
10. My child feels nervous with people he/she doesn't know well.	○	○	○
11. My child gets stomachaches at school.	○	○	○
12. When my child gets frightened, he/she feels like he/she is going crazy.	○	○	○
13. My child worries about sleeping alone.	○	○	○
14. My child worries about being as good as other kids.	○	○	○
15. When he/she gets frightened, he/she feels like things are not real.	○	○	○
16. My child has nightmares about something bad happening to his/her parents.	○	○	○
17. My child worries about going to school.	○	○	○
18. When my child gets frightened, his/her heart beats fast.	○	○	○
19. He/she gets shaky.	○	○	○
20. My child has nightmares about something bad happening to him/her.	○	○	○

Rating Scales

- SCARED – 5 Item

Anxiety (SCARED, 5-item) in Children/Youth

Then, for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

---

1. I get really frightened for no reason at all.
   ◯ **Not true or hardly ever true** (0.0) ◯ **Somewhat true or sometimes true** (1.0) ◯ **Very true or often true** (2.0)

2. I am afraid to be alone in the house.
   ◯ **Not true or hardly ever true** (0.0) ◯ **Somewhat true or sometimes true** (1.0) ◯ **Very true or often true** (2.0)

3. People tell me that I worry too much.
   ◯ **Not true or hardly ever true** (0.0) ◯ **Somewhat true or sometimes true** (1.0) ◯ **Very true or often true** (2.0)

4. I am scared to go to school.
   ◯ **Not true or hardly ever true** (0.0) ◯ **Somewhat true or sometimes true** (1.0) ◯ **Very true or often true** (2.0)

5. I am shy.
   ◯ **Not true or hardly ever true** (0.0) ◯ **Somewhat true or sometimes true** (1.0) ◯ **Very true or often true** (2.0)

Rating Scales – Preschool Anxiety Scale Revised

Subscale Scoring Items (sum of ratings)

OCD = 3 + 9 + 18 + 21 + 27

Social Anxiety = 2 + 5 + 11 + 15 + 19 + 23

Separation Anxiety = 6 + 12 + 16 + 22 + 25

Physical Injury Fears = 7 + 10 + 13 + 17 + 20 + 24 + 26

GAD = 1 + 4 + 8 + 14 + 28

Total Score Sum of Scores for Items = sum of 1 to 28

Question 29 is an open-ended, non-scored item relating to the child's experience of a traumatic event

Preschool Anxiety Scale Revised (PASR)

Child's name:	**Date:**
Your name:	**Your relationship to child:**

NOTE: Below is a list of items that describe children. For each item please circle the response that best describes your child. Use the scale below from not at all true to very often true. Please answer all the items as well as you can, even if some do not seem to apply to your child.

Not at all true	Seldom true	Sometimes true	Quite often true	Very often true
0	1	2	3	4

		Not at all	Seldom true	Some times	Quite often	Very often
1.	Has difficulty stopping him/herself from worrying	0	1	2	3	4
2.	Worries that s/he will do something to look stupid in front of other people	0	1	2	3	4
3.	Is afraid of doctors and/or dentists	0	1	2	3	4
4.	Is scared to ask an adult for help (e.g. a preschool or school teacher)	0	1	2	3	4
5.	Would be upset at sleeping away from home	0	1	2	3	4
6.	Is scared to heights (i.e. high places)	0	1	2	3	4
7.	Is afraid of meeting or talking to unfamiliar people	0	1	2	3	4
8.	Worries that something bad will happen to his/her parents	0	1	2	3	4
9.	Is scared of thunderstorms	0	1	2	3	4
10.	Is afraid of talking in front of the class/preschool group (e.g. show and tell)	0	1	2	3	4
11.	Worries that something bad might happen to him/her (e.g. getting lost or kidnapped), so he/she won't be able to see you again	0	1	2	3	4
12.	Is nervous of going swimming	0	1	2	3	4
13.	Worries that s/he will do something embarrassing in front of other people	0	1	2	3	4
14.	Is afraid of insect and/or spiders	0	1	2	3	4
15.	Becomes distressed about your leaving him/her at preschool or with a babysitter	0	1	2	3	4

Evidence-Based Treatment for Anxiety Disorders

- Psychoeducation
- Relaxation techniques
- Cognitive behavioral therapy (CBT)
- Supportive Parenting for Anxious Childhood Emotions (SPACE)
- SSRIs/SNRI

Education

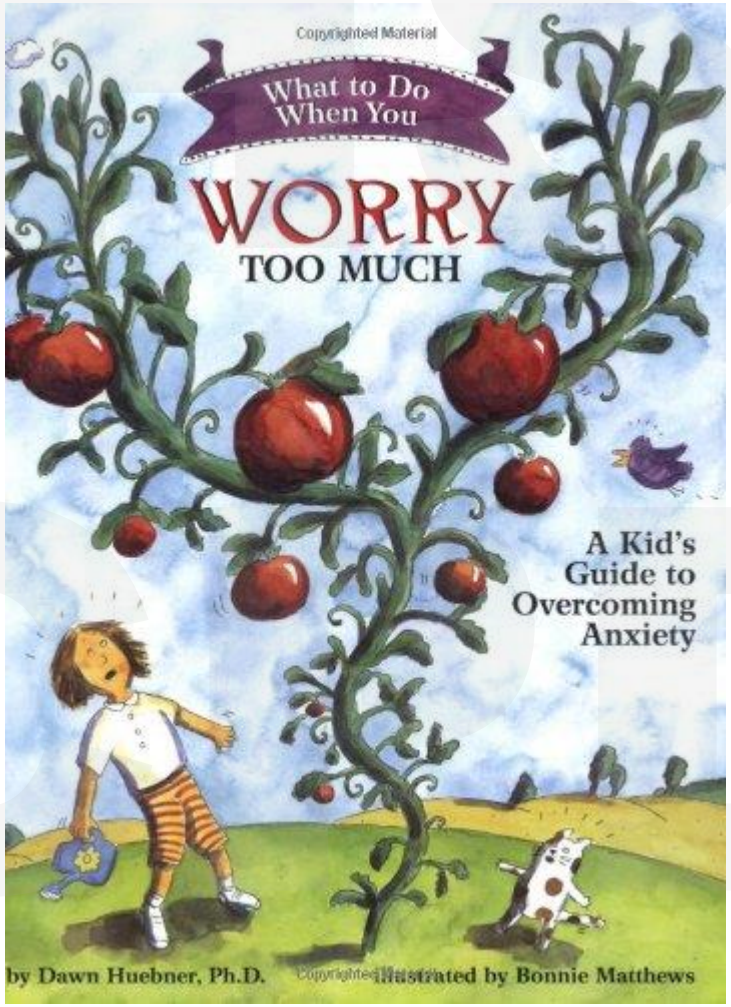
- “Fight, flight, or freeze”
- Anxiety Thermometer
  - Daily log of anxiety level, physical symptoms, triggers

If I avoid every scary thing
I can just stay home and be safe.

