NEW JERSEY PEDIATRIC PSYCHIATRY COLLABORATIVE

New Jersey Pediatric Psychiatry Collaborative

Anxiety Toolkit and Resources

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Table of Contents

01
NJPPC Anxiety Guidelines for PCPs

03
Medications to Treat Anxiety Disorders in Children & Adolescents

04
Anxiety "Clinical Pearls" For Primary Care Providers

09
Resources for Providers

10
Resources for Caregivers

11
Frequently Asked Questions

ANXIETY GUIDELINES FOR PRIMARY CARE PROVIDERS

PCP visit:

- Screen for behavioral health problems using age-appropriate universal screening tools
  - Pediatric Symptom Checklist-(PSC17, PSC35 or PSC-Y)
  - If screen is positive, conduct **focused assessment**
- If concern for imminent danger, refer to hospital or crisis team for psychiatric assessment
- Consult with NJPPC Hub CAP as needed

Focused assessment including clinical interview, medical workup, mental status exam, and standardized symptom rating scales (see **Anxiety Clinical Pearls**)
SCARED: parent and child versions for ages 8-18 (total score ≥25)
GAD-7: self-report ages 12+ (5-9 mild, 10-14 moderate, ≥15 severe)
Preschool Anxiety Scale: parent report ages 2½ - 6½ (total score >60)

Sub-clinical to mild anxiety: Guided self-management with follow-up

Moderate anxiety (or self-management unsuccessful)**:** Refer for therapy (CBT preferred); consider medication

Severe anxiety: Refer to specialty care for therapy (CBT preferred) and medication management until stable

Medication Initiation and Monitoring: Acute Treatment Phase

Refer to ***Medications to Treat Anxiety Disorders in Children & Adolescents*** table for specific guidelines

- Select a first-line evidence-based medication for anxiety
- Start daily test dose for 1-2 weeks
- If test dose tolerated, increase daily dose
- Monitor weekly for agitation, suicidality, and other side effects; for severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency evaluation
- Consult with NJPPC Hub CAP as needed

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At 4 weeks, re-assess symptom severity with SCARED, GAD-7 or Preschool Anxiety Scale

- **If screen is positive and impairment persists, increase daily dose**
- **Monitor every 2-weeks for agitation, suicidality, and other side effects**
- **For severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency psychiatric assessment**
- **Consult with NJPPC Hub CAP as needed**

At 8 weeks, re-assess symptom severity with SCARED, GAD-7 or Preschool Anxiety Scale

- **If screen is positive and impairment persists, increase daily dose**
- **Monitor every 2-weeks for agitation, suicidality, and other side effects**
- **For severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency psychiatric assessment**
- **Consult with NJPPC Hub CAP as needed**

Medication Management: Maintenance Phase

At 12 weeks, re-assess symptom severity with SCARED, GAD-7 or Preschool Anxiety Scale

- **If screen is positive and impairment persists, consult with NJPPC Hub CAP for next steps**
- **If screen is negative with mild to no impairment, remain at current dose for 6-12 months**
- **Monitor monthly for maintenance of remission, medication adherence, side effects, agitation or suicidality**
- **For severe agitation or suicidal intent or plan, refer to hospital or crisis team for emergency psychiatric assessment**
- **Consult with NJPPC Hub CAP as needed**

Medication Management: Discontinuation Phase

After 6-12 months of symptom remission, re-assess symptom severity with SCARED, GAD-7 or Preschool Anxiety Scale

- **If screen is negative with no impairment, then consider tapering medication according to the following schedule:**
  - **Decrease daily dose by 25-50% every 2-4 weeks to starting dose, then discontinue medication**
  - **Tapering should ideally occur during a time of relatively low stress**
- **Maintenance of medication may be considered beyond the 6-12 month period in cases of high severity/risk, recurrent pattern, and/or long duration of illness**
- **Monitor with SCARED, GAD-7 or Preschool Anxiety Scale for several months after discontinuation for symptom recurrence**
- **Consult with NJPPC Hub CAP as needed**

