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Clinical Practice Guideline:

November 2023

Outpatient Screening and Treatment for Pediatric Anxiety Disorders

Rationale & Scope

Anxiety is a multisystem response to a perceived threat or danger. It is a future-oriented emotion, characterized by perceptions of uncontrollability and unpredictability over potentially aversive events. It activates the fight or flight response system in the body. From the point of view of a small child, it gives the feeling of being out of control and afraid. Anxiety type physiological response is a normal reaction to stress and can actually be beneficial. If it becomes excessive, a person may have difficulty controlling it and their daily function and health may be negatively affected.

The prevalence of children who suffer from anxiety complaints (severe enough to interfere with daily life and functioning) varies widely from 2.5%–41%. Percentages vary depending on the type of anxiety disorder. The most common anxiety disorders found among children are generalized anxiety, social phobia, specific phobia, and separation anxiety. Co-morbidities often occur with anxiety disorders, including depression, ADHD, autism spectrum disorder, and eating disorders. There are often overlapping symptoms which can lead to confusion around the diagnosis, for example many young children with anxiety or with ADHD will exhibit oppositional behaviors.

This guideline is intended to be used in any outpatient pediatric care setting where mental or physical health is assessed to assist caregivers who are not formally trained as mental health professionals. While this guideline was not developed for mental health services or the acute care setting, it may serve as a reference.

Pediatric – Outpatient Screening and Treatment of Anxiety Disorders Carepath v1.0
Appendix A: Anxiety Disorders DSM-5 Criteria A

Summary of Key Guidance and Management Statements

- Anxiety disorders can be genetic and/or a response to environmental stress.
- There are many different types of anxiety disorders, these include: separation anxiety disorder, generalized anxiety disorder (GAD), social phobia, specific phobia, panic disorder, post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD).
- The USPSTF recommends universal anxiety screening in children and adolescents aged 8-18 years. In consideration to the challenges and barriers to universal screening, primary care may take an alternative approach and screen all children 2.5 to 18 years of age based on symptoms and presentation. See "Screening for Anxiety Disorders".
- Patients found to have positive screen for anxiety or clinical diagnosis for anxiety are recommended to be offered cognitive behavioral therapy (CBT) with the addition of medication therapy based on severity and impairment.
- Patients found to have anxiety should be assessed for suicide ideation. The ASQ is a screening tool that has been validated down to the age of 10 but can be used for younger children.
- At any time, if the patient endorsing suicide ideation, complete a risk assessment (e.g. SAFE-T/C-SSRS) and follow recommendations based on determined risk level.
- Selective serotonin reuptake inhibitors (SSRIs) are the first line anxiolytic medication that is recommended to be offered.
- Youth diagnosed with anxiety and their health care professional should decide together with the parents or guardians what treatment is right for them.
- Refer patients to psychiatry that are treatment resistant after 2 SSRI and 1 selective norepinephrine reuptake inhibitor (SNRI) medication trials. Treatment resistant is typically defined as failing an adequate trial at the optimal dose.

Inclusion and Exclusion Criteria

(Who is this guideline for?)

- This guideline is intended for physicians, advanced practice practitioners, pharmacists and nurses involved with the care for pediatric patients.
- While this guideline was not developed for mental health services or the acute care setting, it may serve as a reference and is not an absolute exclusion.
- In children less than 8 years old, there is not enough evidence to recommend universal screening, health care professionals should use their judgment based on individual patient circumstances when determining whether to screen for anxiety.

Inclusion Criteria

a. Child or adolescent in outpatient clinic setting 2.5-18 years old

Exclusion Criteria

a. Child less than 2.5 years old (<30 months old)

Risk Factors for Anxiety Disorders	*(What leads to the development of an anxiety disorder?)*
The following etiologies, events, or circumstances may lead to the development of anxiety in children or adolescents:	
Genetic	Heritability of anxiety disorders is 25-45%; a child with a parent who has an anxiety disorder is at increased risk to develop one themselves
Environment	• Stress exposure to a parent or caregiver's and the parent or caregiver's response to stress • Transitions in the lives of children can generate certain levels of anxiety that persist in some children (ex: start daycare or school) • Attachment difficulties such as parental separation or parental overprotection • Major life events may disrupt a child's life and sense of control to a great degree and lead to anxiety or posttraumatic stress disorder (PTSD). Examples include: death in the family, violence, divorce, conflict between parents, and/or natural disaster • Child mistreatment
Temperament	• Cautious type children who are inhibited or fearful and withdrawn with new people and situations • Children that are self-critical, inflict high standards upon themselves, and/or exhibit perfectionism • Children who were described as slow to warm or fussy/difficult in early childhood may later develop anxiety.
Special Populations	• Older adolescents aged 12-17 years • LGBTQ or transgender youth • Chronic medical conditions

Symptoms of Anxiety or Red Flags *(When to suspect or be concerned about anxiety in a child or adolescent?)*

- Easily distressed or agitated when in a stressful situation
- Reassurance seeking, repetitive questions, "what if" concerns, inconsolable, or not responsive to logical arguments
- Somatic complaints such as headaches and/or stomachaches. Regularly too sick to go to school
- Anticipatory anxiety—worrying hours, or days, or weeks ahead
- Sleep disruption with difficulty falling asleep, nightmares, or not wanting to sleep alone
- People-pleasing, overly concerned that others are upset with him/her, excessive/unnecessary apologizing
- Avoidance, such as refusing to participate in expected activities and/or school
- Disruption of child or family functioning, not wanting to go to a friend's house, religious activities, family gatherings, etc.
- Demonstrates insecure attachment dynamic between caregiver and patient

Diagnosis and Description of Most Common Anxiety Related Disorders

- The full chapter on anxiety disorders and diagnostic criteria may be found in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5-TR). **https://doi.org/10.1176/appi.books.9780890425787.x05_Anxiety_Disorders**
- See Appendix A for an excerpt from the DSM-5 with the criteria A for the anxiety disorders listed below.

