Guidelines for Selected Disorders involving Children and Adolescents

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TDMHSAS BEST PRACTICE GUIDELINES

Anxiety Disorders in Children and Adolescents

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1. Introduction

Anxiety is a normal part of growing up. Sometimes, though, people experience so much anxiety that it interferes with their ability to function normally. It is then that anxiety becomes a disorder for which treatment might be needed.

In children, this disorder can begin as early as 7-9 months of age with "stranger" anxiety. Perhaps the most troubling problem about anxiety is the fact that if left untreated, it may results in the manifestation of more serious mental disorders like depression (Huberty, 2004). About 13 percent of youth 9 to 17 years of age experience some kind of anxiety disorder, with females more affected than males. Further, close to half of the young people with anxiety disorders have a comorbid disorder (SAMHSA, 2006).

2. DSM-IV TR Criteria for Anxiety Disorders

Generalized Anxiety Disorder

- Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)
- The person finds it difficult to control the worry.
- The anxiety and worry are associated with three or more of the following six symptoms (with at least some symptoms present for more days than not during the past 6 months).

  Note: Only one item is required in children.

  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 (e.g., difficulty falling asleep, staying asleep, or restless sleep).

- The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder); being embarrassed in public (as in Social Phobia); being contaminated (as in Obsessive-Compulsive Disorder); being away from home or close relatives (as in Separation Anxiety Disorder); gaining weight (as in Anorexia Nervosa); having multiple physical complaints (as in Somatization Disorder); or having a serious illness (as in Hypochondriasis); and the anxiety and worry do not occur exclusively during Posttraumatic stress disorder.

- The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.

Social Phobia (formerly called Social Anxiety Disorder)

- A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing.

  Note: ***In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults***.

- Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or predisposed Panic Attack.

  Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.

- The person recognizes that the fear is excessive or unreasonable.

  Note: In children, this feature may be absent.

- The feared social or performance situations are avoided or else are endured with intense anxiety or distress.

- The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- In individuals under age 18 years, the duration is at least 6 months.
- The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Body Dysmorphic Disorder, or a Pervasive Developmental Disorder).
- If a general medical condition or another mental disorder is present, the fear in the first criterion is unrelated to it, e.g., the fear is not of stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.

Panic Disorder

- Recurrent and unexpected panic attacks. A panic attack is a discrete period of intense fear or discomfort, with four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

    1. palpitations, pounding heart, or accelerated heart rate.
    2. sweating.
    3. trembling or shaking.
    4. sensations of shortness of breath or smothering.
    5. feeling of choking.
    6. chest pain or discomfort.
    7. nausea or abdominal distress.
    8. feeling dizzy, unsteady, lightheaded, or faint.
    9. derealization (feelings of unreality) or depersonalization (being detached from oneself).
    10. fear of losing control or going crazy.
    11. fear of dying.
    12. paresthesias (numbness or tingling sensations).
    13. chills or hot flushes.

- At least one of the attacks has been followed by at least 1 month of one of the following:
    - persistent concern about having additional panic attacks.
    - worry about the implications of the attack or its consequences (e.g., losing control, having a heart attack, "going crazy");
    - a significant change in behavior related to the attacks
- The Panic Attacks are not due to the direct physiological effects of a substance (e.g., drug of abuse, medication) or a general medical condition (e.g., hyperthyroidism).
- The Panic Attacks are not better accounted for by another mental disorder, such as Social Phobia (e.g., occurring on exposure to feared social situations); Specific Phobia (e.g., on exposure to a specific phobic situation); Obsessive-Compulsive Disorder (e.g., on exposure to dirt in someone with an obsession about contamination); Posttraumatic Stress Disorder (e.g., in response to stimuli associated with a severe stressor); or Separation Anxiety Disorder (e.g., in response to being away from home or close relatives).