MEDICATIONS TO TREAT ANXIETY DISORDERS IN CHILDREN & ADOLESCENTS

1st Line SSRI Selective Serotonin Reuptake Inhibitor		
Sertraline Zoloft™	FDA Approved Indication/Age	OCD, Age ≥ 6 yrs
	Typical Dosing Range	Children 25-100 mg Adolescents 50-150 mg
	Typical Starting Dose	12.5 mg - 25 mg daily
	Typical Titration Increments*	12.5 - 25 mg for doses < 50 mg 25 mg for doses > 50mg
	Max Daily Dose	200 mg
	Common Adverse Effects	GI upset, headaches, insomnia
	Rare Potential Serious Side Effects	Serotonin syndrome, boxed warning for suicidal thoughts
Fluoxetine Prozac™	FDA Approved Indication/Age	MDD, OCD, Age > 8
	Typical Dosing Range	Children 5-10 mg Adolescents 10-40 mg
	Typical Starting Dose	5-10 mg daily
	Typical Titration Increments*	5 mg for doses < 20 mg 10 mg for doses > 20 mg
	Max Daily Dose	60 mg
	Common Adverse Effects	Nausea, headache, weight reduction, abdominal pain
	Rare Potential Serious Side Effects	Serotonin syndrome, boxed warning for suicidal thoughts, hepatic failure
Escitalopram Lexapro™	FDA Approved Indication/Age	GAD, Age > 7
	Typical Dosing Range	2.5-20 mg
	Typical Starting Dose	2.5-5 mg daily
	Typical Titration Increments*	5 mg
	Max Daily Dose	20 mg
	Common Adverse Effects	GI upset, headaches, insomnia
	Rare Potential Serious Side Effects	Serotonin syndrome, boxed warning for suicidal thoughts, QT Prolongation
2nd Line SNRI Serotonin-norepinephrine Reuptake Inhibitor		
Duloxetine Cymbalta™	FDA Approved Indication/Age	GAD, Age ≥ 7 yrs
	Typical Dosing Range	Children, Adolescents 30-60 mg
	Typical Starting Dose	20 - 30 mg daily
	Typical Titration Increments*	20 - 30 mg
	Max Daily Dose	120 mg
	Common Adverse Effects	Nausea, headache, weight reduction, abdominal pain

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***Titration Tips:**
Initial increase: Can increase dose after 2 – 4 weeks after ensuring tolerability
Subsequent increases: Would wait 4 – 8 weeks between dose adjustments to allow medication to reach steady state before assessing for efficacy

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ANXIETY "CLINICAL PEARLS" FOR PRIMARY CARE PROVIDERS

I. CLINICAL HISTORY	
Recommended Procedure	**Clinical Pearls**
Assess current symptom severity, ideally using a standardized symptom rating scale	**Pearl:** Symptom severity will suggest appropriate level and type of treatment. Primary Screen: Pediatric Symptom Checklist; Secondary Screens: SCARED (ages 8-18), GAD-7 (ages 12+) or Preschool Anxiety Scale (ages 2.5 to 6.5)
Assess avoidant behavior	**Pearl:** Avoidance of activities and circumstances that provoke anxiety often are the most disabling aspects of anxiety disorders for children and adolescents, at times contributing to developmental delays. Avoidant behaviors become habitual and may be reinforced by family members and teachers. Avoidant behaviors may result in patients with severe anxiety disorders to be "free" of subjective feelings of anxiety. In addition to psychotherapy referral, primary care providers should educate patients and families regarding the importance of exposure in order to address this aspect of the disorder.
Assess for acute and chronic stressors which may be contributing to presentation	**Pearl:** Stressors may trigger the onset of an anxiety disorder or exacerbate the course of one. Therapy referral is helpful to support effective coping.
Assess chronicity of symptoms	**Pearl:** Anxiety disorders tend to be recurrent and persistent. There is some evidence that psychotherapy is more durably effective than medication treatment and should be included in the treatment plan in order to mitigate risk of recurrence.
Assess for current or previous non-suicidal or suicidal thinking and behavior (self-harm, suicide attempts) and previous suicidal crises	**Pearl:** Anxiety disorders can be associated with suicidal ideation with or without comorbid depression.
Assess for multiple anxiety disorders	**Pearl:** Patients commonly meet criteria for more than one anxiety disorder. The accurate identification of the type(s) of anxiety disorder is pertinent to the psychotherapy treatment plan, less so for the medication treatment plan.
Assess for the presence of other psychiatric symptoms and/or substance use and abuse	**Pearl:** The most common co-occurring psychiatric diagnoses include ADHD, Depression, and Substance Use Disorders. These issues should be assessed and treated concurrently.