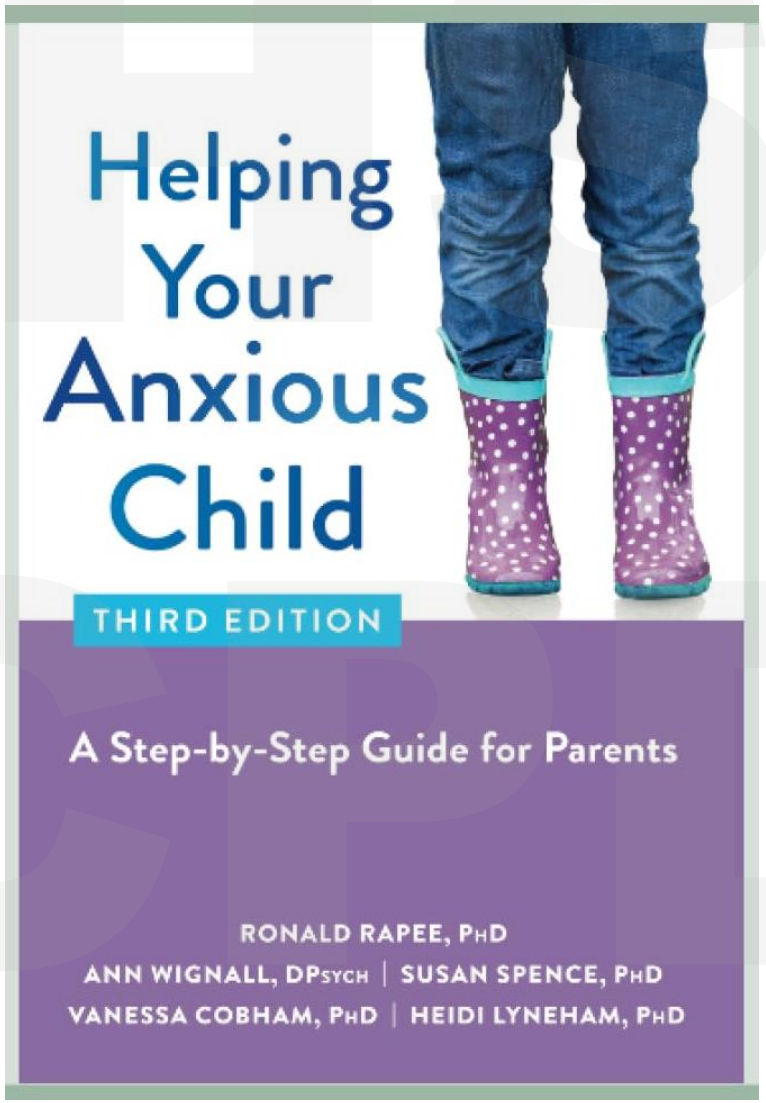
But it's not a great life strategy.

Exposure and Response Prevention

Handbook for Parents to Use



Excellent Book for Parents



The Role of Accommodation

THE WALL STREET JOURNAL.

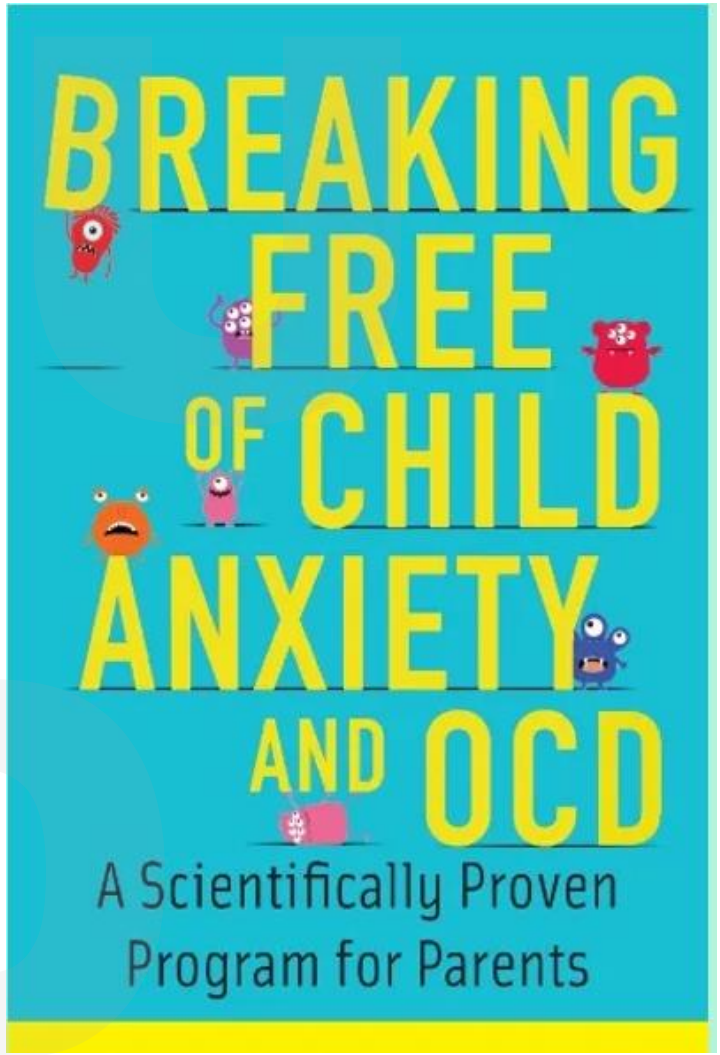
By Andrea Petersen Dec. 8, 2017 12:59 pm ET

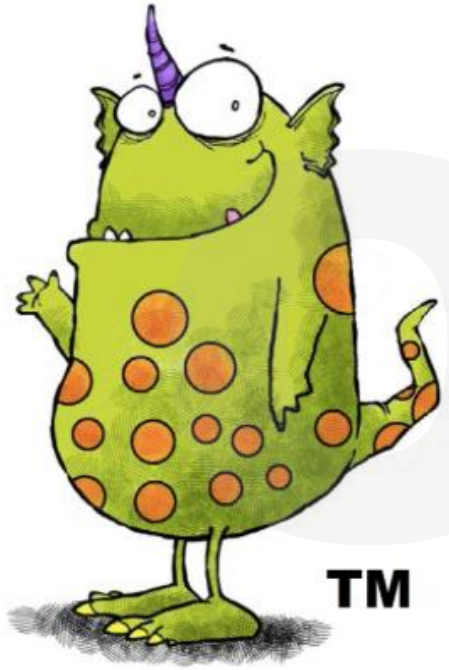
- Rescuing
- Avoiding
- Too Much Reassurance
- Over-Protecting

SPACE

- SPACE stands for Supportive Parenting for Anxious Childhood Emotions
- Parent-based treatment program for children and adolescents with anxiety, OCD, and related problems
- Found efficacious in RCTs

