Clinical Pearls in Child Psychiatry

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Learning Objectives

- Discuss Major Tenants of Psychiatric Care of Children and Adolescents
- Review Diagnosis and Treatment
  - ADHD
  - Autism Spectrum Disorders
  - Bipolar Disorder
  - Disruptive Mood Dysregulation Disorder
  - Depression
  - Anxiety

Key Points in Psychiatric Treatment of Children and Adolescent

- First line treatment for the majority of psychiatric illness should include behavioral therapy
- Start low and go slow
- Avoid polypharmacy if possible
- Parental consent and patient assent is essential to care
- Monitor for side effects
- Children metabolize quicker than adults so BID dosing might be indicated

Attention Deficit Hyperactivity Disorder

Diagnostic Criteria for ADHD

A persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, as characterized by inattention and/or hyperactivity

Note: The symptoms are not solely a manifestation of oppositional behavior, defiance, hostility, or failure to understand tasks or instructions. For older adolescents and adults (age 17 and older), at least five symptoms are required.

Inattention: **Six** (or more) of the following symptoms have persisted for at least **6** months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities: Developmental Considerations

- Often fails to give close **attention to details** or makes careless mistakes in schoolwork, at work, or during other activities (e.g., overlooks or misses details, work is inaccurate).
- Often has difficulty **sustaining attention** in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
- Often does not seem to **listen when spoken to** directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
- Often does not **follow through on instructions** and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked).
- Often has difficulty **organizing** tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganized work; has poor time management; fails to meet deadlines).
- Often avoids, dislikes, or is reluctant to engage in tasks that **require sustained mental effort** (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
- Often **loses things** necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones).
- Is often easily **distracted** by extraneous stimuli (for older adolescents and adults, may include unrelated thoughts). i. Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

Hyperactivity and impulsivity: **Six** (or more) of the following symptoms have persisted for at least **6** months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

- Often **fidgets** with or taps hands or feet or squirms in seat.
- Often **leaves seat** in situations when remaining seated is expected (e.g., leaves his or her place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
- Often **runs about or climbs** in situations where it is inappropriate. (Note: In adolescents or adults, may be limited to feeling restless.)
- Often unable to play or engage in leisure activities quietly. e. Is often **"on the go,"** acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
- Often **talks excessively.**
- Often **blurts** out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
- Often has **difficulty waiting his or her turn** (e.g., while waiting in line).
- Often **interrupts** or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

Diagnostic Criteria for ADHD

- Several inattentive or hyperactive-impulsive symptoms were present **prior to age 12 years**.
- Several inattentive or hyperactive-impulsive symptoms are present in **two or more settings** (e.g., at home, school, or work; with friends or relatives; in other activities).
- There is clear evidence that the symptoms **interfere** with, or reduce the quality of, social, academic, or occupational functioning.
- The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g., mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal).

ADHD

Consider **Objective Neuropsychological** testing if diagnosis is unclear

Ensure Vanderbilts are completed by home and school, repeat to ensure medications are effective

If concerns for **family history of cardiac problems**, or concerns for cardiac health with patient EKG is indicated

For **preschool patients, behavioral therapy** is first line and should be initiated prior to starting a medication

