Anxiety

Identification and management for Canadian primary care professionals

Compiled by

Helen R. Spenser MD, CCFP, FRCPC,
Children's Hospital of Eastern Ontario, Ottawa, Ontario

Blair Ritchie MD, FRCPC,
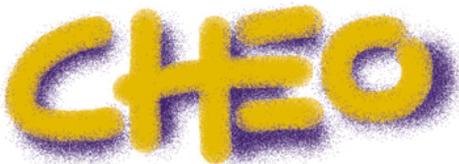Alberta Health Services, University of Calgary

in collaboration with

Peter M. Kondra, MSc, MD, FRCPC,
and Brenda Mills, C&Y MHC
Hamilton Family Health Team
Child & Youth Mental Health Initiative

Disclaimer

Anxiety

Understanding Anxiety in Primary Care

Visit 1 — **History and Information Gathering**

↓

Visit 2 — **Medical and Physical Exam**

↓

Visit 3 — **Education**

↓

Visit 4 — **Treatment Plan**

Non-medication strategies | **Medications** | **Self-Help_Resources**

↓ ↓ ↓

Follow Up and Referral

Online Comprehensive Guides and References

Understanding Anxiety in Primary Care

- [Epidemiology](#)

- [Common presentations in anxious children](#)

- [Normal developmental fears versus pathological anxiety](#)

- Different anxiety disorders:
  - [Selective Mutism](#)
  - [Separation Anxiety](#)
  - [Generalized Anxiety Disorder](#)
  - [Specific Phobias](#)
  - [Social Phobia](#)
  - [Obsessive Compulsive Disorder](#)
  - [Panic Attacks](#) and [Panic Disorder](#)

Epidemiology

- Taken together, anxiety disorders are the most common mental illness in children and youth. Prevalence for having at least one childhood anxiety disorder varies from 6 to 20% over several large epidemiological studies (Costello et al., 2005).

- Often co-occur with other medical and psychiatric conditions

- Comorbidity the rule rather than the exception (Dulcan and Wiener, 2006)

    - In community samples, 15 to 38% have two or more anxiety disorders (McGee, 2010).

- Girls more likely than boys to report anxiety disorder especially specific phobia, panic disorder, agoraphobia and SAD

- Average age of onset varies widely between studies, but panic disorder consistently emerges later in mid-teens (Costello et al., 2005).

Common Presentations in Anxious Children

- Prominent somatic symptoms (e.g., stomach aches, headaches)

- Catastrophic misinterpretation (e.g., "Let's go see the doctor" interpreted as "They are going to lock me in hospital")

- Escape and avoidance behaviours (e.g., school refusal)

- "Fight" (i.e., oppositional/ aggressive) response to avoid anxiety-provoking situation

Normal developmental fears versus pathological anxiety

- Important to differentiate normal developmental fears from pathological anxiety

- Common fears at various ages:

  - 0-1: Loss of support, strangers, loud noise

  - 1-3: Parental separation, toilet, animals, dark

  - 3-5: Separation, darkness, "bad people"

  - 5-7: Being alone, supernatural, harm, dark

  - 7-9: School, injury, appearance, death

  - Adolescence: Personal relations, appearance, school, future, safety, world events, animals

- [Click here](#) for more information about childhood fears and worries

Selective Mutism
(formerly elective mutism)

- Prevalence range less than 1% to 2% (Costello et al., 2005)

- Preschool to 2nd grade and rare in older children (consider another diagnosis)

- Often referred by teachers

- Child tends to "talk a blue streak" at home but says almost nothing for months at a time in classroom

- Thought to be early form of social anxiety

- Treatment best implemented in school

    - Treatment of choice: speech therapist in school can help

    - Reduce pressure on child to talk

    - Encourage one close friend and small groups with whom child can interact and complete school work rather than classroom environment to talk.

Separation Anxiety

- Prevalence range 2-5% in children with significant decrease in youth (McGee, 2010)

- May appear suddenly or follow stressful event

- Leads to avoidance behaviours, nightmares with separation themes and many physical symptoms

- Age-inappropriate excessive and disabling anxiety about being separated from parents or home

- These children often have trouble going to school, fear bad things happening to self and parents, have difficulty attending sleepovers, often tough time sleeping without family member close by, reluctant to attend camp (Dulcan and Wiener, 2006).