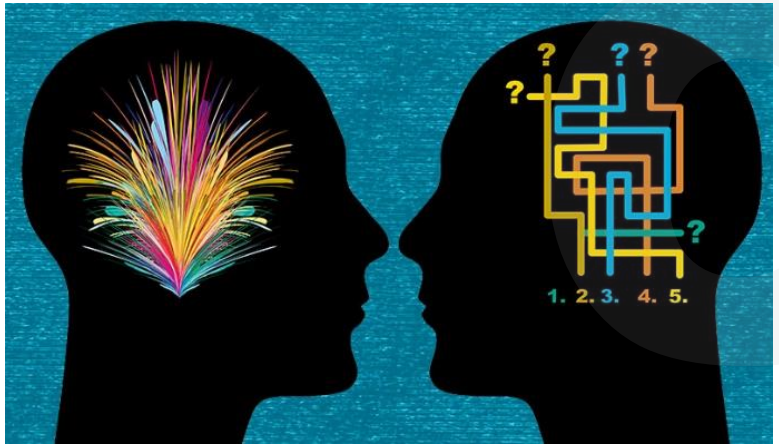
- www.spacetreatment.net



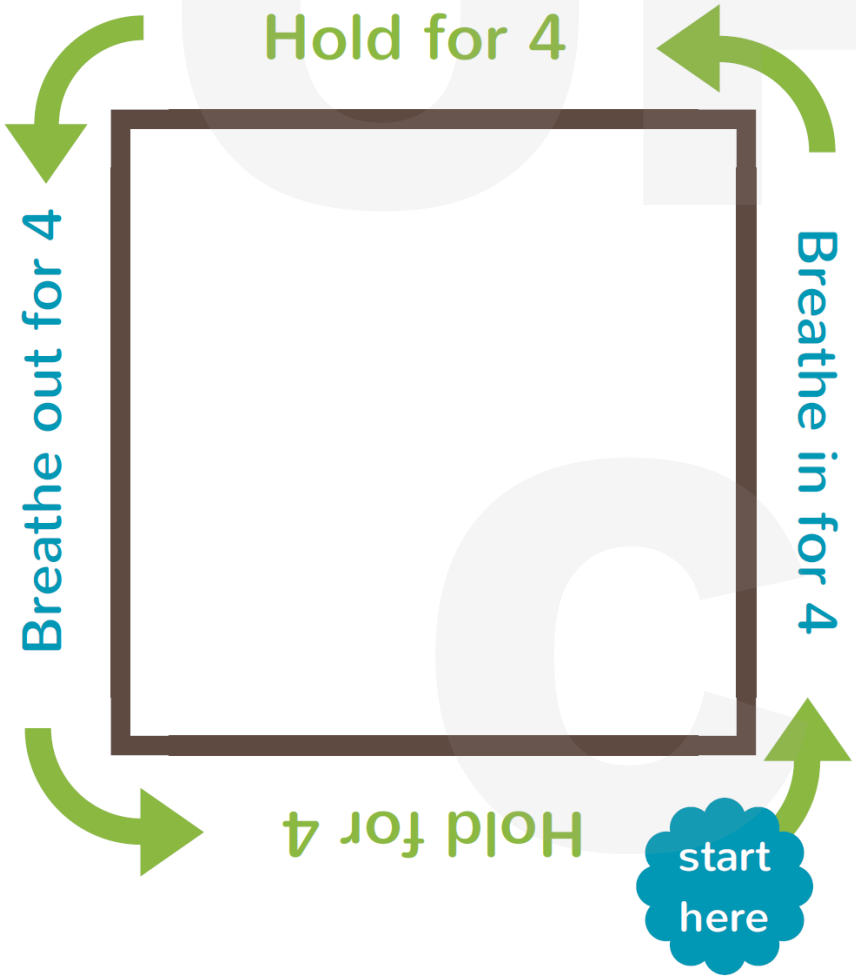


Externalizing the Problem

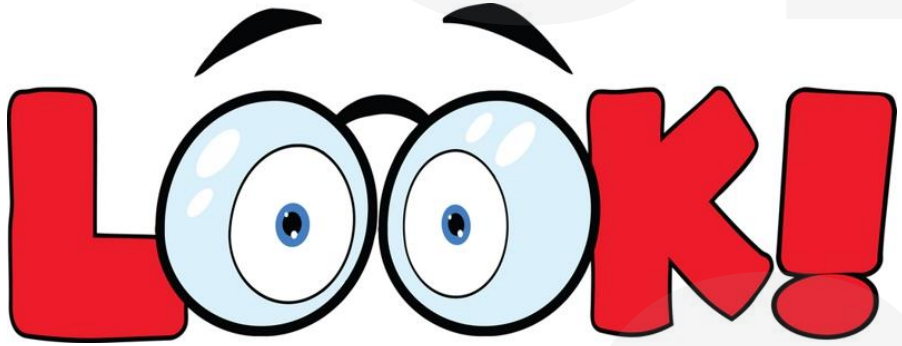
- The power of language
  - “the dragon or the worry bully”
  - Older children and adolescents
    - Thinking brain and emotional brain

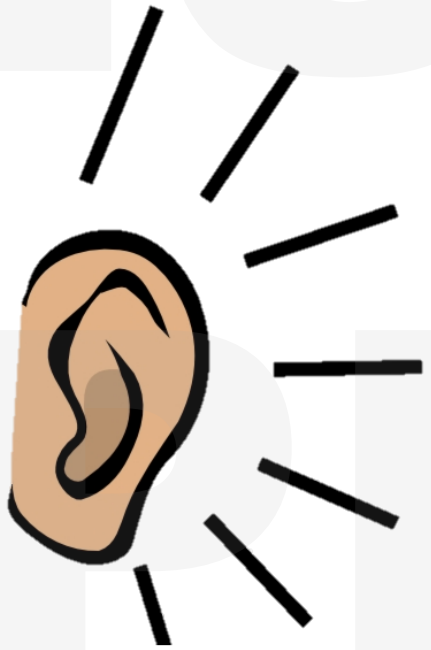


Relaxation Techniques



3 3 3 Rule





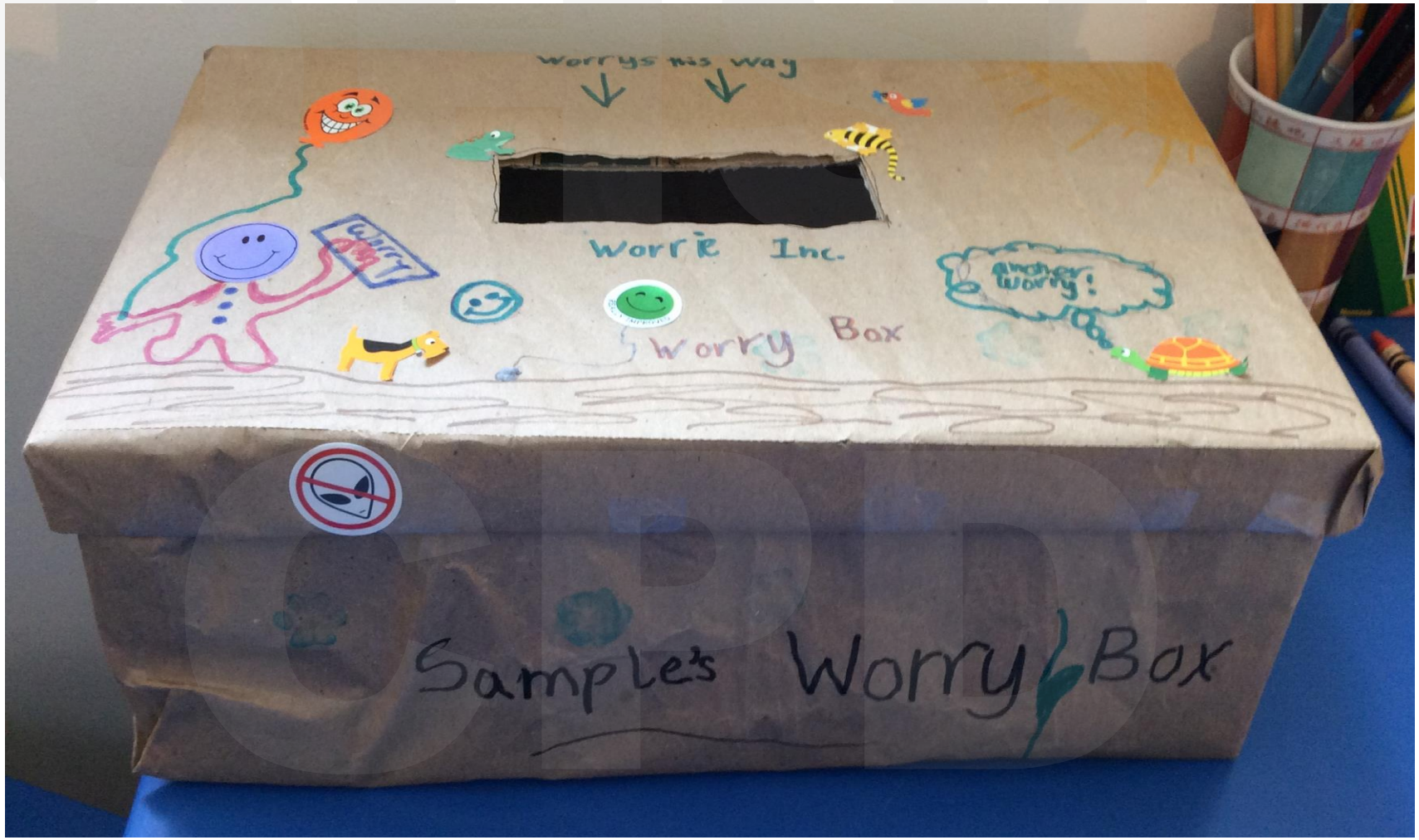
Other Ways to Lower Stress Level

- Exercise
- Progressive muscle relaxation
- Guided imagery

Worry Time

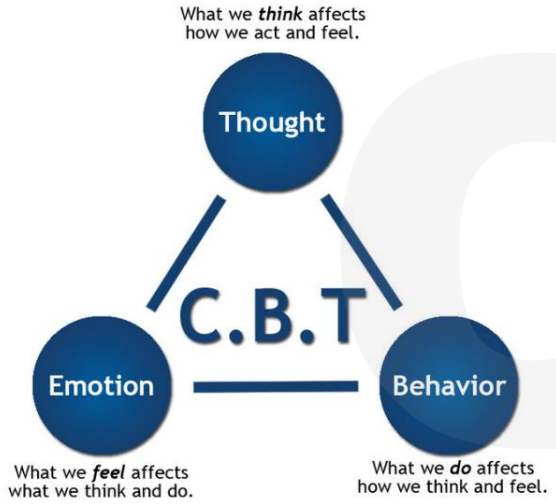
- Set aside 15 minutes each day
- Protected time from siblings
- Review worries
- Leftover time is “Talk Time”

