Child Psychiatry Update 2017: Anxiety Disorders

Phoenix Area IHS Integrated Behavioral Health
objectives

- identify signs and symptoms of anxiety disorders in children
- update knowledge of evidence-based therapies for childhood anxiety
- use, or refer for, the most effective types of psychotherapy or medical treatment based on the diagnosis and individual situation
when is anxiety a disorder?

- Shyness, worrying, and fearfulness can very widely in normal children.
- When they cause significant distress or impairment in social, school, or family functioning, more days than not, over a period of time, an anxiety disorder is present.
- The perception of ‘normal’ varies widely among families.
anxiety can start young

- around **12%** of children meet criteria for an anxiety disorder by mid-childhood
- another **11%** meet criteria in adolescence
  - lifetime prevalence for adults **25-30%**
- **M : F** ratio varies with type of anxiety, though not greatly so

childhood anxiety d/o

- anxiety disorders are probably **30-40% heritable** (due to genes) over all
  - compare to around 80% for ADHD
- *many genes* are implicated, not the same ones in all anxiety disorders
  - generalized anxiety, panic disorders, agoraphobia vs. simple phobias
multifactorial genetic transmission

- when many genes contribute, having more disorder-associated genes will convey a higher risk of developing the disorder
  - earlier age at onset
  - higher intensity or severity
- moderated by gene-gene, gene-environment interactions
HEIGHT as an example of multifactorial transmission

- studies around the world place the heritability of height between 60% and 80%
- while largely a matter of genetics, environment is a factor
  - nutrition, stress
- other genetic factors can interact
  - age at puberty
multifactorial illness threshold

environmental factors: stress, infectious disease, nutrition...
wide variation in anxiety disorders

- the particular blend of genes and their interaction with the environment can affect the specific expression
- anxiety has many variations
a useful way to look at anxiety

- think of ‘STATE vs. TRAIT’ anxiety
  - does it only happen in certain external states, or is it a ‘default’ setting (trait) for the affected child?
  - not an either-or deal; on a continuum
anxiety: from outer-focused to inner-focused

- spiders
- public speaking
- selective mutism
- agoraphobia/school refusal
- worrying about EVERYTHING
for different focus, different treatment

- more focused anxiety states (phobias, etc.) tend to respond well to therapy
- more global, non-situation-dependent anxiety may require medication
- Cognitive-Behavioral Therapy (CBT) is the therapy with the most research evidence for children with various kinds of anxiety*

[http://effectivechildtherapy.org/content/ebp-options-specific-disorders](http://effectivechildtherapy.org/content/ebp-options-specific-disorders) *
simple phobias

- needles
- dentists
- dogs
- airplanes
- spiders
- lightning
managing simple phobias

- how often does the child encounter the feared stimulus?
  - if it is unavoidable (needles, the dentist, dogs), **cognitive behavioral therapy** is helpful for desensitization
  - if it is rare (flying, an unusual medical procedure), or if therapy is impractical, consider **premedication*** (lorazepam)

* off-label
exposure therapy for simple phobias

- gradual approach to feared situation
- help child make a list from least scary to most scary, then start working the list
  - tell a story about a dog, look at pictures of dogs, look at a real dog from a car, then with car window open, etc.
- teach and use relaxation techniques during gradual exposure
glossophobia
(fear of public speaking)

• normal in most cases
• usually improves with experience
• preparation
• relaxation techniques
• premedication (adults)
• groups, such as Toastmasters
selective mutism

- consistent **failure to speak** in certain situations: around....
  - **strangers** (stores, restaurants)
  - **teacher/classroom**
  - **peers**
  - **anyone but immediate family**
selective mutism: assessment

- if child is not fluent in the home environment, refer for hearing test
- there is usually a family history of extreme shyness or mutism
- the family may perceive it as a normal behavior
selective mutism

- lifetime social phobia incidence 37%
- first degree family history
  - social phobia 70%
  - selective mutism 37%

selective mutism

- speech/language assessment and services at school
  - assessment usually starts with a test of **receptive** language (a pointing test)
- speech therapist, teacher, parents, and therapist work together
- SSRI medication can be helpful if the problem is longstanding, or if progress is not seen after a semester
working with kids with selective mutism

- abandon expectation of speech at start
- minimize eye contact
- be “next to”, not “across from”
- talk “around” the child, don’t use their name
- focus on something other than the child
- respond to child’s gestures
Social anxiety

“approach ↔ avoidance” is one axis of normal temperament

- the tendency to seek or avoid new experiences, people
- present and observable trait in infants, stable throughout life
- it’s not a disorder unless there is functional impairment
Social anxiety

- Extreme shyness and avoidance, limiting function - can’t make friends, participate in activities

- Perception of disability varies with family norms, parents’ temperaments
Help for social anxiety

- small, structured activities like scouts, karate if tolerated
- medication may be needed (SSRI)
- it is *not as responsive to CBT* as simple phobias, but CBT still helps

School refusal (agoraphobia)

- often presents as an intractable physical problem without objective findings
  - headaches, GI complaints
- can be seen in teens as well as younger children
  - ask about earlier separation problems: day care, kindergarten?
- ask about frequency of child-parent contact on a typical day (for most kids it is zero during school day)
School refusal (agoraphobia)

