Vanderbilt Health
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Treating Anxiety Disorders in Pediatric Primary Care

When? How? Why?

Housekeeping Notes

- Our goal is to have this be an interactive session, so please submit your questions throughout the presentation and we will be sure to answer as many as we can in the last 15 minutes.
- No worries about scrambling to take notes. As a follow-up, we will send an email of the video recording and the entire deck for your records.
- We invite you to participate in the surveys featured during today's presentation.
- We'd love to hear from you! If we don't cover something, or if your question isn't answered, contact us.

Email us at info@vhan.com and we will get you a response as soon as possible.

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Webinar Overview

At the end of the session, the learner will be able to:

- Diagnose Separation, Social, and Generalized Anxiety Disorders.
- Treat mild to moderate anxiety disorders using pharmacologic interventions.
- Describe the critical components of therapy for anxiety.
- Evaluate progress in treatment using outcomes measures.

Poll

Is your practice currently screening for anxiety disorders?

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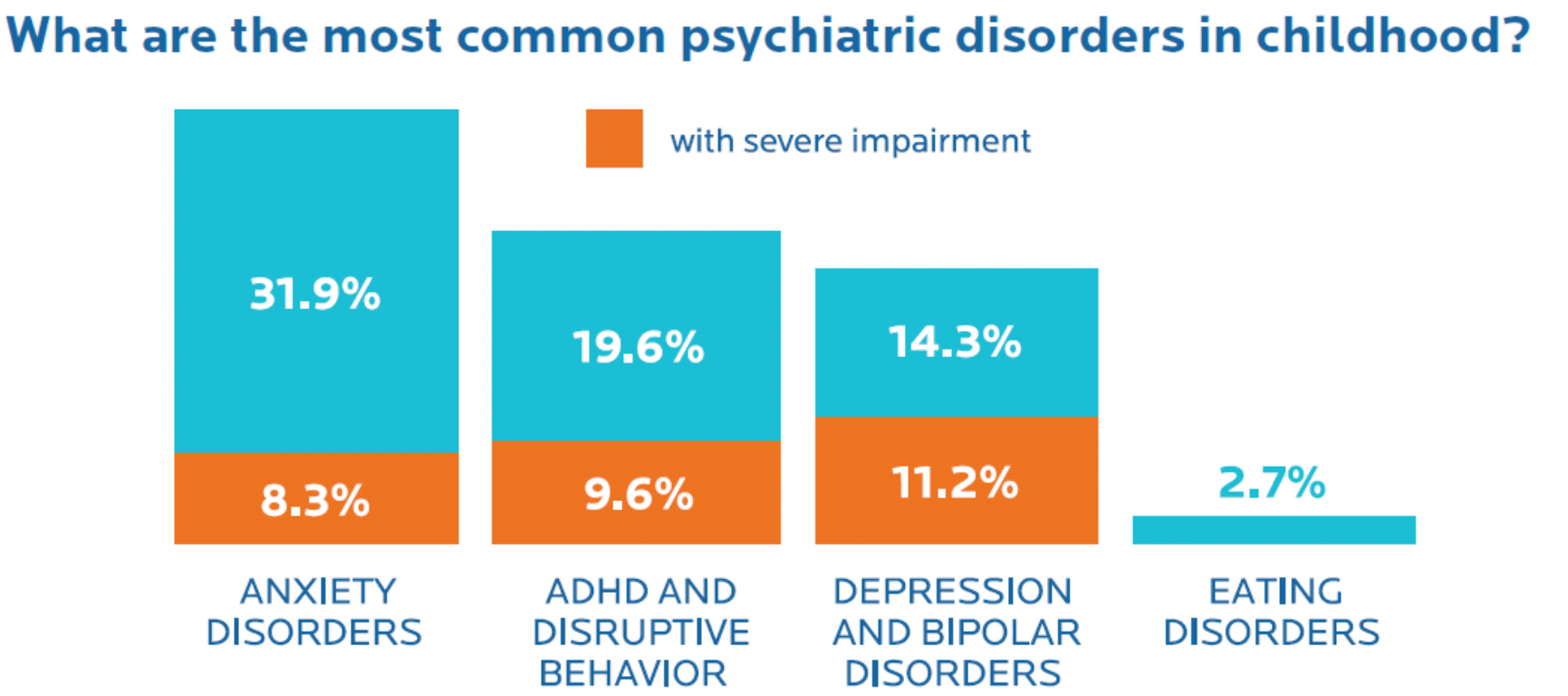
Why?

Anxiety disorders are highly prevalent



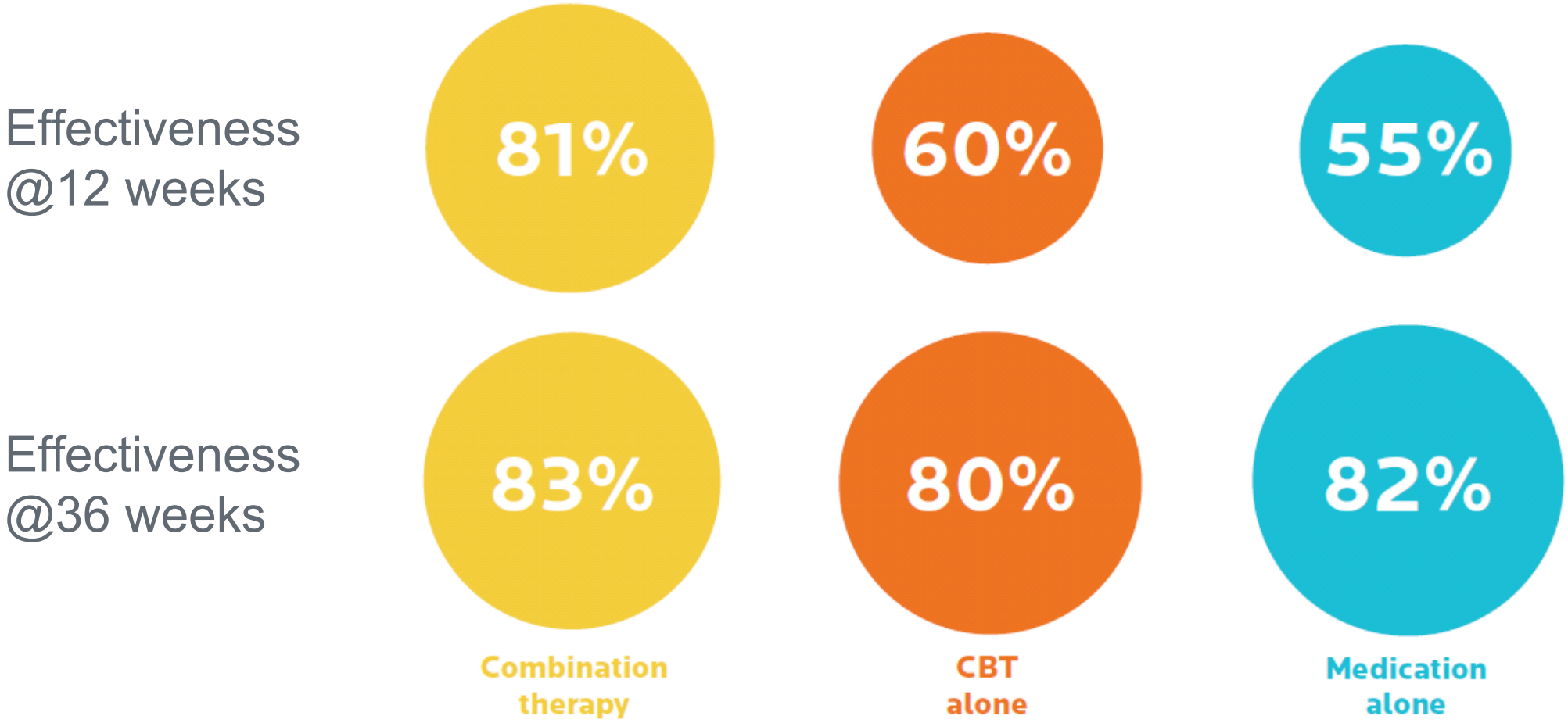
These estimates are based on diagnostic interviews done by professionals with a large, representative sample of young people ages 13–18.[6]