Worry Box


Worrys his way
Worrie Inc.
another worry!
Worry Box
Sample's Worry Box

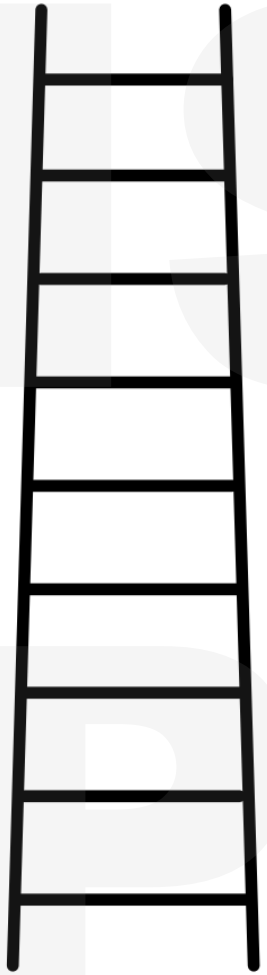
Challenging Unhelpful Thoughts

- Cognitive restructuring
  - Changing thoughts rather than feelings



The fear that I am facing is _____

Big fear or worry = 10



Situation	Anxiety 0-10

Little fear or worry = 0

Fear Ladder worksheet

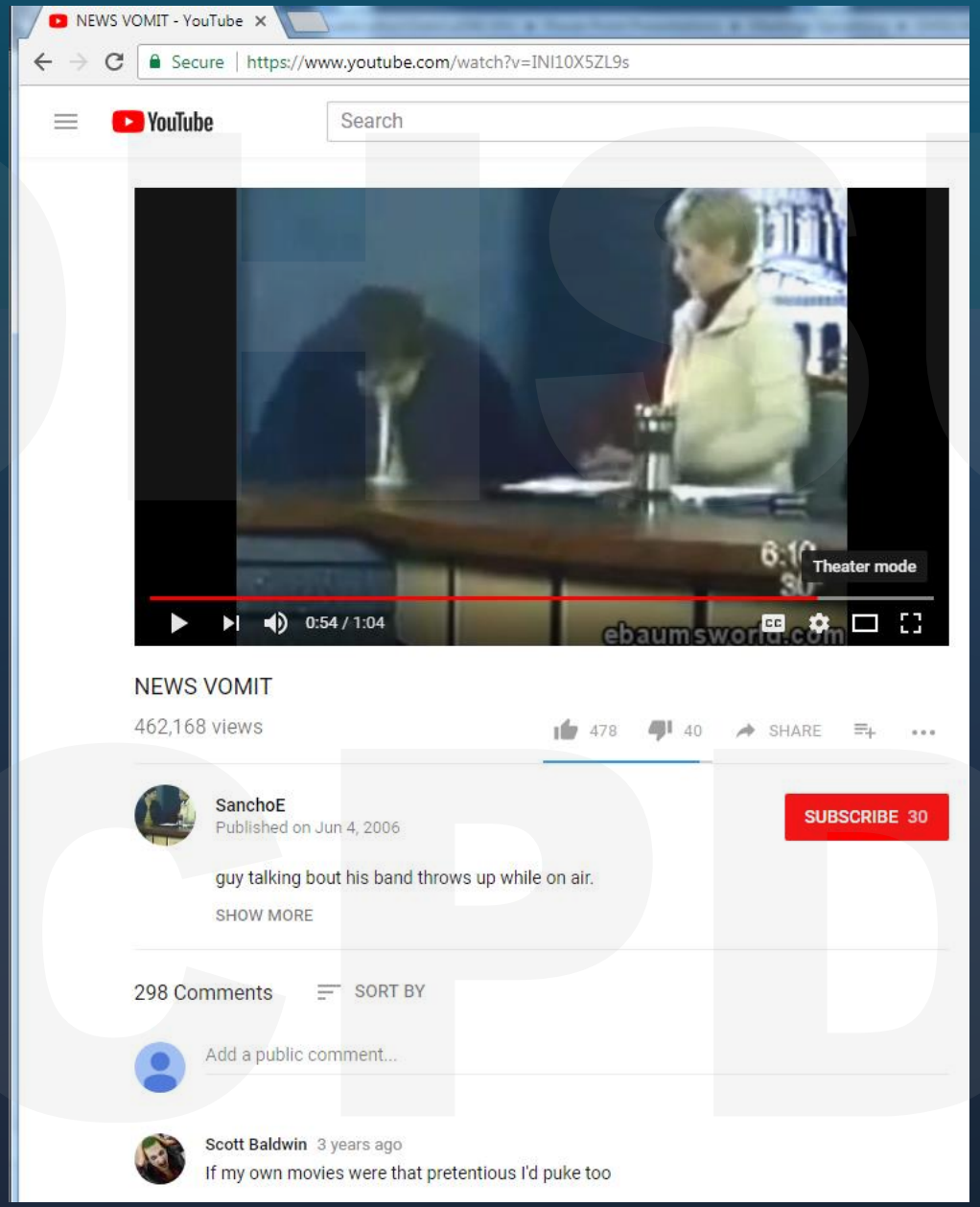
Exposure

Help child discover that the feared situation is not dangerous

Different forms of exposure

- Imaginal
- In vivo

Specific Phobia to Vomit/Vomiting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462,168 views
478
40
SHARE
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Published on Jun 4, 2006
SUBSCRIBE 30
guy talking bout his band throws up while on air.
SHOW MORE
298 Comments
SORT BY
Add a public comment...
Scott Baldwin 3 years ago
If my own movies were that pretentious I'd puke too

