Childhood Anxiety Disorders: A Practical Approach

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Objectives:

1. To learn key aspects of assessment of anxiety in children
2. To understand the role of cognitive behavioral therapy in treatment of childhood anxiety disorders
3. To understand the role of medication in treatment of childhood anxiety disorders

Common assessment questions:

- How can you tell if it's behavior or anxiety?
- How can you tell if it's the parents' anxiety or the child's that is the problem?
- Who needs CBT? Medication? Both? Something else?

Anxiety is:

A physical sensation

A thought

A behavior

A feeling

- It is a healthy response to danger.
- It is a disorder when: it is exaggerated, it persists unabated, it interferes with functioning.

Anxiety is abnormal when:

- It stops the child from doing common activities that the average child of that age can do (home, school, peer-related)
- It is persistent (> 1 month)
- It is distressing (note: not all children report distress)

Anxiety Disorders in Children

- DSM-IV: Separation Anxiety Disorder
- Specific Phobia
- Social Phobia, ?Selective Mutism
- Generalized Anxiety Disorder
- Panic Disorder
- PTSD
- OCD

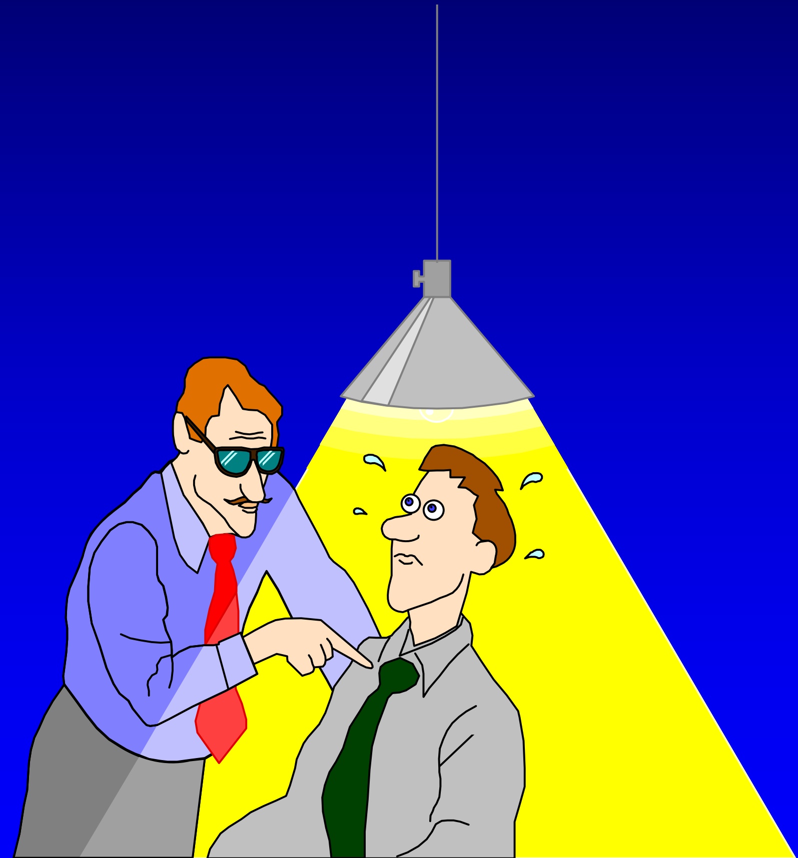
When assessing, remember...

Anxiety disorder is a threshold phenomenon so:

- Happy-go-lucky children rarely have new onset of anxiety disorder unless there's a trauma or it's panic (puberty), or it's secondary to another dx
- Reducing an unnecessary stress may help more than intensive treatment in some cases eg. frequent transitions, too many activities, learning problems, bullying or humiliation, high conflict families
- Treatment improves coping, but doesn't eliminate anxiety completely

The Environment

- Reduce frustration, increase empathy
- Increase predictability & consistency
- Reduce unnecessary stress
- Teach skills
- Encourage anything that promotes self-efficacy
- Coordinate the system



When assessing, remember...