Untreated anxiety leads to other disorders.

- ~45% of children with onset of social anxiety disorder before age 14 will have had at least one episode of major depression within the next 10 years
- ~50% of adolescents with social anxiety drop out of high school or college prematurely
- 1.5 – 2X increased odds of developing alcohol or cannabis dependence by age 24 in adolescents with social anxiety disorder

Children with anxiety disorders are less likely to receive treatment than children with other disorders.

Anxiety treatment works



The NEW ENGLAND JOURNAL of MEDICINE

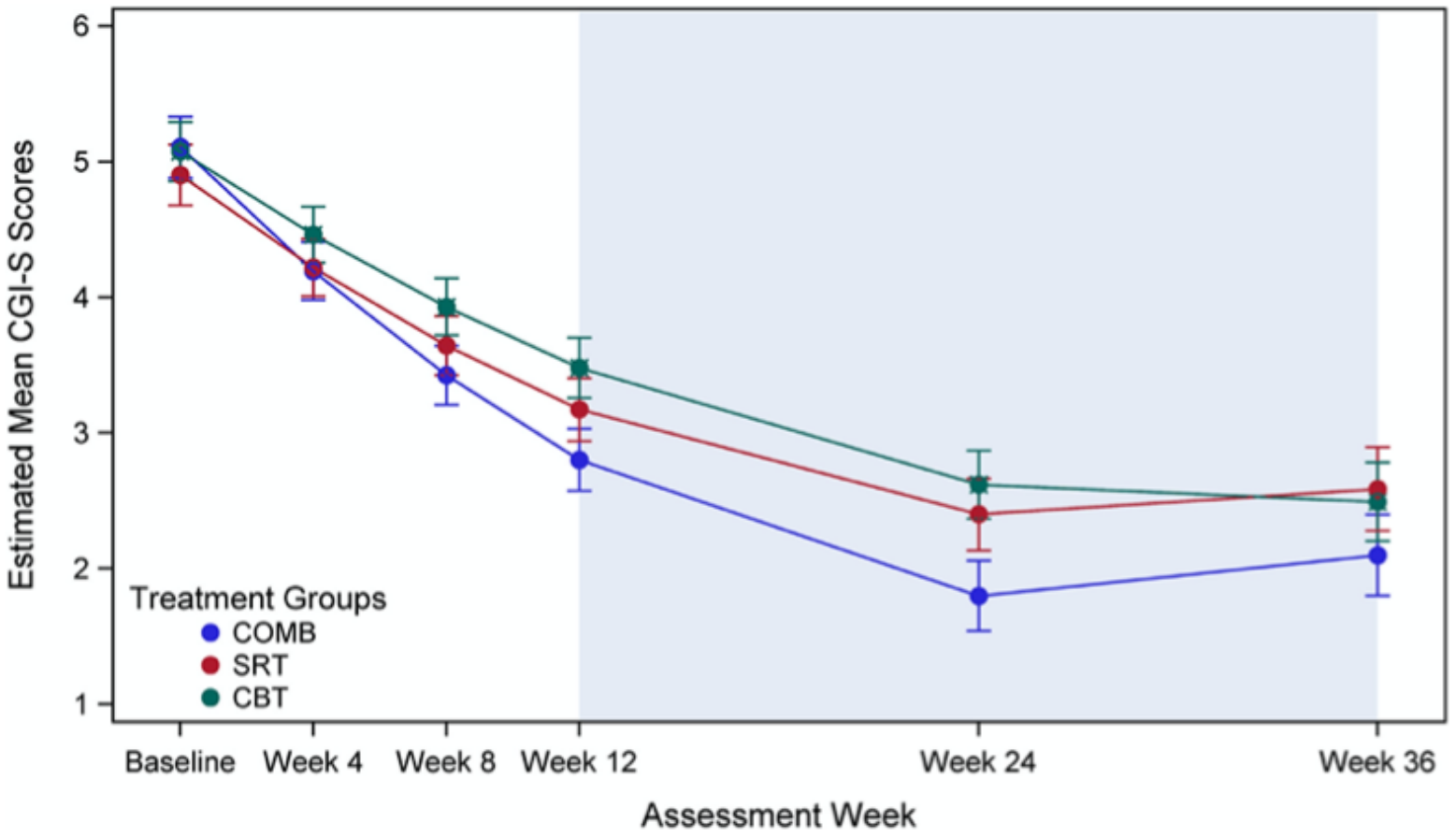
ESTABLISHED IN 1812 DECEMBER 25, 2008 VOL. 359 NO. 26

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.*

Child–Adolescent Anxiety Multimodal Study (CAMS)

- n=488 youth with primary anxiety disorder ages 7 to 17
- Randomized to
  - Placebo
  - Sertraline
  - CBT
  - Combination
- At 12 weeks, SERT = CBT < COMB
- At 36 weeks, SERT = CBT = COMB



Walkup et al (2008) NEJM

For youth with severe anxiety, NNT = 14 SERT; 8 CBT; 3 COMB (Taylor et al 2018)

When?

