Curbside Consult with a CAP: Identifying and Treating Anxiety and Co-Morbidities in Pediatric Primary Care
Today’s Presenter:

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Hackensack Meridian Health
There Are No Disclosures
As a result of attending the webinar presentation, participants will be able to:

1. Define the classifications of anxiety disorders, as described in the DSM-5 Manual
2. Identify a possible anxiety disorder in their pediatric patients
3. Understand relationship with common co-morbidities, and how to identify whether a patient's symptoms are related to anxiety or ADHD, or possibly both
4. Discuss various treatment options for anxiety disorders
5. Communicate effectively about anxiety disorders with patients and their parent/caregiver
6. Discuss common questions and concerns related to identification and management of patients with anxiety disorder
Part 1: A Brief Primer on Anxiety Disorders in Youth
Prevalence

Up to 50% of pediatric office visits involve a behavioral, emotional or educational concern.
Cumulative lifetime prevalence of major classes of DSM-IV diagnoses

Source: Anne Marie Albano Ph.D., ABPP
Columbia University Clinic for Anxiety and Related disorders

NCS-A, N=10,123; Merikangas et al., 2010, JAACAP
According to an American Academy of Pediatrics (AAP) survey published in 2008:

- More than 80% of primary care pediatricians reported that it was their responsibility to identify children with attention-deficit/hyperactivity disorder (ADHD), anxiety, depression, and substance abuse.
- Most (70%) also thought it was their responsibility to manage ADHD.
- Only about one-fourth thought it was their responsibility to manage anxiety (29%), depression (25%), or substance abuse (21%).
Antidepressant prescribing by pediatricians

The likelihood of prescribing an antidepressant in an adolescent with and anxiety disorder is shown in A, while the likelihood of prescribing an antidepressant to an adolescent with a depressive disorder or a co-morbid anxiety and depressive disorder are show in B and C, respectively. Increasing x-axis values reflect higher likelihoods of prescribing.
A  
- any anxiety disorder (31.3%)
- any depressive disorder (28.6%)
- any substance use disorder (no nic.) (33.6%)

B  
- Specific Phobia (14.7%)
- Social Phobia (7.0%)
- Agoraphobia (3.8%)
- Panic Disorder (3.8%)
- GAD (4.3%)
Lifespan View of Anxiety Disorders
Types of anxiety disorders based on the DSM-5 manual

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

OCD & PTSD in DSM 5 are no longer placed under anxiety disorder & will not be among the disorders discussed in this presentation
Separation Anxiety Disorder (DSM-5)

- Cannot be alone
- Bad things happening to parent &/or child
- Difficulty falling asleep or sleeping with loved ones
- Physical aches and pains
- Avoidance S, M, L, XL, XXL
- Accommodations by adults S, M, L, XL, XXL
- Can be diagnosed after 18yrs of age
- Duration 6 months
Generalized Anxiety Disorders

- Excessive worry and apprehensiveness
- Restless, keyed up, or on edge
- Fatigued at end of school day
- Concentration problems, “choking on tests”
- Sleeping problems (falling asleep)
- Unable to control the worry
- Impairment or distress
Social Anxiety Disorder

Fear of social &/or performance situations. Can be:

- Specific
- Generalized
  - Slow to warm up socially
  - Anxious about being with other people
  - Reticent to talk in social settings
  - Self-conscious & anticipate being embarrassed
  - Anticipate others will judge them
  - Worry before an event where other people will be
  - Avoid places where there are other people
  - Blush, sweat, tremble around other people
  - Feel nauseous or sick to their stomach when with other people
  - Depersonalize or de-realize when with other people
NOTE:
DSM states that anxiety in children must occur in peer and adult situations
Selective Mutism

- Failure to speak in specific social situations
- Duration is for > 1 month
- Not limited to the 1st month of school
Panic disorder