Be sure to ask about **SLEEP**

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

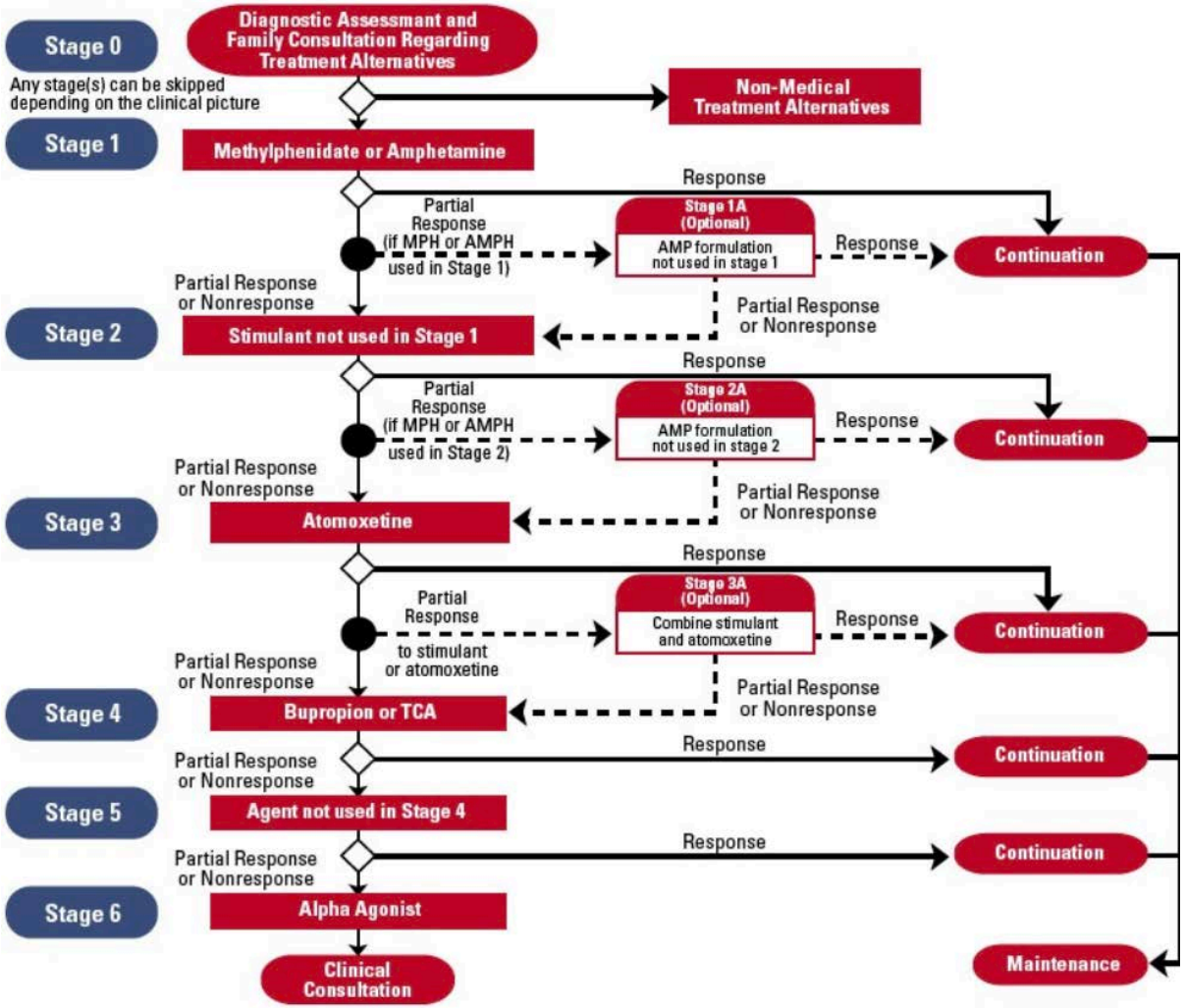
Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3

FIGURE 1

PHARMACOLOGIC TREATMENT OF CHILDHOOD ADHD WITH NO SIGNIFICANT COMORBID DISORDERS*[57]



* The algorithm predates the FDA approval of guanfacine ER in September 2009. With this approval, the sequence of medication trials should be the use of approved medications before the off-label use of alternative medications. The algorithm offers the sequence of monotherapeutic medication trials and has not considered polypharmaceutical treatment in child/adolescent ADHD.

MPH=methylamphetamine; AMP=amphetamine; TCA=tricyclic antidepressant; FDA=Food and Drug Administration; ER=extended release.