II. MEDICAL WORKUP	
Recommended Procedure	**Clinical Pearls**
Perform general standard medical assessment	**Pearl:** General medical assessment is part of good medical care for youth presenting with concerning anxiety symptoms
Assessment of medical conditions that can present with anxiety symptoms (i.e., thyroid abnormalities, cardiac arrhythmias)	**Pearl:** Identification and intervention for general medical problems presenting with psychiatric symptoms may help with assessment and treatment planning; consider NJPPC phone consultation to discuss complex situations.
Assessment of medical treatments that can present with anxiety symptoms as untoward reactions (i.e., steroid treatments, anti-convulsants, pseudephedrine, etc.)	**Pearl:** Identification and intervention for medical treatments presenting with psychiatric symptoms may help with assessment and treatment planning; consider NJPPC phone consultation to discuss complex situations.
Assessment of medical conditions and concurrent medical treatments that may affect treatment planning	**Pearl:** Identification of medical conditions that could impact antidepressant treatment (i.e., liver disease, renal problems) or medications with significant drug-drug interaction potential; consider NJPPC phone consultation for complicated situations.

III. MENTAL STATUS EXAMINATION	
Recommended Procedure	**Clinical Pearls**
Common mental status findings	**Pearl:** Clinicians may observe difficulties with separation, selective mutism, behavioral inhibition, or especially in younger children, over-arousal and hyperactivity. Mental status exam may be entirely normal. Children may have poor insight into anxiety symptoms and may actively try to minimize or obscure symptoms.
Suicidality ideation: suicidal thoughts, degree of planning, degree of intent, sense of control, ability to communicate with others and reach out for help, reasons for living	**Pearl:** Reports of active suicidal planning or intent or recent suicidal behavior increase safety risk; consider Psychiatric Crisis referral or NJPPC phone consultation.

IV. DIFFERENTIAL DIAGNOSIS	
Recommended Procedure	**Clinical Pearls**
Adjustment reactions to acute stressors (symptoms clearly correlated to recent and likely time-limited negative life event)	**Pearl:** Adjustment reactions rarely require pharmacological intervention; consider general health education, health maintenance strategies, or referral for psychotherapy as first-line intervention. Consider NJPPC phone consultation for complex situations.
Consider bullying	**Pearl:** Children who are victims of bullying may present with avoidance and anxiety symptoms, which represent acute or recurrent adjustment reactions to bullying. Also consider that patients with anxiety disorders may be targets of bullying behavior, therefore the experience of bullying doesn't exclude the possibility of an anxiety disorder.
Bipolar disorders	**Pearl:** Bipolar disorders in youth can be complicated in terms of assessment; consider NJPPC phone or face-to-face consultation prior to initiating treatment if the youth is presenting with signs of bipolar disorder.
Anxiety disorder due to another medical condition	**Pearl:** First-line treatment would be intervention for the medical problem; consider interventions for anxiety as indicated. Consider NJPPC consultation in complex situations.
Substance use disorder	**Pearl:** Patients with anxiety disorders may self-medicate with substances and present with subjective anxiety associated with cravings and withdrawal. Careful assessment of the onset and course of the anxiety symptoms can help with differential diagnosis. In the case of dual diagnosis, it is necessary to treat both the anxiety disorder (avoiding benzodiazepines) and the substance use disorder concurrently.
Autism spectrum disorder	**Pearl:** Patients with autism frequently have significant anxiety symptoms, which may be attributed to the core symptoms of autism. Consider consulting with NJPPC for help in clarifying diagnosis and addressing these symptoms.

V. ASSESSMENT OF RISK	
Recommended Procedure	**Clinical Pearls**
Assess youth comprehensively for suicidal thinking or behavior as main, short-term concern is risk of self-harm, suicidal behavior, or completed suicide	**Pearl:** Refer for immediate and emergent Crisis Assessment with Emergency Psychiatric Service providers in the following situations: • Any evidence of recent suicidal behavior • Current active intent to engage in suicidal behavior • Current significant planning for suicidal behavior • Any degree of lack of cooperation in assessment from youth or family where risk for suicide has been identified • Evidence that youth or family will not or cannot access Emergency Psychiatric Service providers in times of worsening risk • Consider NJPPC phone consultation for complex or confusing situations

