Identifying Pediatric Anxiety Disorders

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Disclosures

I have no financial interests or relationships to disclose
Goals for Mental Health in Primary Care

Reflect and Empower Family’s Capacity

- To be mentally healthy
- To maximize functionality
Primary Care MH Impact

- **Promotion and Prevention**: No Problems, “Typical”
- **Early Intervention**: Mild to Moderate problems
- **EB Treatment**: Diagnosed MH Disorder
Population Level Interventions
Mental Health

- Brain Health Promotion
- Problem-Focused
- Therapy +/- Med
- Med AND Therapy

Increasing Disease Acuity
What Pediatricians See

• An 8-year-old with an 'attitude',
• 11-year-old with chronic abdominal pain
• 16-year-old asking to be homeschooled ....

• These are normal presentations in primary care
  – How do you know if an anxiety disorder is getting in the way?
  – Decisions around when to ignore/intervene with anxious youth

• Is there such a thing as "good stress"?
Learning Objectives

1. Realize anxiety can cause significant problems in child health outcomes, and the sequelae of not intervening

2. Recognize when anxiety disorders are present and elicit key information to aid in clinical decision making

3. Respond to pediatric anxiety disorders with the goal of (impairing) symptom remission
Fight, Flight, Freeze, Flop

Physical Indications of Fight or Flight Response

dilated pupils
pale or flushed skin

trembling
rapid heart beat and breathing
Anxiety is Normal… Until it is Not

• Anxiety is a sense of uneasiness, nervousness, worry, fear or dread in response to a stressor or situation.

• Anxiety becomes a disorder when it causes significant changes in functioning, often leading to avoidant behaviors
  – Sleep, social interactions, body/somatic sensations
  – School refusal, poor concentration, selective mutism, eloping
Development of the Stress Response

• **Lower Brain** (Survival Center) – “Connection/Memory Maker”
  - Hypothalamus – Cruise control
  - Hippocampus – Memory maker
  - Sympathetic Nervous System – Gas
  - Parasympathetic Nervous System – Brake

• **Amygdala** – “Emotion Maker”
  - Kids ages 1-3 are all amygdala

• **PFC** (PreFrontal Cortex) – “Decision Maker”
  - Higher Brain = comes later (ages 5-25 years)
  - Keeps amygdala in check (ability to have emotional regulation)
    - Slow to develop in ADHD, incomplete development in toxic stress
Childhood Doses of Stress

Positive Stress
- Short-lived stress response necessary for healthy development
- Taking test, playing a game/sport
- Gain confidence, competency

Tolerable Stress
- More severe, but limited in duration and allows for recovery

Toxic Stress
- Extreme, frequent, or extended activation of the body’s stress response without the buffering presence of a supportive adult

- Adrenaline
  - Short term response
  - Increased heart rate, pupil dilation
  - Fight/Flight response

- Cortisol
  - Long-term response
  - Blood pressure and blood sugar regulation
  - Body’s metabolism and immune response
  - Helps regulate body’s stress response
Toxic Stress = Too much cortisol

• Impacts brain development
  – Hippocampus (Memory Maker)
  – Amygdala (Emotion Maker)
  – Prefrontal Cortex (Decision Maker)

• Higher stress reactivity
  – More likely to fight (verbal, physical)
  – More likely to runaway/elope

• Makes it hard to Learn
  – Poor concentration
    • Math
    • Reading comprehension
  – Poor impulse control
  – Poor decision making

• Changes your body chemistry
  – Higher susceptibility to Obesity, blood vessel disease, immune system problems
Identifying Anxiety in Primary Care

• Anxiety is normal… Until it causes Impairment

• Anxiety Disorders Avoid and Distract you
  – Don’t Look at ME!!!
    • Irritability is common – tantrums, grouchy
    • Socially programmed to give “right answer”

• Watch for Non-verbal cues
  • Eye contact (avoidant, seeks visual support from caregiver)
  • Pauses before speaking, or rapid/long responses

  ➢ YOU change approach (accommodate)
DSM-5-TR  Generalized Anxiety Disorder

A. Excessive anxiety or worry (apprehensive expectation) at least 6 months more days than not, about various events/activities

B. Difficult to control the worry

C. Associated with 3 or more symptoms present for > 6 months.... Kids only need ONE
   1. Restlessness or feeling keyed up or on edge
   2. Being easily fatigued
   3. Difficulty Concentrating or mind going blank
   4. Irritability
   5. Muscle tension
   6. Sleep disturbance