Revised (JAACAP, June 2006)
Uncomplicated ADHD:

1. **Stimulant**
2. **2nd Stimulant**
3. **Atomoxetine**
4. **Bupropion or TCA**
5. **Alternate (BPA/TCA)**
6. **Alpha-2 agonist**

Clinical Practice

First Line: **Stimulant**

Hyperactivity and Impulsivity: **Alpha Agonist** (Guanfacine, Clonidine)

Inattention: **Atomoxetine**

Special Considerations

- Adolescent with Co-morbid depression: **Bupropion**
- ADHD co-morbid with anxiety: **Atomoxetine**
- Combined Treatment with **Stimulant and Alpha-Agonist**

Stimulants

ORIGINAL ARTICLE (FREE PREVIEW)

Psychosis with Methylphenidate or Amphetamine in Patients with ADHD

Lauren V. Moran, M.D., Dost Ongur, M.D., Ph.D., John Hsu, M.D., M.S.C.E., Victor M. Castro, M.S., Roy H. Perlis, M.D., and Sebastian Schneeweiss, M.D., Sc.D.

BACKGROUND The prescription use of the stimulants methylphenidate and amphetamine for the treatment of attention deficit–hyperactivity disorder (ADHD) has been increasing. In 2007, the Food and Drug Administration mandated changes to drug labels for stimulants on the basis of findings of new-onset psychosis. Whether the risk of psychosis in adolescents and young adults with ADHD differs among various stimulants has not been extensively studied.

METHODS We used data from two commercial insurance claims databases to assess patients 13 to 25 years of age who had received a diagnosis of ADHD and who started taking methylphenidate or amphetamine between January 1, 2004, and September 30, 2015. The outcome was a new diagnosis of psychosis for which an antipsychotic medication was prescribed during the first 60 days after the date of the onset of psychosis. To estimate hazard ratios for psychosis, we used propensity scores to match patients who received methylphenidate with patients who received amphetamine in each database, compared the incidence of psychosis between the two stimulant groups, and then pooled the results across the two databases.

RESULTS We assessed 337,919 adolescents and young adults who received a prescription for a stimulant for ADHD. The study population consisted of 221,846 patients with 143,286 person-years of follow up; 110,923 patients taking methylphenidate were matched with 110,923 patients taking amphetamines. There were 343 episodes of psychosis (with an episode defined as a new diagnosis code for psychosis and a prescription for an antipsychotic medication) in the matched populations (2.4 per 1000 person-years): 106 episodes (0.10%) in the methylphenidate group and 237 episodes (0.21%) in the amphetamine group (hazard ratio with amphetamine use, 1.65; 95% confidence interval, 1.31 to 2.09).

CONCLUSIONS Among adolescents and young adults with ADHD who were receiving prescription stimulants, new-onset psychosis occurred in approximately 1 in 660 patients. Amphetamine use was associated with a greater risk of psychosis than methylphenidate. (Funded by the National Institute of Mental Health and others.)

α-2 Agonists : Dosage, Treatment, and Side Effects

- **Useful for residual hyperactivity & impulsivity,** insomnia, treatment emergent tics, & aggression Clonidine (0.1 – 0.3 mg/d) & Guanfacine (1 – 3 mg/d)
- Routine PE/VS prior to initiation of Rx
- Contraindications: CAD, impaired liver/renal function
- Side Effects: Rebound HTN/tachycardia, HOTN, sedation, dizziness, constipation, H/A, fatigue
- Dosage: Start with HS and titrate toward morning
- Monitor BP, but ECG not routinely necessary

Additional Medication

- Atomoxetine
  - Similar structure to SSRI's
  - Can require 4-6 weeks at appropriate does to see effect
  - Potentially useful with comorbid anxiety, Tics, Disruptive Disorders and Substance Use
- Omega-3 Fatty Acids
  - Some positive findings, small effect size
  - Support with mood disorders in youth
- Bupropion
  - Contraindicated in eating disorders
  - Inhibits reuptake of norepinephrine and dopamine
- Modafinil
  - Positive RTC's in children
  - Careful with Steven Johnson's Syndrome

Autism Spectrum Disorder

DSM V Diagnostic Criteria for Autism Spectrum Disorder

A. Persistent **deficits in social communication and social interaction** across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):

- 1. Defic**its in social-emotional reciprocity**, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
- 2. **Deficits in nonverbal communicative behaviors** used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
- 3. Deficits in developing, maintaining, and understanding **relationships**, ranging, for example, from difficulties adjusting behavior to suit various social contexts; to difficulties in sharing imaginative paly or in making friends; to absence of interest in peers.