- Recurrent, unexpected panic attacks
- Sudden surge in anxiety, which then peaks, during which 4 of following symptoms occur
  - Palpitations
  - Sweating
  - Trembling
  - Feelings of choking
  - Chest pain
  - Nausea
  - Feeling dizzy/faint
  - Chills or heat sensations
  - Paresthesias
  - Fear of losing control “going crazy”
  - Derealization
  - Fear of dying
Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 1 of 2 (To be filled out by the CHILD)

Name: ___________________________ Date: ________________________

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

<table>
<thead>
<tr>
<th></th>
<th>0 Not True or Hardly Ever True</th>
<th>1 Somewhat True or Sometimes True</th>
<th>2 Very True or Often True</th>
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</thead>
<tbody>
<tr>
<td>1. When I feel frightened, it is hard for me to breathe</td>
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<tr>
<td>2. I get headaches when I am at school</td>
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<td>3. I don’t like to be with people I don’t know well</td>
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<td>4. I get scared if I sleep away from home</td>
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<tr>
<td>5. I worry about other people liking me</td>
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<tr>
<td>6. When I get frightened, I feel like passing out</td>
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<tr>
<td>7. I am nervous</td>
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<tr>
<td>8. I follow my mother or father wherever they go</td>
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<tr>
<td>9. People tell me that I look nervous</td>
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<tr>
<td>10. I feel nervous with people I don’t know well</td>
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<tr>
<td>11. My I get stomachaches at school</td>
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<tr>
<td>12. When I get frightened, I feel like I am going crazy</td>
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<tr>
<td>13. I worry about sleeping alone</td>
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<tr>
<td>14. I worry about being as good as other kids</td>
<td></td>
<td></td>
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<tr>
<td>15. When I get frightened, I feel like things are not real</td>
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<tr>
<td>16. I have nightmares about something bad happening to my parents</td>
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<tr>
<td>17. I worry about going to school</td>
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<tr>
<td>18. When I get frightened, my heart beats fast</td>
<td></td>
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<tr>
<td>19. I get shaky</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>20. I have nightmares about something bad happening to me</td>
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</table>
Mark’s mother is worried. When she and her husband take Mark to a family party – he will cling, cry, appear shrink away, have a tantrum & refuse to speak. She said this also happens when Mark is taken to a play group when he is around other children.

Select One (1):
A. Social Anxiety
B. Selective Mutism
C. Generalized Anxiety Disorder (GAD)
D. Separation Anxiety
E. Panic Disorder
Case Study: Daisy (12 years old)

History reports that she has not spoken audibly outside of her home since she first learned to talk. She talks to her parents and twin brother at home in an audible and appropriate voice. Outside of the home she may use non-verbal communication such as nodding her head. She performs well academically except for class participation or oral presentations. She has no history of school refusal.

Select One (1):
A. Social Anxiety
B. Selective Mutism
C. Generalized Anxiety Disorder (GAD)
D. Separation Anxiety
E. Panic Disorder
Case Study: Mary (12 years old)

Mary worries about everything. She worries about being on time, natural disasters, academic performances and friendships. The worry is excessive and difficult to control. She worries about her grade even though she is a straight A student. She is described by her mother as a perfectionist.

Select One (1):
A. Social Anxiety
B. Selective Mutism
C. Generalized Anxiety Disorder (GAD)
D. Separation Anxiety
E. Panic Disorder
Case Study: Sam (7 years old)

Is described as a clingy child, who has difficulty sleeping alone, frequently tells his mother he does not want to school because his belly hurts every morning.

Select One (1):
A. Social Anxiety
B. Selective Mutism
C. Generalized Anxiety Disorder (GAD)
D. Separation Anxiety
E. Panic Disorder
Case Study: Dylan (16 years old)

“I was sitting in my math class staring out of the window as usual. When all of a sudden my heart started pounding and my hands started sweating. I thought I was having a heart attack. The next time it happened was when I was watching a movie in the basement. The same thing my heart started racing & all of a sudden I started to feel hot and nauseous & my heart started racing again. I thought I was dying so I asked my parents to take me to the ED.