VI. TREATMENT PLANNING	
Recommended Procedure	**Clinical Pearls**
Present to family clinical impressions and recommendations regarding the need for treatment	**Pearl:** Consult with NJPPC by phone as needed regarding developing an appropriate treatment plan.
Using NJPPC guidelines, discuss treatment options with family, including Cognitive Behavioral Therapy (CBT), medication, and school-based accommodations. Ascertain family preferences for treatment.	**Pearl:** Family preferences regarding treatment choices can be taken into account along with many other factors in determining initial treatment plan in many situations; consider NJPPC phone or face-to-face consultation for complicated situations.
With medication treatment, utilize standard informed consent procedures discussing potential benefits of treatment, potential side effects, alternatives to medication treatment, and prognosis with and without medication treatment; include discussion of “black box” warning regarding treatment-emergent suicidality associated with all anti-depressants for patients ages 25 and younger. Document this discussion in clinical record. Although only duloxetine is FDA-approved for the treatment of anxiety in children and adolescents older than age 7, the SSRIs (especially sertraline and fluoxetine) generally are preferred despite lacking FDA approval due to their greater tolerability along with proven effectiveness in research studies.	**Pearl:** Consult with NJPPC Hub CAP as needed regarding any concerns about informed consent as it applies to treatment planning.
Discuss plan for medication monitoring, dosage adjustment, and discontinuation.	**Pearl:** Monitoring response to treatment, ideally with a standardized symptom rating scale and adjusting medication dose as indicated may lead to an improved outcome; the plan for medication discontinuation after symptom remission should be discussed.
NJPPC currently does NOT recommend the use of routine pharmacogenetic testing for initial medication selection strategies in primary care for youth with anxiety.	**Pearl:** Pharmacogenetic testing is considered experimental and is not incorporated at this time into any standard practice guidelines for youth with anxiety. There may be specialized situations where pharmacogenetic testing is appropriate in specialty care. Consider phone consultation with NJPPC Hub CAP to discuss further as warranted.

VII: MEDICATION MANAGEMENT (Refer to MEDICATIONS TO TREAT ANXIETY DISORDERS IN CHILDREN & ADOLESCENTS)	
Recommended Procedure	**Clinical Pearls**
Acute Treatment Phase	**Pearl**: Goals - remission and/or reduction of symptoms, improvement in function ● Initiation and close monitoring of medication treatment response and tolerance ● Monitor medication adherence and tolerance ● If youth is experiencing side effects from medication, do not advance dose until side effect remits fully ● Reassess anxiety symptoms at 4, 8, and 12 weeks using GAD-7, SCARED or Preschool Anxiety Scale ● Follow guidelines and consult with NJPPC Hub CAP as needed ● If patient does not respond to or tolerate first medication, consult with NJPPC Hub CAP
Maintenance Phase	**Pearl**: Goals - youth will continue to demonstrate reduction and/or remission of symptoms and improvement in function after positive acute treatment response ● Maintain active treatment plan (medication, psychotherapy) during this period ● Monitoring generally less involved or intensive assuming ongoing symptom improvement ● Monitor medication adherence and tolerance ● Ongoing collaboration with therapist if present ● Consult with NJPPC Hub CAP as needed ● If symptoms and functioning improve for 6-12 months, reassess with GAD-7 or SCARED or Preschool Anxiety Scale ● Discussion with NJPPC Hub CAP of treatment discontinuation phase if response has been sustained for 6-12 months
Treatment Discontinuation Phase	**Pearl**: Goals - safely and thoughtfully withdrawn treatment and monitor for symptom recurrence ● Informed consent with family: potential benefits of withdrawing treatment, potential risks of withdrawing treatment, plan to deal with problems or recurrence if needed ● Discuss medication strategies with family (consult with NJPPC Hub CAP as needed) ● Active monitoring for several months during this phase; re-evaluate need for resuming medication if assessment scales suggest episode relapse or recurrence ● Ongoing collaboration with therapist if present ● Consult with NJPPC Hub CAP as needed

Resources for Providers

Screening Tools:

- Preschool Anxiety Scale (PAS) Parent Report
- Screen for Child Anxiety Related Disorders (SCARED)
  - Child Version
  - Parent Version
- General Anxiety Disorder-7 (GAD-7)

Books:

- American Academy of Pediatrics: Understanding Anxiety Disorders in Children - Brochure
- American Academy of Pediatrics: Pediatric Psychopharmacology for Pediatric Primary Care by Mark Riddle

Online Resources:

- American Academy of Pediatrics: Pediatric Anxiety: Tools and Resources for Primary Care
- American Academy of Child and Adolescent Psychiatry: Anxiety Resource Center

Other:

- Medication Side Effects Diary Template
- Section 504 Protections for Students with Anxiety Disorders (Dept. of Education)