- [Click here](#) for more information about separation anxiety

Generalized Anxiety Disorder (GAD)

- Prevalence range 3-7% (McGee, 2010)

- Chronic or exaggerated worry (often described by parents as "worry warts") with an almost constant anticipation of bad things happening without provocation

- Apprehensive worry without cause even in face of contradictory evidence

- Often co-morbid with depression and under-diagnosed

- DSM-5 criteria: (no significant changes from DSM-IV except that more stress is given to point that the anxiety and worry is not confined to another disorder such as fear of having a panic attack, worry about contamination, or fear of gaining weight in anorexia)
    - Presence of unrealistic excessive worry about multiple events or activities more days than not for at least 6 months.

    - Difficulty controlling the worry

- Three or more somatic symptoms such as restlessness, irritability, muscle tension, sleep disturbances, problems concentrating, and feeling easily fatigued

- Impairment of social and occupational functioning

  (Dulcan and Wiener, 2006)

Specific Phobias

- 4-5% of children

- Peak onset 10-13 years (Costello et al, 2005)

- Constant extreme disabling fear of specific objects or situations that pose little danger leading to avoidance or disrupted routine (Dulcan and Wiener, 2006)

Social Phobia

- Up to 3% of children and higher in girls (Costello et al, 2005)

- Age of onset early to mid-adolescence

- Marked persistent fear of being focus of attention or doing something humiliating

- Children likely highly emotional, fearful, inhibited, sad, and lonely

- Associated symptoms include:
  - Hypersensitivity to negative feedback
  - Rejection sensitivity
  - Unassertiveness
  - Low self-esteem
  - Underdeveloped social skills
  - Underachievement at work or school
  - Avoidance

- Click here for more information about teens and social anxiety disorder

  (Dulcan and Wiener, 2006)

Panic Attacks

New in DSM-5: Panic attacks can be added as a specifier to the anxiety disorders, for example, generalized anxiety disorder with panic attacks.

- Sudden escalation and rapid (minutes) peak of four or more symptoms:

    - feeling dizzy, life is not real

    - fear of losing control, dying, going crazy

    - feeling of choking

    - accelerated heart rate

    - chest pain, shortness of breath

    - upset stomach

    - trembling, numbness or tingling sensations

    - sweating, hot flashes/chills

- Panic attacks occur frequently outside of panic disorder and are often situational

- Often occurs with other psychiatric disorders (e.g., someone with social phobia having a panic attack in a busy restaurant)

(Dulcan and Wiener, 2006)

Panic Disorder

- 1-2% of children

- Peak onset between 15 and 25 (later)

- Family/twin/adoption studies show genetic inheritance

- Definition:

    - recurrent unexpected ("out of the blue") panic attacks

    - persistent worry about having another attack, behaviour change-related attacks

- Appears with or without agoraphobia

- Fear or avoidance of places where escape difficult or help not available in event of having a panic attack or suddenly feeling sick (panic-type symptoms)
(Dulcan and Wiener, 2006)

- In DMS-5 Panic Disorder and Agoraphobia are separated as individual disorders. Agoraphobia involves being fearful of a number of situations outside of the home where escape would be difficult or help not available in the event of severe anxiety.

Obsessive Compulsive Disorder (OCD)

New in DSM-5: OCD and PTSD are no longer in the anxiety disorder section but in their own sections.

- OCD affects 2.5% of children

- Onset earlier in boys (9-12 years old) and more common onset during adolescence in girls (Costello et al, 2005)

- Course often chronic and life-long

- Co-morbidity with social phobia and major depressive disorder

- Genetic component

- In childhood, contamination obsessions and hand-washing compulsions most common presentation but nature of obsessions and compulsions more likely to change or wax and wane in childhood than in adulthood

- Presence of obsessions and/or compulsions (do not need both) are disruptive, cause distress and, though recognized by others as excessive, may not be noted by child as problem.

- They may know they are upset but feel this is because parents interfere with what they are trying to do. This is sometimes referred to as "Ego Syntonic".