When is Anxiety a Symptom?

- Normal anxiety
  - Predictable triggers
  - Proportionate reaction
  - Can happen anytime in development
  - Can be severe and chronic
- Pathological
  - Triggers are normative experiences
  - Excessive, disproportionate reaction
  - Predictable age of onset
    - SAD, SoAD, GAD ages 6-12;
    - Panic – late adolescence
  - Highly stereotyped across anxious individuals

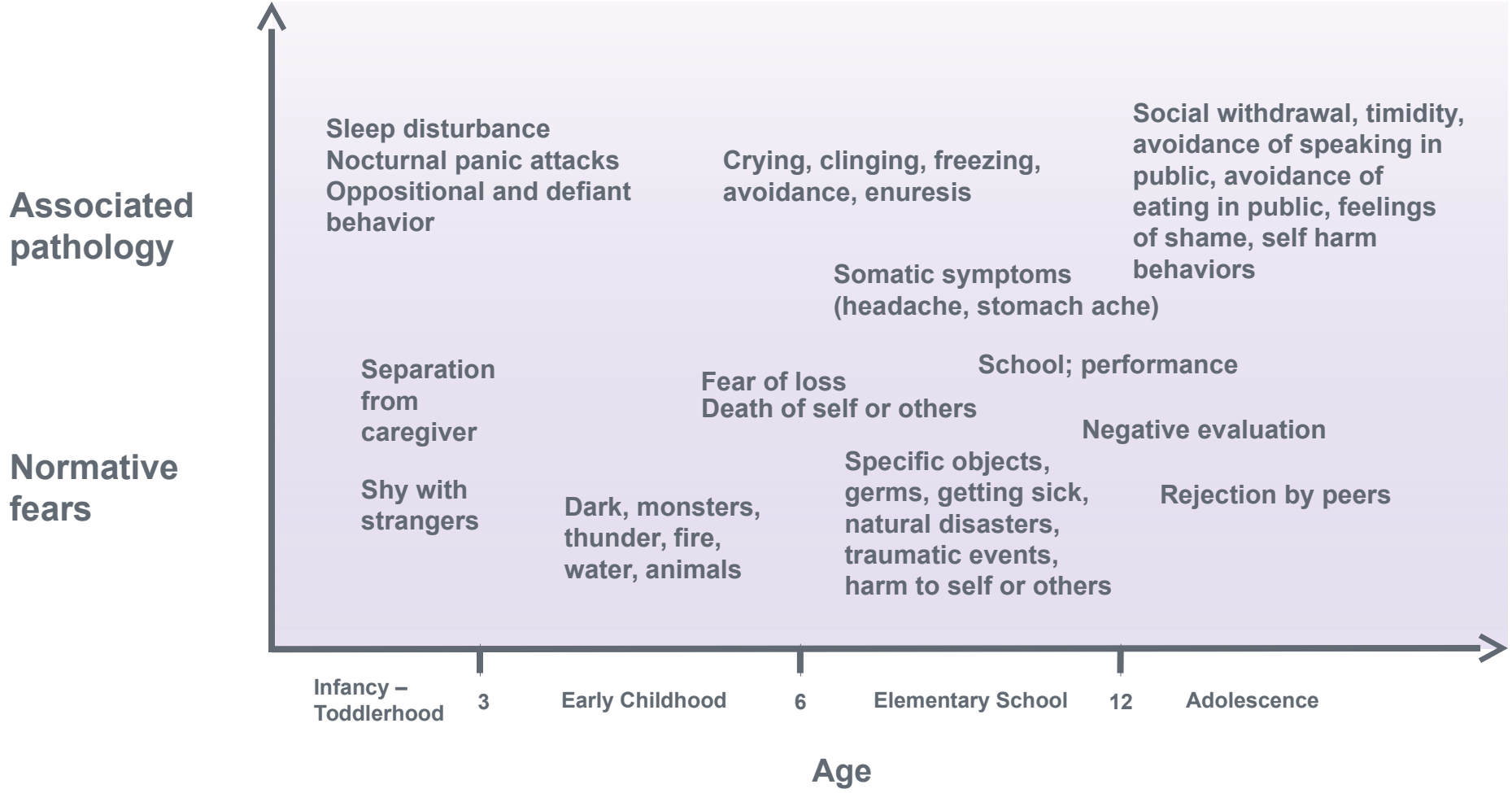
Treatment recommended when symptoms are interfering with daily activities and persist for more than 3 to 4 weeks