Resources For Caregivers

Apps/Videos:

- Calm
- Headspace
- Buddhify
- Breathe, Think, Do with Sesame (4+)
- 5 Tips on Anxiety
- Grounding Techniques

Books:

- For Children
  - Breathing with ElmoThe Explosive Child by Ross W. Greene
  - Breathe like a Bear by Kira Willey
  - You've Got Dragons by Kathryn Cave
  - I Can Handle It by Laurie Wright
  - My Mouth is a Volcano by Julia Cook
  - Outsmarting Worry (An Older Kid's Guide to Managing Anxiety) by Dawn Hubner
  - What to Do When You Worry Too Much: A Kid's Guide to Overcoming Anxiety (What-to-Do Guides for Kids Series) by Dawn Hubner
  - Breathe With Me by Miriam Gates
- For Caregivers
  - The Opposite of Worry by Lawrence Cohen PhD
  - Helping Your Anxious Child by Ronald Rapee PhD
  - Freeing Your Child From Anxiety by Tamar C Chansky PHD
  - Breaking Free of Child Anxiety and OC by Eli R. Lebowitz

Online Resources:

- Coping Cat Parents (For Caregivers and Kids)
- American Academy of Pediatrics: Help Your Child Manage Anxiety: Tips for Home & School - HealthyChildren.org
- American Academy of Child and Adolescent Psychiatry: Facts for Families: Anxiety and Children
- Child Mind Institute: Anxiety
- National Alliance of Mental Illness: Anxiety Disorders
- New Jersey/Community Resources
  - State Parent Advocacy Network
  - Center for Family Services

Frequently Asked Questions

The following section contains Frequently Asked Questions, compiled throughout the Anxiety Boot Camp Learning Collaborative series. A special thank you to the following New Jersey Pediatric Psychiatry Collaborative Champions and subject matter experts for their contributions to these FAQs:

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Frequently Asked Questions

Screening Tools/Diagnosis:

- What are your recommendations for screening younger patients?
- How can I help parents consider their child may have anxiety?
- Do you use the SCARED questionnaire to monitor progress?
- What is your preferred screening for anxiety and is there a preferred age range for use?

Medication Management/Treatment:

- How do you start treatment in children and adolescents? How long to treat anxiety and when to continue weaning medications?
- If medication is prescribed, how often should the patient be seen for follow up; and if changing medication, do you wean off one before starting another?
- Do different ethnic groups respond differently to the medications? Are some medications contraindicated in specific ethnic groups?
- What are your thoughts on genetic testing regarding medications?
- Do you have any recommendations for patient handouts on side effects?
- What do you tell parents when medication has a Black Box Warning?
- How do you distinguish true side effects from medication vs symptoms caused by anxiety surrounding fear of medication?
- In patients that fail multiple SSRIs and SNRI, do you consider pharmacogenomics or drugs outside of these categories like buspirone?

Anxiety and Co-morbidities:

- What are the best treatment and evaluation options for ADHD and Anxiety?
- When anxiety is comorbid with autism, what screens do you recommend and are there more specific scales for ASD patients?

Non-Medication Management/Resources:

- What are the best non-medication strategies to treat anxiety?
- CBT: What is it? Where can we find providers in our area who practice it? Are there resources or books to help us learn basic CBT or skills to teach our patients with mild/moderate anxiety?
- How do we build resilience in kids and what interventions help with an episode of anxiety?

Other Anxiety Related Questions

- Can you explain how to handle school avoidance?
- What is the role of the school guidance counselor when it comes to helping children with anxiety?
- How much does parental anxiety and stress put a child at risk for the development of correlating behaviors and how can we have that conversation with parents or help them find coping strategies to not further impact their kids?

Screening Tools/Diagnosis

What are your recommendations for screening younger patients?

Preschool age groups can be screened using Spence Preschool Anxiety Scale, Parent and Teacher scale. The age range is 2 1/2-6 1/2 years. The most common anxiety disorders in preschool populations are separation anxiety disorders, social phobia, specific phobia and generalized anxiety disorder. When assessing preschool anxiety disorders, it is critical to distinguish normative situational fear from those that cross the clinical threshold. The high levels of distress and functional impairment include avoidance of important activities such as peer interaction and disruption of family functioning. Evidence based options for treatment in this age group includes a variety of parenting and psychotherapeutic interventions. Cognitive behavioral therapy with parent involvement and parent child interaction therapy are helpful. A combination of training in parenting skills, cognitive restructuring and exposure has been shown to reduce progression to anxiety disorders in preschoolers. Medications are reserved for highly impaired children who are not candidates for therapy or have failed other modalities. It is best to consult with a child and adolescent psychiatrist for medication management.