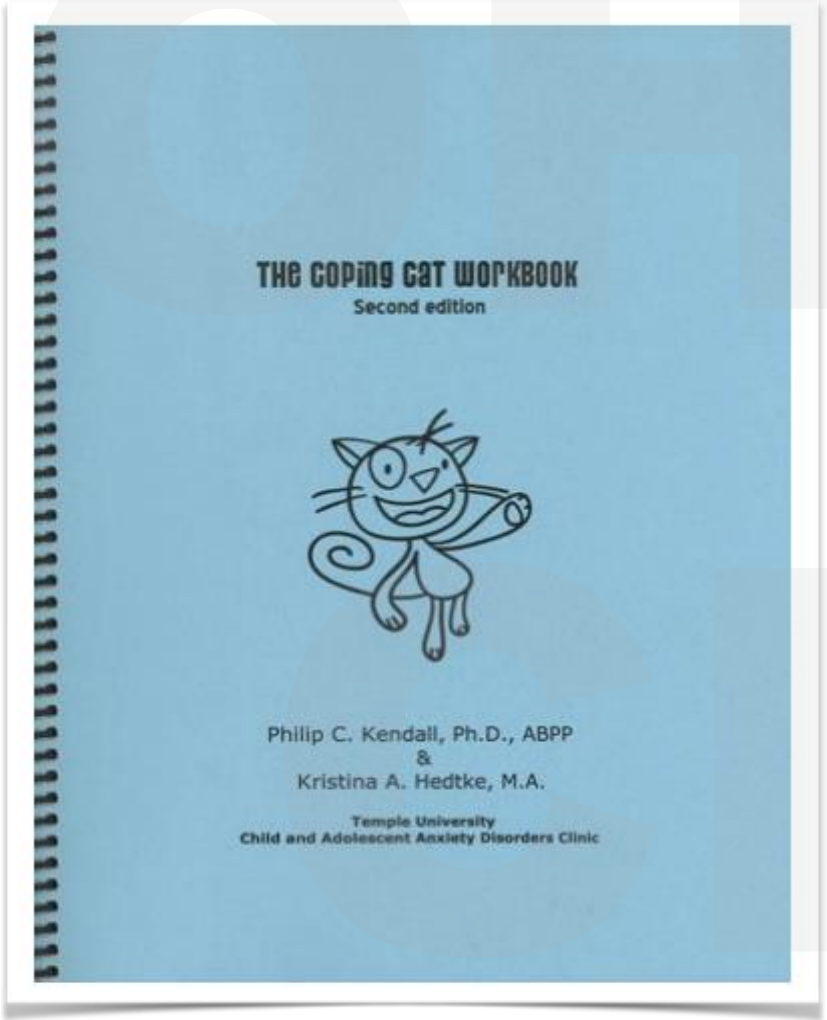
How to Find a CBT Therapist

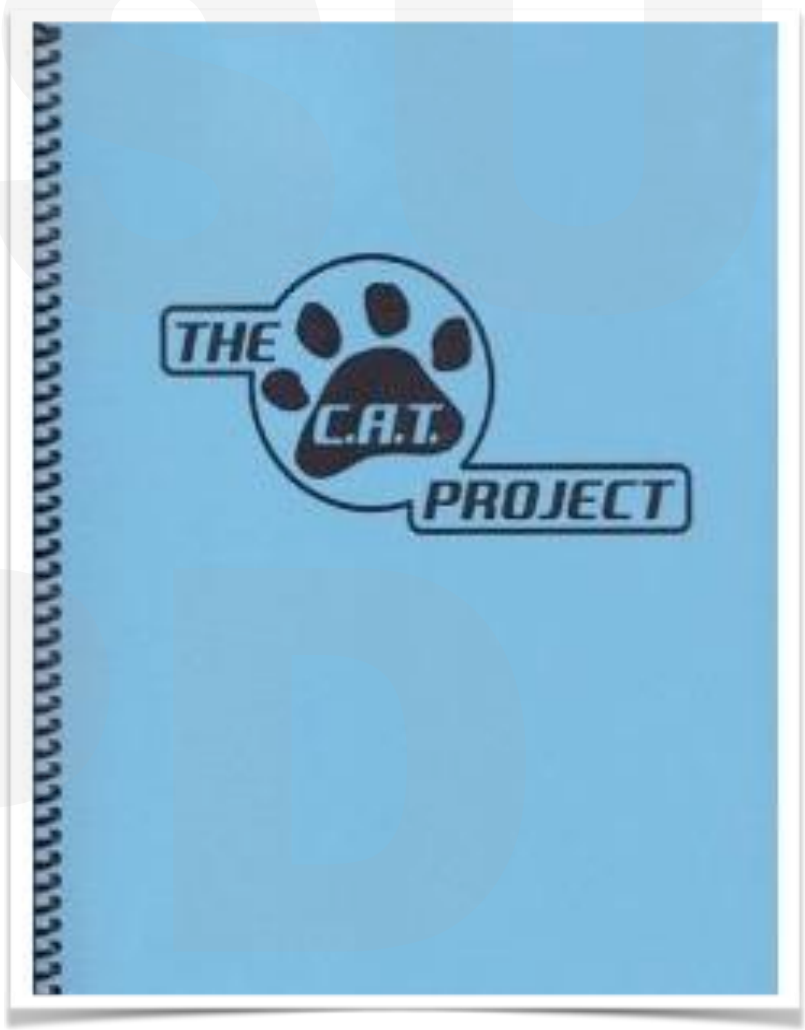
- www.abct.org lists cognitive behavioral therapists by state
- www.opa.org lists psychologists and their specialty

Online Therapy Options

- Talk Space down to 12 years old – www.talkspace.com
- Array down to 5 years old – www.arraybc.com
- Charlie Health – www.charliehealth.com
- NOCD – www.treatmyocd.com

Workbooks Used by CBT Therapists





Pharmacotherapy for Pediatric Anxiety Disorders

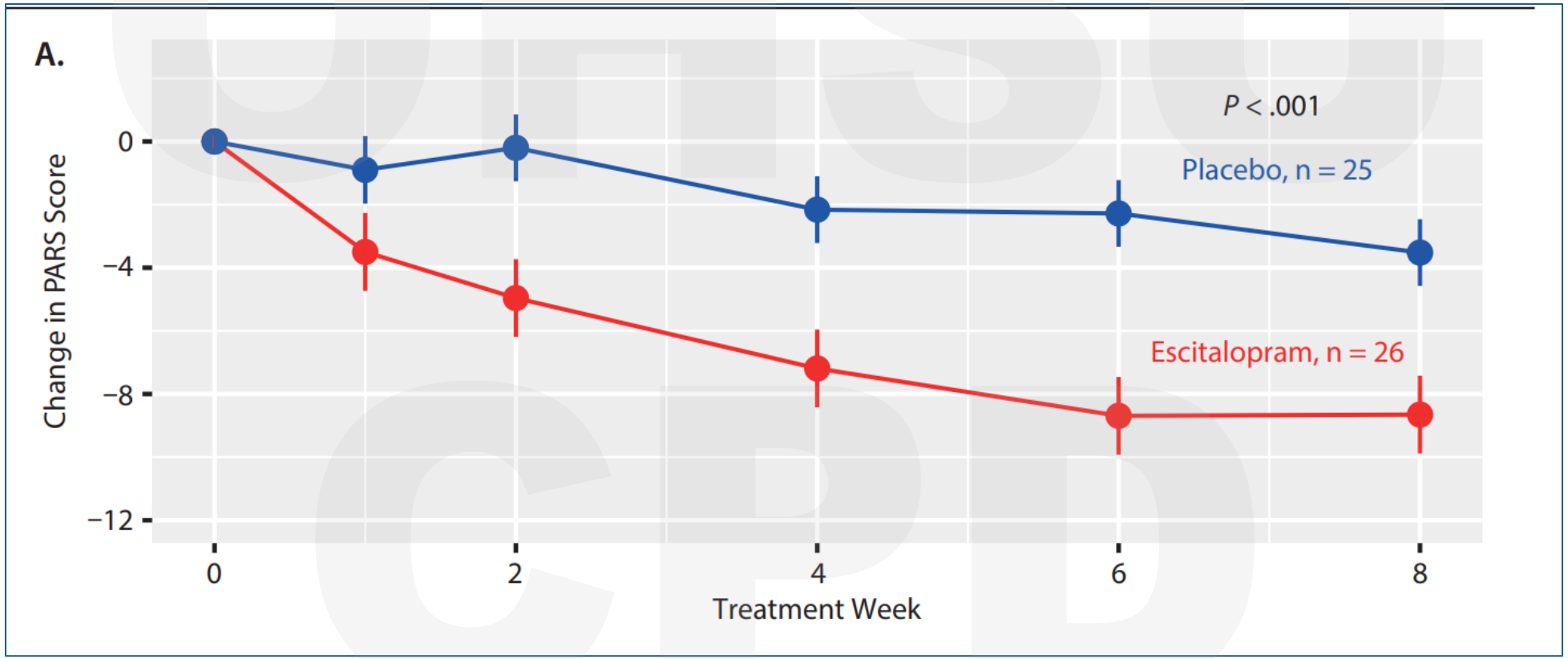
Two Medicines are FDA approved for Non-OCD Anxiety Disorders in Youth

- Duloxetine
- Escitalopram

- Mean duloxetine dose was 53.6 mg
- Last prescribed dose for duloxetine patients during acute phase treatment was:
  - 30 mg (27.4%)
  - 60 mg (30.4%)
  - 90 mg (29.6%)
  - 120 mg (12.6%)

Strawn JR, et al. J Am Acad Child Adolesc Psychiatry 2015;54(4):283-293

Escitalopram now FDA Approved to Treat GAD



Strawn JR, et al. J Clin Psychiatry 2020;81.5. https://doi.org/10.4088/JPC.20m13396

JOURNAL OF CHILD AND ADOLESCENT PSYCHOPHARMACOLOGY
Volume 33, Number 3, 2023
Mary Ann Liebert, Inc.
Pp. 91–100
DOI: 10.1089/cap.2023.0004

Original Articles

Open camera or QR reader and scan code to access this article and other resources online.