- Typical obsessions (thoughts, images, or impulses that come over and over like hiccups):

  - Contamination worries, doubts, aggressive impulses, sexual images, disasters…

- Typical compulsions (ritualistic repeated behaviours or mental acts performed to decrease anxiety):

  - Cleaning, checking, counting, repeating, seeking reassurance, ordering

- Associated symptoms:

  - Avoidance of situations that trigger an obsession or compulsion, hypochondriasis, guilt, overresponsibility, sleep disturbance, skin conditions from excessive washing or picking

(Dulcan and Wiener, 2006)

Visit 1: History and Information Gathering

- [Anxiety questions/tools](#)

- [Assessing functional impairment](#)

- [Assessing for co-morbidity](#)

- [Safety assessment and planning](#)

Anxiety Questions and Tools

Diagnostic criteria and questions: (<u>Note</u>: While scales below were developed based on earlier DSM criteria, there is still enough overlap with DSM-5 to make them useful)

- See specific sections on various anxiety disorders above

- Free domain screening tools (unlike MASC and other pay-per-use tools)

  - Screen for Child Anxiety Related Disorders (SCARED)
    - <u>Child Self-Report</u>
    - <u>Parent Report</u>

  - <u>Kutcher Generalized Social Anxiety Scale for Adolescents (K-GSADS-A)</u>

  - <u>T-CAPS</u> and <u>Weiss Symptom Record</u> below also have screening questions for the various anxiety disorders.

Whenever the issue of self-harm and suicide is on a self-report questionnaire, ensure youth fills out questionnaire in presence of qualified office staff.

- Creating a safe, supportive environment for teens is important. Click here for tips on developing a therapeutic alliance with teens (Kutcher and Chehil, 2009).

Assess functional impairment

The degree of functional impairment along with the severity of symptoms will guide your management plan. Some free domain tools are listed below:

- [Teen Functional Assessment](#) (TeFA) (self-report)

- [Weiss Functional Impairment Scale (Self-report)](#)

- [Weiss Functional Impairment Rating Scale (Parent report)](#)

Assess for co-morbidity

Screen for other mental health problems:

- Depression (PHQ-9 Adolescent Depression Screen or KADS-6)

- Substance use disorder (CRAFFT Substance Use Screen)

- Trauma or bullying

- ADHD and learning problems (SNAP-IV Questionnaire 90-item, SNAP-IV Questionnaire 26-item, SNAP-IV Questionnaire 18-item)

- Eating disorder (Eating disorder questions)

- Significant negative life events (e.g., death of loved one)

Whenever the issue of self harm and suicide is on a self-report questionnaire, ensure youth fills out questionnaire in presence of qualified office staff

Free domain tools for assessing a number of co-morbid mental illnesses:

- T-CAPS

- Weiss Symptom Record

Back to top

Safety Assessment and Planning

- **Check in about safety at each visit.**

- **Develop and implement a safety plan when there is a risk of self-harm or suicide.** Click here for a guide on developing and implementing a safety plan from "Mental Health in the Primary Care Setting: Addressing the Concerns of Children and Youth, 2nd edition, a Desk Reference".

- **If there are any safety concerns, you can arrange to have the person assessed in the closest emergency department. The options available to have someone assessed vary from province to province. Common options include (1) a physician certifying a patient in their office, (2) the police bringing a patient into hospital, or (3) the family seeking an order from a Justice of the Peace to have an assessment completed. Please check your provincial Mental Health Act to determine what options are available in your province.**

- 15-20% of teenagers report suicidal ideation

- 5% attempt suicide

- More attempts in females and more completions in males

- Asking about suicidal ideation does not increase suicidal ideation or suicides

- Free domain suicide risk screening tool: TASR-AM

- Click here for a handout for youth about suicide from the GLAD-PC (Guidelines for Adolescent Depression – Primary Care) toolkit

- For more information on SSRIs and suicidal ideation, see treatment section

Visit 2: Medical and Physical Exam

- As with any mental health presentation, perform **review of systems**, **complete physical exam**, and **screening bloodwork if indicated**. Consider:

  - Anemia (CBC and differential)

  - Infection (CBC and differential, monospot, STIs)

  - Thyroid problems (TSH)

  - Chronic illness (liver tests, electrolytes, kidney tests)

  - Medications (over the counter, alternative, and prescribed)

  - Pregnancy

  - Malnutrition (Vitamin B12, Folate, Vitamin D)

  - Less frequent conditions like cancer

Visit 3: Education

- Provide education, such as the following handouts:

  - [What Is Anxiety?](#)

  - [Anxiety Problems in Children and Adolescents](#) (Offord Centre) (Please note that this handout still includes OCD and PTSD under anxiety disorders. As mentioned above, these have moved to their own sections in DSM-5.)