Disorder	Description
Separation anxiety disorder	Excessive and developmentally inappropriate anxiety concerning separation from home or attachment figures that begins prior to 18 years of age, has been present for at least four weeks, and causes clinically significant distress or impairment in important areas of functioning.
Generalized anxiety disorder (GAD)	Excessive anxiety and worry that is difficult to control, not focused on a specific situation or object, and unrelated to a recent stressor. GAD occurs most days over a six-month period and is associated with at least one physical symptom, and causes clinically significant impairment.
Social Phobia	Marked and persistent fear of situations in which there is a likelihood of social interaction, lasting at least six months. Social phobia leads to avoidance or attempts at avoidance of situations and causes significant impairment.

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Disorder	Description
Specific Phobia	Persistent developmentally inappropriate fear in the anticipation either of a specific object or of an event (such as excessive fear of dogs or bad weather). Specific phobia also leads to avoidance or attempts at avoidance of situations and causes clinically significant distress or impairment
Panic Disorder	Sudden occurrence of a cluster of symptoms (e.g., palpitations, sweating, trembling, feelings of shortness of breath, chest pain nausea, dizziness) that peaks within 10 minutes. Panic disorder reoccurs unexpectedly and is associated with at least one month of chronic worry or fear about future attacks, consequences regarding attacks, and leads to avoidance of situations that might trigger a panic episode.
Post-Traumatic Stress Disorders	(Classified under trauma and stress related disorders in DSM 5.) Exposure to a traumatic event leads to persistent flashbacks, (e.g., intrusive thoughts or images), persistent avoidance of situations of persons associated with the event and increased arousal (e.g., hypervigilance, sleep disturbance.) Present for at least one month.
Obsessive-Compulsive Disorder (OCD)	(Classified under a separate category in DSM 5.) Characterized by obsessive thoughts, impulses, images, which last over one hour a day, and lead to marked distress and clinically significant impairment. In OCD, attempts are made to ignore obsessions; relieve distress by performing compulsions.

Screening for Anxiety Disorders

(See section - How was this guideline developed?)

- **In children, 7 years or younger** there is not enough evidence to recommend universal screening.
  - In the absence of a diagnosed anxiety disorder or signs/symptoms of anxiety, the US Preventive Services Task Force (USPSTF) states that benefits and harms of screening for anxiety is uncertain, and the balance of benefits and harms cannot be determined.
  - Healthcare professionals should use their judgement based on individual patient circumstances when determining whether to screen for anxiety. Validated anxiety instruments are available for children aged 2.5 – 7 years presenting with symptoms for anxiety disorder or presence of risk factors.
- **In children and adolescents aged 8 to 18 years**, who do not have a diagnosed anxiety disorder or are not showing recognized signs or symptoms of anxiety, the USPSTF states with moderate certainty that universal screening for anxiety has a moderate net benefit in improving outcomes such as treatment response and disease remission.
  - The USPSTF made this recommendation based on adequate evidence that treatment of anxiety with psychotherapy is associated with a moderate magnitude of benefit. Additionally, they found adequate evidence to link screening and early treatment of anxiety to a moderate benefit in improving health outcomes such as treatment response and disease remission. However, they did not find any studies that directly looked at either benefits or harms of screening for anxiety on health outcomes.
  - **In consideration to the challenges and barriers to universal screening**, primary care may take an alternative approach:
    - In outpatient offices with the available resources, screen all children and adolescents aged 8-18 years for anxiety with a validated screening tool annually and upon new clinical concern for anxiety.
    - In outpatient offices that are unable to screen universally, screen all children and adolescents aged 8 – 18 years for anxiety if presenting with symptoms for anxiety disorder or presence of risk factors with a validated anxiety instrument.
- **In children and adolescents with a known anxiety disorder**, consider re-screening if treatment response to medication or therapy is unclear.

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Validated Anxiety Screening Tools

- Anxiety screening instruments are heterogeneous. Some screening instruments are designed to assess for a specific anxiety disorder while others are designed to assess several anxiety disorders.[5]
- Anxiety screening tools alone are not sufficient to diagnose anxiety. If a screening tool is positive for anxiety, a confirmatory diagnostic assessment and follow-up is required.[5]
- The table below lists the screening tools used at Rainbow Babies & Children's Hospital. This list is not comprehensive and not all screening instruments are feasible for use in primary care settings because of length.
- None of the list tools are validated for a 7 year old child. Healthcare providers should consider the maturity level of the patient and ability to answer the questions and then choose between the SCAS Preschool Anxiety Scale and SCARED.

