CPS Position Statement on Anxiety Disorders (Part 2: Treatment)

Developed by Luke MacDonald and Dr. Susan Bobbitt for PedsCases.com.
December 17, 2023

Introduction:

Hello, my name is Luke MacDonald and I'm a 2nd year medical student from Dalhousie University in Saint John, NB, working with Dr. Susan Bobbitt, a developmental pediatrician at the Alvin Buckwold Child Development Program at Kinsmen Children's Centre in Saskatoon, Saskatchewan. Today we will review Part 2 of the CPS anxiety position statements which focuses on the treatment and management approach for children and adolescents with anxiety disorders.

Part 1 of this podcast series discussed the difference between developmentally appropriate fears and anxieties and the clinically diagnosable anxiety disorders in the pediatric population. It is commonly believed that some children will 'grow out of' their anxiety disorders, but in reality they are unlikely to remit without intervention. Thankfully, anxiety disorders are well-understood and typically responsive to treatment in children and adolescents, with appropriate consideration of the following factors:

- severity
- age and developmental stage
- medical or psychiatric comorbidities
- acceptability of the treatment by patient and family
- family functioning
- availability and accessibility of treatment modality
- parental anxiety, which can contribute to a child's experience of anxiety

There are a number of different approaches to the treatment of anxiety disorders in youth, which again depends on factors involving the patient, family, and the community in which they are being treated. The three main categories of treatment modalities are psychoeducation, psychotherapy, and pharmacotherapy. Let's talk a little bit about each!

Psychoeducation is a crucial component of anxiety disorder management when first approaching a patient in your practice who is presenting with symptoms of an anxiety disorder. Healthcare providers can begin the psychoeducation process by discussing anxiety symptoms and manifestations with the patient and their family. For the child in

question, it is important to highlight the different somatic, cognitive, and behavioral experiences that may be linked to anxiety, so that the patient can better understand their diagnosis. For the parents and family, it is helpful to be able to understand any underlying developmental or environmental factors that may be contributing to the child's anxiety. Parents are often distressed or anxious themselves when dealing with an anxious child, so part of the role of the compassionate healthcare professional is to help normalize the experience, and counsel parents to engage supportive strategies in response to life stressors or anxiety triggers. The CPS position statement on anxiety disorders offers a number of psychoeducational suggestions for parents and caregivers to employ to help support the patient; these include:

1. Helping the child or adolescent recognize, acknowledge, and label their feelings. this will help the patients become more aware of their anxiety and be able to associate it with certain physical or cognitive experiences.
2. Use gentle but firm encouragement in response to efforts to avoid certain experiences or situations. As discussed previously, avoidance is a common response to anxiety-provoking situations, so this can help to push children out of their comfort zone in a supportive and encouraging manner.
3. Empathize and validate, but don't enable! Ensure that when the child is expressing their anxiety, that they feel heard, but also ensure to encourage them to overcome the anxiety rather than give into it. For example, using phrases like "I know this is scary for you, and I also know that you are brave and strong enough to give it a try!"
4. Maintain secure attachments and encourage attachment-forming with others. This can be done by making sure that there is sufficient one-on-one time for parent and child, as well as showing an interest in building of friendships and connections in the child's community.
5. Inspire confidence using praise! Using specific and timely praise for when the child says or does something desirable will help to reinforce positive behaviors. Even for things that may seem trivial or small - young children are especially responsive to praise.
6. Foster independence in your child or adolescent by encouraging them to make their own decisions, and celebrating positive outcomes when they are able to problem-solve on their own.
7. When anxiety is provoked by a task or situation, help make it more manageable by breaking it down into smaller or more realistic goals.
8. Focus on strengths rather than shortcomings; this means being able to reward and praise the child for the attempts that they make to overcome a task, whether successful or unsuccessful.
9. Discuss and implement healthy coping strategies that they may be able to employ independently – this includes skills like deep breathing exercises, progressive muscle relaxation, imagery, mindfulness, and positive self-talk
10. Involve yourself in the school life where possible and appropriate. For example, there may be cases where some teachers may benefit from a discussion with the parent or caregiver, to help better understand the child's anxiety and resources that may be available.

These are some of the positive parenting strategies that may be effectively used to support a child or adolescent as they work to overcome their anxiety disorder. It is important to keep in mind that there may be additional tools that clinicians can suggest to parents or caregivers if their anxiety disorder is specific to certain situations, like school, conflict, or physical experiences.

The second broad category of treatment modalities for anxiety disorders in children and youth is **psychotherapy**. This is a widely-used and highly effective clinical tool in which trained therapists will use evidence-based techniques to treat patients and clients with a variety of psychological disorders or stressors. The gold standard psychotherapeutic modality in the treatment of anxiety disorders is cognitive behavioral therapy, or CBT. CBT is best described as a goal-oriented and time-limited therapy that provides patients with tools and strategies to recognize their heightened emotions, and employ relaxation and cognitive strategies to manage them. When available, CBT can help children and adolescents understand their anxiety symptoms and use a variety of skills to temporize them, while simultaneously building a therapeutic relationship with a non-judgmental provider. In both pediatric and adult populations, it is well-established that CBT and pharmacotherapy used in conjunction with one another are more effective in the management of anxiety disorders than either treatment on their own.