How can I help parents consider their child may have anxiety?

As we work with families, we know we need to meet them where they are on their journey. When I'm evaluating a child with anxiety, I listen carefully to the language that children and families use to describe distress or discomfort, and I won't lead with anxiety as a term if the family is still talking about stress or worry. I'll join them and use that language. We'll look for opportunities to identify the consequences of worry or stress, the impact of these symptoms on their child's functioning, and point to the way that this has long-term consequences for them. Then, I slowly begin to introduce the various constructs that help us understand worry, like fight or flight, and information about the brain-body connection. I bring them along to a place where we can introduce terms like anxiety disorder. I also find that the fact sheets provided by AACAP can be useful. We understand that families absorb and consume information in multiple different ways. I generally send families home with a fact sheet to continue reviewing and considering.

Many parents just have no clue. That is why screening at all well-childcare encounters is so important. If abnormalities are found on the screeners you're doing, they can be used as a device to introduce that language to parents. It helps start thinking about things like anxiety and how their child responds to certain stressful situations. Sometimes, you have no idea, and you do the screeners, and it's positive which leads to a discussion. That further underscores the importance of using the PSC (Pediatric Symptom Checklist) in your well-visits to catch early symptoms that may emerge before adults notice significant changes in functioning. It's a little more difficult to identify some of these symptoms in younger children. There are other developmental screening tools, such as the SWYC, which essentially has a mini PSC and a pediatric PSC embedded in the screen. Responses to those questions can also spark discussion.

Do you use the SCARED questionnaire to monitor progress?

Yes, you can use the SCARED to monitor progress. It's a great way to quantify the symptoms that the child is having to note change from visit to visit, especially after a treatment intervention like an increase in dose.

What is your preferred screening for anxiety and is there a preferred age range for use?

The SCARED is validated for children age 8-18. It takes a bit more time to administer and a bit more time to score, but it actually provides more useful information. The GAD-7 asks questions about generalized anxiety, but the SCARED provides information about other anxiety disorders, so it's really helpful to have that information at hand when you then plan to meet with that child or teen and ask your follow-up questions. We know the children who have anxiety symptoms in one cluster or disorder tend to have co-existing symptoms in other diagnoses, including other anxiety diagnoses, so you want to know if those symptoms are there so that you're treating to target and to remission

Medication Management/Treatment

How do you start treatment in children and adolescents? How long to treat anxiety and when to continue weaning medications?

Acute Phase of Treatment: Start low and go slow when beginning medication. Start at low doses to test tolerance, limit side-effects and improve adherence. Slowly titrate to see full therapeutic benefit while understanding it may take 4-6 weeks to see response. Maintenance Phase: Once remission has been achieved, continue to treat for 6-12 months. Continue to monitor adherence and assess for side-effects. Discontinuation Phase: After that 6-12 month maintenance phase, gradually taper medication over several months. Actively monitor during this phase, assessing for any discontinuation symptoms or return of primary anxiety symptoms. Tapering must be individualized; may consider 25% reduction as tolerated.

I**f medication is prescribed, how often should the patient be seen for follow up; and if changing medication, do you wean off one before starting another?**

During initiation, evaluate the patient weekly for first 4 weeks. This may include a combination of in-office and telehealth visits. It is especially important to assess for tolerance and emergence of suicidal thinking. Thereafter, consider seeing the patient monthly. If changing medication, the most conservative approach is to taper and discontinue the first SSRI before adding the second. However, children may not tolerate this approach because of the return of original symptoms of anxiety. Cross-tapering medication may avoid this issue, but dosing changes must be individualized based on medication choices and patient's symptoms (was the first medication not effective or was it associated with side-effects?). Children also need to be carefully monitored during cross-tapering. Working with an NJPPC CAP for individual cross-tapering plans is recommended.

Do different ethnic groups respond differently to the medications? Are some medications contraindicated in specific ethnic groups?

The answer is unknown as there are genetic variants within ethnic groups themselves so people from same ethnic group can have different responses. There are genetic-based enzymes that drives metabolism of medications, i.e. slow metabolism vs fast metabolism of medications which can affect the metabolism and distribution of medications causing side effects, requiring higher dose vs lower dose. No, there are no medications contraindicated to specific ethnic groups at this time.