Screening Tool	Indication and Description	Comments
Spence Children's Anxiety Scale (SCAS), Preschool Anxiety Scale	• Ages 2.5-6 years old • 28 item questionnaire completed by parent	• Available free online
Screening for Child Anxiety Related Emotional Disorders (SCARED)	• Ages 8-18 years old • 41 item questionnaire that assesses for 5 types of anxiety: panic disorder, GAD, separation, social, and school avoidance • Completed by parent and patient	• Available free online • Lengthy however useful in differentiating types of anxiety • Responses may be discrepant between parent and child/adolescent version due to parent awareness and patient internalization of symptoms
Generalized Anxiety Disorder – 7 (GAD-7) Child	• Ages 11 years old to adulthood • Brief 7 item instrument completed by the patient	• Available free online • Brief tool and may be preferred for universal screening • Questions worded ideally for adolescents

Management and Treatment Recommendations

(See "How was this guideline developed?")

- **Patients found to have anxiety should be assessed for suicide ideation.** The ASQ is a screening tool that has been validated to the age of 10 but can be used for younger children.
- **Parent Education and Guidance**: Tell parents about symptoms of the disorder, course, treatment options, risks of treatment and consequences of not seeking treatment. Parents should attend to their child's concerns. They should model positive coping styles and help prepare children for anxiety-producing transitions by practicing new routines and exploring new environments. Encourage parents not to restrict the child's daily activities because of their anxiety. Instead, Parents should be supportive and encouraging of participation saying "I know you can do it." See the Parent and Family Education resources.
- **Psychotherapy:**
  - **Cognitive Behavioral Therapy (CBT)** components include psycho-education; body awareness (including training in abdominal breathing and progressive muscle relaxation); cognitive restructuring, which helps children identify automatic thoughts and to think about more rational responses; exposure/response prevention (desensitization to situations which trigger anxiety); and emphasis on personal control through skill building.
    - Therapists trained in CBT would be the best resource when looking for this kind of therapy. For therapy to be **most** effective it **typically** needs to happen at least every other week and it often takes about 2-3 months to see improvements.
    - Therapy should involve "homework" where child and parent are practicing skills and strategies at home between sessions. Usually it takes at least 3 sessions for kids to get comfortable enough with a therapist to know if they are a good fit, and for children with more significant anxiety it may take longer.
    - The child may need to change therapists before they find the right one. It is important to remember that addressing anxiety is difficult and will not always feel comfortable to the child. Supporting them in continuing with practicing strategies is likely to lead to long-term improvement.
    - Self-regulation teaching involves relaxation and imagery (hypnosis) with or without biofeedback and is an effective tool that can help ameliorate anxiety by teaching a coping skill to gain control over his/her own body's physiological reactions.
    - Play therapy and parent training approaches can work well for young children with language or cognitive impairments which keep them from participating in CBT.

- Group psychotherapy may help children with social phobia.

- **Medication:** When symptoms are severe, and other methods have failed, medication management is another option.
  - Medications should **NOT** substitute for behavioral therapies, but are used when necessary as an adjunct.
  - Most effective medications are SSRIs such as fluoxetine, sertraline, and escitalopram.
- **Academics:** When symptoms affect school functioning, Individualized Education Plan (IEP) or 504 plan may help the teachers work with the child in the classroom during the school day. (*See Interventions Handout for more discussion*)
- **Physical Activity:** Exercise has been shown to decrease anxiety and has other positive effects (*See Interventions Handout for more discussion*)
- **Recommendations for Starting and Adjusting Medications:**
  - Documenting and discussing informed consent with parents is key; including reviewing FDA warning when starting SSRIs/SNRIs to watch for suicidality after initiation
  - For moderate to severe anxiety recommend SSRI as first line medication in combination with CBT
  - Start low and go slow, especially in younger children and children with comorbid neurodevelopmental diagnoses
  - If patients experience mild side effects initially, often these will improve after 2 weeks of consistent treatment
  - Increase dose 2-4 weeks after initiation if tolerated, then may increase every 4-8 weeks as needed to reach therapeutic effect
  - Typically higher doses of SSRIs are needed to treat anxiety than for depression and it may take longer to see desired effects
  - Once therapeutic effect has been reached, continue medication for 12 months before considering taper
  - Medication treatment failure is typically defined as lack of improvement after 6-8 weeks at the optimal dose for a specific medication.
  - May switch to 2nd SSRI following a treatment failure with the initial SSRI.
  - May consider SNRI after 2 failed SSRI trials.
  - Consider consult or discussion with child psychiatry for any of the following:
    - Children < 6 years of age that require treatment with medication
    - Patients that experience two or more medication treatment failures
    - Patients that require titration of medications to doses greater than the listed maximum doses in this document
  - There is minimal evidence supporting benzodiazepines (BZDs), buspirone, atypical antipsychotics (AA), or tricyclic antidepressants (TCAs) to treat pediatric anxiety.