D. Anxiety/worry or physical symptoms cause significant distress OR impairment in important areas of functioning

E. Disturbance not related to substance use or general medical condition in isolation

F. Disturbance is not better explained by other mental disorder (anxiety about panic attacks, OCD, trauma events in PTSD)
# Features of Anxiety Disorders

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separation</td>
<td>Inconsolable distress being away from attachment figure – harm to self, or harm of caregiver</td>
</tr>
<tr>
<td>Social / Selective Mutism</td>
<td>Fear of negative judgment or ridicule of others</td>
</tr>
<tr>
<td>Performance</td>
<td>Excessively terrifying experiences: Situation, medical (needles, emetophobia), weather, animals</td>
</tr>
<tr>
<td>Specific Phobia</td>
<td>Sudden spike of fear, somatic sxs, dysregulated thoughts. Fight/flight/freeze/flop</td>
</tr>
<tr>
<td>Panic</td>
<td>Excessive worry thoughts – not limited to above. Often resulting in irritability and daytime fatigue.</td>
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</tbody>
</table>
Commonalities Across Anxiety Disorders

- Behavior
  - Avoidance
  - Escape
  - Overcompensation
  - Tantrums

- Thoughts
  - Worry
  - Overestimation of danger
  - Lack confidence to overcome

Dependence on caregivers
Anxiety becomes a disorder when it gets in the way of healthy functioning
Impact on functioning across multiple areas of life
Chronic and may change over time
May lead to maladaptive coping strategies

Anxiety becomes a disorder when it gets in the way of healthy functioning and may lead to maladaptive coping strategies.
Other causes of Anxious Response

- Autism Spectrum Disorder
- Attention Deficit Hyperactivity Disorder
- Trauma/Adverse Childhood Experiences
- Speech/language difficulties
- Vision/hearing difficulties
- Auditory Processing difficulty
- Thyroid problems
- Pain
- Substance use / intoxication
- Brain injury
- Context-appropriate response
Poignant Probing Questions: FUNCTIONING

<table>
<thead>
<tr>
<th>Eh..</th>
<th>Better</th>
<th>Even Better… \textit{concrete, discrete}</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you sleep well? How is your sleep?</td>
<td>Is it Easy or Hard to fall asleep… stay asleep?</td>
<td>How many nights a week do you wake up at night and struggle to fall back asleep?</td>
</tr>
<tr>
<td>How is school going?</td>
<td>Do you like school?</td>
<td>How many times have you missed, Or left school early?</td>
</tr>
<tr>
<td>Do you have Anxiety? Worry too much?</td>
<td>Do worries get in the way of doing things sometimes?</td>
<td>Are you GOOD at worrying? How/when do worry thoughts impede?</td>
</tr>
<tr>
<td>Good with friends?</td>
<td>Is it easy/hard to make/keep friends?</td>
<td>Easy/Hard to raise hand in class -- stay at a sleepover -- join a group</td>
</tr>
</tbody>
</table>
**Brief Risk Screeners for Anxiety d/o**

- **PHQ2 or PHQ4 #1-2**
  - Scores 3 +
  - PHQ 9

- **PHQ4 #3-4**
  - Score > 3
  - GAD 7

- **Brief SCARED**
  - Top Score > 3
  - Lower Scr > 4
  - GAD 7
  - PTSD screen

- **Parent Vanderbilt Assessment**
  - #41-47 ++ on 3 AND any Performance Positive
  - 41, 42, 47 → Consider GAD 7
  - 43-46 → Consider PHQ 9

- **Teacher Vanderbilt Assessment**
  - #29-35 ++ on 3 AND any Performance Positive
  - 29,30, 31 → Consider GAD 7
  - 32-35 → Consider PHQ 9

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**Anxiety**

Here is a list of sentences that describe how people feel. Decide if it is “Not True or Hardly Ever True”, “Sometimes True or Sometimes True”, or “Very True or Very Often True” for your child. Then, for each sentence, choose the answer that seems to describe your child for the last 3 months.

- My child gets really frightened for no reason at all.
- My child is afraid to be alone in the house.
- People tell me that my child worries too much.
- My child is scared to go to school.
- My child is shy.