A Multicenter Double-Blind, Placebo-Controlled Trial of Escitalopram in Children and Adolescents with Generalized Anxiety Disorder

Jeffrey R. Strawn, MD,[1–3] Leslie Moldauer, MD, MBA,[4] Rebekah D. Hahn, PhD,[4] Alexandria Wise, PhD,[4] Kristina Bertzos, PhD,[4] Beth Eisenberg, PhD,[4] Edward Greenberg, MD,[5] Chengcheng Liu, PhD,[6] Mallika Gopalkrishnan, MD,[6] Molly McVoy, MD,[7,8] and James A. Knutson, MD[9]

- Multi-site (33 sites), 8 week trial, 7-17 y/o subjects with GAD
- Flexibly dosed escitalopram (10-20 mg)
- Escitalopram superior to placebo and well-tolerated

FLUVOXAMINE FOR THE TREATMENT OF ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS

THE RESEARCH UNIT ON PEDIATRIC PSYCHOPHARMACOLOGY ANXIETY STUDY GROUP*

- 8 week, DB PCT
- N=128, ages 6-17 years
  - Social anxiety disorder, GAD, separation anxiety disorder
- Flexible dosing used with max dose of 250 mg in < 12 y/o's and 300 mg in 12-17 y/o's

NEJM, 2001, 344(17):1279-1285

FLUVOXAMINE FOR THE TREATMENT OF ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS

THE RESEARCH UNIT ON PEDIATRIC PSYCHOPHARMACOLOGY ANXIETY STUDY GROUP*

- Outcome measures: Pediatric Anxiety Rating Scale (PARS) and Clinical Global Improvement Scale (CGI)

- Results:
  - Fluvoxamine > placebo (76% vs 29%)
  - Generally well-tolerated
  - Significant side effects: abdominal discomfort and increased motor activity

NEJM, 2001, 344(17):1279-1285

Fluoxetine

- Single site, 12-week study, double blind
  - Fluoxetine 20 mg or placebo
- N=64, ages 7-17 years
- Outcomes: CGI, PARS, SCARED
- Results:
  - Fluoxetine > placebo (61% vs 35%)
  - Did not separate until 9th week of trial

Birmaher, J Am Acad Child Adolesc Psychiatry 2003, 42(4)

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 25, 2008 VOL. 359 NO. 26

Cognitive Behavioral Therapy, Sertraline, or a Combination in Childhood Anxiety

John T. Walkup, M.D., Anne Marie Albano, Ph.D., John Piacentini, Ph.D., Boris Birmaher, M.D., Scott N. Compton, Ph.D., Joel T. Sherrill, Ph.D., Golda S. Ginsburg, Ph.D., Moira A. Rynn, M.D., James McCracken, M.D., Bruce Waslick, M.D., Satish Iyengar, Ph.D., John S. March, M.D., M.P.H., and Philip C. Kendall, Ph.D.*

Methodology

- 12-week, multi-site, DB PCT
- N=488, ages 7-17 years (mean age 10.7 +/- 2.8)
- GAD, separation anxiety disorder, social anxiety disorder or combination
- Comorbidities allowed including ADHD on stimulant medications

Walkup et al, NEJM 2008, 359(26):2754-2766

Randomized to One of 4 Arms

- Sertraline (N=133)
  - Fixed-flexible dosing schedule (25 to 200 mg)
- Medication placebo (N=76)
- CBT (N=139)
  - 14 one-hour sessions using Coping Cat
- CBT and sertraline (N=140)
  - Subjects knew they were receiving active sertraline in this group

Walkup et al, NEJM 2008, 359(26):2754-2766

Outcome Measures

- Categorical and dimensional ratings of anxiety severity and impairment at baseline and at 4, 8, and 12 weeks
  - CGI, PARS, and the Children's Global Assessment Scale (CGAS)

Walkup et al, NEJM 2008, 359(26):2754-2766

Results

- Very much or much improved on CGI
  - Combination therapy – 80.7%
  - CBT – 59.7%
  - Sertraline – 54.9%
  - Placebo – 23.7%
- Combination superior to either monotherapy (P<0.001)

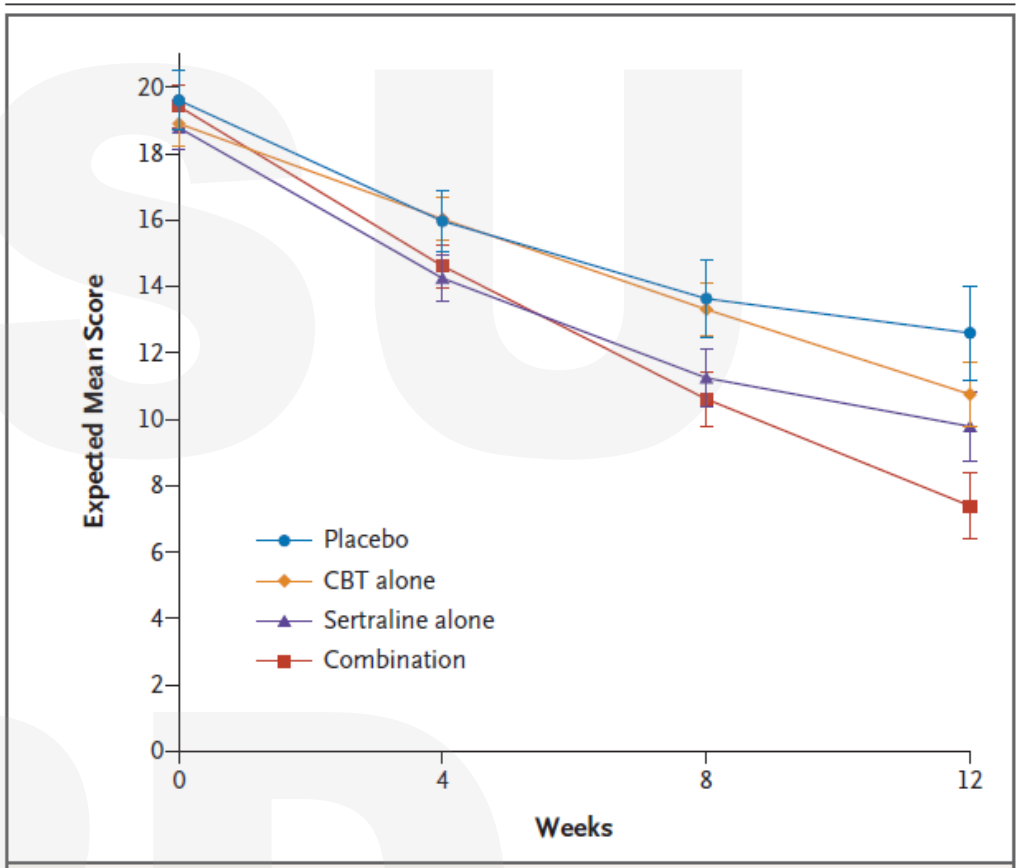


Figure 2. Scores on the Pediatric Anxiety Rating Scale during the 12-Week Study.

Scores on the Pediatric Anxiety Rating Scale range from 0 to 30, with scores higher than 13 consistent with moderate levels of anxiety and a diagnosis of an anxiety disorder. The expected mean score is the mean of the sampling distribution of the mean. The I bars represent standard errors.

