Anxiety Disorders in Children under Age 6

Level 0

Comprehensive assessment that includes history of stressors, trauma, parental anxiety, and observation of child-parent interactions. Refer to Principles of Practice on page 3.

- ✦ Rating scales specifically for young children with anxiety symptoms are limited, but the Preschool Anxiety Scale (parent report) is available at ***https://floridabhcenter.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 refer 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 boxed warning with parents and monitor for suicidality.
- ✦ 8 to 10-week trial of fluoxetine if well tolerated starting at 1 to 2 mg/day.
- ✦ Maximum dosing of fluoxetine: 5 to 10 mg/day.
- ✦ Increased risk of behavioral activation (e.g., difficulty falling asleep, increased motor activity, increased talkativeness) in young children.
- ✦ Discontinuation trial after 6 to 9 months of effective medication treatment with gradual downward titration.

Less than 4 years old, refer to *Principles of Practice in Children under Age 6* on page 3.

Level 3

If fluoxetine is not successful, consider sertraline in combination with concurrent psychotherapy. Start with low dose 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)
- ✦ Ongoing use of benzodiazepines. May be used short-term for severe 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.

Note: For dosing recommendations, refer to Table 9 on page 35.

Anxiety Disorders in Children and Adolescents Ages 6 to 17 Years Old

Level 0

A comprehensive assessment includes evaluation of:

- ✦ Risk factors including: stressors, trauma, bullying, social support systems, coping skills, learning disorders, and school issues.
- ✦ Family coping skills, parenting styles (overprotective or over-controlling), and family accommodations that support child's symptoms.
- ✦ Medical conditions and comorbid psychiatric disorders.
- ✦ Parental and family history of anxiety disorders and psychiatric treatment.
- ✦ 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 https://floridabhcenter.org/.
- ✦ 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). The ADIS-C is not available on the public domain.

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 CBT.
- ✦ **1b.** If CBT is not available, first consider evidence-based psychosocial interventions or online/web-based therapy.
  - ✧ 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, progress in addressing anxiety symptoms, and decreasing avoidance.
  - ✧ If parental anxiety disorders interfere with treatment progress, provide referral for parent.

Level 2

If moderate to severe anxiety disorder or inadequate response to CBT alone:

- ✦ **2a.** Initiate treatment with fluoxetine or sertraline monotherapy or in combination with CBT.
  - ✧ Combination therapy with CBT has been shown to be more effective than medication alone.
  - ✧ Review boxed warning with family and monitor for treatment emergent suicidality and behavioral activation (e.g., difficulty falling asleep, increased motor activity, increased talkativeness).
- ✦ **2b.** If first SSRI trial with fluoxetine or sertraline is not effective and/or there are treatment-limiting side-effects, switch to the other SSRI not used in Level 2a (fluoxetine or sertraline) and initiate/continue CBT.

Level 3

If moderate to severe anxiety disorder and Levels 1 and 2 are not successful:

- ✦ **3a.** Duloxetine monotherapy or in combination with CBT. Monitor height, weight, blood pressure and pulse with duloxetine.
- ✦ **3b.** Consider escitalopram monotherapy or in combination with CBT for ages 12-17 years.
- ✦ **3c.** Consider fluvoxamine monotherapy or in combination with CBT.
  - ✧ Monitor for treatment emergent suicidality and behavioral activation (see above).

Level 4

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

If Level 3 is not successful, may consider citalopram or venlafaxine in combination with CBT. Monitor for treatment emergent suicidality and behavioral activation. For venlafaxine, monitor height, weight, blood pressure, and pulse.

Not Recommended:

- ✦ Paroxetine as first or second line treatment (concern about increased adverse effects, e.g., insomnia, behavioral activation, decreased appetite, vomiting, discontinuation symptoms, suicidal ideation).
- ✦ Benzodiazepines (BZD) as first-line monotherapy for long-term treatment of childhood anxiety disorders.

Notes:

Despite limited evidence, if partial or poor response with SSRIs, duloxetine, or venlafaxine, may consider monotherapy or augmentation with other medications such as buspirone, alpha-2 agonist, clomipramine, and low dose benzodiazepine. If prescribed, benzodiazepines should be reserved for short-term use only.

For dosing recommendations, refer to Table 9 on page 35.

Medications for the Treatment of Anxiety Disorders

Clinicians should realize that data below age 6 for treating anxiety disorders is limited. Caution in using pharmacological treatment below age 6 is warranted.

Table 9.