**Scared** Score ___

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**Posttraumatic Stress**

Here is a list of sentences that describe how people feel. Decide if it is “Not True or Hardly Ever True”, “Sometimes True or Sometimes True”, or “Very True or Very Often True” for your child. Then, for each sentence, choose the answer that seems to describe your child for the last 3 months.

- My child has scary dreams about a very bad thing that once happened to her/him.
- My child tries not to think about a very bad thing that once happened to her/him.
- My child gets scared when she/he think back on a very bad thing that once happened to her/him.
- My child keeps thinking about a very bad thing that once happened to her/him, even when she/he doesn’t want to think about it.

**PTSD** Score ___

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AAP Bright Futures: Anxiety Screening Tools

Spence Children’s Anxiety Scale

Generalized Anxiety Disorder-7 (GAD-7)
- GAD, Panic, Social Anxiety, Post-Traumatic Stress Disorders.

Screen for Child Anxiety Related Disorders (SCARED)—Parent Version
Screen for Child Anxiety Related Disorders (SCARED)—Child Version

Child and Adolescent Trauma Screen-Caregiver (CATS-C): 3–6 Years
Child and Adolescent Trauma Screen-Caregiver (CATS-C): 7–17 Years
Child and Adolescent Trauma Screen (CATS): 7–17 Years
Child and Adolescent Trauma Screen (CATS) Scoring

GAD-2 and GAD-7 Scales

Over the past two weeks, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th>Feeling nervous, anxious, or on edge</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than one half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total GAD-2 score: 

Worrying too much about different things
- Not at all
- Several days
- More than one half of the days
- Nearly every day

Total GAD-7 score: 

Interpretation: a positive GAD-2 result is a score of at least 3 points; a positive GAD-7 result is a score of 8 or 9 points. The authors of the validation study recommend a cutoff of 8 or more points for an abnormal GAD-7 screen; however, a cutoff of 9 points has a higher LR+ compared with a cutoff of 8 points and a similar LR-.

<table>
<thead>
<tr>
<th>Generalized anxiety disorder</th>
<th>Total score (points)</th>
<th>LR+</th>
<th>LR-</th>
<th>PPV (%)</th>
<th>NPV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAD-2 ≥ 3</td>
<td>5.1</td>
<td>0.17</td>
<td>0.56</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>GAD-7 ≥ 9</td>
<td>4.3</td>
<td>0.13</td>
<td>0.52</td>
<td>97</td>
<td></td>
</tr>
<tr>
<td>Panic disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GAD-2 ≥ 3</td>
<td>4.0</td>
<td>0.30</td>
<td>0.47</td>
<td>94</td>
<td></td>
</tr>
<tr>
<td>GAD-7 ≥ 9</td>
<td>3.6</td>
<td>0.27</td>
<td>0.50</td>
<td>93</td>
<td></td>
</tr>
</tbody>
</table>

LR+ = positive likelihood ratio; LR- = negative likelihood ratio; PPV = positive predictive value; NPV = negative predictive value.

*—Assumes pretest probability of 20 percent.
# Targeted Screens: Monitor & Respond

<table>
<thead>
<tr>
<th>PHQ 9 Mod (11-17 years)</th>
<th>GAD 7 Score (12+ years)</th>
<th>SCARED (8+ years)</th>
<th>Approximate Severity*</th>
<th>Clinical Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>0-5</td>
<td></td>
<td>None</td>
<td>Preventive Brain Health</td>
</tr>
<tr>
<td>5-9</td>
<td>6-10</td>
<td>&gt; Threshold for subscale only</td>
<td>Mild</td>
<td>Educate – D/O Consider CBT/Office Interv.</td>
</tr>
<tr>
<td>10-14</td>
<td>11-15</td>
<td>25-30</td>
<td>Moderate</td>
<td>Active monitoring Consider CBT/Office Interv Rx if needed</td>
</tr>
<tr>
<td>15-19</td>
<td>&gt; 30</td>
<td></td>
<td>Moderate-Severe</td>
<td>Active Monitoring Consider Rx AND CBT</td>
</tr>
<tr>
<td>20-27</td>
<td>16-21</td>
<td></td>
<td>Severe</td>
<td>Active Monitoring Rx AND CBT T/C Referral to psychiatrist</td>
</tr>
</tbody>
</table>

*Diagnosis depends on meeting clinical criteria for the disorder
Clinical Response to Suicidality

- Risk/Severity Assessment
  - How quickly do they need more help?
  - Non-specialists