What are your thoughts on genetic testing regarding medications?

The use of genetic testing to guide medication management in anxiety disorders is still in it's early stages. Most of the research is based on adult populations. Therefore, pharmacogenetic testing is not widely recommended or used often in clinical practice. The American Academy of Child and Adolescent Psychiatry still recommends evidence based treatment approaches such as CBT and/or SSRIs. However, pharmacogenetic testing can be considered useful for children with treatment-resistant anxiety or those who have experienced unusual side effects with previous medications.

Do you have any recommendations for patient handouts on side effects?

The American Academy of Child and Adolescent Psychiatry has a Facts for Families section on their website which also includes medication facts, common side effects, etc.

What do you tell parents when medication has a Black Box Warning?

I go through what the common side effects are. When I talk about rare side effects, I tell them that in 2004, the FDA put out a black box warning for all antidepressants for anyone taking them who is 24 and younger. The reason they did that was because they found that in a very, very, very small group of individuals treated with antidepressants, there was an increase in suicidal thinking. I go on to tell them that nobody actually attempted suicide, and the risk of having more suicidal thinking was 1% in patients treated with antidepressants, compared to 0.2% in those patients who took placebo. If they're able to understand this, I will go on to say that that was statistically insignificant. I then go on to say that although this is incredibly rare, I take it very seriously, which is why I want them to send me a message in a week letting me know how their child is doing, and this is why I need to see them back regularly. Usually, by the time most people get to me, they've generally been in therapy—not all the time, but often enough. That's why I also say that's the other reason why it's important that they continue therapy, because I'll collaborate with the therapist. If they're seeing their therapist weekly and they're seeing me every two to four weeks while we're getting the medicine onboard, then I'm not really worried. Then, I will tell them what they need to look for. I remind them how their child is presenting and what they're struggling with. I will go through that if their child appears much more depressed, angry, agitated, or engaging in behaviors that are the complete opposite of what they were or what they expect, they need to call me. They need to have a low threshold, and then it becomes my worry to figure out whether or not this is medicine-related.

How do you distinguish true side effects from medication vs symptoms caused by anxiety surrounding fear of medication?

During my initial evaluation, I like to get a good sense of how often insomnia, GI distress, poor appetite, and headaches occur so that I can gauge the frequency. For example, a patient has a headache every single day but no GI issues. If they call me back in the week saying that they have headaches every day, that's not a side effect, that's just ongoing headaches. I think if you're able to obtain that information right at the outset, you can then remind your patient that this may not be a side effect; it's just continuation and to give it a little bit more time. When you have that data in front of you, it's a little bit easier to know yourself that this is not a side effect. The second thing that I do: depending on the age, if the child is young, I generally will really only have this conversation with the parents for this very reason. I will go into detail about common and rare side effects. I will tell the parents what I am going to tell the child. I will bring the child in with the parents and keep it at a bare minimum, and don't go into all those details. Now, if they're older—13, 14-24—that's a little bit different. In those patients, I still have to educate them and tell them about it, but I really emphasize how rare it is, I really emphasize how benign it is. For those patients, they might do better with a sooner 15-minute follow-up than some other patients that I see. The last thing that you really could do if you have a patient that tends to just have side effects to everything is there is actually a rating scale that you can give to patients beforehand that assesses for all sorts of side effects. You can have them fill that out again before they come back to see you so you can gauge more concretely what they were experiencing before and what they are experiencing now.

In a patient that fails multiple SSRIs and SNRI, do you consider pharmacogenomics or drugs outside of these categories like buspirone?

Please refer to a specialist or the NJPPC for follow-up.

Anxiety and Co-Morbidities

What are the best treatment and evaluation options for ADHD and Anxiety?

For evaluation of both, I would encourage you to not only use the PSC, but if you see an elevated score in the attentional complex, to use the Vanderbilt as a secondary screener which will give you more info about the symptoms of inattention and/or hyperactivity. In terms of treatment of a child who has ADHD and anxiety, I think it's important to identify which cluster of symptoms is causing the most significant impairment in the moment and then proceed with prioritizing treatment for that symptom cluster or that disorder. A child with both may be more sensitive to side effects of medications and so we'll take a nuanced approach. This is the beauty of the NJPPC and the collaboration that you will have with the CAP in your hub, and the opportunity to walk through your clinical decision making, visit by visit, dose change by dose change.