“Typical” presentation

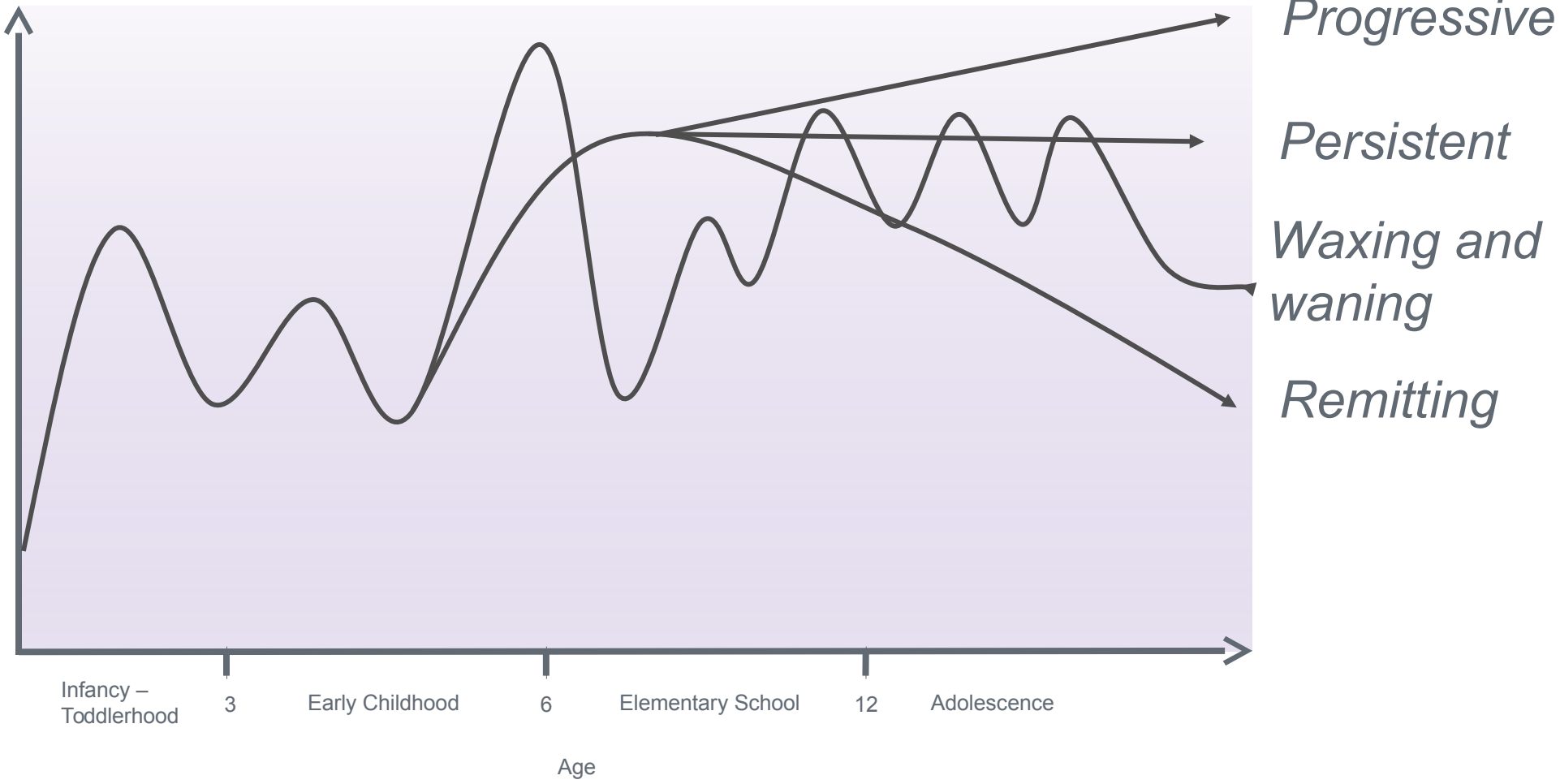
Another “typical” presentation

Don’t forget that anxiety may also present with irritability—anxiety is an under-recognized contributing factor to “oppositional” behaviors

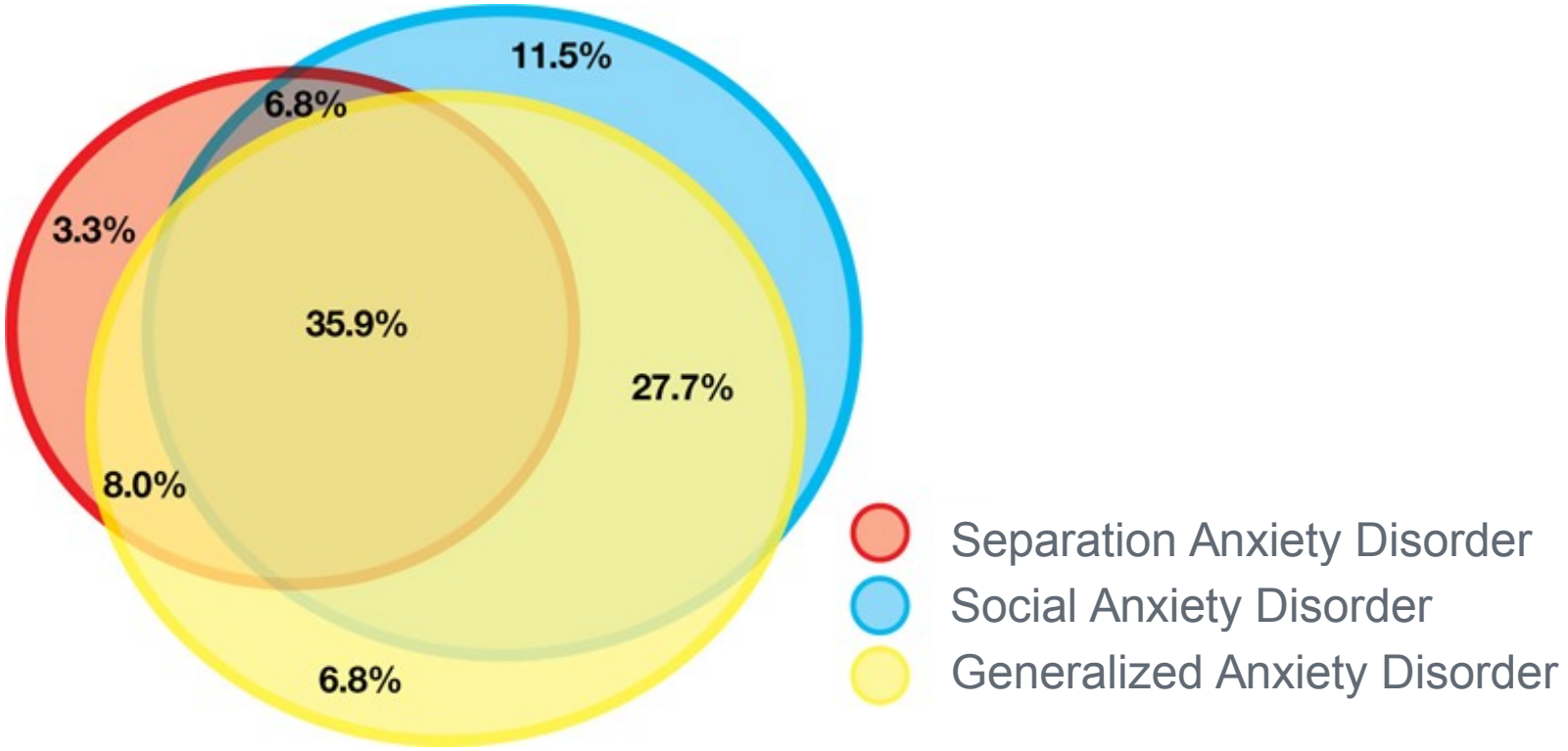
Relationship of anxiety disorders to normal developmental fears



Course of illness is variable



The Pediatric Anxiety Triad
Anxiety disorders rarely occur in isolation



Strawn & McReynolds 2012
Data from CAMS Walkup et al 2008

Separation anxiety

- Recurrent distress when separated from caregiver
- Fears that something bad will happen to caregiver
- Fears that something bad will happen to self
- Refusal to go to school or elsewhere
- Fear of being alone
- Will not sleep alone or sleep away from home
- Nightmares with separation theme
- Physical symptoms in context of separation

Social Phobia

- A marked and persistent fear of social situations
  - Fear of scrutiny by others
  - Worries about performance
  - Exacerbated by unfamiliar people/situations
- Exposure to the stimulus almost invariably provokes anxiety
- Recognition of fear as excessive or unreasonable
- Avoidance or experience of intense distress

Social Phobia

- “Generalized” Social Phobia:
  - subtype of social phobia in which the fears are present in most social situations
- “Specific” Social Phobia:
  - Writing, eating, speaking in public, etc.