- Safety Assessment
  - What level of care does this person need?
  - Psychiatric specialists

- Safety Management
  - Reinforce Protective Factors and Resilience
  - Decreasing Risk Factors
AAP Clinical Report: Guidance for Clinician Rendering Pediatric Care

- Identification and Management of adolescent at risk for suicide
  - Suicide risk can Never be eliminated, only reduced
  - Risk factors provide no more than guidance

  - Care for suicidal adolescents improved in Primary Care
    - Ready access to appropriate community resources and MH professionals

ADDRESSING SUICIDALITY AND SAFETY

- Identify Suicidality Risk
  - CSSR for Primary Care or ASK 5Q
- Elicit Risk/Protective Factors
- Safety Planning is Shared Decision
  - Triggers
  - Strengths/supports
  - Communication paths
- Follow-up
  - Antidote to Worthlessness/Hopelessness

AAP Pediatric Mental Health: Compendium, 2020
The Role of Caregivers

- Anxiety disorders impede healthy social-emotional development and require an evidence-based intervention.
- Young children are vulnerable to events involving safety and harm.
- Ability to cope is directly related to caregiver’s response to distress.

- Parent Protector = Accommodations
  - Reinforce anxious thoughts, making the inaccurate or unhelpful thoughts ‘right’.

- Key Factor = Parental Functioning.

- GOAL – Shift from Protector to Coach
  - Help child learn HOW to approach situation in healthy way.
  - Foster more mature response (decrease cortisol load over a lifetime).
Treatment Education

• Cognitive Behavioral Therapy has BEST evidence for treating mild to moderate pediatric anxiety disorders (ages 6 years+)
  • Core Avoidance ➔ Exposures are key to recovery

• Medications are highly effective too
  • SSRI are better at treating OCD > Anxiety >>> Depression

• Best Evidence = combining Rx + CBT (ages 6 years+), for Moderate +

• Risks of NOT treating delays the development of important social-emotional milestones, Toxic stress exposure
What about Medication?

• Consider medication as an alternative or adjunct if…
  - Moderate to severe anxiety
    - Significant impairment in several areas of functioning
    - Impedes ability to engage in therapy (attendance, exposures)
  - Family does not have access to therapy or has significant barriers to attending
  - Has had sufficient CBT without significant improvement
  - Comorbid Major Depressive Disorder, Panic Disorder
# Pediatric Rx with FDA-Approval

<table>
<thead>
<tr>
<th>Class</th>
<th>Medication</th>
<th>Age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>SSRI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td></td>
<td></td>
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<tr>
<td>Escitalopram</td>
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<td></td>
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<tr>
<td>Fluoxetine</td>
<td></td>
<td></td>
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<tr>
<td>Fluvoxamine</td>
<td></td>
<td></td>
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<tr>
<td>Paroxetine</td>
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<tr>
<td>Sertraline</td>
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<tr>
<td>Vilazodone</td>
<td></td>
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<tr>
<td>Vortioxetine</td>
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<tr>
<td>SSNRI</td>
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<tr>
<td>Duloxetine</td>
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<tr>
<td>Desvenlafaxine</td>
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<tr>
<td>Venlafaxine</td>
<td></td>
<td></td>
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<tr>
<td>Atypical antidepressant</td>
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<tr>
<td>Bupropion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mirtazapine</td>
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<tr>
<td>Trazodone</td>
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</tbody>
</table>
1. OPTIMIZE dose

2. Monitor MONTHLY to assess response to dose changes

- Do NOT rely on patient/family assessment of their progress
  - “My anxiety is much better”
  - Information to guide your clinical decision making relies on ‘objective’ evidence
    - SCREENING TOOL
    - Quantify Functioning

REASONS TO ADJUST DOSE

- Functioning still Impaired
  - A little better is not goal
  - Goal is maximal symptom remission

- Activation Presents 1-3 days after dose change (common)
  - Decrease dose or change SSRI