- Children with symptoms but no significant impairment may do fine with reassurance, encouragement, “Keys to Parenting”
- Getting a detailed description (he says/she says) of situations where anxiety flares: may be very informative re: getting ‘unstuck’ & dynamics; behavioral baseline

eg. morning routine until school, routine after school, homework time, bedtime

Differential Diagnosis/Comorbidity

- ADHD, ODD, or Conduct Disorder
- Depression
- Learning disabilities
- Abuse or other trauma
- Eating Disorder
- PDD or Autism
- Medical: thyroid, caffeine, asthma/inhalers, substances

- Improved coping (not 'cure'), improvement from baseline (so do one!)
- Family, school, and peer functioning
- Less frequent or less severe episodes
- "Game plan" for recurrences
- Preventing depression (comorbids have worse long term outcome)
- Empathic encouragement (confidence + support)
- Parents are integral to change!

Pearls for Parents:

- When anxiety is ‘over the top’, stop talking and just sit and offer comfort
- Your anxious child is more capable than you think (a child with a problem: not a problem child!)
- Emphasize capability, not just probability
- Focus on effort and partial success
- Deliberately ignore setbacks, or at least minimize talking and negative emotion
- One problem at a time (P.A.S.T.E.)

Children who Benefit from CBT

- Internalizing disorder is most urgent and impairing mental health problem
- Limited externalizing symptoms
- Psychotropic medication if needed, ideally on stable dose (attributions on change)
- At least average intelligence
- 8 years old or above
- Able to stay on task for a 45 minute session
- Recognition of problem & willing to work on it

Parent Characteristics

- **Have a stable home**
- **Have stable custody arrangements if divorced**
- **Have limited interpersonal conflict**
- **Have limited personal psychopathology**
- **Are well-organized and committed to their child’s treatment**
- **Are not in the midst of a major life crisis (eg. life-threatening illness, recent separation)**
- **Recognize they have a part to play in their child’s recovery**