  - [Helping Anxious Children](#)

  - [Separation Anxiety](#)

  - [Childhood Fears and Worries](#)

  - [Social Anxiety Disorder in Teens](#)

Visit 4: Treatment Plan

- [Non-medication strategies](#)

- [Medications](#)

- [Self-help resources](#)

Non-medication strategies

Lifestyle:

- Sleep: see sleep hygiene handout, GLAD-PC, p. 121, or click here.
- Diet
- Exercise
- Relaxation (e.g., relaxation handout, MindMasters website) and socialization
- Mood-Enhancing Prescription (Activity Plan)

Therapy:

- CBT is an evidence-based practice for the treatment of anxiety in children and adolescents.

- 3 CBT-based essentials to overcome anxiety (patient handout)

- Both individual and group CBT have received strong support in the literature for first-line treatment of childhood anxiety disorders.

- Practice elements of CBT include:
  - Exposure therapy (Overcoming Fears Through Exposure – guide for teens from Anxiety BC)
  - Cognitive restructuring (Checklist of Cognitive Distortions)
  - Coping skills
  - Gradual desensitization
  - Problem-solving skills

- Sample treatment resources:
  - [Worried Self-Talk](#)
  - [Negative to Positive Thinking](#)
- Family therapy
- Specific therapies for certain anxiety disorders are modified forms of CBT:
  - Phobias: systematic desensitization
  - OCD: exposure response prevention
- Non-medication treatments should be tried before SSRIs **except** in cases where a child's anxiety is so severe that it interferes with normal, age-appropriate functioning, i.e., they are not able to go to school, leave the house, interact with peers or focus on activities of daily living. In those situations, SSRI medication may be necessary in order in combination with cognitive behavior therapy. In most cases symptoms will improve significantly in 4 to 6 weeks. In the case of panic attacks, medication may need to be initiated earlier to prevent avoidance that could lead to agoraphobia.

School Consultation

- [Managing Anxiety Problems at School](#)
- [School Accommodations to Assist Anxious Children](#)

(Connolly, 2007)   [Back to top](#)

Medications

- SSRIs are first line

- Well-executed RCT research studies show that Sertraline (Zoloft), Flovoxamine (Luvox) and Fluoxetine (Prozac) have been found to be effective in children and youth with anxiety. Though there are some studies using SNRI's and Paroxetine, many physicians choose not to use these medications because of their short half-lives. Teenagers tend to forget medications from time to time and this causes flu-like side effects. For more information, see the AACAP practice parameter.

- Non-medication treatments should be tried before SSRIs **except** in cases where a child's anxiety is so severe that it interferes with normal, age-appropriate functioning, i.e., they are not able to go to school, leave the house, interact with peers or focus on activities of daily living. In those situations, SSRI medication may be necessary in order in combination with cognitive behavior therapy. In most cases symptoms will improve significantly in 4 to 6 weeks. In the case of panic attacks, medication may need to be initiated earlier to prevent avoidance that could lead to agoraphobia.

- Benzodiazepines are not recommended on a regular basis.

- Medication is not recommended for specific phobia.

- For brief review of use of antidepressants in children and youth including SSRIs and suicidal ideation, see CANMAT guidelines (Lam et al., 2009).

Self-Help Resources

- Click here for a list of resources (websites, books, etc.) for parents and children

- Click here for a list of teen-friendly websites

Back to top

Follow-up and referral

- Depending on the severity/situation, follow-up might be required as frequently as weekly

- There is agreement on close follow-up when antidepressants are started. The guidelines below are copied from the National Alliance on Mental Illness (NAMI):
  - First four weeks seen at least once a week with family contact
  - Weeks five through eight, seen every other week by the treating provider
  - See again at week 12
  - See as clinically indicated after this
  - Face-to-face contact as well as family contact are emphasized as important

- Urgent/emergent referral is required for significant/acute suicidality, homicidality, or psychosis

- Uncertainty of diagnosis or treatment plan or lack of improvement are some other reasons to consider referring a patient

- See GLAD-PC for a guide to making referrals or click here.