Generalized Anxiety Disorder (GAD)

- Excessive worry and anxiety more days than not for at least 6 months
- Person finds it difficult to control the worry
- Three or more of:
  - Restless, keyed-up, on edge
  - Easily fatigued
  - Difficulty concentrating
  - Irritability
  - Muscle Tension
  - Sleep Disturbance

Note: Can be difficult to distinguish from depressive symptoms!

Panic Attacks

- A discrete period of intense fear or discomfort, with at least 4 of the following symptoms developed abruptly and reaching a peak within 10 minutes:

Physiologic Symptoms of Panic Attack		Psychological Symptoms of Panic Attack
Heart racing	Chest pain	Fear of dying
Sweating	Nausea	Fear of losing control
Trembling	Dizziness	Derealization/depersonalization
Shortness of breath	Numbness/tingling	
Feeling of choking	Chills/hot flushes	

Panic Disorder

Panic attack

â

Anticipatory Anxiety

â

Phobic Avoidance

Panic attacks may occur with any of the anxiety disorders.

Panic Disorder is rare in kids.

Screening for anxiety disorders in primary care

SCARED
42 items; most complete anxiety screener

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When I feel frightened, it is hard to breathe	O	O	O	PN
2. I get headaches when I am at school.	O	O	O	SH
3. I don't like to be with people I don't know well.	O	O	O	SC
4. I get scared if I sleep away from home.	O	O	O	SP
5. I worry about other people liking me.	O	O	O	GD
6. When I get frightened, I feel like passing out.	O	O	O	PN
7. I am nervous.	O	O	O	GD
8. I follow my mother or father wherever they go.	O	O	O	SP
9. People tell me that I look nervous.	O	O	O	PN
10. I feel nervous with people I don't know well.	O	O	O	SC
11. I get stomachaches at school.	O	O	O	SH
12. When I get frightened, I feel like I am going crazy.	O	O	O	PN

Cutoff > 25

Subscales
Panic/Somatic Symptoms
Generalized Anxiety
Separation Anxiety
Social Anxiety
School Avoidance

GAD-7
7 items; only asks about generalized anxiety

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

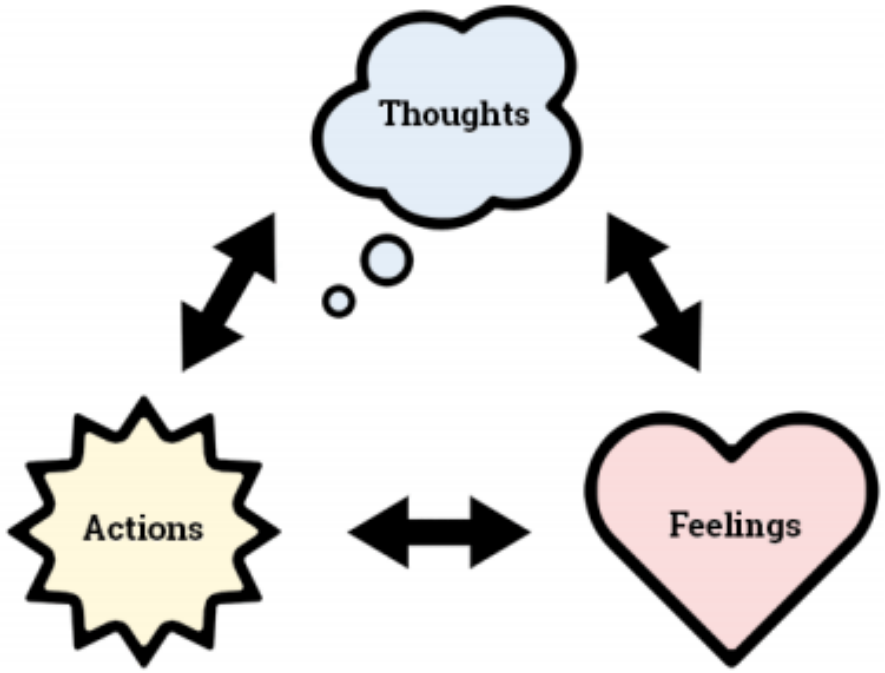
Screening questions

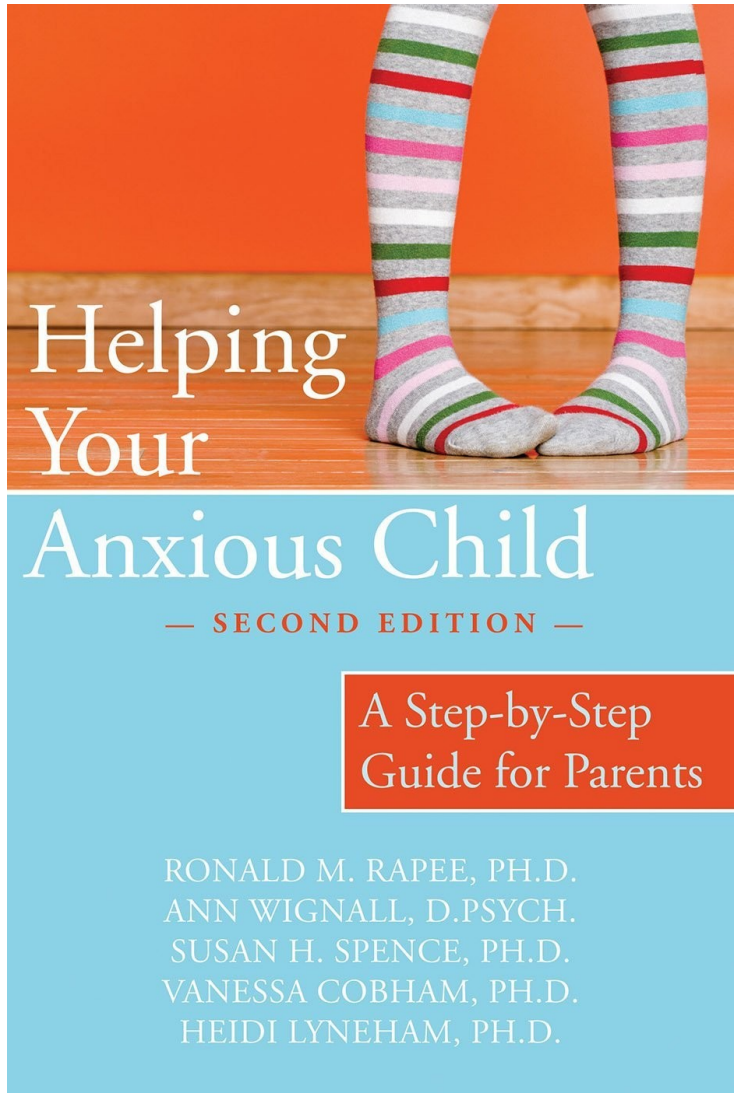
- Social anxiety
  - Are you very shy? Does feeling shy every get in the way?
  - Will you order your own food in a restaurant?
  - Will you ask to use the bathroom at school if needed?
  - Will you go to birthday parties, scouts, team events?
- Separation anxiety
  - Are you afraid something terrible might happen to parent or self?
  - What is your bedtime routine? Do you prefer to sleep alone or with someone else?
  - Are there places in the house where you are afraid to go?
- Generalized Anxiety
  - Do you worry a lot?
  - Is it hard to shut your thoughts off?
  - Is it hard to let go of little things?
  - Associated symptoms: restlessness, fatigue, muscle aches, poor concentration, insomnia