Points of Intervention

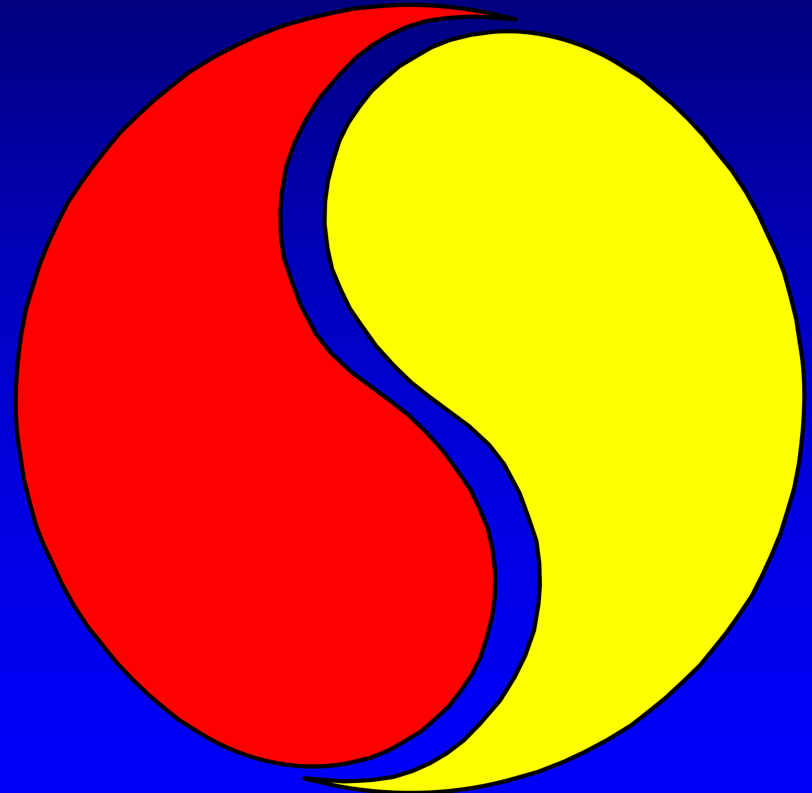
Feeling

Thought

Behaviour

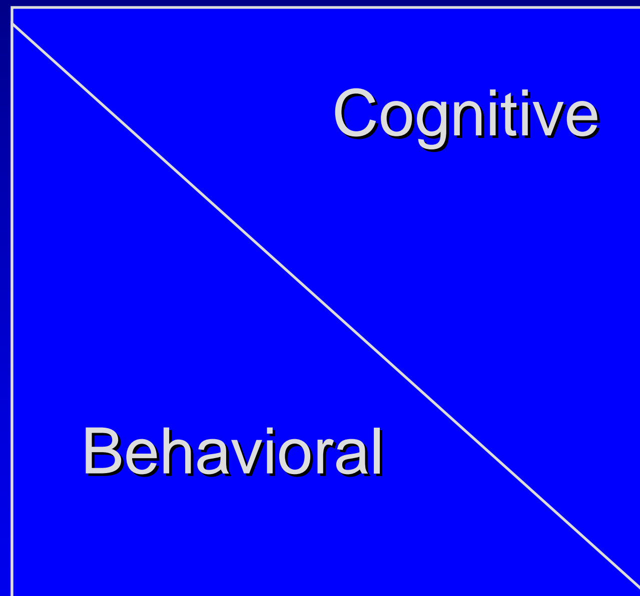
Feelings: Physiological Strategies

- Relaxed breathing
- Progressive muscle relaxation
- Meditation
- Do as a family
- Regular exercise & sleep routines
- Avoid stimulants



Treatment Emphasis

Level of Functioning



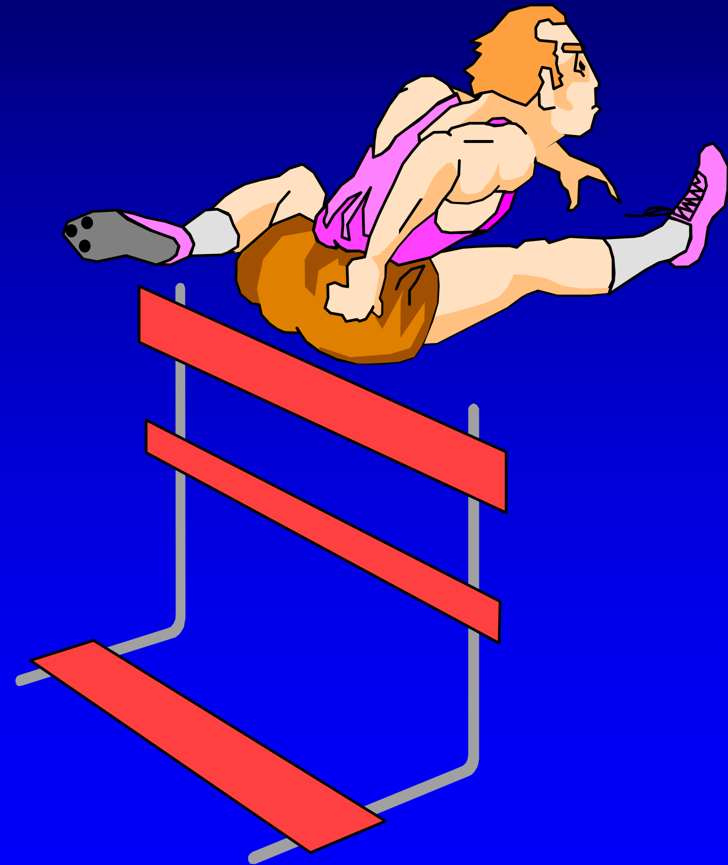
Age or Cognitive Level

Behavioural Strategies

- Facing what is feared
- Parents as coaches

"It must seem scary, but you can do it"