Anxiety Prevention

- **Catching anxious symptoms early is important for preventing dysfunctional anxiety.** Asking parents at routine visits about any worry or fears in their child and use of screening tools can be a helpful way to find those children at higher risk. Pediatricians can provide parents with guidance in how they can model appropriate behavior, reduce their own anxious behaviors, and avoid focusing on potentially threatening aspects of the environment.
  - **Prevention of anxiety disorders** includes both child focused and parent focused methods
    - **Child Focused Methods**: There are many ways to teach children stress management coping skills, these include:
      - Deep breathing
      - Muscle relaxation
      - Meditation
      - Yoga
      - Utilizing the child's creativity with drawing, music, and drama, etc.
    - **Parent Focused Methods:**
      - Model healthy coping skills and provide their children with instruction in how to cope with fear and anxiety.
      - Promote resilience. A child who has good social supports from family and community, encouragement in developing inner strengths supporting self-esteem and confidence, and development of interpersonal and problem solving skills is likely to have strong resilience.
  - **Environment**
    - Protect from anxiety provoking media exposure TV, news that includes disturbing information, and violent or frightening video games

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Medications Used for Anxiety Disorders

First Line SSRI Medications						
Medication	**Formulation**	**Dosing Guidance**				**Pearls**
		Starting Dose	Titration Increments	Effective Range	Max Dose	
Escitalopram (Lexapro)	Liquid, tablet	Children: 2.5 mg daily Adolescents: 5 mg daily	5 mg	10– 20 mg	20 mg	• Very well tolerated
Fluoxetine (Prozac)	Liquid, capsule, tablet	Children: 5 -10 mg daily Adolescents: 10 – 20 mg daily	10 mg – 20 mg	10- 60 mg	Children: 40mg Adolescent: 60mg	• Approved for OCD • Long half-life so can consider in patients in whom adherence may be an issue • Can cause agitation or behavioral activation especially in younger kids, best dosed in AM
Sertraline (Zoloft)	Liquid, capsule, tablet	Children: 12.5 – 25 mg daily Adolescents: 25 – 50 mg daily	If current dose under 100 mg: titrate by 12.5 mg – 25 mg If current dose over 100mg: titrate by 50mg	25-200 mg	200 mg	• Approved for OCD • Usually given daily, however, some evidence that younger children metabolize quickly; may split doses and administer twice daily based on side effects or if a rapid metabolizer (i.e. seems like "wearing off" halfway through the day)

- **Consider discussing with child psychiatry**, if: 1) starting medication in a child < 6 OR 2) increasing the dose above listed max dose at any age
- **Titration Tip**: Increase dose 2-4 weeks after initiation if tolerated, then may increase every 4-8 weeks as needed to reach therapeutic effect.
  - If an antidepressant dose has been maximized and maintained for at least four weeks but no improvement in symptoms is noted or major side effects are experienced, a different SSRI should be used. A cross titration approach may be used in which the first SSRI is tapered by the following increments and intervals, and the second SSRI is titrated as in the table below:

Medication	Tapering Increment	Time Interval
Fluoxetine	10mg	1-2 weeks
Sertraline	25 mg	1-2 weeks
Citalopram	10 mg	1-2 weeks
Escitalopram	5 mg	1-2 weeks

- **Common Side Effects for SSRIs**: headaches, GI upset, insomnia, nausea, sexual
- **More serious but less common side effects** for SSRIs: serotonin syndrome when combined with other serotonergic agents, suicidal ideation (FDA black box warning), may increase bleeding risk by interfering with platelet activation, may precipitate mania in children with bipolar disorder

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Medications Used for Anxiety Disorders

Second Line SNRI Medications						
Medication	**Formulation**	**Dosing Guidance**				**Pearls**
		Starting Dose	**Titration Increments**	**Effective Range**	**Max Dose**	
Duloxetine (Cymbalta)	Capsule, sprinkle	Children: 20 mg daily Adolescents: 30 mg daily	20-30 mg	30-60 mg	120 mg	• FDA approved for GAD, sprinkle formulation may be added to applesauce
Venlafaxine ER **(Effexor XR)**	Tablet, capsule	Adolescents: 37.5 mg daily	37.5 mg – 75 mg	75-225 mg	225 mg	• Caution with hypertension as it may increase BP, may cause weight loss, discontinuation syndrome may be severe if stopped suddenly • Generally not used in patients < 13 years of age due to side effects
As Needed Medication						
Hydroxyzine (Atarax, Vistaril)	Liquid, capsule, tablet	**Effective Dose:** Children: 12.5- 25 mg every 6 hours PRN Adolescents: 25-50 mg every 6 hours PRN				• May be useful for panic attacks, can cause anti-cholinergic side effects such as dry mouth and urinary retention, some kids may experience paradoxical excitation, low risk of abuse and dependence

- **Consider discussing with child psychiatry,** if: 1) starting medication in a child < 6 OR 2) increasing the dose above listed max dose at any age
- **Titration Tip:** Increase dose 2-4 weeks after initiation if tolerated, then may increase every 4-8 weeks as needed to reach therapeutic effect
- **Common Side Effects for SNRIs**: nausea, headache, abdominal pain
- **Rare Serious Side Effects for SNRIs**: suicidal ideation (FDA black box warning), hepatic failure with duloxetine
- There is minimal evidence supporting BZDs, buspirone, AAs, or TCAs to treat pediatric anxiety.

Major References

1. Talia R. Lester, Jessica E. Herrmann, Yair Bannett, Rebecca M. Gardner, Heidi M. Feldman, Lynne C. Huffman; Anxiety and Depression Treatment in Primary Care Pediatrics. Pediatrics May 2023; 151 (5): e2022058846. 10.1542/peds.2022-058846
2. Stahl, S.M. (2018). Stahl's essential psychopharmacology: prescriber's guide – children and adolescents (1st ed). Cambridge University Press.
3. Clinical Manual of Child and Adolescent Psychopharmacology, Fourth Edition. edited by Molly McVoy, M.D., Ekaterina Stepanova, M.D., Ph.D., and Robert Findling L., M.D., M.B.A. Washington, DC, American Psychiatric Publishing, 2024
4. Viswanath M, et al. Screening for Anxiety in Children and Adolescents. Evidence Report and Systematic review for the US Preventative Service Task Force. JAMA 2022;328(14):1445-1455.
5. US Preventative Services Task Force. Screening for Anxiety in Children and Adolescents Recommendation Statement. JAMA 2022;328(14):1438-1444.
6. Walter HJ, et al. Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents with Anxiety Disorders. J Am Acad Child Adolesc Psychiatry. 2020;59(10):1107-1124.

