Anxiety Disorders in Children under Age 6

**Level 0**
Comprehensive assessment (see Principles of Practice) that includes history of stressors, trauma, parental anxiety, and observation of child-parent interactions.
- Rating scales specifically for young children with anxiety symptoms are limited but the Preschool Anxiety Scale (parent report) is available at [http://medicaidmentalhealth.org/](http://medicaidmentalhealth.org/)
- Child and parent rating of anxiety symptom severity and impairment with feelings thermometer or faces barometer.

**Level 1**
Start with psychotherapy for at least 12 weeks that includes the parents and exposure-based cognitive behavioral therapy (CBT) adapted to young children.
- Assess primary caregivers for anxiety disorders and referral for treatment if impacting child’s treatment progress.
- Address parental accommodation to child’s symptoms of anxiety.

**Level 2**
If poor or partial response to psychosocial treatment after at least 12 weeks, consider combination treatment with fluoxetine and concurrent psychotherapy for children 4 to 5 years old.
- Review black-box warning with parents and monitor for suicidality.
- 8 to 10 week trial of fluoxetine if well tolerated starting at 1-2mg/day.
- Maximum dosing of 5-8 mg/day.
- Increased risk for disinhibition and behavioral activation in young child.
- Discontinuation trial after 6 to 9 months of effective medication treatment with gradual downward titration.

Less than 4 years old, see Principles of Practice.

**Level 3**
If fluoxetine is not successful, consider sertraline or fluvoxamine in combination with concurrent psychotherapy. Start with low dosing and monitor closely.

**Not Recommended for Children Under Age 6 with Anxiety Disorders:**
- The use of medication without psychosocial treatment.
- Use of tricyclic antidepressants (TCAs) or alpha-agonists.
- Ongoing use of benzodiazepines. May be used short-term for extreme anxiety with medical or dental procedures.

The data for treating anxiety disorders with psychopharmacologic medication in young children is limited. Thus, exercise caution in prescribing pharmacological treatment below age 6.
Anxiety Disorders in Children and Adolescents Ages 6 to 17 Years Old

Level 0
A comprehensive assessment includes:

♦ Assessment of risk factors including: stressors, trauma, bullying, social support systems, coping skills, learning disorders, and school issues.
♦ Assessment of family coping skills, parenting styles (overprotective or overcontrolling), and family accommodations that support child’s symptoms.
♦ Evaluation of medical conditions and comorbid psychiatric disorders.
♦ Evaluation of severity of anxiety symptoms and impairment from anxiety disorder.
♦ Assessment of parental and family history of anxiety disorders and psychiatric treatment.
♦ Evaluation of severity of anxiety symptoms and impairment from anxiety disorder.
  ◊ Screening and monitoring for anxiety symptoms with multi-informant, validated rating scales for childhood anxiety (parent and child report) such as Self-Report for Childhood Anxiety Related Disorders (SCARED) and Spence Children’s Anxiety Scale (SCAS). Available at http://medicaidmentalhealth.org/resourcesLinks/diagnosticTreatmentScales.cfm
♦ Assessment of baseline somatic symptoms prior to medication trials.

Note: The Anxiety Disorders Interview Schedule for Children (ADIS-C) may assist clinicians to differentiate the specific anxiety disorders (Silverman and Albano, 1996).

Level 1
If mild to moderate anxiety disorder:

♦ 1a. Provide family with psychoeducation regarding anxiety disorders and cognitive behavioral therapy (CBT).
  ◊ Initiate treatment with exposure-based cognitive behavioral therapy.
♦ 1b. If CBT is not available, first consider evidence-based psychosocial interventions.
  ◊ Provide family with psychoeducation regarding anxiety disorders and CBT.
♦ Train parents to monitor child’s anxiety symptoms (e.g. feelings thermometer or faces barometer) and set up behavioral program with positive reinforcement for child’s efforts and progress in addressing anxiety symptoms and decreasing avoidance.
♦ If parental anxiety disorders interfere with treatment progress, provide referral for parent.
Anxiety Disorders
in Children and Adolescents Ages 6 to 17 Years Old (continued)

Level 2
If moderate to severe anxiety disorder or inadequate response to CBT alone:
- 2a. Initiate monotherapy treatment with fluoxetine or sertraline.
- Combination therapy with CBT and selective serotonin reuptake inhibitors (SSRI).
- Review black box warning with family and monitor for treatment emergent suicidality.
- 2b. If first SSRI trial is not successful, try another SSRI in the same group (fluoxetine or sertraline).