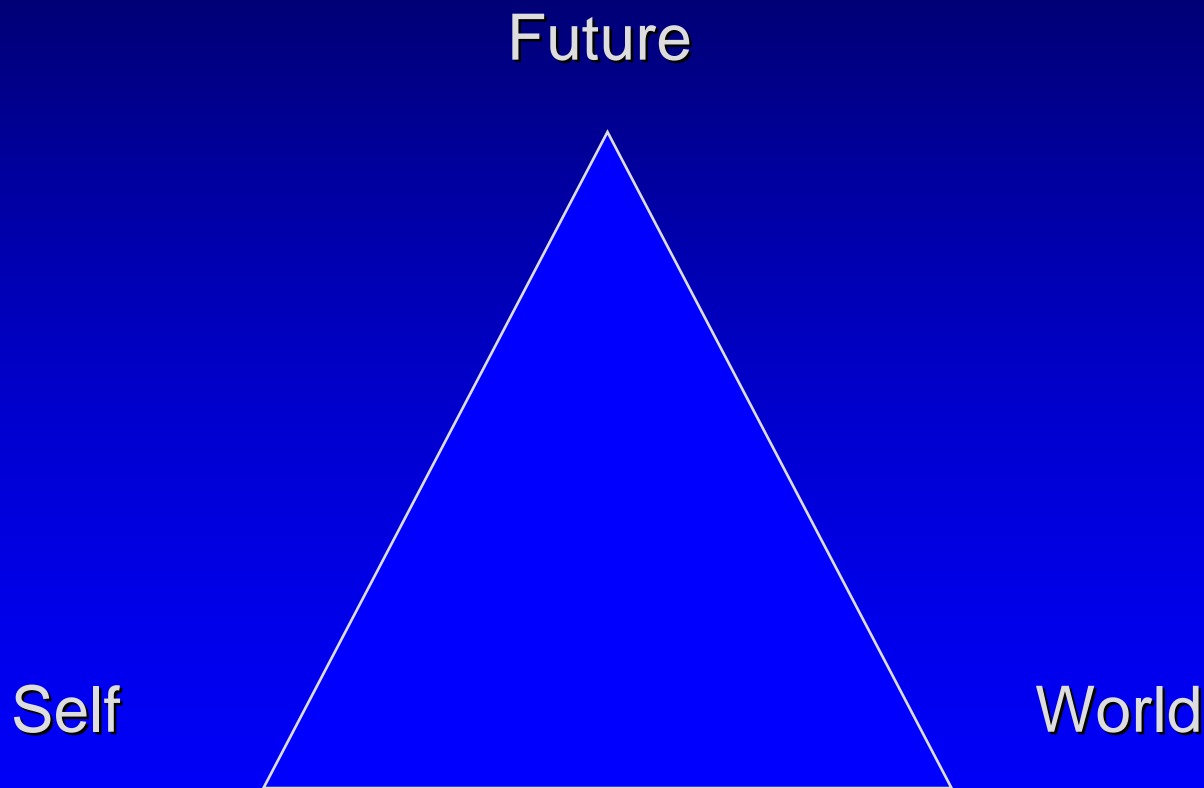
- Flooding or gradual desensitization
- Small steps, frequent, consistent, half an hour, expect off days, one problem at a time
- focus on progress



Behavioral Strategies (cont'd)