How was this Guideline Developed?

- This guideline was developed by a multi-disciplinary group of caregivers and subject matter experts experienced in the diagnosis and treatment of anxiety in children and adolescents.
- The major aforementioned references were reviewed by the guideline team and recommendations were made based on the best available evidence and with consideration to local context and available resources.

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Acronyms and Abbreviations

AA	Atypical Antipsychotics
BZD	Benzodiazepine
CBT	Cognitive Behavioral Therapy
GAD	Generalized Anxiety Disorder
PTSD	Post-Traumatic Stress Disorder
SSRI	Selective Serotonin Reuptake Inhibitor
SNRI	Selective Norepinephrine Reuptake Inhibitor
TCA	Tricyclic antidepressants

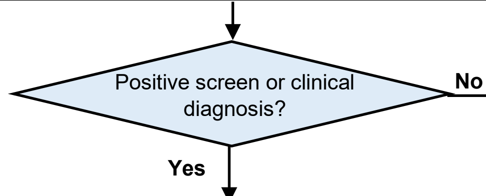
Disclaimer: Practice recommendations are based upon the evidence available at the time the clinical practice guidance was developed. Clinical practice guidelines (including summaries and pathways) do not set out the standard of care and are not intended to be used to dictate a course of care. Each physician/practitioner must use his/her independent judgement in the management of any specific patient and is responsible, in consultation with the patient and/or the patient's family to make the ultimate judgement regarding care. If you have questions about any of the clinical practice guidelines or about the guideline development process please contact the Rainbow Evidence Practice Program at RainbowEBPprogram@uhhospitals.org

Initial Approval January 2024

Child or Adolescent with Concern for Anxiety Disorder in Outpatient Setting

Inclusion: patient/family reports risk factors or symptoms for anxiety (Box 1)
Exclusion: Inpatient management or child < 2.5 years old

Screen for Anxiety
Perform history and clinical interview and/or offer validated age appropriate screening tool (Box 2)



Off Pathway; offer anxiety prevention education if applicable

At any time, if patient endorsing **suicidal ideation**, complete risk assessment (e.g. SAFE-T/C-SSRS) and follow recs per risk level

Assess severity of symptoms
Perform screening tool if not yet performed

Mild =
Minor severity of symptoms and minor functional impairment and no suicidal ideation

- Recommend CBT for anxiety alone

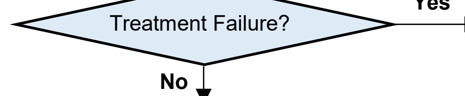
Moderate =
Moderate severity of symptoms and moderate functional impairment/moderately distressing symptoms and no suicidal ideation

- CBT +/- medication
- Consider medication for moderate symptoms/ impairment or if preferred by parent or child
- Consider medication if CBT option unavailable

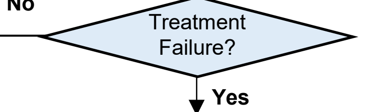
Severe =
Severe symptoms and intensity of symptoms leading to markedly impaired functioning.
Can include suicide ideation

- Recommend CBT in conjunction with medication.
- 1st line medication is SSRI (Box 3)
- If endorsing **suicide ideation**, complete risk assessment (e.g. SAFE-T/C-SSRS); follow recs per risk level

- Assess for suicide risk using validate tool (e.g. ASQ) if not yet performed
- Continue CBT for a minimum of 6-8 weeks
- Recommend follow-up every 4 weeks when initiating/adjusting medications
- Re-assess patient at least every 3 months once treatment plan established



- Start 1st SSRI if not yet
- Trial 2nd SSRI if treatment failure with 1st SSRI
- Augment with CBT if not already done



- Continue CBT for a minimum of 6-8 weeks
- Recommend follow-up every 4 weeks when initiating/ adjusting medications
- Re-assess patient at least every 3 months once treatment plan established
- Continue medication treatment for a minimum of 1 year from symptoms improvement

- Trial 2nd SSRI if treatment failure with 1st SSRI
- Trial SNRI after 2nd treatment failure with SSRI
- Augment with CBT if not already done

Refer to Psychiatry
- Recommend referring to psychiatry when patient has failed 2 SSRI and 1 SNRI medication trials

Box 1: Risk Factors and Symptoms for Anxiety

Genetic
- Heritability of anxiety disorders is 25-45%

Environment
- Exposure to environmental stress, including caregiver response to stress
- Transitions or changes in routine (ex: start daycare or school)
- Attachment difficulties such as parental separation or parental overprotection
- Major life events Examples include: death in the family, violence, divorce, conflict between parents, and/or natural disaster
- Child mistreatment

Temperament
- Cautious, inhibited or fearful
- Self-critical or perfectionistic
- Fussy or difficult as an infant

Special Populations
- Ages 12-17
- LGBTQ or transgender youth
- Chronic medical conditions