One advantage of CBT is that it can be delivered in a variety of settings, including individually, in groups, or in a virtual format, with little variation in treatment outcomes when these are compared to one another. They can also be adjusted to meet the developmental levels of younger children, so that it is not limited to older children and adolescents in areas where CBT is available. CBT programs that have been developed specifically for children with neurodevelopmental disorders like autism spectrum disorder have also shown to be effective and an important aspect of management of co-occurring anxiety in these populations.

The final treatment modality in the management of pediatric anxiety disorders is **pharmacotherapy**, which can also be an excellent tool to engage when done so by a trained prescriber. The most effective medications used to treat anxiety in children and adolescents are the **selective serotonin reuptake inhibitors**, or SSRIs. The American Academy of Child and Adolescent Psychiatry currently recommends these for use in patients aged 6 to 18 years old. The similar class of medications known as the selective norepinephrine reuptake inhibitors, or SNRIs, can also be considered, as they have been studied in the management of social anxiety, separation anxiety, and generalized anxiety disorder, as well as panic disorder. As mentioned before, the greatest improvement in global functioning is achieved when SSRIs and cognitive behavioral therapy are used together, which also demonstrates a lower rate of relapse when compared to either treatment alone. There is no robust data to prove that any one SSRI is more effective over another, however paroxetine is not advised in the pediatric population because of the short half-life and higher risk of SSRI discontinuation syndrome.

The standard prescribing regimen for SSRIs in children and adolescents follows the 'start low and go slow' rule. Initiating therapy at a low dose, and then gradually titrating upwards every 2 to 4 weeks, depending on treatment response and the experience of any adverse effects. Patients and parents should be counselled that while some children may report an improvement in symptom severity within 2 weeks of induction, it is noted that significant improvement is not observed until roughly 6 to 8 weeks post-initiation, with maximal beneficial effects being yielded typically around 12 weeks. The CPS position statement on the treatment of anxiety disorders has listed the SSRIs citalopram, escitalopram, fluvoxamine, sertraline, and fluoxetine as potential pharmacotherapy considerations, as well as SNRIs venlafaxine and duloxetine. It is important to remember that patients and caregivers should be counselled on both common and rare side effects.

We have now had the chance to discuss the use of psychoeducation, psychotherapy, and pharmacotherapy in the management of anxiety disorders in children and adolescents. Once one or more of these treatment modalities have been employed, there are a couple of things for clinicians to consider as we move forward through the treatment process. If the child is in school at the time of treatment, it is important for caregivers and clinicians to advocate for the use of supports in the school environment. These may include accommodations for the student, such as adjusting time requirements for tests or assignments, or involving an educator, EA, or a mental health provider in the school to collaborate with the care team. As for the treating physician, it is advised that the use of validated scales, assessments of global functioning, and measures of patient satisfaction, adherence, and remission are employed throughout the treatment process.

In closing, there are some recommendations for pediatric healthcare providers that have been listed in the CPS position statement for the treatment of anxiety disorders. Let's go through a few of them before we finish up:

- Be involved with the school or daycare when needed. Help develop education plans for children and youth, and advocate for accommodations when required.
- Refer and help confer access to a mental healthcare provider; this might include a therapist, psychologist, social worker, or an employee of the school or district.
- Advocate for access to cognitive-behavioral therapy in your community, since this is one of the first-line and most effective treatments for anxiety disorders in children and adolescents.
- Offer patient- but also family-centered treatment planning, and be aware of the impacts of parent mental health on global functioning and treatment success.
- Be sure to take into account special considerations before initiating a medication trial, including diagnosis, developmental age and stage, medication efficacy and safety, potential side effects, and interactions with any other medications or supplements.
- Lastly, evaluate each patient's response to treatment on a regular and ongoing basis. The treatment of an anxiety disorder in youth is a longitudinal and complex process. Ensure that you are continually assessing for features like suicidal

ideation, global functioning, treatment adherence, and patient and parent satisfaction.

This concludes today's podcast reviewing part 2 of the Canadian Pediatric Society Position Statement on the management of anxiety disorders in the pediatric population. Thanks for listening, and stay tuned for future podcasts!

References

Klein, B., Rajendram, R., Hrycko, S., Poynter, A., Ortiz-Alvarez, O., Saunders, N., & Andrews, D. (2023). Anxiety in children and youth: Part 2-The management of anxiety disorders. *Paediatrics & Child Health*, *28*(1), 37–51. https://doi.org/10.1093/pch/pxac102