Then it happened again & again- and the doctors did all kind of tests- I thought I was going to die or something.

But all the tests came back normal and my family doctor finally told me I had panic disorder.

Select One (1):
A. Social Anxiety
B. Selective Mutism
C. Generalized Anxiety Disorder (GAD)
D. Separation Anxiety
E. Panic Disorder
Child/Adolescent Anxiety Multimodal Study (CAMS):

- CAMS was a six-year, six-site, randomized controlled trial.
- Four hundred eighty-eight (N = 488) children and adolescents (ages 7-17 years) with DSM-IV-TR diagnoses of SAD, GAD, or SoP were randomly assigned to one of four treatment conditions: CBT, SRT, COMB, or PBO.
- The primary findings from the CAMS suggest both CBT and SRT reduced the severity of anxious symptoms in children and adolescents diagnosed with moderate to severe SAD, GAD or SoP; however, the combination of the two therapies showed the most benefit.
Summarizing pharmacology treatment of pediatric anxiety disorders

- **When** to begin medication, **What** medication to begin, and **How long** to medicate (??)

- Specifically, psychopharmacologic trials data in pediatric patients with non-OCD anxiety disorders suggest that SSRIs and SSNRIs are efficacious and well-tolerated.

- However, placebo-controlled studies do not support the efficacy of benzodiazepines or buspirone in the treatment of youth with anxiety disorders.

- Moreover, we are beginning to appreciate that certain clinical and demographic variables may ultimately predict successful treatment outcome, including a family history, baseline anxiety severity, and comorbidity.
Consult with a CAP

- Start with a telephonic consult. Collaborate on the assessment and management
- Consider defining who is going to do what.
- Consider administering PHQ-A, SCARED, VADERBILT, CRAFFT initiation of treatment
- Request face-face visit if despite initiating treatment youth is not improving
- Request face-face if more assistance and guidance is needed
- Request face-face if case is complex (multiple inpatient/residential facility admissions)
- Request face-face if youth is at risk (psychosis, manic, self harm)
- Imminent suicidal cases - should be seen in the ED
CBT Targets Anxiety Triad

Thoughts

Problem Solving Realistic Thinking

Anxiety Triad

Feelings

Exposure Foster Brave Behavior

Behaviors

Relaxation Visualization
Part 2:
School Refusal Behavior on a Spectrum
Collaboration and Consultation in Primary Care
Epidemiology in the Community

School refusal affects approximately 5% of all children annually,

- Affecting girls and boys in equal numbers
- With 2 peaks in incidence at the ages of 5 to 6 years and again at 10 to 11 years.
- Approximately half of children and teenagers with school refusal have a treatable psychiatric illness.

In the Great Smoky Mountain Study of 2003, where more than 1,400 children were observed, they categorized children as being anxious school refusers, truant, or “mixed school refusers,” with features of both truancy and anxiety.

  - In children with truancy or anxious school refusal, 25% had a psychiatric illness.
  - In the mixed school refusers, they found 88% had at least one psychiatric diagnosis and 42% had somatic complaints.

While pure truancy will require different management strategies from school and parents, those young people who display features of both anxiety and truancy around school attendance are most likely to be suffering from a psychiatric illness.

Those illnesses most commonly associated with difficulty attending school include anxiety disorders (separation anxiety, social phobia, generalized anxiety disorder) and depression.
CAMS Long Term Response

Source: Anne Marie Albano Ph.D., ABPP  
Columbia University Clinic for Anxiety and Related disorders
SR Prevalence

- 1%-2% of general population of youth; 5-15% of clinic referred youth
  - Increased in youth with history of anxiety, depression, or previous SR
- Boys = girls
- All rates increased in: inner cities, public schools, older grades, more impoverished schools
- Peak ages:
  - 5-6 years old
    - Kindergarten
    - More acute onset
  - 10-13 years old
    - Middle School
    - More insidious onset
    - More severe absenteeism
  - 14-15 years old
    - High School

