ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS—IN BRIEF:

Assessment and Diagnosis

Assessment Recommendations:

- **Recommendation I:** Evaluate any patient at high risk (i.e., with risk factors such as family history, difficulties sleeping, avoidance of specific feared items, inattention/distraction, irritability, trauma, psychosocial adversity, family conflict, refusal to separate from parents, school avoidance, etc.) for the possibility of an anxiety disorder.

- **Recommendation II:** When evaluating a child or teen with possible anxiety, conduct separate Interviews with the child/adolescent and guardian using DSM 5 criteria. See criteria online at https://psychcentral.com/disorders/anxiety/

- **Recommendation III:** Assess with validated anxiety rating sales to help guide the diagnosis and increase diagnostic precision of an anxiety disorder

  - The SCARED (Screen for Child Anxiety Related Disorders) is an easy-to-use assessment scale for children and adolescents, both with a parent version and a child version.
  - Generalized Anxiety Disorder 7-item (GAD-7) scale can be used for older teens.
  - Both scales can be downloaded at no cost, https://www.cappcny.org/home/clinical-rating-scales/

- **Recommendation IV:** Assess safety/suicide risk

  Red Flags or "High Risk" Considerations to determine suicidal risk:
  - Suicidal ideation, suicidal gestures, and suicide attempts
  - Individuals with severe panic disorder may be at increased risk for suicide
  - Multiple areas of poor/impaired functioning (school, social and family)
  - Co-morbid substance abuse
  - Abuse (physical, sexual, emotional, neglect)

Differential Diagnosis:

Psychiatric conditions that can resemble anxiety disorders include the following:

- ADHD
- Psychotic Disorders
- Autism Spectrum Disorder
- Learning Disabilities
- Bipolar Disorder
- Depression
- Oppositional Defiant Disorder
- Communication Disorders
- Posttraumatic Stress Disorder
- Obsessive-Compulsive Disorder

Comorbidities:

- Anxiety disorders most often are comorbid with other anxiety disorders.
- 10-15 percent of children and adolescents with anxiety disorders have a depressive disorder, though 15-75% of youth with depression meet criteria for an anxiety disorder (Cummings, Coporino, & Kendall, 2014).
- 15–25 percent of children and adolescents with anxiety disorders meet the criteria for ADHD. It is not uncommon for both conditions to be present in a patient.

Medical conditions that can resemble an anxiety disorder:

- Hyperthyroidism
- Caffeinism
- Migraine
- Asthma
- Seizure disorders
- Lead intoxication
- Less common conditions: Hypoglycemia, pheochromocytoma, CNS disorder, and cardiac arrhythmias
- Prescription drugs: antiasthmatics, sympathomimetics, steroids, selective serotonin reuptake inhibitors (SSRIs), and atypical antipsychotics
- Nonprescription drugs with side effects that may mimic anxiety include diet pills, antihistamines, and cold medicines

Treatment

Initial Management Recommendations:

- **Recommendation I**: Clinicians should educate and counsel families and patients about anxiety and options for the management of the disorder.
- **Recommendation II**: Clinicians should develop a treatment plan with patients and families and set specific treatment goals in key areas of functioning including home, peer, and school settings.
- **Recommendation III**: Establish links with community mental health resources, which may include patients and families who have dealt with anxiety.
- **Recommendation IV:** Establish a safety plan, which includes restricting access to lethal means, engaging a concerned third-party, and establishing an emergency communication mechanism.

Treatment Recommendations:

- **Recommendation I**: In cases of ***mild*** anxiety, consider a period of active support and monitoring before starting other evidence-based treatment**.**
- **Recommendation II**: Consider Cognitive Behavioral Therapy for mild cases and antidepressant treatment such as SSRIs for moderate cases.
- **Recommendation III**: If a Primary Care Physician (PCP) identifies a child or adolescent with moderate or severe anxiety or complicating factors such as co-existing substance abuse, consultation with a mental health specialist should be considered.
- **Recommendation IV:** PCPs should actively support anxious adolescents who are referred to mental health. Consider sharing care with mental health agencies/professionals when possible.