Medications for the Treatment of Anxiety Disorders			
Drug Name	**Young Child (4 – 6 Years)**	**Child (6 – 12 Years)**	**Adolescent**
Selective Serotonin Reuptake Inhibitors (SSRIs)			
***Fluoxetine**			
Starting Dose: Maximum Dose:	1-2 mg/day 5-10 mg/day (limited data)	2.5-5 mg/day 40 mg/day	5-10 mg/day 60-80 mg/day
***Sertraline**			
Starting Dose: Maximum Dose:	5-10 mg/day 50-75 mg/day (limited data)	10-12.5 mg/day 100-150 mg/day	25 mg/day 150-200 mg/day
***Fluvoxamine**			
Starting Dose: Maximum Dose:	5 mg/day 50-75 mg/day (limited data)	12.5-25 mg/day 100-200 mg/day	25 mg/day 150-300 mg/day
Escitalopram			
Starting Dose: Maximum Dose:	1-2 mg/day 5-10 mg (limited data)	2.5 mg/day 10-20 mg/day	5 mg/day 20mg/day
Citalopram			
Starting Dose: Maximum Dose:	No data	5 mg/day 20-40 mg/day	10 mg/day 40 mg/day
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)			
‡*Duloxetine			
Starting Dose: Maximum Dose:	No data	20-30 mg/day 60 mg/day	30 mg/day 120 mg/day
***Venlafaxine**			
Starting Dose: Maximum Dose:	No data	XR: 37.5 mg/day XR: 75-112.5 mg/day (25-39 kg)	XR: 37.5 mg/day XR: 150 mg/day (40-49 kg) XR: 225 mg/day (>50 kg)

**Indicates placebo-controlled studies in children 6 to 17 years with anxiety disorders.*

‡Duloxetine is FDA approved for Generalized Anxiety Disorder in children and adolescents ages 7 years and older.

Note: The FDA does not currently provide any dosing guidelines for fluoxetine, sertraline, fluvoxamine, escitalopram, citalopram, or venlafaxine in children or adolescents and does not recommend use in this population due to mixed results in efficacy trials.

Additional Clinical Information

- May titrate to lowest therapeutic dose once weekly.
- After reaching the lowest therapeutic dose, can increase SSRI or SNRI dose after one month if well tolerated and significant symptoms remain.
- If switching medications, in the absence of side effects, it is preferable to cross-titrate with an overlap of the two medications rather than tapering off one medication before starting the next medication.
- Can consider discontinuation trial of SSRI or SNRI after 12 months of effective medication treatment, during low stress period, and with gradual taper. Monitor for relapse.

Anxiety Disorders and Comorbid Disorders

- ADHD:
  - Stimulant medications can be combined with SSRIs for comorbid ADHD.
  - Non-stimulant medication may be helpful for children with co-morbid anxiety or who cannot tolerate stimulants.
- Depression and bipolar disorder:
  - Fluoxetine is first-line medication for comorbid unipolar depression.
  - For children with comorbid bipolar disorder:
    - Bipolar disorder should be stabilized first. Adding an SSRI or SNRI needs to be considered cautiously after CBT for 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. Ongoing use of benzodiazepines is not recommended.
- Substance use disorder (SUD):
  - Both anxiety disorders and SUD can be treated at the same time. Some substances increase anxiety and panic symptoms complicating 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 and developing alternative coping skills to reduce substance use.
- Autism spectrum disorders (ASD) and developmental disorders (DD):
  - Can modify CBT for anxiety disorders co-morbid with ASD and/or DD.
  - SSRIs may be used for anxiety/irritability and obsessive-compulsive behaviors distressing to the child, but not all ritualized or repetitive behaviors. Consider SSRIs when obsessive features, rigidity of thought, perseveration, rituals, anxiety, depression, and/ or irritability are impairing.
  - For co-morbid ADHD symptoms, atomoxetine may reduce ADHD and anxiety symptom severity.

Resources

- Children
  - What To Do When You Worry Too Much (Huebner, 2005)
  - A Boy and a Bear: The Children's Relaxation Book (Lite, 2003)
  - What To Do When You Dread Your Bed: A Kid's Guide to Overcoming Problems with Sleep (Huebner, 2008)
  - Camp Cope-A-Lot Online (Temple University and The OCD and Anxiety Institute, 2018): ***https://www.copingcatparents.com/Camp_Cope_A_Lot***
- Adolescents
  - My Anxious Mind: A Teen's Guide to Managing Anxiety and Panic (Tompkins and Martinez, 2009)
  - 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 Child with Selective Mutism (McHolm, Cunningham, Vanier and Rapee, 2005)
  - When Children Refuse School: A CBT Approach Parent Workbook (Kearney and Albano, 2007)
  - Helping Your Anxious Child (Rapee, Wignall, Spense, Cobham and Lyneham, 2008)
  - Keys to Parenting Your Anxious Child (Manassis, 2008)
  - The Selective Mutism Treatment Guide: Manuals for Parents, Teachers and Therapists (Perdnick, 2012)
  - Freeing Your Child from Anxiety (Chansky, 2014)
  - Parent training, educational materials, and resources at ***https://www.anxietybc.com/*** and ***http://www.copingcatparents.com/***
  - Coping Cat Parents (OCD and Anxiety Institute, 2018): ***https://www.copingcatparents.com/***
- Websites
  - American Academy of Child and Adolescent Psychiatry (AACAP) ***http://www.aacap.org*** (Resource Centers; Facts for Families)
  - Anxiety and Depression Association of America (ADAA), ***https://www.adaa.org/***
  - Selective Mutism Group-Child Anxiety Network, ***http://www.selectivemutism.org/***
  - Association for Behavioral and Cognitive Therapies, ***http://www.abct.org/Home/***
  - Computer-based CBT treatments (cCBT) for youth with anxiety disorders: The BRAVE Program, BRAVE-Online, and Camp Cope-A-Lot

Note: Above resources and website links were updated at the time of publication.

For a full list of references, visit ***https://floridabhcenter.org/***.