How?

How to treat?

- **CBT *with exposure***
- Pharmacology
  - SSRI's
    - Fluoxetine
    - Sertraline
    - Citalopram
    - Escitalopram
  - SNRI's
    - Venlafaxine ER
    - Duloxetine
  - May consider short term use of benzodiazepines (clonazepam, lorazepam)
  - Consider alpha agonists (guanfacine, clonidine), especially if trauma





Rapee et al 2008

Elements of CBT

1. Psychoeducation
2. Identifying thoughts-feelings-behaviors
3. Practicing coping skills
4. Developing a fear hierarchy
5. Completing exposures
6. Assessing progress

A simple breathing exercise

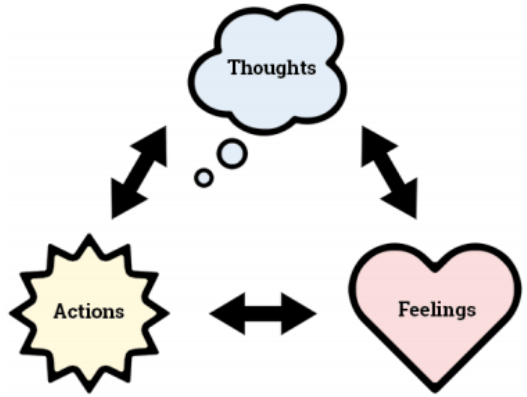
- Think of your favorite cookie—*what is it?*
- Imagine a pan of cookies just came out of the oven. They are too hot to touch. Imagine you are smelling the cookies. Breathe in through your nose and take it in, then blow out through your nose to cool off the cookies.
- Can be anything—pizza, fresh bread, sweet treats.

Thoughts Feelings Actions

Everyone has problems, both big and small. To better solve your big problems, it helps to learn how your **thoughts**, **feelings**, and **actions** are connected.

Imagine you have an upcoming test, and you think "I'm going to fail". Because of this thought, you start to worry. You are so worried that you feel sick just thinking about the test. Because it's so uncomfortable, you decide not to study.

The thought ("I'm going to fail") led to a feeling (worry), which led to an action (not studying). What might have changed if you had a different thought?



Just talking about thoughts, feelings, and behaviors is not enough!

Exposure to feared situations is key to recovery.

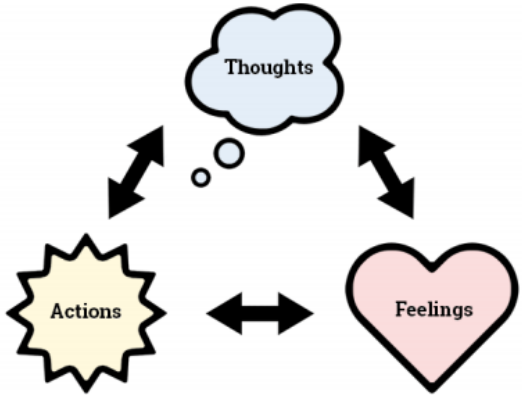
Thoughts Feelings Actions

Everyone has problems, both big and small. To better solve your big problems, it helps to learn how your **thoughts**, **feelings**, and **actions** are connected.

Imagine you have an upcoming test, and you think "I'm going to fail". Because of this thought, you start to worry. You are so worried that you feel sick just thinking about the test. Because it's so uncomfortable, you decide not to study.

The thought ("I'm going to fail") led to a feeling (worry), which led to an action (not studying). What might have changed if you had a different thought?

Avoidance can be one of the most difficult actions to change!
Exposure = sitting with the thoughts, studying
For kids who OVER PREPARE,
Exposure = doing LESS