- **Have to specify the severity with the following categories: “requiring support” (Level 1); “requiring substantial support” (Level 2); “requiring very substantial support” (Level 3).**

DSM V Diagnostic Criteria for Autism Spectrum Disorder (cont.)

B. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):

1. **Stereotyped** or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).

2. **Insistence on sameness,** inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).

DSM V Diagnostic Criteria for Autism Spectrum Disorder (cont.)

3. **Highly restricted, fixated interests** that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interest).

4. **Hyper- or hyporeactivity to sensory input** or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

*Specify Severity

Autism Spectrum Disorder

Gold standard: Autism Diagnostic Interview-R (ADI-R) & Autism Diagnostic Observation Schedule (**ADOS**)

Comprehensive history and physical exam including developmental history (collateral from parent or spouse)

Cognitive & adaptive function testing

Hearing test

Language evaluation

Motor skills/sensory evaluation

Pharmacotherapy

AACAP Practice Parameters

- *Pharmacologic interventions may increase the ability of persons with ASD to profit from educational and other interventions and to remain in less restrictive environments through the management of severe and challenging behaviors.*
- <u>Frequent targets for pharmacologic intervention include:</u>
  - Associated comorbid conditions (e.g., anxiety, depression)
  - Aggression
  - Self-injurious behavior
  - Hyperactivity/inattention
  - Compulsive-like behaviors
  - Repetitive or stereotypic behaviors,
  - Sleep disturbances

Hyperactivity and Inattention

- Methylphenidate
  - Improvement in symptoms, Irritability most common side effect
- Atomoxetine
  - Effects on hyperactivity > inattention in ASD, GI side effects most common
- Alpha-Agonists
  - Improvement in Hyperactivity, Sedation and Constipation most common side effects

Irritability

- Risperidone
  - Side effects: Sedation, dizziness, drooling
- Aripiprazole
  - Side effects: weight gain, sedation

*Start low and Go Slow

Restricted and Repetitive Patterns of Behavior

Consider the adaptive nature of behaviors

Limited data to support use of SSRI's in repetitive behaviors

Adults > Youth improvement

Sleep Disturbances

- Melatonin
- Trazadone
- Clonidine

Bipolar Disorder

Bipolar Affective Disorder Type 1

- Prevalence 1-2%
- Must have at least 1 **manic** episode
  - a distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy, **lasting 1 week** and present most of the day, nearly every day

Bipolar Affective Disorder Type 1

- 3 or more of the following (4 if mood is only irritable).
  - Increased self-esteem or grandiosity
  - Decreased need for sleep
  - Pressured speech
  - Distractible
  - Increase in goal directed activity
  - Increased risk taking behavior

Bipolar Affective Disorder Type 2

- a distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy, **lasting 4 days** and present most of the day, nearly every day
- **Associated with change in functioning yet not severe enough to cause marked impairment**

Treatment of Bipolar Disorder

- Typically Medications will be indicated
- Therapy
  - Family psychoeducation plus skill building currently is the best-proven treatment of children and adolescents with Bipolar Disorder

Treatment of Bipolar Disorder

- Start with an FDA approved agent *(Currently No FDA approved medications under age 10)*
  - Lithium (12 years and older)
  - Risperidone (10–17 years old)
  - olanzapine (13–17 years old)
  - aripiprazole (10–17 years old)
  - quetiapine (10–17 years old)