Source: Anne Marie Albano Ph.D., ABPP
Columbia University Clinic for Anxiety and Related disorders
School refusal is a behavior – NOT a diagnosis

School refusal is a complex problem that may be caused by different risk factors such as individual and contextual factors
Etiology

The Functional Model of School Refusal Behavior describes four main reasons why children develop SR:

- To **AVOID** general school-related distress caused by known or unknown factors (i.e., school is where they experience feelings of rejection or shame);
- To **ESCAPE** from adverse social situations and/or the school evaluation system (i.e., unstructured circumstances, group work, writing on the board);
- To draw the **ATTENTION** of parents (i.e., children have non-compliance, escape, or physical symptoms that occur at home to avoid separation); and
- To obtain **GRATIFICATION** out of not going to school. In this last case, the refusal relates specifically to the possibility of continuing pleasant experiences perceived as more rewarding than attending school, such as watching television or hanging out with friends.
# Heterogeneous Causes

<table>
<thead>
<tr>
<th>Master theme</th>
<th>Sub-ordinate themes</th>
</tr>
</thead>
</table>
| Initial school experiences                       | – Primary school experiences (4)  
  – Transition to secondary school (4)  
  – Multiple schools and relocation (2) |
| Participants’ perceptions of the causes of non-attendance | – Bullying (2)  
  – Nervousness/anxiety (4)  
  – Depression (1)  
  – Chronic fatigue (1)  
  – Fear of teachers (1)  
  – Social isolation in school (1)  
  – Separation from parent (1) |
| School and other support experiences             | – Initial responses and being disbeliefed (4)  
  – Pressure to return quickly or remain in school (4)  
  – Slow or inappropriate support experience (4)  
  – Fragmented support experience (4)  
  – Medication and prescribing (3)  
  – Things that might be done differently (4) |
| Punishment, blame and control                    | – Being labelled naughty (3)  
  – Being punished and controlled (4)  
  – Recognising (but not excusing) why (3) |
| Friendship and belonging                         | – Difficulty accessing a friendship group (1)  
  – Friends as a positive aspect of school (3)  
  – “Belonging” to primary school (2) |
| The future                                       | – Future plans (3)  
  – Anger (4)  
  – Fear (4)  
  – Hiding emotions and keeping secrets (4)  
  – Seeking meaning and making sense (4) |

Note: Numbers in brackets refer to the number of accounts in which each sub-ordinate theme was present.
Primary psychiatric disorders among youth with school refusal behavior

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>32.9 %</td>
</tr>
<tr>
<td><em>Separation anxiety disorder</em></td>
<td>22.4 %</td>
</tr>
<tr>
<td><em>Generalized anxiety disorder</em></td>
<td>10.5 %</td>
</tr>
<tr>
<td><em>Oppositional defiant disorder</em></td>
<td>8.4 %</td>
</tr>
<tr>
<td>Major depression</td>
<td>4.9 %</td>
</tr>
<tr>
<td>Specific phobia</td>
<td>4.2 %</td>
</tr>
<tr>
<td>Social anxiety disorder</td>
<td>3.5 %</td>
</tr>
<tr>
<td>Conduct disorder</td>
<td>2.8 %</td>
</tr>
<tr>
<td>Attention deficit/hyperactivity disorder</td>
<td>1.4 %</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>1.4 %</td>
</tr>
<tr>
<td>Enuresis</td>
<td>0.7 %</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>0.7 %</td>
</tr>
</tbody>
</table>
Spectrum of behaviors in school refusal

- Attends school under stress
- Misbehaviors to avoid school (including tardiness)
- Periodic absences & / or skipping classes
- Complete absence for a longer period of time
- Complete absence from school for an extended period of time.
Assessing School Refusal