Freely available comprehensive guides

- For a comprehensive guide to anxiety in children and youth in primary care, please download the American Academy of Child and Adolescent Psychiatry Practice Parameter (Connolly et al., 2007) or click here

- For comprehensive guides to child and youth mental health in primary care, see "Mental Health in the Primary Care Setting: Addressing the Concerns of Children and Youth, 2nd edition, a Desk Reference" (includes general mental health, depression, suicide and self-harm, anxiety, disruptive behaviour disorders, parental mental illness and infant mental health) or 3rd edition (includes fetal alcohol spectrum disorder, childhood trauma, autism spectrum disorder and eating disorders) by Healthy Minds/Healthy Children and the Southern Alberta Child & Youth Health Network, or visit the Healthy Minds Healthy Children website.

- Anxiety BC developed a self-help tool kit for parents to help their anxious child or teen - a resource of simple, step-by-step instructions on how to help anxious children cope with specific issues such as back-to-school worries, dealing with nightmares, or having difficulty making friends. The resource is available at the AnxietyBC® website at http://www.anxietybc.com/parent/index.php

- For a comprehensive guide to anxiety disorders in **children**, see "Identification, Diagnosis and Treatment of Childhood Anxiety Disorders: A Package for First Contact Health Providers" by Kutcher & MacCarthy or visit http://www.teenmentalhealth.org

- For a comprehensive guide to anxiety disorders in **adolescents**, see "Identification, Diagnosis and Treatment of Adolescent Anxiety Disorders: A Package for First Contact Health Providers" by Kutcher & MacCarthy or visit http://www.teenmentalhealth.org

References

Canadian Attention Deficit Hyperactivity Disorder Resource Alliance (CADDRA). *Canadian ADHD Practice Guidelines* (2008). Available at www.caddra.ca.

Cheung, A., Ghalib, K., Jensen, P., Kelleher, K., Reiss-Brennan, B., Tomb, M., et al. (2010). *Guidelines for Adolescent Depression in Primary Care (GLAD – PC) Tool Kit, Version 2.* Available at http://www.thereachinstitute.org/images/GLAD-PCToolkit_V2_2010.pdf, retrieved June 11, 2015.

Connolly, S. D., Bernstein, G. A.; Work Group on Quality Issues. (2007). Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 46,* 267-283.

Costello, E. J., Egger, H. L., & Angold, A. (2005). The developmental epidemiology of anxiety disorders: phenomenology, prevalence, and comorbidity. *Child and Aolescent Psychiatric Clinics of North America, 14,* 631-648, vii.

Duckworth, K., and Gruttadaro, D. (2005). *What families should know about adolescent depression and treatment options.* Arlington, VA: National Alliance on Mental Illness.

Dulcan, M. and Wiener, J. (2006). *Essentials of Child and Adolescent Psychiatry.* Arlington, VA: American Psychiatric Publishing, Inc.

Healthy Minds/Healthy Children Outreach Services and Southern Alberta Child and Youth Health Network. (n.d.). *Mental health in the primary care setting: Addressing the concerns of children and youth (2nd edition): A desk reference.* Available at http://www.albertahealthservices.ca/hp/if-hp-hmhc-desk-reference-complete-second-edition.pdf, retrieved June 11, 2015.

Healthy Minds/Healthy Children Outreach Services and Southern Alberta Child and Youth Health Network. (n.d.). *Mental health in the primary care setting: Addressing the concerns of children and youth (3rd edition): A desk reference.* Available at http://www.albertahealthservices.ca/hp/if-hp-hmhc-desk-reference-third-edition.pdf, retrieved June 11, 2015.

Kutcher, S. & MacCarthy, D.(2011). *Identification, diagnosis & treatment of adolescent anxiety disorders: a package for first contact health providers.* Available at http://www.teenmentalhealth.org

Kutcher, S. & MacCarthy, D.(2011). *Identification, diagnosis & treatment of childhood anxiety disorders: a package for first contact health providers.* Available at http://www.teenmentalhealth.org

Lam, R., Kennedy, S., Grigoriadis, S., McIntyre, R., Miley, R., Ramasubbu, R., et al. (2009). Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults. III. Pharmacotherapy. *Journal of Affective Disorders, 117*(Suppl. 1), S26-S43.

Manassis, K. (2009). *Cognitive-Behavioral Therapy with children: A guide for the community practitioner.* New York: Routledge.