Obsessive-Compulsive Disorder (OCD)

- Either obsessions or compulsions:
    - *Obsessions as defined by (1), (2), (3), and (4):*
        1. Recurrent and persistent thoughts, impulses, or images that are experienced, at some time during the disturbance, as intrusive and inappropriate and that cause marked anxiety or distress.
        2. The thoughts, impulses, or images are not simply excessive worries about real-life problems (as in generalized anxiety disorder).
        3. The person attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.
        4. The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind (not imposed from without, as in thought insertion).
    - *Compulsions as defined by (1) and (2):*
        1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the person feels driven to perform in response to an obsession, or according to rules that must be applied rigidly.
        2. The behaviors or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation; however, these behaviors

or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive.

- At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.

  Note: This criterion does not apply to children.

- The obsessions or compulsions cause marked distress, are time consuming (take more than 1 hour a day), or significantly interfere with the person's normal routine, occupational (or academic) functioning, or usual social activities or relationships.

- If another Axis I disorder is present, the content of the obsessions or compulsions is not restricted to it (e.g., preoccupation with food in the presence of an Eating Disorder; hair pulling in the presence of Trichotillomania; concern with appearance in the presence of Body Dysmorphic Disorder; preoccupation with drugs in the presence of a Substance Use Disorder; preoccupation with having a serious illness in the presence of Hypochondriasis; preoccupation with sexual urges or fantasies in the presence of a Paraphilia; or guilty ruminations in the presence of Major Depressive Disorder).

- The disturbance is not due to the direct physiological effects of a substance (e.g., drug of abuse, medication) or a general medical condition.

Posttraumatic Stress Disorder (PTSD)
(*<u>Note</u>: In the new DSM-5, PTSD will be included in a new chapter on Trauma- and Stressor-Related Disorders. There will also be <u>four</u> distinct diagnostic clusters instead of three: avoidance symptoms, arousal/reactivity symptoms, intrusion symptoms, and negative mood and cognitions. The new DSM-5 criteria for PTSD are said to be more developmentally sensitive for children and adolescents as well [American Psychiatric Association, 2012; Falco, 2012; National Center for PTSD, 2012; NCTSN, 2012.)

- Person has been exposed to traumatic event in which **both** of the following were present:

  1. Participation in, witnessing or confrontation with an event(s) that involved actual/threatened death or serious injury, or threat to physical integrity of self/others.

  2. Response involved intense fear, helplessness, or horror. ***Note: In children, the expression may involve disorganized or agitated behavior***.

- Traumatic event is persistently reexperienced in at least one of the following ways:

  1. Recurrent/intrusive distressing recollections of the event(s). This could include images, thoughts, or perceptions. ***Note: Young children may exhibit these themes or aspects of the trauma through repetitive play***.

  2. Recurrent distressing dreams of the event(s). ***Note: Children may experience frightening dreams without recognizable content***.

3. Acting or feeling as though the traumatic event(s) was recurring. Manifestations might include a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, even when under the influence of alcohol. ***Note: Trauma-specific reenactment may occur in young children***.

4. Intense psychological distress when exposed to internal or external cues that symbolize/resemble an aspect of the traumatic event(s).

5. Physiological reactivity when exposed to internal or external cues that symbolize/resemble an aspect of the traumatic event(s).

- Persistent avoidance of stimuli connected with the trauma and numbing of general responsiveness (behavior not present prior to the trauma), as indicated by at least three of the following:

  1. Efforts to avoid thoughts, feeling, or conversations linked with the trauma.

  2. Efforts to avoid activities, place, or people that awaken recollections of the trauma.

  3. Inability to recall an important aspect of the trauma.

  4. Markedly diminished interest/participation in significant activities.

  5. Feeling of detachment/estrangement from others.

  6. Restricted range of affect (e.g., an inability to have loving feelings).

  7. Sense of foreshortened future (e.g., does not expect to have a normal life span).

- Persistent symptoms of increased arousal (behavior not present prior to the trauma), as indicated by at least two) of the following:

  1. Difficulty falling/staying asleep.

  2. Irritability/outbursts of anger.

  3. Difficulty concentrating/staying focused.

  4. Hypervigilance.

  5. Exaggerated startle response.

- Symptoms in bullets two through four last longer than a month.