- Mania concerns present 3-4 weeks after dose change
  - Stop medication immediately
  - Consult with psychiatrist
<table>
<thead>
<tr>
<th>FIRST LINE</th>
<th>FDA Approval *Common Uses</th>
<th>STARTING Doses</th>
<th>TITRATION by</th>
<th>Therapeutic Range (Max dose)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLUOXETINE (Prozac) Caps/Tab/Liquid</td>
<td>MDD 8 yo+ OCD 7 yo+ Off-Label *Generalized Anxiety Disorder (GAD) *MDD &lt; 8 yo</td>
<td>AM dosing 10 mg 5 mg if &lt; 12 yo or comorbid anxiety</td>
<td>10 mg Every 1-2 weeks initially, then every 4 weeks</td>
<td>MDD 20-40 mg (60 mg) GAD/OCD 30-60 mg (80 mg)</td>
</tr>
<tr>
<td>SERTRALINE (Zoloft) Tab/Liquid</td>
<td>OCD 6 yo+ Off-Label *MDD *GAD (+Evidence), *Panic, PMDD</td>
<td>Evening dosing 25 mg 12.5 mg &lt; 12 yo with comorbid anxiety</td>
<td>12.5-25 mg Every 2-4 weeks</td>
<td>75-200 mg (200 mg)</td>
</tr>
<tr>
<td>ESCITALOPRAM (Lexapro) Tab/Liquid</td>
<td>MDD 12 yo+ Off-Label *GAD *MDD &lt; 12 yo (+Evidence)</td>
<td>AM or PM dosing 5 mg 2.5 mg if &lt; 12 yo</td>
<td>5 mg Every 4 weeks</td>
<td>10-20 mg (20 mg)</td>
</tr>
</tbody>
</table>
# Adverse Effects

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Common Side Effect</th>
<th>Adverse Effect</th>
<th>Withdrawal Syndrome / ABRUP T CESSATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRI Primary Care – Fluoxetine, Sertraline (ages 6+ OCD)</td>
<td>“Activation” (restlessness, insomnia, impulsiveness, talkativeness); days after dose change</td>
<td></td>
<td></td>
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<tr>
<td>Escitalopram (age 12+)</td>
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<td></td>
<td></td>
<td>Akathisia (uneasy/restless feeling, have to move = rare)</td>
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<tr>
<td></td>
<td>Decrease dose</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Consider change SSRI</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>GI upset, nausea, loose stools. Mild, about 4-5 d</td>
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<tr>
<td></td>
<td>Warn patient</td>
<td></td>
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<tr>
<td></td>
<td>Self-limited</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexual (decreased libido, delay ejac)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Autonomic (diaphoresis, mydriasis)</td>
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<tr>
<td></td>
<td>Cardiovascular (flushing, sinus tach, HTN)</td>
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<tr>
<td></td>
<td>DECREASE DOSE</td>
<td></td>
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<tr>
<td></td>
<td>Manic Activation – Dec need for sleep, grandiose, high risk/inc sexualized beh., long rage (about 3-4 weeks after dose change)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>STOP SSRI NOW</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNRI - Duloxetine (FDA-Approved GAD, but 2nd line d/t side effects)</td>
<td>Nausea, dry mouth, somnolence, constipation, dec appetite, hyperhidrosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dizziness, h/a, n/v, insomnia, irritability, anxiety, fatigue, hyperhidrosis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SSRI Treatment Failure

• Defined as ≥ 8 weeks on medication (total) AND max tolerated, therapeutic dose > 4 wk

– Dose equivalent (minimum therapeutic tolerated)

  Fluoxetine 40 mg (20 mg)
  Escitalopram 20 mg (10 mg)
  Sertraline 200 mg (75-100 mg)

Adapted from G. Emslie. Annual Meeting of the American Academy of Child & Adolescent Psychiatry 2012
SSRI Cessation

• Goals met = No longer with significant impairment
  – Scores < 5 (Functioning at Goal) > 6-12 months
    • Skills actively reduce impairment, Neuroplasticity > 6 mo

• Patient can recognize relapse symptoms
  – Target symptoms that led to significant impairment

• Slow taper ↓ 10-25% dose, every 4 weeks

• Continue to monitor sxs AFTER stopping
  – At 3, 6 and 12 months
Additional Primary Care Meds

• Focus on FUNCTIONING – Sleep, Getting to School, Social opportunities
  – **Melatonin** 0.5 mg at dinner time AND 1-3 mg HS
    • Less is more, > 5 mg = no benefit
    • No SE, “Sleep trainer”, Light CANCELS effect
      ❖ Caution in pediatric pt with Neurodevelopmental d/o
  
  – **Hydroxyzine PRN** 10-25 mg po q 6 hr (liquid Atarax, pill Vistaril)
    • Anxiety/school refusal
    • Loses efficacy with chronic use