Psychosocial Interventions:

- Numerous studies have shown that Cognitive Behavioral Therapy (CBT) and its variants are effective for the treatment of anxiety disorders in children and adolescents (Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2015).
- CBT with children, exposure, modeling, CBT with parents, and psychoeducation are considered “well-established” treatments and have the most empirical support (Higa-McMillan et al., 2015).
- Studies have shown that the combination of both medication and CBT is the most effective strategy for reducing and treating symptoms of anxiety disorders (Walkup et al., 2008).

Pharmacotherapy:

See Medication Chart below for starting doses, titration strategy, therapeutic, and maximum recommended doses.

The following delineates potential adverse effects of SSRI/SNRI:

- Serious Adverse Effects
    - Serotonin Syndrome (muscle rigidity, tremulousness, myoclonus, autonomic instability, agitated confusion, rhabdomyolysis)
    - Akathisia (uncontrollable internal motor restlessness)
    - Hypomania
    - Discontinuation syndromes (nausea, vomiting, headache, tremor, dizziness, fatigue, irritability, palpitations, rebound depression/anxiety)

- *Common Adverse Effects*
    - *GI effects (dry mouth, constipation, diarrhea)*
    - Sleep disturbance
    - Irritability
    - Disinhibition
    - Agitation/jitteriness
    - Headache

Recommendation - Collaborative Care

- Primary Care clinicians should actively support children and adolescents who are referred to mental health for anxiety symptoms. Consider sharing care with mental health professionals if possible.

- **The free Psych TLC** service is available for:
    - Consultation on psychiatric medication related issues including:
        - Advice on diagnosis and initial management for your patient
        - Titration of psychiatric medications
        - Side effects of psychiatric medications
        - Combination of psychiatric medications with other medications
        - Referral and services consultation regarding children with mental health issues

    - A licensed mental health professional (MHP) and a child and adolescent psychiatrist (CAP) are available via telephone to provide consultation and support to PCPs from 8am-5pm, M-F. Simply call **(844) 547-5688 or (501) 320-7270** to contact the Psych TLC Call Center. One of our expert MHPs will obtain basic information from your about the child and then set up a convenient time for Peter S. Jensen, MD, or another child & adolescent psychiatrist to call you back, usually within 30 minutes to 2 hours.