Treatment of Bipolar Disorder

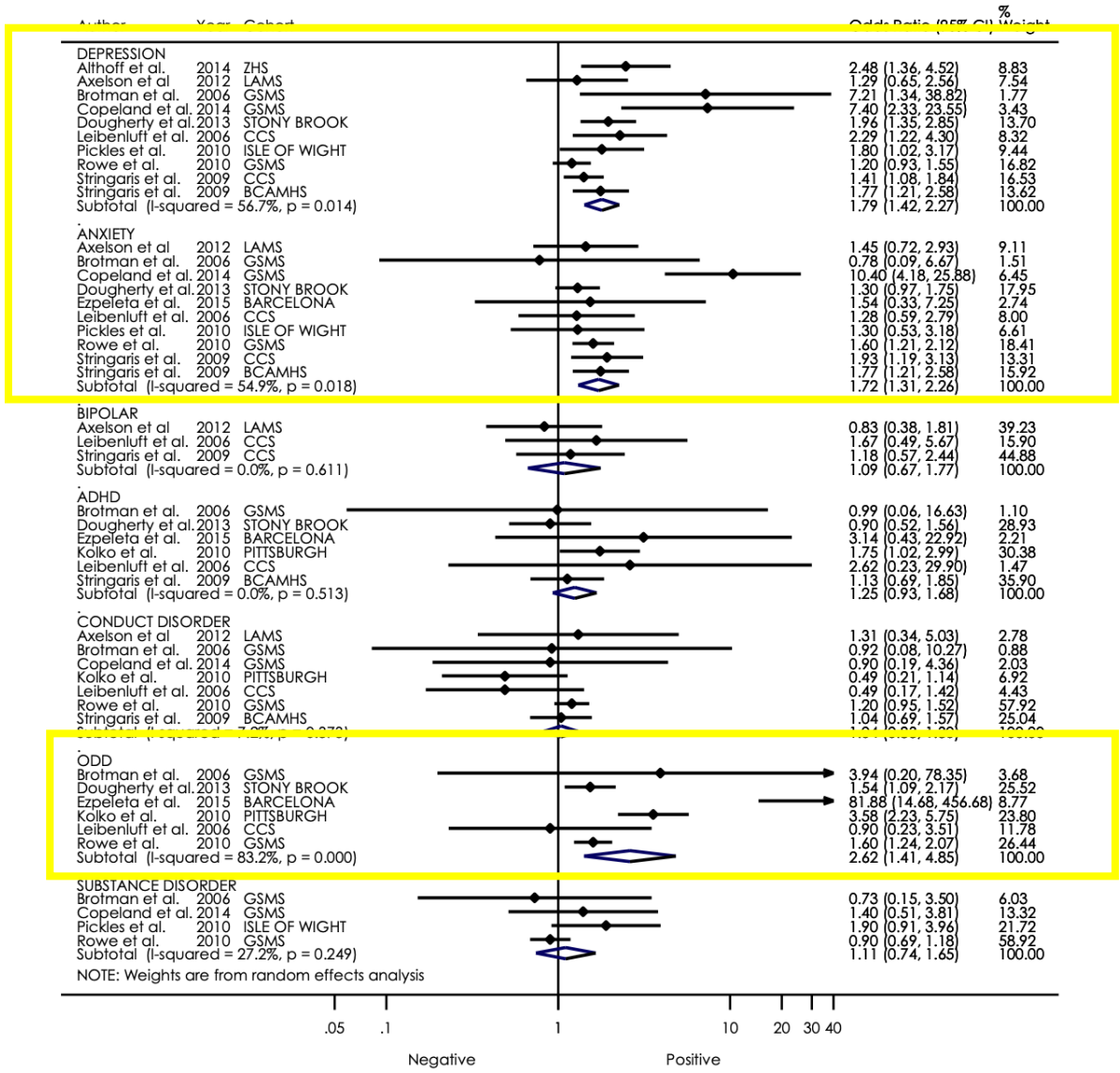
Consider Lithium*, and anticonvulsant or an atypical as monotherapy

Add medication from different class if partial response

If no response from initial monotherapy switch to a different class

Disruptive Mood Dysregulation Disorder

FIGURE 2 Forest plot of irritability as a predictor of future psychiatric disorders. Note: Points represent the estimated odds ratio of each study; the lines bisecting the point correspond to the 95% CI. Pooled effect sizes are represented by diamonds. Weights for each study are given in the far-right column. ADHD = attention-deficit/hyperactivity disorder; ODD = oppositional defiant disorder.