Walkup et al, NEJM 2008, 359(26):2754-2766

Adverse Events

- No increase in suicidal or homicidal ideation when sertraline used
- No child attempted suicide
- Among children in CBT group, there were fewer reports of insomnia, fatigue, sedation, and restlessness or fidgeting than in the sertraline group

Walkup et al, NEJM 2008, 359(26):2754-2766

NEW RESEARCH

Check for updates

The Impact of Antidepressant Dose and Class on Treatment Response in Pediatric Anxiety Disorders: A Meta-Analysis

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Objective: To determine the trajectory and magnitude of antidepressant response as well as the effect of antidepressant class and dose on symptomatic improvement in pediatric anxiety disorders.

Method: Weekly symptom severity data were extracted from randomized, parallel group, placebo-controlled trials of selective serotonin reuptake inhibitors (SSRIs) and selective serotonin–norepinephrine reuptake inhibitors (SNRIs) in pediatric anxiety disorders. Treatment response was modeled for the standardized change in continuous measures of anxiety using Bayesian updating. Posterior distributions for each study served as informative conjugate prior to distributions update subsequent study posteriors. Change in symptom severity was evaluated as a function of time, class and, for SSRIs, standardized dose.

Results: Data from 9 trials (SSRIs: n = 5; SNRIs, n = 4) evaluating 7 medications in 1,673 youth were included. In the logarithmic model of treatment response, statistically, but not clinically, significant treatment effects emerged within 2 weeks of beginning treatment (standardized medication–placebo difference = −0.054, credible interval [CI] = −0.076 to −0.032, $p = .005$, approximate Cohen's $d \leq 0.2$) and by week 6, clinically significant differences emerged (standardized medication–placebo difference = −0.120, CI = −0.142 to −0.097, $p = .001$, approximate Cohen's $d = 0.44$). Compared to SNRIs, SSRIs resulted in significantly greater improvement by the second week of treatment ($p = .0268$), and this advantage remained statistically significant through week 12 (all p values <.03). Improvement occurred earlier with high-dose SSRI treatment (week 2, $p = .002$) compared to low-dose treatment (week 10, $p = .025$), but SSRI dose did not have an impact on overall response trajectory ($p > .18$ for weeks 1–12).

Conclusions: In pediatric patients with generalized, separation, and/or social anxiety disorders, antidepressant-related improvement occurred early in the course of treatment, and SSRIs were associated with more rapid and greater improvement compared to SNRIs.

Key words: selective serotonin reuptake inhibitor (SSRI, SRI), selective serotonin–norepinephrine reuptake inhibitor (SSNRI, SNRI), separation anxiety disorder (SAD), social phobia (SoP), generalized anxiety disorder (GAD)

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Having an anxiety disorder during childhood or adolescence—a critical neurodevelopmental period—results in devastating psychosocial morbidity.[1,2] Anxiety disorders during this period culminate in an increased risk for developing major depressive disorder,[3-5] secondary anxiety disorders,[6] and suicidality.[7] Importantly, pediatric anxiety disorders frequently respond to first-line psychopharmacologic treatments, including selective serotonin reuptake inhibitors (SSRIs) and selective serotonin–norepinephrine reuptake inhibitors (SNRIs).[8-10] To date, nearly all randomized controlled trials of these medications in pediatric patients with generalized, separation, and/or social anxiety disorders support their efficacy[11-18]; however, response varies among individual patients. Increased understanding of the time course of treatment response as well as the impact of specific antidepressant characteristics (including antidepressant class and dosing) on this response could substantially affect clinical practice. Furthermore, understanding the variability in antidepressant treatment response could inform the duration of treatment trials and may decrease uncertainty related to the typical course of antidepressant-related improvement for patients and their families.

Recent meta-analyses that leverage longitudinal data reveal clinically relevant findings regarding the time course of antidepressant treatment response and medication dose in adults with major depressive disorder (MDD)[19] and obsessive-compulsive disorder (OCD),[20,21] as well as in pediatric patients with these disorders.[22,23] These studies suggest that antidepressant-related improvement occurs early in the course of treatment in adolescents with MDD and OCD[22,23] and, in adults with MDD, higher SSRI dose is associated with a greater response.[19] However, in youth with anxiety disorders, the time course of antidepressant response and the effect of antidepressant dose or class on response trajectory and magnitude are unknown. Despite this, SSRIs (compared to SNRIs) have been recommended as first-line psychopharmacologic interventions for pediatric anxiety disorders,[24] and there is consensus that improvement may be dose related.[25] In fact, recommendations in the current AACAP Practice Parameters for the Treatment of Pediatric Anxiety Disorders are consistent with these beliefs: "clinicians should consider increasing SSRI doses for patients if significant improvement is not achieved by the fourth week of treatment."[25]

Although nearly all trials of SSRIs and SNRIs in anxious youth demonstrate the superiority of individual antidepressant treatments compared to placebo,[10] variability among individual clinical trials has precluded direct comparisons of SSRIs and SNRIs. However, our prior meta-analysis of antidepressants in pediatric patients with anxiety

Conclusions of this Meta-Analysis

1. Antidepressant-related improvement occurs early in treatment
   - ~ 50% of improvement at week 12 occurred by week 4
2. Greater trajectory and magnitude of SSRI response versus SNRIs
   - At week 8, SNRIs showed only 40% of treatment response of SSRIs
   - Difference in trajectory apparent by 2nd week of treatment
3. Earlier improvement with high-dose SSRI versus low-dose SSRI

"In pediatric patients with generalized, separation and/or social anxiety disorders, antidepressant-related improvement occurs early in the course of treatment and SSRIs are associated with more rapid and greater improvement compared to SSNRIs".

Strawn JR, et al. The impact of Antidepressant Dose and Class on Treatment Response in Pediatric Anxiety Disorders: A Meta-Analysis, J Am Academy of Child Adolesc Psychiatry 2018

Medications for Anxiety

Medication	Indication	Age	Comparable dose
Escitalopram (Lexapro)	GAD	7 - 17	5 mg
fluoxetine (Prozac)	OCD	7 - 17	10 mg
Sertraline (Zoloft)	OCD	6 – 13	25 mg
Fluvoxamine (Luvox)	OCD	8 – 17	35 mg
Duloxetine (Cymbalta)	GAD	7 - 17	?

Medications for Anxiety

Medication	Starting dose (child)	Starting dose (adol)	Increase by	Max dose
Escitalopram (Lexapro)	2.5 – 5 mg	5 – 10 mg	2.5 – 5 mg	20 mg
fluoxetine (Prozac)	5 mg	5 – 10 mg	5 – 10 mg	80 mg
Sertraline (Zoloft)	6.75 mg BID	12.5 mg BID	12.5 – 25 mg QD	200 mg
Fluvoxamine (Luvox)	12.5 - 25 mg	50 mg	25 – 50 mg	200-300 mg
Duloxetine (Cymbalta)	20 mg	20 – 30 mg	20 – 30 mg	120 mg

Starting Medication

Start low but don’t necessarily go slow

Titrate every 2 – 4 weeks

Improvement generally within 2 – 4 weeks

> 8 weeks, consider dose change


Paroxetine/Paxil
Venlafaxine/Effexor

How Long to Continue?

