Anxiety Disorders in Children and Adolescents: The Role of Pediatricians

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There Are No Disclosures

Today’s presentation will address...

• Classifications of Anxiety Disorders

• Identifying Anxiety in Pediatrics: Why Pediatricians are Important and What Can They Do?

• DSM-5 diagnoses of anxiety disorders

• Treatment options for anxiety disorders
What are Anxiety Disorders?

- Extreme, often disabling anxiety is primary symptom
- May be accompanied by physical symptoms
- Causes significant distress
- Interferes with functioning
- Marked by time consumption

Facts about Childhood Anxiety

- Most common class of child psychiatric disorders
- Starts early
- Somatic complaints, peer neglect, impairment at school
- Majority of cases not identified (Chavira et al., 2004)
- Runs chronic course when untreated
- Risk for depression and substance use in adolescence
Normal Fears and Anxiety

Infants & Toddlers
- Separation from caregivers, fear of strangers
- Animals, insects, water, dark, loud noises

School-aged and Middle childhood
- Separation/death, injury, germs, natural disasters

Late Childhood and Adolescents
- Competency-based concerns; Self-conscious, social fears, school/performance anxiety, future oriented worry

When is Anxiety a Problem?

**Anxiety Disorders**: Frequency and intensity are excessive in relation to developmental norms

**THE FOUR D’s**
- **Disproportion**: Excessive and out of proportion to the context or trigger
- **Disruption**: Interferes with ability to function or with quality of life
- **Distress**: Burdensome and bothersome
- **Duration**: Consistent over a period of time
DSM-5 Anxiety Disorders

Now 3 separate classifications and chapters

- Anxiety Disorder
- Obsessive Compulsive and Related Disorders
- Trauma and Stress-Related Disorders

DSM-5 Anxiety Disorders

- Separation Anxiety Disorder
- Social Anxiety Disorder
- Generalized Anxiety Disorder
- Specific Phobia
- Panic Disorder
- Agoraphobia
- Selective Mutism
Separation Anxiety Disorder

• Separation anxiety normal about 7 months to 30 months

• Excessive anxiety concerning separation from home or parents/caregivers

• Average onset 6-8 years

• 4 to 5% prevalence

Separation Anxiety: Common Behaviors

• Excessive distress when separated from parent; beg or plead for parent to stay

• Will not sleep in room alone

• Worry about harm to themselves or caregivers

• Reluctance or refusal to go school, on sleepovers, playdates, or to camp

• Fearful to be alone at home

• Physical complaints when separation occurs
Specific Phobia

- Excessive, persistent fear of a specific object or situation
- Exposure provokes immediate anxiety response (may be panic attack)
- Must cause distress and impairment
- Last 6 month or more
- Reaction: Avoidance or endure with dread
- Typical onset 7-9 years
- 10% Prevalence

Specific Phobia Subtypes

- **Animal Type**: dogs, bees, snakes, insects
- **Natural environment**: storms, thunder, water, dark, heights
- **Blood-injection-injury**: doctor, dentist, blood test, injection
- **Situational**: bridges, tunnels, elevators (similar to agoraphobia)
- **Other**: Costumed characters, vomiting, choking
Generalized Anxiety Disorder

• Diffuse excessive worry over a wide variety of activities
  • School, performance, world events, health, financial
  • Family interaction
  • "What if" concerns span far into future
• Difficulty controlling the worry
• 6 months or more chronic worry that is unfounded or more severe than most
• Onset about 10-14 years
  • Prevalence 3.2%

Generalized Anxiety Disorder

• Attend to negative and threat related information
• Often described as worriers
• Chronic inability to relax
• Excessive attempts to seek reassurance or approval from others
• Low risk-taking: cannot tolerate uncertainty
  • Perfectionism: high internal standards
GAD Somatic Symptoms

- Often have physiological or somatic symptoms
- Headaches, stomachaches, nausea
- Inability to relax, muscle tension, restlessness
- Fatigue
- Trouble sleeping
- Irritability, poor concentration
- Frequent urination

Social Anxiety Disorder

- Intense fear of social and performance situations
- Fears of embarrassment, negative evaluation, and rejection
- Situations avoided or endured with distress
- Academic and/or social functioning impaired
- Goes unidentified because seen as “just shy”
- Starts early but peak onset is 12 years old
- Prevalence 12% in adolescents; 6.8% children
Common Signs of Social Anxiety