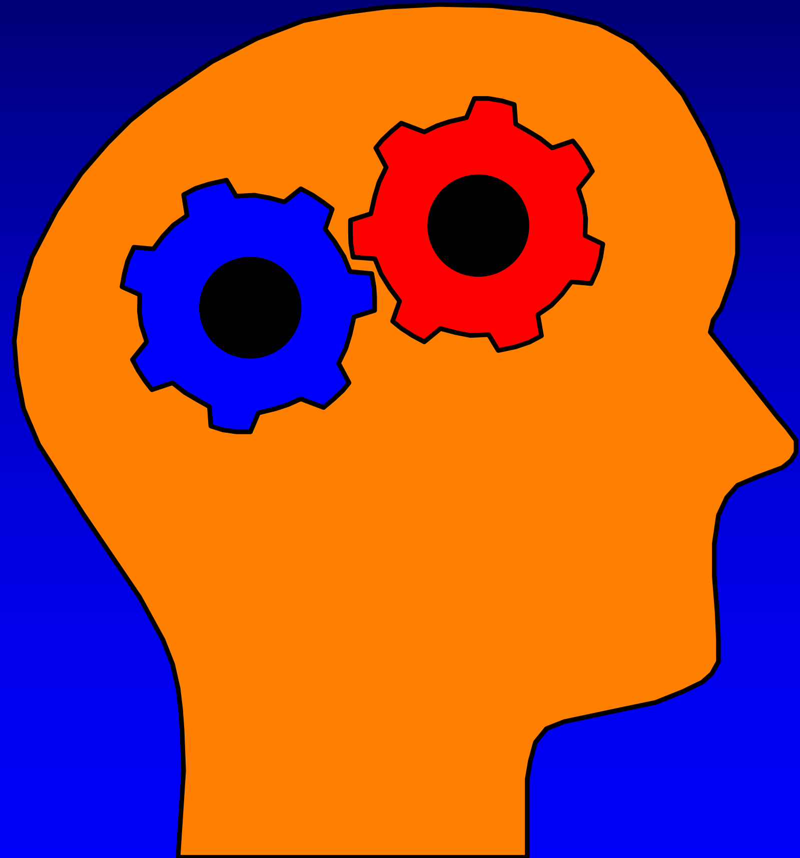
- Start with a significant problem (but not the hardest one) & desensitize in small steps
- Record baseline and changes regularly
- Incentives the child values
- Small, frequent rewards
- Natural consequences, "grandma's rule"
- Transitional objects

The Cognitive Triad: Any affect!



Thoughts: Cognitive Strategies

- Reduced helplessness & realistic assessment of risk (n.b. assumes risk exaggerated)
- Modeling to self-talk
- Verbal, older (>7), aware, mild to mod. anxious child
- Practice consistently between sessions
- Parents reinforce



Cognitive Strategies (cont’d)

- F.E.A.R.: Feeling frightened, Expecting bad things to happen, Attitudes and Actions, Results and Rewards (Kendall et al.)
- Individual or Group
- Requires verbal working memory
- Parents may need to work on own thoughts
- Can be combined with exposure (phobias) and/or medication and/or relaxation

What’s the Problem with CBT?

Efficacy:

- Does the treatment work when studied in academic centers?
- Yes, numerous RCT’s internationally

Effectiveness:

- Does the treatment work when used in the community?
- Not studied except Schools (sub-clinical)
- Anecdotally “Sometimes yes, sometimes no”

Cognition: eg. Separation Anxiety

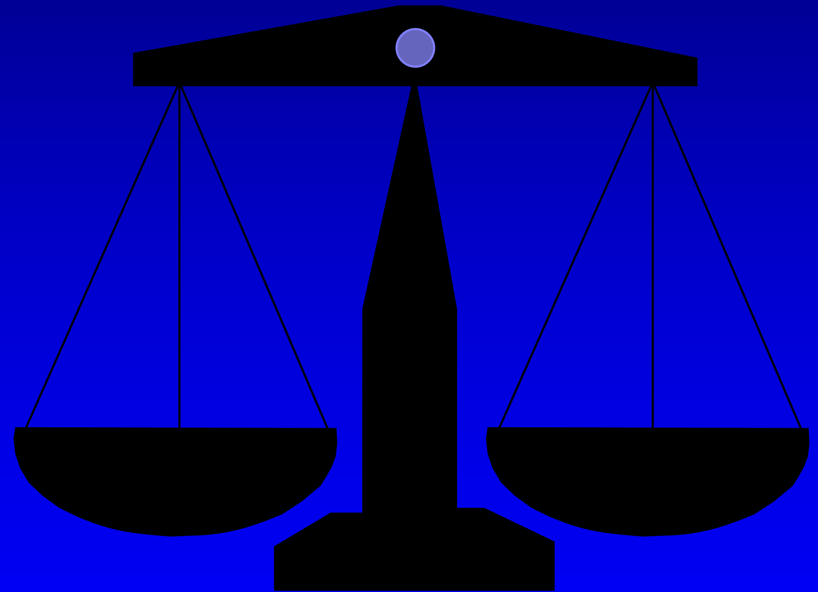
- Parents have gone out for the evening and you're worried they might get in an accident & not come home tonight.
- "But that's not the same as mom being late"
- Children often cannot generalize from one situation to another, especially if NVLD or Asperger's
- Try doing a FEAR plan if you have poor working memory or ADHD