6 – 12 months after remission

What About…

Alpha-agonists (clonidine or guanfacine)

- Some evidence

Buspirone

- Not a lot of evidence

Hydroxyzine

- Insufficient evidence/Not recommended

Propranolol

- Insufficient evidence/Not recommended

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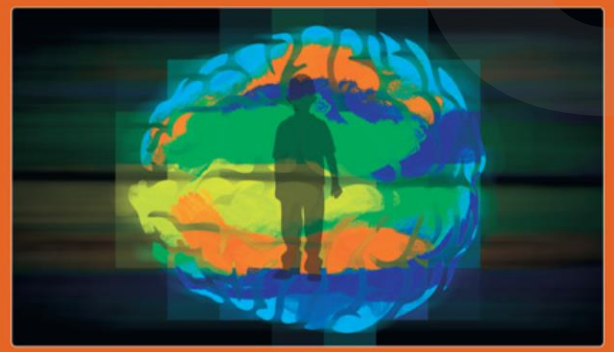

Advancing the science of pediatric mental health and promoting the care of youth and their families

AACAP OFFICIAL ACTION

Check for updates

Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders

Heather J. Walter, MD, MPH, Oscar G. Bukstein, MD, MPH, A. Reese Abright, MD, Helene Keable, MD, Ujjwal Ramtekkar, MD, MPE, MBA, Jane Ripperger-Suhler, MD, Carol Rockhill, MD, PhD, MPH

Anxiety disorders are among the most common psychiatric disorders in children and adolescents. As reviewed in this guideline, both cognitive-behavioral therapy (CBT) and selective serotonin reuptake inhibitor (SSRI) medication have considerable empirical support as safe and effective short-term treatments for anxiety in children and adolescents. Serotonin norepinephrine reuptake inhibitor (SNRI) medication has some empirical support as an additional treatment option. In the context of a protracted severe shortage of child and adolescent–trained behavioral health specialists, research demonstrating convenient, efficient, cost-effective, and user-friendly delivery mechanisms for safe and effective treatments for child and adolescent anxiety disorders is an urgent priority. The comparative effectiveness of anxiety treatments, delineation of mediators and moderators of effective anxiety treatments, long-term effects of SSRI and SNRI use in children and adolescents, and additional evaluation of the degree of suicide risk associated with SSRIs and SNRIs remain other key research needs.

Key Words: clinical practice guideline, anxiety, child psychiatry, assessment, treatment

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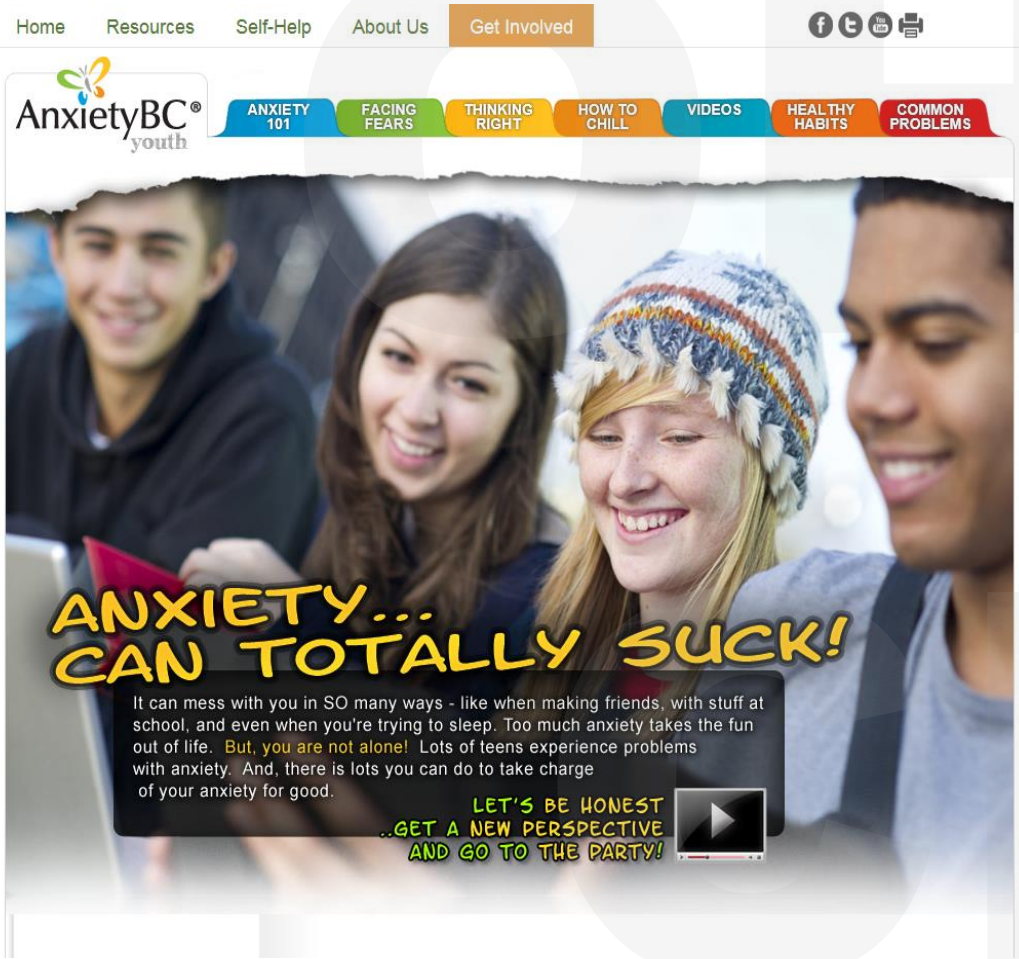
Some Resources



anxietycanada.com

https://childmind.org/topics/anxiety/

https://www.seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line/fast/

https://www.aacap.org/aacap/Families_and_Youth/Resource_Centers/Anxiety_Disorder_Resource_Center/Home.aspx

https://www.spacetreatment.net/

Other Resources

Portland Anxiety Clinic http://portlandanxietyclinic.com/

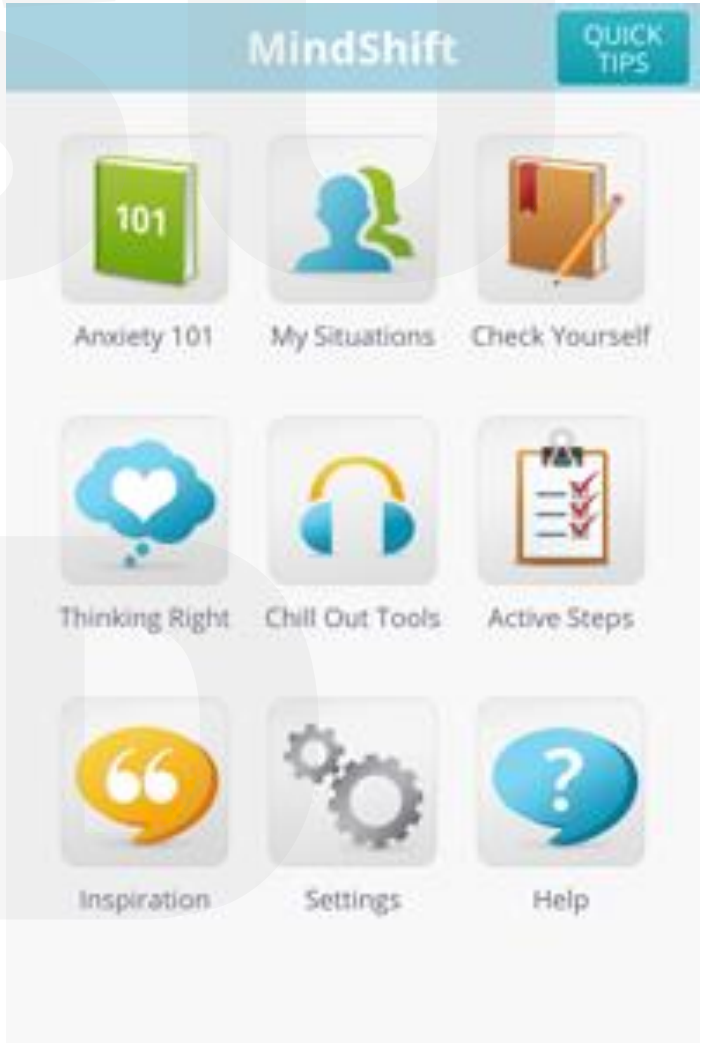
NW Anxiety Institute https://www.nwanxiety.com/

Portland Psychotherapy https://portlandpsychotherapy.com

Portland OCD and Anxiety Center
https://www.portlandocd.com/

Smartphone Apps

Calm



Conclusions

Psychoeducation, relaxation instruction, CBT effective

SSRIs and SNRIs are effective treatments for anxiety

- SSRIs associated with greater and faster improvement
- Duloxetine and escitalopram are the only medicines FDA approved for a non-OCD anxiety disorder, GAD

Activation is a common side effect associated with SSRIs

When treating anxiety, best to start low but not necessarily slow

The End

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