- The disturbance causes clinically significant distress/impairment in social, occupational, or other important areas of functioning.

- Establish subtype of PTSD present.

  - Acute
  - Chronic

- With delayed onset

If the duration of symptoms is	The diagnosis is	Comments
Less than 1 month	Acute stress disorder (not PTSD)	These are symptoms that occur in the immediate aftermath of the stressor and may be transient and self-limited. Although not yet diagnosable as PTSD, the presence of severe symptoms during this period is a risk factor for developing PTSD.
1–3 months	Acute PTSD	Active treatment during this acute phase of PTSD may help to reduce the otherwise high risk of developing chronic PTSD.
3 months or longer	Chronic PTSD	Long-term symptoms may need longer and more aggressive treatment and are likely to be associated with a higher incidence of comorbid disorders. Such a presentation is known in the literature as Complex PTSD (Field, 2005) or Type II PTSD (Tremblay, Hebert, & Piché, 2000) and is most often associated with maltreatment trauma that is both chronic and inflicted within a close caregiver relationship.

Specific Phobias (Formerly called Simple Phobias)

- Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).
- Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed Panic Attack.

  Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.

- The person recognizes that the fear is excessive or unreasonable.

  Note: In children, this feature may be absent.

- The phobic situation(s) is avoided or else is endured with intense anxiety or distress.
- The avoidance, anxious anticipation, or distress in the feared situation(s) interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.

- In individuals under age 18 years, the duration is at least 6 months.

- The anxiety, Panic Attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as Obsessive-Compulsive Disorder (e.g., fear of dirt in someone with an obsession about contamination); Posttraumatic Stress Disorder (e.g., avoidance of stimuli associated with a severe stressor); Separation Anxiety Disorder (e.g., avoidance of school); Social Phobia (e.g., avoidance of social situations because of fear of embarrassment); Panic Disorder With Agoraphobia; or Agoraphobia Without History of Panic Disorder.

Separation Anxiety Disorder

- Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:

    1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated.

    2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures.

    3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped).

    4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation.

    5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings.

    6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home.

    7. repeated nightmares involving the theme of separation.

    8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated.

- The duration of the disturbance is at least 4 weeks.

- The onset is before age 18 years.

- The disturbance causes clinically significant distress or impairment in social, academic, occupational, or other important area of functioning.

The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder with Agoraphobia.

Selective Mutism (formerly Elective Mutism)

- Consistent failure to speak in specific social situations (in which there is an expectation for speaking, e. g., at school) despite speaking in other situations.
- The disturbance interferes with educational or occupational achievement or with social communication.
- The duration of the disturbance is at least 1 month (not limited to the first month of school).
- The failure to speak is not due to a lack of knowledge of, or comfort with, the spoken language required in the social situation.
- The disturbance is not better accounted for by a Communication Disorder (e. g., Stuttering) and does not occur exclusively in the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder.

***Criteria Source**: American Psychiatric Association, 2000.*

Comorbidity of Anxiety Disorders

Most children with an anxiety disorder (79 percent) also suffer from other psychiatric conditions, mainly other anxiety disorders (Kendall, Brady & Verduin, 2001). Of course, some of this may be an artifact of the structure of the current nosological system (Achenbach, 1995). Other common comorbid conditions include the "externalizing behavior" diagnoses, including ADHD and ODD (Kendall, *et al.*, 2001).

3. Impact on Learning

Anxiety has both a positive and a negative impact on learning. The degree of anxiety as perceived by the learner will be the determining factor on which type of impact it has. According to the **Yerkes–Dodson law,** there is an empirical relationship between performance and physiological arousal (anxiety) such that performance increases with mental or physiological arousal, but only up to a point. Performance decreases when levels of arousal become too high. This law was developed in 1908 by psychologists Robert Yerkes and John Dillingham Dodson, both of whom were psychologists (Wikipedia, 2013).