When anxiety is comorbid with autism, what screens do you recommend and are there more specific scales for ASD patients?

There certainly is a high degree of comorbidity between the anxiety disorders and other psychiatric or developmental conditions. I think it's important to consider multiple screeners as part of baseline evaluation and then identify screeners for particular conditions or disorders when there is a new presenting complaint. So, looking at screeners for autism as part of baseline, but if the child is presenting with symptoms that get you thinking about anxiety symptoms, then bringing the SCARED into the conversation. If the child is non-verbal, look at pictorial versions of checklists that are available.

Non-Medication Management/Resources

What are the best non-medication strategies to treat anxiety?

View session 2 of the NJPPC Anxiety Boot Camp Learning Collaborative Series Bridging the Gap: Implementing Psychosocial Treatments and Practical Coping Skills for Anxiety in Pediatric Setting, for non-medication strategies to treat anxiety.

CBT: What is it? Where can we find providers in our area who practice it? Are there resources or books to help us learn basic CBT or skills to reach out patients with mild/moderate anxiety?

CBT stands for Cognitive Behavioral Therapy. It is a type of structured therapy that helps with recognizing negative or inaccurate thinking, and teaches more effective strategies to respond to difficult or challenging situations. Additionally, it teaches people how to problem solve. CBT is often used to treat a wide variety of conditions such as anxiety, depression, OCD, insomnia and phobias to name a few. CBT is time limited and short term, often requiring patients to do homework after the sessions. Some helpful resources include:

- What to Do When You Worry Too Much: A Kid's Guide to Overcoming Anxiety (What to Do Guides for Kids) by Dawn Huebner
- What to Do When You Worry Too Much: A Kid's Guide to Overcoming Anxiety by Dawn Huebner
- Freeing Your Child from Anxiety, Revised and Updated Edition: Practical Strategies to Overcome Fears, Worries, and Phobias and Be Prepared for Life—from Toddlers to Teens by Tamar Chansky, PhD
- Outsmart Your Worry Tool Kit for Kids. Ages 5-11by Tool Kits for Kids. LLC, 2008
- Outsmart Your Worry Tool Kit for Kids. Ages 11-18,by Tool Kits for Kids, LLC, 2009

How do we build resilience in kids and what interventions help with an episode of anxiety ?

Focusing on protective factors, and the child's strengths and interest, and at the same time fostering positivity helps build resilience as long as there is also support to foster these from the community, social, family, and school. Relaxation/breathing techniques, STOP (Stop what you are doing, Take slow breaths, Observe what is happening, Proceed), and mindfulness are interventions that can help. It's best to practice these even when not anxious so that it is automatic like normal breathing. These can be done at any age. For a younger age, Elmo's Belly Breathing can help.

Other Anxiety Related Questions

Can you explain how to handle school avoidance?

View the Back to School Challenges: Evaluating the Patient with School Refusal webinar by Dr. Debra Koss for strategies to handle school avoidance.

What is the role of the school guidance counselor when it comes to helping children with anxiety?

Our patients are in the school setting for a large portion of their day. Teachers, guidance counselors, and school nurses hold a lot of information. I generally work with the family to help identify the person at school who knows the student best, and then I will establish an initial conversation to obtain that baseline information. I will then set up some type of periodic check-in so that, as we're proceeding with treatment interventions, we can ask the school to provide feedback on any changes they're seeing. A guidance counselor is, of course, a critical part of that as well. We're looking for updates on academic performance, behaviors within the classroom and the school, as well as social interactions, as we know each of these domains can be impacted by symptoms of anxiety. For primary care providers, it's difficult to fit all of this in during the course of a busy day when you're seeing 20-30 patients. It's difficult to make the time for significant collaboration, but there are certainly going to be cases where you just don't have a choice and it is the best thing to do for the patient. You have to know what's going on at school, and if the parent is unable to provide that information to you, then you have to reach out and have direct collaboration with either the school guidance counselor or the school nurse.

How much does parental anxiety and stress put a child at risk for the development of correlating behaviors and how can we have that conversation with parents or help them find coping strategies to not further impact their kids?

Children learn by observing, hearing, and even emulating behaviors of adults because they perceive it as acceptable behavior. That said, anxiety is normal, and parents should model toleration or habituation of anxiety (normalization) and respond in healthy ways to deal with anxiety, such as doing relaxation techniques, STOP, mindfulness, positive thinking, reframing. If we want children to react and behave more positively, then we parents should model it.

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Questions?
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