• Comorbid ADHD
  – **Atomoxetine (Strattera) 2nd Line**
    • Weight-based 0.5 mg/kg x 4 DAYS, max 1.2 mg/kg/day
    • Slow metabolizer – 0.5 mg/kg x 4 weeks, max 1.2 mg/kg
    • Stomachache, appetite suppression common ➔ **Divide the dose**
Anxiety Meds WITH Psychiatrist

NOT FDA-APPROVED in Youth

- **Beta Blocker [Propranolol]** – as needed or daily
  - Performance/Test anxiety

- **Buspirone [Buspar]** 5-10 mg BID, max 30mg
  - Panic w/max tolerated SSRI
  - Monotherapy if unable to tolerate SSRI

- **Trazodone** 25 mg – 150 mg HS
  - Insomnia
  - Serotonergic at higher doses
TAKE HOME MESSAGES

• Anxiety CAN be Helpful OR Pathologic
  • Usually chronic – present differently due to developmental milestones
  • Disorders cause IMPAIRMENT in functioning

• Use a screening tool – this is an Internalizing disorder [GAD-7, SCARED ]
  • Easily embarrassed / avoidance is theme.
    – Treatment = exposure (do the opposite)

• Consider cultural differences in approach to mental illness – What does anxiety disorder mean to the family?

• Early intervention supports development of healthy brain pathways and facilitates healthy social-emotional development
  • Foster referred positive coping to outweigh maladaptive strategies
Adults can Buffer Stress

- In the moment
  - Activate relaxation pathway
    - First take deep, SLOW breaths
    - Do it again

  - Grounding exercises to create mindfulness, focus
    - Relational connection

  - Rational thinking
    - Only occurs when calm

- In the environment
  - Safety and security
    - Avoid re-traumatization

  - Social Connectedness
    - Prosocial attachment practice

  - Personal competence
    - Mastery of industry/inferiority
    - Strength-based approach
Optimize SSRI Dose ➔ Primary
• Improvement is dose-related
• Improvement depends on serotonergic activity
• Anxiety d/o responds to EARLY treatment

**Therapeutic range for Anxiety Rx**
- Fluoxetine = 30-60 mg
- Sertraline = 75-200 mg
- Escitalopram = 20 mg
  (less effective with comorbid depression)

- **Reasons to Increase Dose**
  - “I am fine now”
  - Functioning **still Impaired**
    • Sleep disturbances, panic, school avoidance
    • May plateau or lose gains

- **Treatment “Not working”**
  - Poor adherence
  - Inadequate med dosing
  - Inadequate duration

Consultation/Referral Support

Psychiatry Resources

- Psychiatric general referral Eval/Tx
  - CCHMC Psychiatric Intake Response Center
    - **PIRC = 513-636-4124**

- Psychiatric Safety Evaluations
  - Bridge Clinic through PIRC
    - **PIRC = 513-636-4124**

- Psychiatric Consultation
  - CCHMC Physician Priority Link: 24/7
    - 513-636-7997 or
    - Toll free 1-888-636-7997
  - eConsult through Epic

Therapy Resources

- Cincinnati Children’s Behavioral Medicine and Clinical Psychology, BMCP
  - Integrated Behavioral Health clinicians in office
    - 513-636-8107
- Cincinnati Children’s Psychiatry (LiSW, LPCC)
  - 513-636-4124
  - [www.mindpeacecincinnati.com](http://www.mindpeacecincinnati.com)
    - School-based TH
  - [www.psychologytoday.com](http://www.psychologytoday.com)

- Higher Levels of Care
  - Intensive Outpatient (IOP, Norwood), “CBT Bootcamp”
  - Day Treatment / Partial Hospitalization (Lindner, Green Twp, Norwood)
<table>
<thead>
<tr>
<th>Indications</th>
<th>EPB Sources</th>
<th>Common Elements of EBPs Amenable to Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms of emotional distress in young children (e.g., dysregulation, aggression, extreme tantrums, irritability, unhappy mood, extreme anxiety, lack of social reciprocity with caregiver, poor attachment)</td>
<td>Parenting education (See examples in the “Parenting Education” cell earlier in this table.) Promoting First Relationships Parents as Teachers Child-Parent Psychotherapy Cognitive behavioral therapy</td>
<td>Reframe child’s perceived bad behavior. Reinforce strengths and protective factors. Teach... - Prevention of unnecessary or extreme triggers - Attention and praise for positive behavior - Clear, simple commands and limit setting - Relaxation and anxiety management - Consistent, safe responses to negative behavior. Special time (&quot;time in&quot;) with parents</td>
</tr>
</tbody>
</table>

Abbreviations: EB, evidence-based practice; PCIT, Parent-Child Interaction Therapy; PTSD, post-traumatic stress disorder.