- Screen for school refusal history in the past before school year begins
- What is the primary function of school refusal (avoidance, escape)
- What motivates the behavior
- What Maintains the behavior
- Multi-method assessment (School Refusal assessment scale, PHQ-9, Vanderbilt, Scared)
- Multi-informant assessment – parent, teacher, counselor, attendance officer
- School reports
Dig Deeper

- Inadequate treatment planning (increase intensity frequency of Tx, adjunctive treatment such as HRT, medication augmentation)
- Comorbidity
- Developmental tasks not mastered
- Social/Environmental stress (bullying, peer issues, social media)
- Unidentified learning problem (neuropsychological testing)
- Family (are parents following through with their part)
Socioemotional Consequences

- Short Term:
  - Somatic Complaints
  - Poor academic performance
  - Disruption of extracurricular activities
  - Family conflict / Child maltreatment
  - Peer difficulty / social alienation

- Long term:
  - School drop out
  - Unstable job history / unemployment
  - Alcohol abuse
  - Chronic anxiety and depression
  - Legal problems
Collaborative care treatment
(Putting it all together - assigning roles)

- The child role
- The parent role
- The School role (have a point person)
- Pediatricians role- (Do not write the child out of school)
- The community therapist role
- The PPC HUB Case navigators role
- The PPC HUB Child & Adolescent psychiatrists role
School Accommodations

- More resource rooms
- Modified assignments
- Creation of cover story
- Reduce public speaking
- Testing in private quiet space
- Use nurses office rest room
- Free passes to visit guidance counselor
- Dropping a class
- Fun activity breaks

*** Remove or reduce after a defined period of time
Alternative Schooling options (For chronic school refusal with significant emotional, behavioral, family needs)

- Consult with an educational advocate
- Placement options:
  - Smaller private school
  - Special education schools with enhanced therapeutic support
  - 1:1 school settings
  - Residential schools
  - Day treatment programs
  - Wilderness programs
Sobering take home message

- Follow up is needed
- Youth should be back in school within 1 week of school refusal
- Many youth are in need of longer and more robust treatments
Pediatric Psychiatry Collaborative
Regional Hubs

Atlantic Health Hub @ Newton Medical Center
Atlantic Health Hub @ Goryeb Children’s Hospital
Hackensack Meridian Hub @ Hackensack University Medical Center
Hackensack Meridian Hub @ Palisades Center
Hackensack Meridian Hub @ Saint Peter’s Family Health Center
Hackensack Meridian Hub @ Jersey Shore University Medical Center
Cooper Hub @ Cooper University Medical Center
Cooper Hub @ Pennsville

Essex County served by Rutgers University Behavioral Health Care.
More information on the Essex Hub can be found here: [link here]

[Map of New Jersey with hub locations indicated]

[Logos of various health care providers]
PPC Hub Benefits

- A child and adolescent psychiatrist available for consultative support through the Child Psych. consult line

- A psychologist/social worker available to:
  - Assist the pediatrician with diagnostic clarification and medication consultation,
  - Speak with a referred child’s family regarding the child’s mental health concerns and to assist in providing diagnostic clarification.

- One-time evaluation by a child and adolescent psychiatrist (CAP) at no charge to the patient when appropriate.

- Based on the recommendation of the CAP, the PPC Hub staff will work with the family to develop the treatment and care coordination plan.

- Continuous education opportunities in care management and treatment in the primary care office for the common child mental health issues: ADHD, depression, anxiety, etc.
References

Child/Adolescent Anxiety Multimodal Study (CAMS): rationale ...
https://www.ncbi.nlm.nih.gov › pmc › articles › PMC2818613

Results From the Child/Adolescent Anxiety ... - NCBI - NIH

Solutions to school refusal for parents and kids | MDedge ...

The Great Smoky Mountains Study - NCBI
https://www.ncbi.nlm.nih.gov › pmc › articles › PMC3939681
Thank you! Questions?

Please contact:

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To Register to Participate:
http://njaap.org/programs/mental-health/ppc/