Anxious students get caught in a cycle that includes cognitive interference and decreased engagement, which leads to poor achievement relative to potential, further decreasing the

students' motivation to study or participate while increasing the students' negative self-evaluation and academic self-concept which leads to increased anxiety.

Specifically, Separation Anxiety Disorder and Generalized Anxiety Disorder may lead to learning problems because of refusal to attend school or pay attention in class. Since avoidance is common in all anxiety disorders, school attendance may suffer indirectly even if school performance per se is not anxiety-producing.

If it is determined that anxiety is having a negative impact on the child's school performance, the clinician may opt to go beyond client focused interventions and work with the school system directly to develop classroom based interventions and/or accommodations. These interventions and accommodations may even be written into a student's Individualized Educational Plan (Connolley & Bernstein, 2007).

4. Differential Diagnosis

General Medical	*Psychiatric/Environmental*
• Medication side effects (including akathisia)	Mood disorders
• Hypoglycemic episodes	Pervasive developmental disorders
• Hyperthyroidism	ADHD
• Cardiac arrhythmias	Substance abuse (including caffeine)
• Asthma/Chronic respiratory illness	Eating disorders
• Pheochromocytoma	Schizophrenia
• Seizure disorders	Personality disorders
• CNS disorders • Pediatric autoimmune neuropsychiatric disorder associated with streptococcal infection	Normal reaction to severe environmental stressors or dangers (e.g., ongoing victim of abuse, divorce)
•	Adjustment and other disruptive disorders
•	Factitious disorder

5. Screening, assessment and/or evaluation

1. Interview the youth as part of the initial mental health assessment. ***Direct interviews, using developmentally appropriate language, are essential in the screening and diagnosis of anxiety disorders***. Questions should be based on the DSM-IV-TR (Connolly & Bernstein, 2007).

2. Determine onset and development of symptoms, as well as the context in which the symptoms occur and are maintained.

a. Is anxiety stimulus specific, spontaneous, or anticipatory?

b. Are there "extreme" stressors/traumatic events?

c. Is avoidant behavior present?

d. Do comorbid syndromes exist?

e. What is the adaptive function, if any, of the anxiety? (Bernstein, 2006).

3. Gather information from multiple sources, including the youth, parents, and/or teachers. Children may be more aware of their inner distress while parents or teachers may have more awareness of family or school functioning. For youth at least eight years of age, self-report measures like the Screen for Child Anxiety Related Emotional Disorders (SCARED) can help with screening and monitoring response to treatment.

4. If screening indicates significant anxiety, conduct further evaluation to differentiate anxiety disorders from developmentally appropriate worries or fears. Sections of available diagnostic interviews like the Anxiety Disorders Interview Schedule (ADIS) can assist with differentiation. Measures that tease out specific anxiety disorders are also available.

5. Ask the child and parent about impairment in functioning and symptom severity. The ADIS offers a great way for children to quantify and monitor their ratings of fear and problems in functioning.

6. Rule out physical conditions that may present with anxiety like hyperthyroidism, asthma, seizure disorders, and lead intoxication. Further rule out prescription and nonprescription drugs that may mimic anxiety.

7. Look for comorbid conditions such as attention disorders, Asperger's, bipolar, and depression (Connolly & Bernstein, 2007).

6. Prevention

Anxiety is an unavoidable condition of being human. However, the "human" factor means that, as individuals, we have some power over the way we respond to anxiety-provoking events and situations (MyOptumHealth, n. d.). In children and adolescents, early detection can reduce symptom severity and/or manifestation and improve their quality of life (Children's Hospital Boston, 2007). Learning to use active coping strategies, distraction strategies, and problem-focused rather than avoidant-focused coping have been encouraged in anxious youths (Connolly & Bernstein, 2007). It may also be helpful to regularly incorporate at least one of the following lifestyle strategies into the youth's routine:

- Reductions in caffeine intake.
- Reductions in nicotine use.
- Regular aerobic exercise.
- Good sleep hygiene.
- Relaxation techniques.
- Encourage caregivers to receive treatment for their own anxiety disorders, if present.