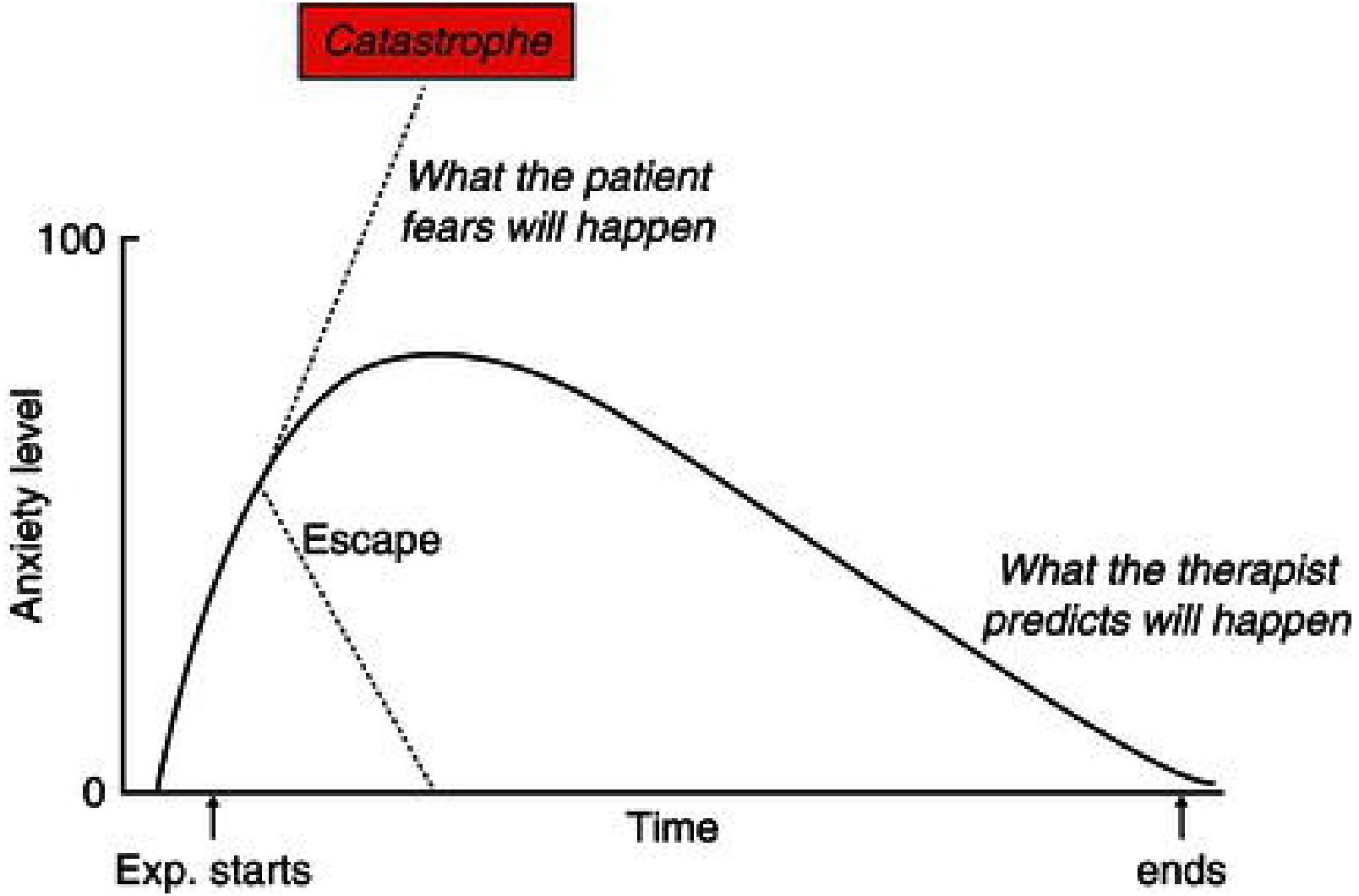
Addressing parental accommodation is critical to treatment success

Parent accommodation impairs new learning

- May be driven by
  - Parent's anxiety
  - Fear of backlash
  - Exhaustion

Rescue	Exposure
Remember situation at height of fear	Remember success
Prevents habituation	Learns anxiety passes on its own
No experience of mastery	Encourages mastery, ability to approach increasingly challenging situations
Escape is reinforced	Distress tolerance is reinforced

Exposure therapy



Pharmacologic management of mild to moderate anxiety disorders in primary care

Typical doses for SSRIs and SNRIs
increase dose every 4 to 7 days as tolerated

Medication	Initial dose age <12	Initial dose age 12-17	Target dose (mg/d)
Citalopram	5	10	20 to 40
Escitalopram	2.5	5	10 to 20
Fluoxetine	5	10	20 to 40 (children) 20 to 60 (adolescents)
Sertraline	12.5	25	150 to 200
Duloxetine	20	20	60
Venlafaxine	37.5	37.5	150

Adapted from Strawn & McReynolds 2012

Side effects

- Typically very well tolerated
- Common side effects:
  - Nausea; GI upset
  - Headache
  - Dizziness
  - Sleep changes
- Rare serious side effects
  - Significant activation/switch to mania
  - Suicidal thoughts or behaviors

Black Box Warning
NIMH guidance for parents

What Did the FDA Review Find?

In the FDA review, no completed suicides occurred among nearly 2,200 children treated with SSRI medications. However, about 4 percent of those taking SSRI medications experienced suicidal thinking or behavior, including actual suicide attempts—twice the rate of those taking placebo, or sugar pills.

In response, the FDA adopted a "black box" label warning indicating that antidepressants may increase the risk of suicidal thinking and behavior in some children and adolescents with MDD. A black-box warning is the most serious type of warning in prescription drug labeling.

The warning also notes that children and adolescents taking SSRI medications should be closely monitored for any worsening in depression, emergence of suicidal thinking or behavior, or unusual changes in behavior, such as sleeplessness, agitation, or withdrawal from normal social situations. Close monitoring is especially important during the first four weeks of treatment. SSRI medications usually have few side effects in children and adolescents, but for unknown reasons, they may trigger agitation and abnormal behavior in certain individuals.

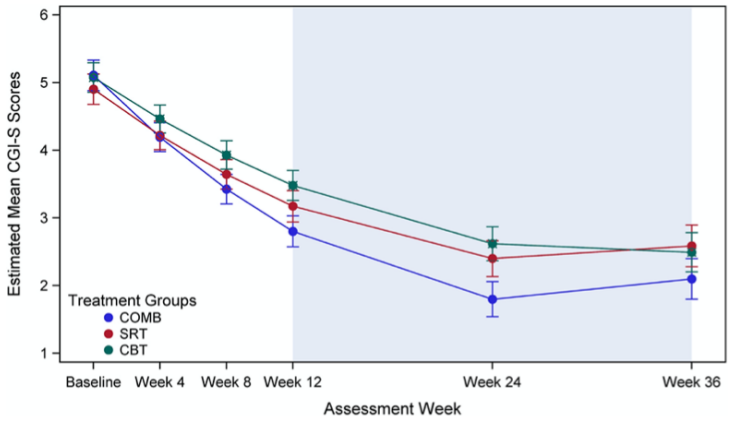
https://www.nimh.nih.gov

What to expect from treatment: therapy
Typical manualized treatments are 12 to 16 weeks

- Don’t expect that you’ll have things sorted out in just a few weeks
- Do expect that there will be noticeable changes before completing the program
- Do expect to make progress in zig-zag fashion rather than a straight line (two steps forward and one step back)
- Do expect that any narrow or highly defined worries will be easier to make progress on than broad or generalized worries
- Do expect that children will need to keep practicing skills for some time until their new skills in thinking and behaving become every-day habits