The Status of Irritability in Psychiatry: A Conceptual and Quantitative Review Pablo Vidal-Ribas, MSc, Melissa A. Brotman, PhD, Isabel Valdivieso, MSc, Ellen Leibenluft, MD, Argyris Stringaris, MD, PhD, MRCPsych

Disruptive Mood Dysregulation Disorder (DMDD)

- **Severe recurrent temper** outbursts grossly out of proportion in intensity and duration
- Inconsistent with **developmental** age
- Occur **3** or more times per week
- Mood in between outburst is **irritable or angry**

Disruptive Mood Dysregulation Disorder (DMDD)

- Present **12** months or more
- In at least 2 of 3 settings, at least 1 setting must be severe
- Age of onset before 10 years of age
- Diagnosis should not be made for the first time before 6 or after 18 years of age

Disruptive Mood Dysregulation Disorder (DMDD)

- No history of Mania or Hypomania
- **Cannot** be explained by Depression, Autism Spectrum Disorder, Post Traumatic Stress Disorder, Anxiety, Dysthymia.
- Diagnosis **can't** co-exist with: Oppositional Defiant Disorder, Intermittent Explosive Disorder, Bipolar Affective Disorder
- It **can co-exist** with Depression, ADHD, Conduct and Substance Use Disorders

Disruptive Mood Dysregulation Disorder

Remember DMDD is a relatively new diagnosis in the DSM-V

Current meta-analysis recommends several different medications from several different classes to be effective

Avoid polypharmacy when possible

Consider symptom targets to guide treatment.

Treatment DMDD

Therapies addressing delayed goal attainment

Cognitive Behavioral Therapy

Alderian Play Therapy

Interpretation Bias Training

Treatment DMDD

- Treatment of Aggression
  - Alpha-agonists
  - Stimulants
  - SSRI’s and SNRI’s
  - Atypical Antipsychotics
  - Lithium
- Treatment of Irritability
  - Atypical Antipsychotics
  - Stimulants

Depression

- **Irritability** or anger
- Continuous feelings of **sadness** and **hopelessness**
- Social **withdrawal**
- Fatigue and **low energy**
- Increased sensitivity to **rejection**
- Changes in appetite and **sleep**-either increased or decreased
- Impaired thinking or **concentration, failing grades**
- **Somatic complaints**
- **Decreased interest** in activities
- Feelings of **worthlessness** or **guilt**
- Thoughts of death or **suicide**

Ages 6-17 yo

BRIGHT FUTURES TOOL FOR PROFESSIONALS

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number _____

Score _____

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	____	____	____	____
2. I did not feel like eating, I wasn't very hungry.	____	____	____	____
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	____	____	____	____
4. I felt like I was just as good as other kids.	____	____	____	____
5. I felt like I couldn't pay attention to what I was doing.	____	____	____	____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	____	____	____	____
7. I felt like I was too tired to do things.	____	____	____	____
8. I felt like something good was going to happen.	____	____	____	____
9. I felt like things I did before didn't work out right.	____	____	____	____
10. I felt scared.	____	____	____	____

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	____	____	____	____
12. I was happy.	____	____	____	____
13. I was more quiet than usual				

Depressive Disorder

- Consider type of therapy being indicated, typically CBT is considered more effective for MDD, than supportive alone
- Consider using a rating scale (PHQ-9, CES-DC) to monitor for treatment response
- Remember the black box warning for depression, although untreated depression is a greater risk factor for suicide, you want to ensure you are assessing for suicidality during treatment with SSRI's
- Start low and go slow

Treatment Continued

- CBT is most studied non-pharmacologic intervention for depression in Children AND Adolescents
- Positive effects for SSRIs are the most studied pharmacologic intervention for depression in youth
- **NIMH TADS clinical trial of 439 adolescents with MDD found combination SSRI + CBT is most effective for teens**

Treatment Considerations Medication

- Considerations: effectiveness, safety, familial response, patient by in
  - SSRIs are safest
  - Fluoxetine and Lexapro are FDA approved
  - Can take 4-6 weeks at optimal dose until improvement is seen
  - Continue treatment 6 months to one year after recovery