Johns Hopkins Children's Center has released a study where they used a family-based program of cognitive behavioral therapy to prevent or alleviate anxiety disorders in children who had anxious parents. While this initial study was very small (40 children), the results suggest that a family based intervention may prevent anxiety in children whose parents have been diagnosed with an anxiety disorder. They are currently in the process of researching a larger number of participants (Ginsburg, 2009). The AACAP also state that "Parent skills-training programs that teach parents anxiety management and foster healthy parent-child relationships may reduce the development of anxiety disorders in young children at risk" (Connelly & Bernstein, p. 280, 2007).

7. Early Intervention

Parental awareness of the effects of stressful situations on development of anxiety disorders is key to early intervention. Since parental response may exacerbate anxiety in children, awareness on the part of caregivers about this phenomenon is important. Children, especially younger ones, may not have the life-experience to correctly assess and make proper attributions of the likelihood of realistic outcomes of stressful events, and thus may become anxious when there is little to be realistically feared. Parental stability and consistency should mitigate this.

8. Treatment

The goal of any treatment for anxiety in youth should be to return the child to a typical level of functioning (Huberty, 2004). ***Start with a multimodal treatment approach*** that includes psychoeducation for the child and his/her parents about the disorder; consultation with school and primary care professionals; and cognitive-behavioral interventions (Connolly & Bernstein, 2007). Some research promotes psychosocial interventions such as cognitive-behavioral therapy (CBT) as first line, especially in milder cases (Meyers, 2006). However, 2007 AACAP practice parameters add psychodynamic, family, and drug therapy to the first-line treatment options, depending on the presenting anxiety disorder. Whether used alone or in combination. selective serotonin reuptake inhibitors (SSRIs) should be the pharmacological intervention of choice (Connolly & Bernstein, 2007). If SSRIs are used, youth must be carefully monitored. ***SSRIs are antidepressants*** and carry a **"BLACK BOX" warning**. (Refer to the General Guidelines section for more information on "Black Box" warnings.)

Research has indicated that parents and families can have an impact on the development and maintenance of childhood anxiety. Therefore, child-focused interventions may need to be supplemented with interventions that address parent-child relationships, improve family problem solving and parenting skills and reduce parental anxiety. (Connelly & Bernstein, 2007).

Psychosocial Interventions for Specific Anxiety Disorders

Generalized Anxiety Disorder

- Psychoeducation for the child, family and other significant persons in youth's life. Treatment includes recognition of physiological and psychological symptoms. Youth further should learn to use positive "self-talk" as a strategy (The Child Anxiety Network, 2006).

Separation Anxiety Disorder

- A concerted effort for the child to continue attending school.
- A behavioral program involving service recipient, parents, and school personnel.
- Family interventions, including family therapy, parent-child interventions, parental guidance and psychoeducation.
- Cognitive-behavioral therapy (CBT).
- Consider the use of SSRI medication for resistant cases.
- In severe cases, consider short-term benzodiazepine use.

Social Phobia

- Cognitive-behavioral therapy (CBT).
- Group psychotherapy.
- Social Skills Training (Connolly & Bernstein, 2007)
- SSRI medication. Commonly prescribed medications include Celexa, Lexapro, Luvox, Paxil, Prozac, and Zoloft. Effexor is also prescribed. However, the FDA has not approved specific medications for the treatment of social phobia in children and adolescents

Specific Phobias

- Cognitive-behavioral therapy (CBT), specifically systematic desensitization. Also including cognitive modification of unrealistic fears and participant modeling

(demonstrations by therapist and parent of approaching feared objects or situations) (Connelly & Bernstein, 2007).

Panic Disorder

- Cognitive-behavioral therapy.
- SSRI medication.
- In severe or treatment refractory cases, consider benzodiazepine.