What to expect from treatment: medications

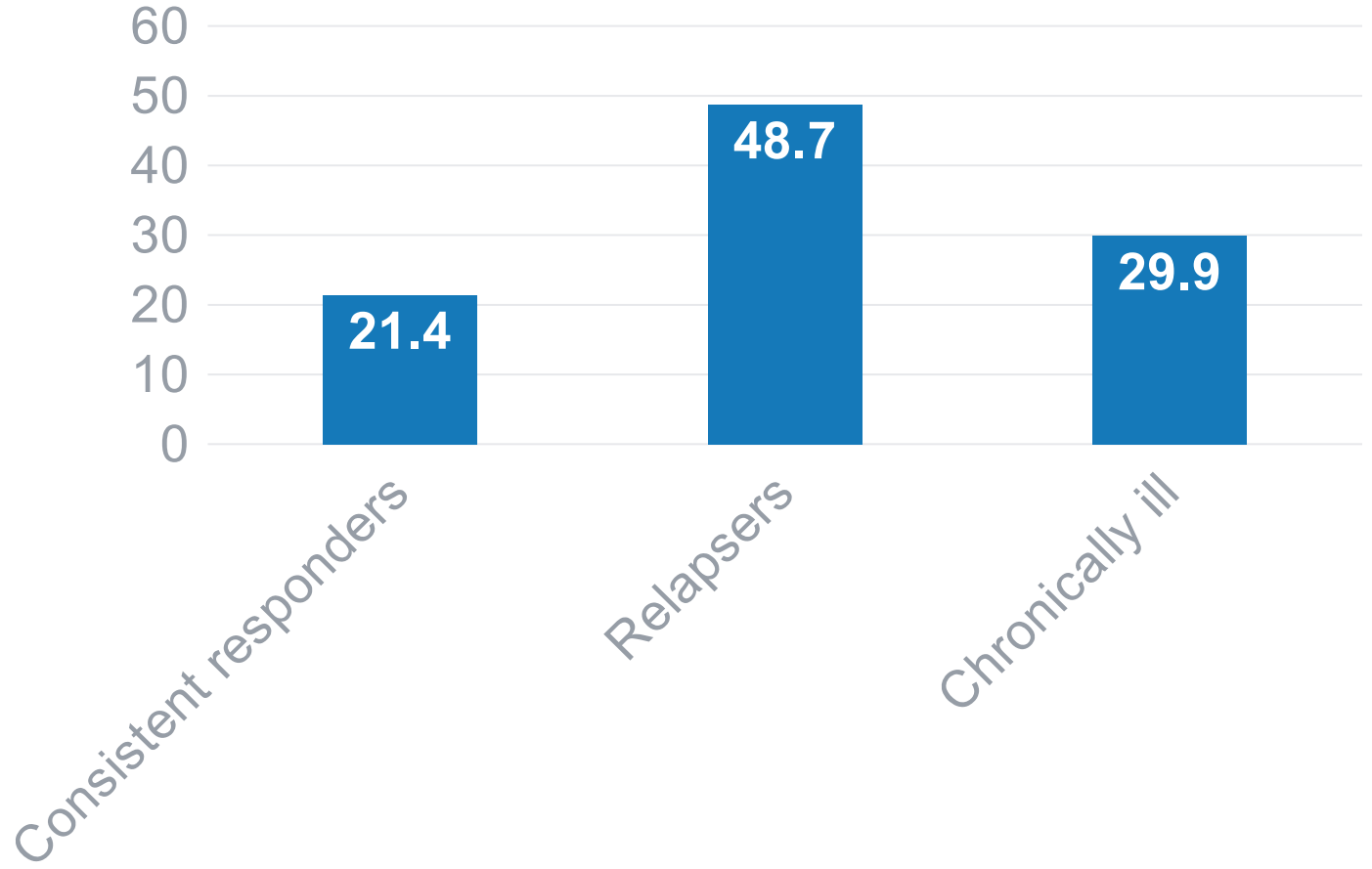
- Expect some benefit within first 2-3 weeks. If no response, switch meds.
- Anxiety may get worse at first.
- If not tolerable, can lower dose or change meds.
- Expect continued improvement up to 6 months
- Continue treatment for at least 12 months



Predictors of treatment response in CAMS study

- Combined medication and CBT treatment
- Younger age
- Lower severity at study entry
- Absence of social anxiety
- Absence of comorbid ADHD
- Positive expectations – more likely to persist with exposure work

Long-term follow-up
CAMS 6 years later



Most relapsers did not resume treatment!

Ginsburg, et al (2018) JAACAP

Measuring outcomes in pediatric anxiety disorders

Clinical trials outcomes:

- Pediatric Anxiety Rating Scale (PARS)
- Clinical Global Impression (CGI) anxiety severity
- CGI anxiety improvement

None of these measures are great for routine clinical practice.

Choose a target symptom and monitor.

GAD 7 is reliable measure for generalized anxiety.

Conclusions

- Anxiety disorders are common, impairing disorders of childhood that are not frequently treated.
- Untreated anxiety is a risk for depression, substance use, academic failure, family dysfunction
- Treatment works
  - CBT= SSRI < COMB
- SSRIs are safe and effective treatments
- CBT for anxiety must include exposure

Anxiety Disorders:

Parents' Medication Guide

American Academy of Child & Adolescent Psychiatry
www.aacap.org

American Psychiatric Association

Vanderbilt Health
Affiliated Network

VHAN Pediatric Behavioral Health Consult Line

Danielle McDonough, LMSW

Network Behavioral Health Partners, Pediatric

Behavioral Health Integration Services

Danielle and Vanessa are Licensed Social Workers who partner with the Vanderbilt Health Affiliated Network to provide real time clinical guidance through the Pediatric Behavioral Consult Line.

(615) 205-9367
Available Monday - Friday
8 AM - 4 PM CST

Learn more at vhan.com/behavioral

Pediatric Behavioral Health Consult Line:

Get a real time consult with a Licensed Clinical Social Worker, Monday – Friday, 8 AM –4 PM CST if you have a child or teen in your practice experiencing behavioral or emotional difficulties and you are uncertain how to best help them. ***This service is available for all patients, regardless of insurance carrier.***

- Some ways the consult line can assist include: medication consultation with child/ adolescent psychiatry, development of a behavioral health care plan, assistance with level of care determinations, safety planning, strategic resource and referral navigation, and direct follow-up and care coordination with families

- A consult note will be routed to you electronically with written recommendations and follow-up

- Please call 615-205-9367 to access the behavioral health consult line

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