Side Effects

- Suicidality*
- Manic switch
- Akathisia
- Agitation
- Irritability
- Disinhibition
- Nightmares/sleep disturbances

- Gastrointestinal
- Weight gain
- Sexual
- Bleeding
- Withdrawal syndrome
- Serotonin Syndrome

SSRIs and Suicidality

- 2004 FDA issued black box warning for all SSRIs
  - *Antidepressants increase the risk of suicidal thinking and behavior in youths with MDD and other psychiatric disorders. Anyone considering the use of an antidepressant in a child or adolescent for any clinical use must balance risk of increase suicidality with clinical need. Patients should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised to closely observe patient and to communicate with prescriber.*

Start Low and Go Slow….

Anxiety Disorders DSM V

- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder
- Anxiety disorders due to:
  - Substance Use
  - General Medical Condition

Anxiety Disorders: Presentation

- Somatic Complaints
- School Avoidance
- Crying
- Irritability
- Angry Outbursts (at times out of no-where)
- Nightmares
- Parental reassurance
- Sleeping problems
- Difficulty with transitions

- Hypervigilance
- Reactivity to Novel Stimuli
- Biased interpretation of experiences as threatening
- Avoidance Coping
- Catastrophic Reactions
- Parental Accommodation
- Midline Physical Symptoms

Screen for Child Anxiety Related Disorders (SCARED)

PARENT Version—Page 1 of 2 (to be filled out by the PARENT)

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent, M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pittsburgh *(October, 1995). E-mail:* birmaherb@upmc.edu

See: Birmaher, B., Brent, D. A., Chiappetta, L., Bridge, J., Monga, S., & Baugher, M. (1999). Psychometric properties of the Screen for Child Anxiety Related Emotional Disorders (SCARED): a replication study. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*(10), 1230–6.

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 your child. Then, for each statement, fill in one circle that corresponds to the response that seems to describe your child *for the last 3 months*. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True	
1. When my child feels frightened, it is hard for him/her to breathe	O	O	O	PN
2. My child gets headaches when he/she am at school.	O	O	O	SH
3. My child doesn't like to be with people he/she does't know well.	O	O	O	SC
4. My child gets scared if he/she sleeps away from home.	O	O	O	SP
5. My child worries about other people liking him/her.	O	O	O	GD
6. When my child gets frightened, he/she fells like passing out.	O	O	O	PN
7. My child is nervous.	O	O	O	GD
8. My child follows me wherever I go.	O	O	O	SP
9. People tell me that my child looks nervous.	O	O	O	PN
10. My child feels nervous with people he/she doesn't know well.	O	O	O	SC
11. My child gets stomachaches at school.	O	O	O	SH

read aloud, speak, play a game, play a sport).				
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	O	O	O	SC
41. My child is shy.	O	O	O	SC

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific. **TOTAL =**

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**. **PN =**

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**. **GD =**

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety SOC**. **SP =**

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**. **SC =**

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**. **SH =**

Anxiety

- Cognitive Behavioral Therapy is considered the first line and evidence based treatment for anxiety disorders
- If therapy is not successful medications can be helpful, but the combination of therapy and medications is most beneficial for children and adolescents
- **Studies have also shown that a child's anxiety improves with parental improvement of anxiety i.e. anxious parents make anxious children**

Anxiety Treatment

- To date, the only medication approved by the FDA for treatment of non-OCD anxiety in youth is Duloxetine (Cymbalta)*.
- For OCD 3 FDA approved SSRI's
  - Sertraline > 6 years old
  - Fluoxetine > 7 years old
  - Fluvoxamine > 8 years old

Pharmacotherapy for anxiety disorders in children and adolescents

Treatment

- Evidence base for children established in 2008 (Walkup et. al., 2008)
  - Combination treatment most effective- 80% response rate
  - SSRI’s and CBT both effective 55-60%
  - Placebo response rate < 25%

Anxiety and SSRIs

Start Low and Go Slow….

Consider increasing dose after 4 weeks…

1 year, come off during low stress period

Consider family history

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