Symptoms or Anxiety "Red Flags"
- **Easily distressed or agitated** when in a stressful situation
- **Reassurance seeking** (e.g. repetitive questions, "what if" concerns)
- **Somatic complaints;** regularly too sick to go to school (e.g. headaches and/or stomachaches)
- **Anticipatory anxiety**—worrying hours or weeks ahead
- **Sleep disruption** (e.g. early insomnia, refusal to sleep alone, nightmares)
- **People-pleasing**
- **Avoidance** (e.g. refusing to participate in expected activities and/or school)
- **Insecure attachment** dynamic between caregiver and patient

Box 2: Screening Tools for Mental Health

Tool	Description and When to Use
SCAS – Preschool Anxiety Scale	• Ages 2.5-6 years old
SCARED	• Ages 8-18 years old • Assess anxiety broadly • Parent and child/adolescent version
GAD-7	• Ages 11 years old to adulthood • Brief tool and easy to complete • Questions worded ideally for adolescent
ASQ	• Age 8 years and older • Brief tool to assess for suicide • Positive screens identifies children that need further mental health or suicide safety assessment

Box 3: Medication Treatment Tips for Anxiety

- **SSRIs first-line** (preferred) (e.g. escitalopram, fluoxetine, and sertraline)
- **SNRIs** second or third line (e.g. duloxetine and venlafaxine)
- **Titration:** SSRI or SNRI, increase dose 2-4 weeks after initiation if tolerated; then may increase every 4-8 weeks as needed to reach therapeutic effect. Anxiety usually requires higher doses than depression. See Box 4 for SSRI Titration Table
- **Consider discussing with child psychiatry,** if: 1) starting medication in a child < 6 OR 2) increasing the dose above listed max dose at any age
- **Treatment Failure:** typically defined as lack of improvement after 6-8 weeks at the optimal dose for the specific medication

Box 4: SSRI Titration Table

A cross titration approach may be used in which the first SSRI is tapered by the following increments and intervals, and the second SSRI is titrated up

Medication	Tapering Increment	Time Interval
Fluoxetine	10mg	1-2 weeks
Sertraline	25 mg	1-2 weeks
Citalopram	10 mg	1-2 weeks
Escitalopram	5 mg	1-2 weeks

Appendix A:

Anxiety Disorders DSM-5 Library Criteria A

The following is an excerpt from the DSM-5 online library for select anxiety disorders included in the anxiety chapter. Criteria A includes the required diagnostic criteria that must be present or reported to make a diagnosis.

See the full DSM-5 reference for additional information.

Separation Anxiety:

Developmentally inappropriate and excessive fear or anxiety concerning separation from those to whom the individual is attached, as evidenced by at least three of the following:

1. Recurrent excessive distress when anticipating or experiencing separation from home or from major attachment figures.
2. Persistent and excessive worry about losing major attachment figures or about possible harm to them, such as illness, injury, disasters, or death.
3. Persistent and excessive worry about experiencing an untoward event (e.g., getting lost, being kidnapped, having an accident, becoming ill) that causes separation from a major attachment figure.
4. Persistent reluctance or refusal to go out, away from home, to school, to work, or elsewhere because of fear of separation.
5. Persistent and excessive fear of or reluctance about being alone or without major attachment figures at home or in other settings.
6. Persistent reluctance or refusal to sleep away from home or to go to sleep without being near a major attachment figure.
7. Repeated nightmares involving the theme of separation.
8. Repeated complaints of physical symptoms (e.g., headaches, stomachaches, nausea, vomiting) when separation from major attachment figures occurs or is anticipated.

Specific Phobia:

Marked fear or anxiety about a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood).

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

Social Anxiety Disorder:

Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech).

Note: In children, the anxiety must occur in peer settings and not just during interactions with adults.

Panic Disorder:

Recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four (or more) of the following symptoms occur:

Note: The abrupt surge can occur from a calm state or an anxious state.

1. Palpitations, pounding heart, or accelerated heart rate.
2. Sweating.
3. Trembling or shaking.
4. Sensations of shortness of breath or smothering.
5. Feelings of choking.
6. Chest pain or discomfort.
7. Nausea or abdominal distress.
8. Feeling dizzy, unsteady, light-headed, or faint.
9. Chills or heat sensations.
10. Paresthesias (numbness or tingling sensations).
11. Derealization (feelings of unreality) or depersonalization (being detached from oneself).
12. Fear of losing control or "going crazy."
13. Fear of dying.

Note: Culture-specific symptoms (e.g., tinnitus, neck soreness, headache, uncontrollable screaming or crying) may be seen. Such symptoms should not count as one of the four required symptoms.

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).

This info is an excerpt only and last updated in November 2023. See the online full DSM-5 chapter on anxiety disorders for complete and up to date information.

Patient and Family Education

Anxiety Disorders: What Parents Need to Know

Anxiety is a part of a normal development

Anxiety is a part of normal development. Infants can be afraid of strangers, preschoolers fearful of the dark and monsters, and younger school-aged children worry about storms. Older school-aged children may worry about academics and social situations.

When is anxiety not normal?

When worries get in the way of normal everyday activities much of the time, they may be signs of an anxiety disorder. Here are some examples:

- A preschool child cannot fall asleep because of fears of monsters. The usual soothing things don't work.
- A young child is so afraid of lightening or thunder that she refuses to leave the house, or she has to check the sky all the time.
- A school-age child gets physically ill on many school days, but feels much better as soon as he gets to stay home.