- Sensitivity to negative evaluation and rejection
- Present as shy or socially withdrawn
- Avoid conversations and interactions with peers
- Public speaking, reading aloud, being called on in class, may impair comprehension or grades
- Reluctance or refusal to invite others to get together
- May sit alone in the library or cafeteria, and hang back
- Appear on the fringes of the group
- Limited eye contact
  - Noticeable somatic symptoms: blushing, sweating, shaking

Social Skills Difficulties

- Starting a conversation
- Maintaining conversations
- Inviting others to get together
- Non-verbal skills (eye contact, smiling)
- Lack of Assertiveness
- NOT SAME AS SOCIAL SKILLS DEFICITS IN AUTISM OR ADHD
Selective Mutism

- Consistent failure to speak in specific social situations (typically school)
- Speaks in other situations
- Interferes with achievement or communication
- Lasts at least 1 month
Panic Disorder

Panic Attacks

- At least 4 physical symptoms
- Racing heart, chest pain, sweating, shortness of breath or choking sensation, trembling, shaking, dizziness, nausea, chills
- Fear of losing control, dying, or going crazy
- Occurrence of panic attacks and worry about future attacks
- Significant change in behavior related to attacks

Panic Disorder Varies by Age

- Mostly in adolescents; rare in childhood
- Younger children panic attacks related to specific triggering events (separation, specific)
- Core fear is of physical symptoms and their implications
- Adolescents more unexpected attacks
- Prevalence: 1 to 5%
Agoraphobia

Now a separate diagnosis in DSM-5

Fear of physical sensations or inability to escape or get help

• Fear and avoidance of at least 2 situations:
  • Being outside of home alone
  • Crowds or enclosed spaces (elevators)
  • Being in line
  • Bridge or tunnel
  • Traveling in car; public transportation
    • Malls, grocery stores, sporting events
    • Restaurants or movie theatres

Treatment of Anxiety Disorders

Most empirical support for cognitive behavioral interventions

Treatment may include:

- Psychoeducation
- Relaxation Strategies
- Cognitive Reappraisal or Realistic Thinking
- Social Skills Training
- Exposure
- Parent Training and Involvement, Contingency Management
- School consultation and involvement
Psychoeducation: What Fuels Anxiety?

The Anxiety Triad

Physical

Cognitive

Behavioral

Cognitive Symptoms

• Worry thoughts
• Negative predictions about situations (harm, losing control, rejection, poor performance)
• Negative self-talk (No one will like me, I can’t do this, I am not doing well, doubt)
Physical Symptoms of Anxiety

Physiological Component

<table>
<thead>
<tr>
<th>System</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac</td>
<td>Increased heart rate, chest pain, palpitations, heart pounding</td>
</tr>
<tr>
<td>GI</td>
<td>Stomach pain, nausea, diarrhea, frequent urination</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Smothering or choking sensation, dry mouth, Shortness of breath</td>
</tr>
<tr>
<td>Neurological</td>
<td>Headaches, Numbness, tingling, trembling, shaking</td>
</tr>
<tr>
<td>Temperature Regulation</td>
<td>Sweating, chills, cold/clammy hands</td>
</tr>
<tr>
<td>Vestibular</td>
<td>Dizziness, feeling unsteady, lightheaded</td>
</tr>
<tr>
<td>Sleep</td>
<td>Insomnia, nightmares, excessive fatigue</td>
</tr>
<tr>
<td>Other</td>
<td>Blushing, Redness, Muscle Tension</td>
</tr>
</tbody>
</table>
Behavioral Component of Anxiety

- Escape or Avoidance of feared situations and stimuli
- Social Skills Deficits
- Causes the most impairment in functioning

Interventions: Cognitive Strategies

THOUGHTS  FEELINGS

He’s so cuddly!

He’s going to eat me!
### Realistic Thinking

**Scenario 1** - Imagine you are walking down the hallway at school and you see a friend from school walking toward you. As you pass, you look at her and say hello, but he/she does not say anything back, and keeps walking. You feel upset.

- What thoughts might you have?
- What alternative explanations can there be?
- LOOK AT THE EVIDENCE

### Social Skills

- Initiating and maintaining conversations
- Inviting others to get together
- Assertiveness
- **NON-VERBAL SKILLS:**
  - Eye contact
  - Face the person
  - Don’t fidget or shuffle
  - Speak clearly and so others can hear you
  - Smile (Smile experiment)
Exposure: Facing Fears

- MOST IMPORTANT INTERVENTION
- Repeated contact with a feared situation
- Results in increased tolerance, progressively reduced levels of anxiety, and decrease in negative predictions
- Repeated practice – doing it once not enough
- Stay until you feel comfortable
- Done gradually
- Make a fear ladder (from easiest to hardest)
Parent Involvement