Level 3
If moderate to severe anxiety disorder and Levels 1 and 2 are not successful:
- 3a. Consider another SSRI, such as fluvoxamine, escitalopram or citalopram (not paroxetine) alone or in combination with CBT, and monitor for treatment emergent suicidality.
- 3b. If Level 3a is not successful then consider venlafaxine monotherapy or in combination with CBT. Monitor height, weight, blood pressure, pulse, and treatment emergent suicidal ideations.

Level 4
If Levels 1, 2 and 3 are not successful, then re-evaluate diagnosis or refer to a specialist.

Notes:
1. Despite limited evidence, may consider monotherapy or augmentation with other medications if partial or poor response with SSRIs or venlafaxine. Potential agents include: buspirone, alpha-2 agonist, clomipramine, and low dose benzodiazepine.
2. Benzodiazepines should be reserved for short-term use, long-term use is not recommended.
Medications for the Treatment of Anxiety Disorders

- None of these medications are FDA approved for use in youth with non-OCD anxiety disorders.
- Clinicians should realize that data below age 6 for treating anxiety disorders is limited and caution in using pharmacological treatment below age 6 is warranted.

(*indicates placebo-controlled studies in children 6 to 17 years with anxiety disorders).

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Young Child (4 – 6 Years)</th>
<th>Child (6 – 12 Years)</th>
<th>Adolescent</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Fluoxetine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Dose:</td>
<td>1-2 mg/day</td>
<td>5-10 mg/day (limited data)</td>
<td>2.5-5 mg/day</td>
</tr>
<tr>
<td>Maximum Dose:</td>
<td>5-10 mg/day</td>
<td>20-40 mg/day</td>
<td>5-10 mg/day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20-40 mg/day</td>
<td>40-60 mg/day</td>
</tr>
<tr>
<td>*Sertraline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Dose:</td>
<td>5 mg/day</td>
<td>50-75 mg/day (limited data)</td>
<td>10-12.5 mg/day</td>
</tr>
<tr>
<td>Maximum Dose:</td>
<td>50-75 mg/day</td>
<td>100-150 mg/day</td>
<td>25 mg/day</td>
</tr>
<tr>
<td></td>
<td>100-150 mg/day</td>
<td>150-200 mg/day</td>
<td></td>
</tr>
<tr>
<td>*Fluvoxamine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Dose:</td>
<td>5 mg/day</td>
<td>50-75 mg/day (limited data)</td>
<td>12.5-25 mg/day</td>
</tr>
<tr>
<td>Maximum Dose:</td>
<td>50-75 mg/day</td>
<td>100-200 mg/day</td>
<td>25 mg/day</td>
</tr>
<tr>
<td></td>
<td>100-200 mg/day</td>
<td>150-300 mg/day</td>
<td></td>
</tr>
<tr>
<td>Escitalopram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Dose:</td>
<td>1-2 mg/day</td>
<td>5-10 mg (limited data)</td>
<td>2.5 mg/day</td>
</tr>
<tr>
<td>Maximum Dose:</td>
<td>5-10 mg</td>
<td>10-20 mg/day</td>
<td>5 mg/day</td>
</tr>
<tr>
<td></td>
<td>10-20 mg/day</td>
<td>20-30 mg/day</td>
<td></td>
</tr>
<tr>
<td>Citalopram</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Dose:</td>
<td>No data</td>
<td>5 mg/day</td>
<td>10 mg/day</td>
</tr>
<tr>
<td>Maximum Dose:</td>
<td>5 mg</td>
<td>20-40 mg/day</td>
<td>40 mg/day</td>
</tr>
<tr>
<td></td>
<td>20-40 mg/day</td>
<td>(check ECG above 40 mg for QTc prolongation)</td>
<td></td>
</tr>
<tr>
<td>*Venlafaxine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starting Dose:</td>
<td>No data</td>
<td>37.5 mg/day</td>
<td>37.5 mg/day</td>
</tr>
<tr>
<td>Maximum Dose:</td>
<td>No data</td>
<td>75-112.5 mg/day (25-39 kg)</td>
<td>37.5 mg/day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>75-112.5 mg/day</td>
<td>150 mg/day</td>
</tr>
<tr>
<td></td>
<td></td>
<td>150 mg/day</td>
<td>225 mg/day (&gt;50 kg)</td>
</tr>
</tbody>
</table>

Note: The FDA does not currently provide any dosing guidelines for venlafaxine in children or adolescents and does not recommend its use in this population due to mixed results in efficacy trials.
**ADDITIONAL CLINICAL INFORMATION**

- After reaching the lowest therapeutic dose, can increase SSRI dose after one month if well tolerated and significant symptoms remain.
- Can consider discontinuation trial of SSRI after 12 months of effective medication treatment, during low stress period, and with gradual downward titration. Monitor for relapse.
- May titrate to lowest therapeutic dose once weekly.