More Study Needed:

- Adaptations for children by age, cognitive ability (verbal & NV), special populations
- What are the key mediators of change?
- How to best teach CBT & adapt to community settings?
- How best to apply in schools?
- Interaction with medication/other treatments?

Why medication?

- 1/3 of the time
- Risk/Benefit Analysis with family
- Severity (distress or impairment)
- Comorbid Depression
- CBT not feasible/avail.
- Risks of NOT medicating



SSRI’s: The controversy

- Suicidal thoughts “doubled” in some studies done in depression (NOT anxiety)
- 4-5% risk versus 2-3% risk (I.e. 95% of the time it’s not an issue)
- consider risk of *not* medicating
- Health Canada: discuss with doctor (case by case), careful monitoring (q1week initially)
- Problem: fewer physicians willing to prescribe results in *less* frequent monitoring

SSRI's

- Evidence for short-term efficacy (RUPP randomized controlled trials, many open trials, ?long term effects)
- No one SSRI stands out re: efficacy for anxiety; Prozac has best evidence for mood
- Ask family history of response
- Choose by side effect profile, be patient esp. in phobic or mute children, add behavioral strategies
- Some increased agitation risk in children (esp. if comorbid ADD), so less activating SSRI's used more
- Case reports of amotivation in adolescents after years

SSRI's (continued)

- Start with a view to tapering after CBT, or after a year of successful treatment
- Start low/go slow (not too slow: adjust q2weeks)
- Liquid fluoxetine if can't swallow pills
- Severe OCD may require augmentation strategies (eg. risperidone), longer term treatment
- Social Phobia may respond especially well; Separation Anxiety less so
- Keep the stresses of the school year in mind
- Studies of CBT + meds ongoing

Other Medications

- Benzodiazepines: specific situation (eg. first period of school; airplane ride), or "just in case"
- Venlafaxine: currently being studied in children, appears well-tolerated
- Buspirone: well-tolerated, ?efficacy
- Tricyclics (anticholinergic, cardiac risk)
- Atomoxetine for ADHD + Anxiety

- r/o hearing, speech & language problem, ESL, developmental delays
- school/home bridges help, need assertive parents
- reinforce steps towards speech, avoid talking for them, speech occurs 1:1 first, single words before open ended questions, sometimes peers before adults, spontaneous speech is usually last
- avoid effusive, embarrassing praise
- SSRI's often very effective for anxiety

- identify contributing factors (home, school, peers, work) and address, r/o truancy
- >1month usually needs gradual re-entry
- desensitization is key, but imipramine/SSRI may improve results
- home instruction rarely helps, routines do
- reduce the affect in the system
- involve neutral parties as escorts

OCD

- Anxiety management first
- Rituals: Exposure and Response Prevention exactly as with Systematic Desensitization
- Externalization in younger kids
- Often combine CBT & medication
- Obsessions: repeating loop tapes, change the affect, thought/action diffs., meditation
- PANDAS: ASOT, but same management

Resilience

- You are more than your anxiety
- Focus on functioning, mood, availability if exacerbation
- Hope

References:

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