Obsessive-compulsive Disorder

- Cognitive-behavioral therapy, specifically exposure and response prevention.
- SSRI medication. (Refer to the Table of Typically Prescribed Medications on the next page to identify FDA-approved medications.)
- ***In severe or treatment refractory cases, consider***:
    1. Combining cognitive-behavioral therapy with an SSRI, which has demonstrated superior effectiveness to either intervention alone.
    2. Augmentation with a second generation (atypical) antipsychotic medication or a tricyclic.

Posttraumatic Stress Disorder

- Psychoeducation involving the child, parents/caregivers, teachers and/or significant others that focuses on the symptoms, clinical course, treatment options, and prognosis.
- Individual trauma-focused therapy including cognitive-behavioral therapy (CBT) with desensitization/exposure techniques. (Insight-oriented, interpersonal, and psychodynamic therapies may be appropriate for some children.)
- Family trauma-focused therapy.
- Group trauma-focused therapy.
- ***When a comorbid psychiatric condition coexists with the PTSD,*** *first-line treatment should comprise a combination of psychotherapy and medication*.

	Recommended	Also consider
Frequency of psychotherapy sessions	Weekly	Twice a week
Duration of psychotherapy sessions	60 minutes*	> 60 minutes* or 45 minutes
Format of psychotherapy sessions	Individual	Combination of individual and group or family therapy
Frequency of medication visits	Weekly for the first month and every 2 weeks thereafter	Weekly for all 3 months Every 2 weeks for all 3 months

*Longer sessions may be needed for exposure therapy to allow for habituation.

Evidence Base for Psychosocial Treatment Recommendations

Problem Area	Level 1- Best Support	Level 2- Good Support	Level 3- Moderate Support	Level 4- Minimal Support	Level 5- No Support
Anxious or Avoidant Behavior	CBT, CBT and Medication, CBT with Parent, Education, Exposure, Modeling	Assertiveness Training, CBT for Child and Parent, Family Psychoeducation, Hypnosis, Relaxation	Contingency Management, Group Therapy	Biofeedback, Play Therapy, Psychodynamic Therapy, Rational Emotive Therapy	Attachment Therapy, Client Centered Therapy, CBT with Parents only, Eye Movement Desensitization and Reprocessing (EMDR), Psychoeducation, Relationship Counseling, Teacher Psycho-education
Traumatic Stress	CBT, CBT with Parents	None	None	Play Therapy, Psychodrama	Client Centered Therapy, CBT and Medication, CBT with Parents only, EMDR, Interpersonal Therapy, Relaxation

Adapted from *Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit. (*American Academy of Pediatrics, revised June, 2011).

Other psychotherapeutic interventions have been developed and the evidence base for effectiveness continues to grow. Interventions promulgated within the provider network in Tennessee include Trauma-Focused Cognitive Behavior Therapy (TF-CBT), which is useful for children exhibiting anxiety symptoms from exposure to traumatic events; Attachment, Self-Regulation and Competency (ARC) therapy, working with fundamental processes for security and self-management of distress, Multisystemic Therapy (MST), disseminated over the last 20 years throughout statewide provider networks and used with a variety of problems, including anxiety symptoms resulting from abuse and neglect.

An excellent resource for information and evidenced-based interventions is the National Child Traumatic Stress Network (www.nctsn.org). Here training, learning collaboratives and access to the research literature can be found. The network has helped with advancing the quality and versatility of therapists across Tennessee via assistance in training in the last 5 years.

Additionally, the American Academy of Child and Adolescent Psychiatry (AACAP) publishes well-researched guidelines that focus specifically on diagnostic entities. Their guidelines on Anxiety Disorders (AACAP, 2007) cover the general category; there are additionally specific guidelines for Obsessive Compulsive Disorder (AACAP, 2012) and Posttraumatic Stress Disorder (AACAP, 2010).

Many of these guidelines have informed the preparation of this document. The guidelines are extensively annotated and referenced; they serve as an excellent elaboration of this document.