- Treatment usually takes a lot of effort over a short time.
- Success requires team-wide “buy in”:
  - Parent
  - School: nurse, teacher
  - Therapist
  - Medical provider
- Being at school, even asleep or in the nurse’s office, is better than being home.
School refusal (agoraphobia)

- educate parent about importance of attendance, be firm about legal requirements
  - explore parent’s anxieties
- contact school nurse, share instructions and have parent deliver them in writing if possible
  - child stays in school unless there is objective evidence of illness (fever, etc.)
  - OK to be in nurse’s office
- school contacts parent if needed
School refusal (agoraphobia)

- start therapy, discuss medication (duloxetine*, SSRI**)  
- if refusal is intense, consider short-term use of benzodiazepine**  
  - clonazepam the night before school for the first week + Monday  
- arrange support if needed to get the child to school  
  - someone else to drive, a teacher to meet the car, etc.

* approved for GAD only, **off-label
School refusal - 20 to 29 year follow up

- 59% had had no children (29%)
- 14% still living with parents (0%)
- 43% received outpatient psychiatric care (17%)

School phobia with separation anxiety disorder: A comparative 20- to 29-year follow-up study of 35 school refusers, Flakierska-Praquin N et al. Comp Psychiatry V 38 No 1; Jan-Feb 1997
Generalized anxiety disorder (GAD)

- all worries, all the time
- stomachaches, headaches
- worries are often inappropriate for age
  - future career, parents’ finances
- catastrophic worries
  - volcanoes, tornadoes, nuclear war
Generalized anxiety disorder (GAD)

- strongly associated with depression
- when both are present depression doesn’t respond unless anxiety is treated
  - would you choose bupropion or an SSRI for the depression? why?
Name the anxiety disorder

- I’m OK, it’s all OK (no disorder)
- I’m OK as long as there are no dogs around
- I’m OK as long as I don’t have to give a talk
- I’m OK as long as I know everybody there
- I’m only OK if I’m with mom, or home
- I’m not OK, nothing is OK, we’re all gonna die
Medications for childhood anxiety

- SSRI’s: first-line but off-label, except in OCD
- duloxetine
- not FDA approved for children
  - other SNRI’s (venlafaxine, mirtazapine)
  - benzodiazepines
  - buspirone
Starting an SSRI or duloxetine

- check for family history of bipolar disorder
  - would still try SSRI, but cautiously and after explaining risks
- advise all parents to watch for activation
  - insomnia, pressured speech, irritability
- consider potential for medication interactions
Fluoxetine*

- the oldest and most studied SSRI in kids
- long half-life
  - forgiving of missed doses (sleepovers, etc.)
  - can titrate by giving 3, 4, 5, 7 days a week
- also comes in a liquid
- potent CYP 2D6 inhibitor

*off-label in anxiety, except for OCD
Citalopram, escitalopram

- **not FDA approved for pediatric use**
  - in adults, escitalopram is approved for GAD
  - lower potential for drug interactions than fluoxetine or sertraline
  - escitalopram less likely to cause QTc than citalopram
- effect is dose-related, and equivalent dose is half that of citalopram
When to consider benzodiazepines

- **not FDA approved for pediatric use**

- premedication for rare events
  - pre-blood draw, pre-flight
  - lorazepam 0.5 to 1 mg po, repeat in 30-60 min if needed

- **very** short-term in school refusal
  - help with reintroduction to school
  - 0.5 mg clonazepam at HS on school nights for the first week and the next Sunday
Katelyn

- Katelyn is 14 years old. She is reportedly irritable and negative about “everything” lately. She has spent the last few weekends in bed asking to be left alone.

- It sounds like she is a kid with big worries, and when you ask, she makes her first real eye contact. Mom recalls that when Katelyn was only 5, she stayed awake worrying if the family would have enough money for their new baby.

- Asked what she worries about these days, Katelyn starts to cry, and says, “if I don’t get a scholarship I’ll just be a burden on everyone”.
Brianna

- Brianna is 8 years old. She’s been coming to your clinic since she was 4 but you’ve never heard her speak. Her mom reports, “you can’t get her to stop chattering” at home.

- In kindergarten, Brianna was accepted by her peers but only spoke in the presence of 2 ‘best friends’. She used gestures to make her wishes known.

- last year Brianna never spoke in class but her teacher overheard her speaking on the playground. This year she speaks to her teacher 1:1. She does not speak in restaurants, or with relatives she rarely sees.
David

David is 9 years old. He loves school and his work and participation are very good. He has one close friend. If his friend is absent, David will go to the library rather than eat in the cafeteria. He gets invited to some birthday parties but rarely goes.

His parents want him to join scouts or go out for a local soccer team to “get him out of his shell”. This is the only issue that seems to make this good-natured child argumentative.
Summary

- Anxiety disorders differ from shyness, worries, or fears
  - Functional impairment is the key

- When severe, anxiety can drive depression
  - Must treat anxiety to improve depression
Summary

- focused/specific anxiety problems respond best to therapy (usually some form of CBT)
- for more pervasive and limiting anxiety, medication may also be needed
  - therapy (CBT) is still important for relaxation, coping skills