Use of common elements approaches for these indications should not delay full diagnostic evaluation or definitive therapy if the patient’s symptoms suggest a psychiatric emergency, severe impairment, or marked distress. Common elements approaches are well suited to the care of patients whose symptoms do not reach a diagnostic threshold, the care of patients who are resistant or otherwise not yet ready to pursue further diagnostic assessment or treatment, and the care of patients who are awaiting further diagnostic assessment and treatment.

See Appendix 6, PracticeWise: Evidence-Based Child and Adolescent Psychosocial Interventions, for more information about these evidence-based practices.
## Common Elements of Evidence-Based Practice Amenable to Primary Care: Indications and Sources

<table>
<thead>
<tr>
<th>Indications</th>
<th>EPB Sources</th>
<th>Common Elements of EBP’s Amenable to Primary Care</th>
</tr>
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<tbody>
<tr>
<td>Symptoms related to past trauma</td>
<td>Trauma-focused cognitive behavioral therapy Young children: Child-Parent Psychotherapy PCIT</td>
<td>Gently challenge negative thoughts about shame, guilt, and hopelessness. Encourage self-care and ways of seeking a feeling of security. When symptoms are prominent, suggest distraction, relaxation, or supportive company. Plan to manage or avoid unnecessary or intense triggers. Provide positive attention for positive behavior. Remove attention for provocative behaviors. Provide safe, consistent consequences for unsafe/acceptable behaviors. Define the importance of a healthy relationship for recovery.</td>
</tr>
</tbody>
</table>

### Anxiety
- (e.g., performance anxiety, stage fright, sports, anxiety disorders, PTSD, phobias)
- Psychophysiologic problems (e.g., enuresis, encopresis, conditioned nausea and vomiting, irritable bowel syndrome, sleep disorders)
- Chronic disease, multi-system disease, and terminal illness (e.g., cancer, hemophilia, AIDS, cystic fibrosis, diabetes, chronic renal disease)

#### Anxiety
- Young children: PCIT
- (See also “Self-regulation therapies and mind-body therapies” cell earlier in this table.)

#### Phobias

#### Cognitive behavioral therapy for anxiety

> Provide psychoeducation. Gradually increase exposure to feared objects or activities. Teach...
> - Relaxation strategies
> - Positive self-talk
> - Thought stopping or substituting
> - Thoughts of a safe place
> Reward brave behavior.
Academy Primary Care Resources

- **AACAP Clinical Resource Center**

- **AAP Pediatric Anxiety Tools for PC**

https://www.cincinnatichildrens.org/patients/coronavirus-information/family-resources/mental-emotional-health
Starting SSRI Dose Examples

- **Sertraline Low dose, Before Puberty:**
  - Sertraline 25 mg Tabs
  - Sig: ½ tab (12.5 mg) daily x 1 week, then increase to 1 tab (25 mg),
  - if tolerated after 1-2 week may increase to 1.5 tab (37.5 mg) daily.
  - See them back in 4 weeks, plan to increase to 50 mg and decide if next step is 75 or 100 mg

- **Sertraline Low dose, After Puberty/or significant Panic:**
  - Sertraline 50 mg tabs
  - Sig: ½ tab (25 mg) daily x 1 week, then increase to 1 tab (50 mg),
  - Phone call check in 2 weeks → if 50 mg tolerated after 1-2 weeks, then increase to 75 mg daily
  - F/U 4-6 weeks (or 1-3 weeks on 75 mg)
    - If still with panic or intense spikes, or sleeplessness → Raise to 100 mg
    - If goals nearly met → Hold for 4 wks while getting CBT, reassess

- **Sertraline Rapid Titration**
  - Sertraline 50 mg tabs
  - Sig: ½ tab (25 mg) x 4-7 days, then increase to 50 mg,
  - 50 mg for 7 days, if tolerated increase to 100 mg
  - RTC in 4 weeks, decide when to increase to 150 mg