Pharmacological

Table of Typically Prescribed Medications

Benefits: Useful for anxiety disorders, especially obsessive-compulsive disorder. Most of the medications on the list are SSRIs (Specific Serotonin Reuptake Inhibitors) that affect the neurotransmitter Serotonin.

Side Effects: Appetite changes, nausea, headache, sweating, insomnia and occasionally tiredness, sexual problems including desire.

MEDICATION NAME		**MAXIMUM RECOMMENDED DAILY DOSAGE****		**NOTES**
Brand Name	**Generic Name**	**Children**	**Adolescents**	
Prozac Serefam	Fluoxetine	20 mg	40 mg	***Fluoxetine has FDA approval in the treatment of obsessive-compulsive disorder in children and adolescents***. It is indicated for youth 7-17 years of age (Brasic, 2012). Start with 10 mg/day. After two weeks, increase to 20 mg/day in adolescents and higher weight children, up to the recommended daily maximum. In lower weight children, keep the maximum between 20-30 mg/day (FDA, 2011; Texas Department of Family & Protective Services…, 2010).
Zoloft	Sertraline	200 mg	200 mg	***Sertaline has FDA approval in the treatment of children and adolescents with obsessive-compulsive disorder only for up to one year***. It can be used with children ages 6 to 18 years. The initial dosage for children (ages 6-12) is 25 mg/day while 50 mg/day for adolescents (ages 13-18). The maximum dosage is not to exceed 200 mg/day and should be based upon clinical response to treatment (FDA, 2012).
Luvox	Fluvoxamine*	200 mg	200 mg	***Fluvoxamine has FDA approval in the treatment of children and adolescents with obsessive-compulsive disorder only*** (FDA, 2011)**.** For children ages 8 to 17 years of age, start with 25 mg daily, making gradual increments in 25 mg dosages every 4-7 days as needed, up to a maximum of 200 mg per day (Marks, 2005).
Paxil Paxil CR Pexeva	Paroxetine	(-) (-) (-)	40 mg 37.5 mg (-)	***Not approved for use in pediatric patients*** (FDA, 2012; Texas Department of Family & Protective Services…, 2010).
Celexa	Citalopram	40 mg	40 mg	***Not approved for use in pediatric patients*** (FDA, 2012).
Lexapro	Escitalopram	20 mg	20 mg	***No anxiety disorder indication for use in pediatric patients*** (FDA, 2011).
Anafranil	Clomipramine			***Clomipramine has FDA approval in the treatment of children and adolescents with obsessive-compulsive disorder only for ages 10-17 years.*** However, it is a ***second-line treatment.*** Careful monitoring is necessary because of the higher severity and rate of adverse effects when used in young people (Brasic, 2012).

*The New England Journal of Medicine published a study that showed fluvoxamine as a safe and effective treatment for children and adolescents with social phobia, separation anxiety disorder, or generalized anxiety disorder (The Research Unit on Pediatric Psychopharmacology Anxiety Study Group, 2001).

**Based on *Psychotropic Medication Utilization Parameters for Foster Children* (2010), as developed by the Texas Department of Family and Protective Services and the University of Texas at Austin College of Pharmacy, and other reliable resources.

Because of the variety of medications and treatment approaches used to treat anxiety disorders, a doctor cannot predict in advance which combination will be most helpful to a specific patient. In many cases the doctor will need to try a new medication or treatment over a six- to eight-week period in order to assess its effectiveness. Treatment trials do not necessarily mean that the patient cannot be helped or that the doctor is incompetent (MyOptumHealth, n. d.).

9. Other Interventions

Parental involvement in the treatment of children and adolescents with anxiety disorders is a must. Some treatment specify a role for parent or caregiver (e. g., Trauma-Focused Cognitive Behavior Therapy) while others are predicated on the involvement of not just caregivers but the broader social system.

School based interventions are often useful as well; several evidenced based programs for anxiety treatment are based in that setting.

10. Bibliotherapy

For Young People with Generalized Anxiety Disorder

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