There are many different kinds of anxiety disorders. Sometimes it is obvious that the child is afraid. Sometimes the child may act in ways that seem "bad" or "mad," or that look like a medical illness. Doctors and psychologists are trained to spot these forms of anxiety disorder.

Facts about anxiety disorders:

- Anxiety disorders are common. They affect 8-12% of children and adolescents – about one in 10.
- 70% of adults with anxiety disorders report that their symptoms began in childhood.
- The more severe childhood anxiety is, the more likely it is to persist.
- Children who have anxiety disorders often also have another mental health or behavior disorder like ADHD, oppositional defiant disorder, depression, learning disorders, autism spectrum disorder, or language disorders.
- An anxiety disorder may go away, but later a new anxiety disorder may take its place.
- There are effective treatments for anxiety disorders. These include counseling, cognitive behavioral therapy, and medication.

Causes of anxiety disorders:

- Transitions and losses (i.e. moving or death of a relative/parent) can trigger anxiety.
- Some children are naturally watchful and tend to become quiet when they are in a new situation or

around people they do not know. We call a style of behavior that children are born with "temperament." Inhibited or "slow to warm up" temperament sometimes leads to anxiety problems.
- Children are more likely to develop anxiety disorders when one or both parents have anxiety. But this does not always happen.
- Children sometimes learn anxious behavior by watching their parents act in anxious ways. For example, a parent may avoid situations that make him feel anxious.
- Parenting that is over-involved, controlling, and highly critical can also lead to anxiety. Family stress, such as a lot of angry arguing, can lead to anxiety.

What to look for:

- Worrying too much
- Stomach aches, headaches
- Getting angry often, for little things. Being irritable.
- What looks like negative or oppositional behavior, when something that makes your child anxious is present (for example, in crowds)
- Anxiety or fears that keep your child from doing normal things, like going to school or enjoying friends.

Different types of anxiety:

- **Separation Anxiety Disorder (SAD):** distress when faced with separation from a parent or other main emotional support people. Your child might follow you around the house and worry excessively about your safety and health.

- **Specific Phobia:** marked fear or anxiety about a specific object or situation such as animals, heights, receiving an injection, seeing blood, or flying.

- **General Anxiety Disorder (GAD):** excessive worry or anxiety. Children with GAD worry about a wide range of topics. They are often perfectionists that constantly need approval and reassurance.

- **Social Anxiety Disorder/Social Phobia:** fear associated with social settings such as classrooms, restaurants, and extracurricular activities. Children with Social Phobia may have difficulty reading or answering questions in class, beginning conversations, using public restrooms, and attending social events.

- **Obsessive Compulsive Disorder (OCD):** distressing thoughts, impulses, or images that intrude on a child's awareness over and over. For example, they may have the thought that something terrible is about to happen, or that they might hurt themselves. In order to cope with these thoughts, they may engage in repetitive behaviors or mental acts; these are called compulsions.

How do doctors diagnose anxiety?

Your primary care provider will ask you and your child questions, and may give you and your child questionnaires to fill out. In addition to finding out about thoughts and feelings that go along with anxiety, the doctor will look into other things like physical symptoms (such as headaches), things that happened in your child's past, and the family medical

This info is a general resource. It is not meant to replace your health care provider's advice. Ask your doctor or health care team any questions. Always follow their instructions.

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Treatment for Anxiety in Children and Teens

The best treatment for anxiety combines several approaches:

- Stress reduction
- Physical exercise
- Lower stress at home and school
- Therapy for the child
- Medication
- Learn more about anxiety
- Treat anxiety in parents and other family members

Stress Reduction

- Talk with your child about stress. Everyone feels stress sometimes. It is ok to feel anxious in certain situations.
- Be a model for your child. Learn techniques that help you and talk with your child about them. Let your child see how you cope with stress.
- Use stress management techniques such as deep breathing, relaxation, and positive imagery. Help your child to use these before stressful events, such tests in school, or after upsetting events.

Physical Exercise

Regular daily exercise should be part of any treatment plan for anxiety. Exercise lowers stress and improves coping. Plan for at least one hour of exercise each day. Many children like variety. Fun is important!

- Think of activities that your child likes.
- Physical activity or active play; try simple activities like walking, biking, and swimming. These can become life-long pleasures. Just being active in green spaces has been shown to help with improving anxiety.
- Group activities are good for socialization and being on a team is fun.
- Family activities bring families together. Play catch. Go for a walk. Kick a soccer ball. Be creative.

Lower Stress at Home

Anxious children respond to stress around them, especially at home. Lowering stress at home can make a big difference:

- Work with your spouse or partner to settle differences of opinion calmly, without angry words, yelling, or violence. If you can't do this on your own, seek help.

- Make a family rule that nobody hurts anybody else. Hurting can be physical (hitting, pinching) or emotional (teasing, put-downs). Enforce the rule.
- Have a family meeting each week to talk together about how you are doing as a family. Is everyone feeling safe? Does everyone get a chance to speak and be heard?

Lower Stress at School

School is often stressful. Try these strategies:

- Ask your child about bullying. It could be physical (pushing, threatening) or emotional (excluding a child, teasing). Ask about what happens at recess, at lunch, and in the hallways. Talk with the principal about the school's anti-bullying plan. Make sure the plan is being implemented.
- Having an adult outside the classroom who can provide problem-solving or anxiety management strategies. Most schools have counselors who do this.
- Taking tests in a quiet, private environment might reduce anxiety.
- Ask your child's teacher. Teachers often have helpful ideas. If your child has one, these can be written into the student's 504 Plan or Individualized Educational Plan.