**ANXIETY DISORDERS AND COMORBID DISORDERS**

- **ADHD:**
  - Stimulant medications can be combined with SSRIs for comorbid ADHD.
  - Strattera, guanfacine and other ADHD medications may be helpful for the subset of children who may not tolerate stimulants.

- **Depression and bipolar disorder:**
  - Fluoxetine is first-line medication for comorbid unipolar depression.
  - Antidepressants, including SSRIs, may be poorly tolerated in children with anxiety (or depression) and family history of bipolar disorder. Use caution.
  - For children with comorbid bipolar disorder, the bipolar disorder needs to be stabilized first. Adding an SSRI needs to be considered cautiously after CBT for the anxiety disorder has been tried.
  - Alternatives to SSRI medications for anxiety disorder symptoms may be considered early in treatment, such as guanfacine for autonomic symptoms.
  - Use benzodiazepines with caution as they can increase disinhibition, mood lability, irritability, or aggression and may have potential for abuse.

- **Substance use disorder (SUD):**
  - Both anxiety disorders and SUD can be treated at the same time. Some substances increase anxiety & panic symptoms and can complicate treatment.
  - Use caution with benzodiazepines in presence of SUD, especially those with short half-life and increased risk for abuse and dependence.
  - Integrate additional psychotherapy components: Motivational strategies and CBT to identify triggers for cravings, develop alternative coping skills to reduce substance use.

- **Autism spectrum disorders (ASD) and developmental disorders (DD):**
  - Can modify CBT for anxiety disorders with ASD and/or DD.
  - SSRIs for anxiety/irritability and obsessive-compulsive behaviors distressing to the child, but not all ritualized or repetitive behaviors. Consider when obsessive features, rigidity of thought, perseveration, rituals, anxiety, depression, and/or irritability present.
  - Stimulants for problems with inattention, concentration, and hyperactivity.
  - Guanfacine or clonidine for impulsivity, explosiveness, and/or restlessness. Assess for trauma history.
  - Atypical antipsychotics (risperidone, aripiprazole) for irritability, aggression, and other severe symptoms. Assess for comorbid mood disorder.
Not Recommended for Childhood Anxiety Disorders:

- Paroxetine is not recommended as first or second line treatment for childhood anxiety disorders due to concerns about increased adverse effects (e.g., insomnia, decreased appetite, vomiting, activation, withdrawal symptoms, and increased risk for suicidal ideations) relative to other SSRIs.

- Using benzodiazepines (BZO) as first-line, monotherapy for long-term treatment of childhood anxiety disorders is not recommended. BZO short-term use as SSRI takes effect or to address severe anxiety and impairment related to brief medical or dental procedures may be helpful.

Resources

- Children
  - What To Do When You Worry Too Much (Huebner, 2005)
  - A Boy and a Bear: The Children’s Relaxation Book (Lite, 1996)

- Adolescents
  - Riding the Wave Workbook for Adolescents with Panic Disorder (Pincus, Ehrenreich, and Spiegel, 2008)
  - Smartphone applications for youth and their parents that provide access to tools taught in CBT sessions (e.g. Mayo Clinic Anxiety Coach)

- Parents/caregivers
  - Helping Your Anxious Child (Rapee, Wignall, Spence, and Cobham, 2008)
  - Keys to Parenting Your Anxious Child (Manassis, 2008)
  - Freeing Your Child from Anxiety (Chansky, 2014)
  - Helping Your Child with Selective Mutism (McHolm, Cunningham, and Vanier, 2005)
  - The Selective Mutism Treatment Guide: Manuals for Parents, Teachers and Therapists (Perednik, 2012)
  - When Children Refuse School: A CBT Approach Parent Workbook (Kearney and Albano, 2007)
  - Parent training, educational materials and resources at [www.anxietybc.com](http://www.anxietybc.com) and [www.copingcatparents.com](http://www.copingcatparents.com)
Relevant websites

- American Academy of Child and Adolescent Psychiatry (AACAP), [www.aacap.org](http://www.aacap.org). (Facts for Families)
- Anxiety Disorders Association of America (ADAA), [www.adaa.org](http://www.adaa.org)
- Selective Mutism Group-Child Anxiety Network, [www.selectivemutism.org](http://www.selectivemutism.org)
- Association for Behavioral and Cognitive Therapies, [www.abct.org](http://www.abct.org)
- Computer-based CBT treatments (cCBT) for youth with anxiety disorders: BRAVE, BRAVE-ONLINE, and Camp Cope-A-Lot

References