MEDICATIONS FOR DEPRESSION AND ANXIETY

	Generic Name	Trade Name	Available Forms	Dosing	Duration	Peak Effect	FDA Indication	Side Effects	Comments
SSRI	citalopram	CELEXA	Tablets: 10, 20, 40 mg Solution: 10 mg/5ml	Start with 10 mg given every morning Dose range: 10-40 mg daily	24 hours	4-6 weeks	MDD (A)	Common: nausea, dry mouth, somnolence, insomnia, tremor, ejaculatory dysfunction, dyspepsia, decreased libido Serious: serotonin syndrome, increased suicidality/worsening depression, mania,	profile. Does not usually cause insomnia
SSRI	escitalopram	LEXAPRO	Tablets: 5, 10, 20 mg Solution: 5 mg/5ml	Start with 5 mg (or less) given every morning Dose range 5-20 mg daily	24 hours	4-6 weeks	MDD (12 - 17 yo) & GAD (A)		S-isomer of citalopram
SSRI	fluvoxamine	LUVOX	Tablets: 25, 50, 100 mg	Start with 25 mg given at bedtime; doses above 50 mg should be divided Dose Range: 50-300 mg daily	24 hours	4-6 weeks	OCD (Child & Adolescents)		Luvox brand discontinued in US
SSRI	paroxetine	PAXIL / PAXIL CR	Tablets: 10, 20, 30, 40 mg Solution: 10 mg/5ml CR Tablets: 12.5, 25, 37.5 mg ER	Start with 10 (12.5 if CR) mg daily (may be given at night) Dose range: 10-50 (12.5-37.5 if CR) mg daily	24 hours	4-6 weeks	Paxil: MDD, OCD, Panic, SAD, GAD, PTSD (A) Paxil CR: MDD, panic, PMDD (premenstrual), SAD (A)		Increased risk of withdrawal symptoms if discontinued aburptly
SSRI	fluoxetine	PROZAC	Tablets: 10, 20, 40 mg Solution: 20 mg/5ml	8-11 yo: Start 5-10 mg given every morning 12 and older: Start 10 mg given every morning Dose range: 5-20 mg in children under 12 y/o and 5-40 (to 80 in some cases) mg in children over 12 y/o	24-72 hours	4-6 weeks	MDD, OCD, Bulimia Nervosa, Panic, PMDD (A) MDD (8-17 y/o), OCD (7-17 y/o)		Weekly form available. Long half life prevents withdrawal symptoms if dose is missed
SSRI	sertraline	ZOLOFT	Tablets: 25, 50, 100 mg Solution: 20 mg/ml	Start 12.5 mg per day Dose range: 50-200 mg daily	24 hours	4-6 weeks	MDD, OCD, Panic, PTSD, PMDD, SAD (A) OCD (6-17 y/o)		
SNRI	venlafaxine	EFFEXOR / EFFEXOR XR	Tablets: 25, 37.5, 50, 75, 100 mg XR Capsules (Extended release): 37.5, 75, 150 mg	Start 75 mg/day in divided doses; XR form can be used once daily Dose Range: 75-225 mg (225 mg max per FDA indication; however, in adults max frequently up to 375 mg)	8-12 hours XR: 24 hours	4-6 weeks	MDD (A) XR: MDD, GAD, Panic, SAD (A)	Common: nausea, dry mouth, somnolence, insomnia, tremor, ejaculatory dysfunction, dyspepsia, decreased libido Serious: serotonin syndrome, increased suicidality/worsening depression, mania, HTN, seizures	Monitor BP closely
OTHER	duloxetine	CYMBALTA	Capsules: 20, 30, 60 mg	Starting dose: 30 mg / day for 2 weeks before considering an increase to 60 mg Dose range: 30 to 120 mg / day 7 - 17 y/o Adults: 40-60 mg/ day for MDD, up to 120 for GAD	24 hours	4-6 weeks	MDD, diabetic neuropathy, GAD	Common: nausea, dry mouth, somnolence, insomnia, tremor, ejaculatory dysfunction, dyspepsia, decreased libido, HTN Serious: serotonin syndrome, increased suicidality/worsening depression, mania, hepatotoxicity, Stevens-Johnson syndrome, seizures	
OTHER	bupropion	WELLBUTRIN	Tablets: 75, 100 mg	Start with 75 mg given twice per day Dose range: 37.5 to 450 mg/day in 2-3 divided doses	12 hours	4-6 weeks	MDD (A)		
OTHER	bupropion	WELLBUTRIN SR	Tablets: 100, 150 mg	Start: 100 mg PO qam, incr. 100 mg/day qwk, divide dose bid Max: 400 mg/day Info: avoid/minimize alcohol use; do not cut/crush/chew	12-24 hours	4-6 weeks	MDD (A)	Common: insomnia, irritability, dry mouth, headaches, stomach upset, agitation, muscle aches, appetite suppression and weight loss, constipation or diarrhea. Less common: Stevens-Johnson syndrome, erythema multiforme, seizures, mania, psychosis, increased heart rate,	
OTHER	bupropion	WELLBUTRIN XL	Tablets: 150, 300 mg	Start: 150 mg PO qam, incr. after 7 days to 300 mg/day Max: 450 mg/day Info: avoid/minimize alcohol use; do not cut/crush/chew	24 hours	4-6 weeks	MDD & SAD (A)	liver failure, severe hypertension, migraines, worsened depression, suicidal thoughts	

NOTE: ALL INFORMATION SHOULD BE CHECKED AGAINST CURRENT PDR