Anxiety in Parents and Other Family Members

Anxiety problems run in families. If your child has anxiety, there is a good chance that you have had anxiety at some point in your life, or maybe your child's other parent. Think about your child's siblings, aunts and uncles on both sides, and grandparents; anxiety is also likely to show up in these relatives.

When parents have anxiety problems themselves, it makes it harder for them to help their children deal with anxiety. Anxiety has a tendency to "rub off." When children see their parents responding with anxiety, they become more anxious. On the other hand, when parents cope with things with calm confidence, children feel reassured and their anxiety tends to go down.

If you know that you have an anxiety problem, get treatment for it. Parents often put off taking care of their own needs because they are too busy looking after everyone else. But leaving your own anxiety untreated can make everything more difficult. It's better to make the time to get the help you need for yourself; then you will be better able to help your child. The same applies if the problem is in your spouse or partner. Support each other in getting your own anxiety problems under control, and you will find that your child's problems will be much easier to manage.

Therapy for Anxiety

For most children, the best therapy is Cognitive Behavioral Therapy (CBT). In CBT, the therapist helps the child change his or her thinking about what is stressing them. Cognitive (thinking) changes lead to changes in emotional and behavioral responses. Several different CBT programs have been proven to work. The best known is called "Coping Cat."

All CBT programs include several different parts. These include:

- explaining anxiety in a way children can understand it;
- relaxation techniques;
- teaching ways of thinking that challenge the anxiety thoughts; and
- gradually exposing the child to the things that (used to) make him or her very anxious.

Not all therapy is CBT

For therapy to be **most** effective it **typically** needs to happen at least every other week and it often takes about 2-3 months to see improvements. Therapy should involve "homework" where you and your child are practicing skills and strategies at home between sessions. Usually it takes at least 3 sessions for kids to get comfortable enough with a therapist to know if they are a good fit, and for children with more significant anxiety it may take longer. You may need to change therapists before you find the right one for your child.

It is important to remember that addressing anxiety is difficult and will not always feel comfortable to your child. Supporting them in continuing with practicing strategies is likely to lead to long-term improvement.

Medication for Anxiety

Medication alone is almost never the answer. Think about medication when you are already using the techniques above, and things still need to get better. Medication and counseling *together* are more effective than either alone. Your therapist may recommend after meeting with you and your child that a trial of medication should be considered.

Before you give your child medication, be sure you can answer the following questions:

- What do you hope will get better? Try to be specific. For example, "My child will have more days when he can go to school without upset, or can feel comfortable taking a walk with me."
- When can I expect these changes to happen? Most anxiety medications take about a month before you can see real differences; but some take less time and others may take more.
- What side-effects should I look for? What mild side effects are common? What are the less common but more severe side effects to be aware of? What should I do if I see side effects?

If you decide on medication, make a specific plan for how you will give it *every day*. It is often very hard to give medication every single day.

The medications that are most often used for all types of anxiety belong to a family of medications called SSRIs (selective serotonin reuptake inhibitors). These medicines are also antidepressants. SSRIs include fluoxetine (brand name is Prozac), escitalopram (brand name is Lexapro), and sertraline (brand name is Zoloft).

Benefits usually appear in 2 - 4 weeks, and get stronger over time. You might see less worry, more calmness, and easier separations. The doses should start low and increase slowly to minimize side effects. As with all medications, the goal is to use the *lowest* dose that works. If you think the medication is not working, or you are concerned about side effects, call the doctor. Don't just stop these medications; that may cause worse side effects.

Common side effects of SSRIs include stomach aches, constipation, diarrhea, weight gain or loss, sweating, dry mouth, headaches, irritability, sleeping much more or much less, restlessness or tremor (shaking), sexual side effects, and increased hyperactivity. More serious side effects include increased risk for self-injury and self-injurious behavior, mania, withdrawal effects.

Learn More about Anxiety

Websites:
www.worrywisekids.org

Videos:
The 5-4-3-2-1 Method: A Grounding Exercise to Manage Anxiety
https://www.youtube.com/watch?v=30VMIEmA114

You Are Not Your Thoughts
https://www.youtube.com/watch?v=0QXmmP4psbA>

Books for Parents and Children

Freeing Your Child From Anxiety: *Powerful, practical solutions to overcome your child's fears, worries, and phobias* (By: Tamar E. Chansky)

Growing up Brave: *Expert strategies for helping your child overcome fear, stress, and anxiety*
(By: Donna B. Pincus)

Helping Your Anxious Child: A step-by-step guide for parents 3rd Edition (2022)
(By: Ronald M Rapee, et al)

The Anxiety Workbook for Teens: Activities to Help You Deal with Anxiety and Worry
(By: Lisa Schab – read on own or with a counselor)

*The Worry Workbook for Teens: Effective CBT Strategies to Break the Cycle of Chronic Worry and Anxiety (*By: Jamie A. Micco)

What to Do When You Worry Too Much (By: Dawn Huebner - best for 6-12 year olds)

Wilma Jean the Worry Machine (By: Julia Cook - best for young children)

This info is a general resource. It is not meant to replace your health care provider's advice. Ask your doctor or health care team any questions. Always follow their instructions.