- Parental behaviors shown to maintain anxiety
  - Excessive Reassurance
  - Over-control & Over-protection
  - Permitting/Encouraging Avoidance

- Teach them to use a coping approach
  - Realistic Thinking (What is worst that could happen? What is likelihood will happen?)
  - Encourage approach
  - Contingency Management

Other Treatment Considerations

- Mindfulness: Tolerating distress; Staying in present moment; Accepting thoughts as thoughts rather than trying to change;

- Consider pharmacotherapy when severity interfering with engaging in exposure or severe functional impairment (school refusal)
  - Antidepressants usually SSRIs
The Pediatric Primary Care Advantage

- Unparalleled access to children and adolescents
- High prevalence of unrecognized anxiety disorder
- Low rates of service use
- Strong association between physical complaints and anxiety
- Reduces stigma of mental health problems
- Parents more willing to disclose to pediatricians

NIH Pilot Study in Pediatrics: PI Dr. Masia Warner

- 40 youth seeking treatment for physical complaints who had comorbid anxiety disorders
- Referred from GI (26), primary care (9), cardiology (5)
  - Mean age = 12.4 years (SD = 2.6; 8 to 16 years)

  Physical Symptoms
  - 12.5% 1 physical symptom
  - 27.5% 2 symptoms
  - 60% 3 or more symptoms

  Type: 92.5% Stomach Pain; 45% Nausea or Vomiting
  - 32.5% Headaches
  - 32.5% Diarrhea/Constipation
  - 30% Acid Reflux
  - 25% Chest Pain/Discomfort
  - 15% Muscle aches or pains

Length and Frequency of Physical Symptoms

- **Onset of Physical Complaints**
  - 30% within last year
  - 27.5% last 2 years
  - 42.5% 3 years or more
  - Mean age of onset = 9.8 (SD = 3.3)
- 72.5% saw referring pediatrician within last 6 months

- **Symptom Frequency**
  - 27.5% at least once a day
  - 57.5% a few times a week
  - 10% once a week
  - 5% a few times a month

Anxiety Diagnoses and Comorbidity

- **Primary anxiety disorder**
  - 32.5% Separation
  - 30% Social
  - 25% GAD
  - 10% Specific
  - 2.5% Other anxiety disorder

- 75% Comorbid (most other anxiety disorders, 15% depression, 7.5% ADHD)
- 52.5% missed school in past month
  - Mean = 6.2 days
  - Median = 3 days

67.5% never received mental health treatment
How to Assess Anxiety in Pediatrics

• **Screen for Child Anxiety Related Disorders**
  (SCARED; Birmaher et al., 1995): Parent and Child
  41-item self-report and parent-report measures
  Includes following subscales
  Generalized anxiety
  Separation anxiety
  Panic disorder
  Social anxiety
  FIVE ITEM VERSION (Birmaher et al., 1999) for pediatric use

Practical Way to Raise Topic of Anxiety
Collaborative Hub Procedure

Referring to the Hub: After required routine screening and/or based on clinical judgement following the exam, providers can fax the PPC Hub. Providers should send a complete referral form, screening tools, and any other clinically relevant information.

What Does the Hub Staff Need? All of the information the PPC Hub staff needs is on the referral form, including relevant background information, current clinical picture, demographic information, and reason for referral. Some providers may choose to send notes from previous visits as well, which can be very helpful, but is not required.

Communicating with the Family: Please be sure you have discussed the PPC Hub with the patient and family prior to faxing a referral to the PPC Hub, so that the family is aware that a Hub staff psychologist/LCSW/other mental health specialist will be contacting them to discuss current concerns and suggestions for support/treatment.

Collaborative Hub Procedure Cont’d

- What will the PPC Hub Staff Do? Hub staff will call the patient’s family and complete a clinical intake. The family will discuss their main concerns. Case managers will evaluate for severity and level of care. Depending on the patient’s needs, Hub staff will:
  - Recommend an appropriate level of care (inpatient, PHP, IOP, or outpatient) - the family is sent a list of referrals for therapy services to address current mental health concerns.
  - Match the patient with a therapist based on their insurance and geographical location – the referrals are researched by staff psychologists/LCSWs, and most often accept patient insurance.
- “Closing” the Loop: Hub staff will communicate with you, sending you notes on what occurred with the family. They will also encourage the family to call them back if they need another resource. Hub staff will also follow-up with referred families 3 and 9 months after initial referral.
Closing Comments

• Child and adolescent anxiety disorders are highly prevalent
• Undetected and untreated
• Serious consequences
• Early detection and treatment prevent negative outcomes
• Screening in pediatrics is essential

Questions?

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