In support of improving quality of care for Emblem Health Members, ValueOptions® is seeking approval for the Clinical Practice Guideline (CPG) “Practice Parameter for the Assessment and treatment of Children and Adolescents with Anxiety Disorders” 1

The ValueOptions Executive Medical Management Committee (EMMC) adopted the American Academy of Child and Adolescent Psychiatry (AACAP) “Practice Parameter for the Treatment of Children and Adolescents with Anxiety Disorders” on August 20, 2012. The guideline was reviewed and renewed by the EMMC on July 21, 2014.

**Name of Clinical Practice Guideline** “Practice Parameter for the Treatment of Children and Adolescents with Anxiety Disorders”

**Source(s):** Journal of the American Academy of Child and Adolescent Psychiatry

**URL(s) (date websites were last verified):**

**Summary of Practice Parameter:**
The American Academy of Child and Adolescent Psychiatry published and adopted the guideline in February 2007, based the guideline upon reviews of research completed between 1996 and 2004, that was available through Medline, OVIDMedline, PubMed and PsychINFO.

The parameter applies to the following major anxiety disorders included in the DSM-IV-TR: Separation Anxiety Disorder (SAD), Generalized Anxiety Disorder (GAD), Social Phobia, Specific Phobia, Panic Disorder (with and without agoraphobia), agoraphobia without panic disorder and selective mutism.

Posttraumatic stress disorder and obsessive compulsive disorder were not covered, as a result of having their own practice parameters.

Eleven Recommendations were made, each of which is repeated below. Clinicians were encouraged to distinguish between fears during childhood that represent normal developmental transitions and/or in response to perceived dangers, and those which have become problematic and impair a child’s functioning.

**A. Clinical Presentation**

1. Separation Anxiety (SAD): Excessive and developmentally inappropriate fear concerning separation from home or significant attachment figures.
2. General Anxiety Disorders (GAD): Chronic, excessive worry in a number of areas with at least one associated somatic symptom.
3. Selective Mutism: In addition to avoiding verbal means of communication, most have symptoms of social phobia.

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4. Panic Disorder: Recurrent, unexpected episodes of intense fear that are uncued or cue in nature.

B. Epidemiology
1. Prevalence rates for having at least one childhood disorder vary from 6% to 20%. Measurement is complicated by evidence that disability can be associated with sub threshold anxiety symptoms, and referral biases.
2. Girls are more likely than boys to report anxiety disorders for specific phobias, panic disorder, agoraphobia and SAD.
3. Children and adolescents with anxiety disorders are at risk of developing new anxiety disorders, depression and substance abuse.
4. Social, family, and academic impairments often result.

C. Risk and Protective Factors
Risk:
1. Genetics and child temperament
2. A parent with an anxiety disorder
3. Parents that exhibit over protective, over controlling parenting styles.
4. Anxious/resistant attachment
5. Avoidant coping strategies

Protective:
1. Active coping strategies
2. Distraction strategies
3. Problem focused strategies

D. Screening
Recommendation 1. The Psychiatric Assessment of Children and Adolescents Should Routinely Include Screening Questions About Anxiety Symptoms.

1. Screen during initial assessment
2. Use developmentally appropriate language, based on the DSM-IV-TR.
3. Use multiple informants
4. As a result of hiding external symptoms, children may be more aware inner distress than parents.
5. Adults may have a more accurate impact of anxiety on family and school functioning.
6. Utilize self reporting scales, such as Multidimensional Anxiety Scale for Children (March et al., 1997) or Screen for Child Anxiety Related Emotional Disorders

E. Evaluation
Recommendation 2. If the Screening Indicates Significant Anxiety, Then the Clinician Should Conduct a Formal Evaluation to Determine Which Anxiety Disorder May Be Present, the Severity of Anxiety Symptoms, and Functional Impairment.

Recommendation 3. The Psychiatric Assessment Should Consider Differential Diagnosis of Other Physical Conditions and Psychiatric Disorders That May Mimic Anxiety Symptoms.

1. Differentiate anxiety disorders from developmentally appropriate worries or fears.
2. Significant psychosocial stressors or traumas should be carefully considered during the evaluation to determine how they may be contributing to the development or maintenance of anxiety symptoms.
3. Somatic symptoms are common, so the mental health assessment should be considered early in the medical evaluation.
4. Documenting physical symptoms before treatment with medication will decrease the likelihood of mistaking baseline somatic complaints as medication side effects.

F. Treatment

**Recommendation 4.** Treatment Planning Should Consider a Multimodal Treatment Approach.

**Recommendation 5.** Treatment Planning Should Consider Severity and Impairment of the Anxiety Disorder.

1. Treatment of children with disorders of mild severity should begin with psychotherapy
2. Studies that examine the efficacy of psychotherapy, along with medication are underway.

**Recommendation 6.** Psychotherapy Should Be Considered as Part of the Treatment of Children and Adolescents With Anxiety Disorders.

1. CBT for childhood anxiety disorders was recommended.
2. CBT elements should include:
   A. Psycho-education with child and parents about the illness,
   B. CBT somatic management skills training (e.g., relaxation, diaphragmatic breathing, self-monitoring),
   C. Cognitive restructuring (e.g., challenging negative expectations and modifying negative self-talk),
   D. Exposure methods (e.g., imaginal and in vivo exposure with gradual desensitization to feared stimuli),
   E. Relapse prevention plans (e.g., booster sessions and coordination with parents and school).
3. Clinicians who conduct CBT and psychodynamic psychotherapy with anxious children routinely involve parents in the treatment process.
4. Group CBT plus parent training compared to group CBT alone resulted in additional benefits for children on several outcome measures.
5. Severity of illness at intake and positive family history of anxiety disorders predicted poorer response at post treatment.

**Recommendation 7.** SSRIs Should Be Considered for the Treatment of Youths With Anxiety Disorders.

1. There is no empirical evidence that a particular SSRI is more effective than another for treatment of childhood anxiety disorders.
2. Clinically, the choice of a medication is often based on side effects profile, duration of action, or positive response to a particular SSRI in a first-degree relative with anxiety (Manassis, 2000).
3. The risk-benefit ratio for a medication trial needs to be carefully assessed because CBT has been shown to be effective and long-term side effects of medications have not been studied in youths.
**Recommendation 8. Medications Other Than SSRIs May Be Considered for the Treatment of Youths With Anxiety Disorders.**

1. The safety and efficacy of medications other than SSRIs for the treatment of childhood anxiety disorders have not been established. However, noradrenergic antidepressants (venlafaxine and tricyclic antidepressants [TCAs]), buspirone, and benzodiazepines have been suggested as alternatives to be used alone or in combination with the SSRIs.

**Recommendation 9. Treatment Planning May Consider Classroom-Based Accommodations.**

G. **Comorbidity**

**Recommendation 10. Comorbid Conditions Should Be Appropriately Evaluated and Treated.**

1. Anxiety disorders are highly comorbid with other including depression, substance abuse, oppositional defiant disorder, learning disorders, and language disorders

2. Diagnosis complicated by overlapping symptoms between anxiety disorders and comorbid conditions, which can lead to misdiagnosis and underdiagnosis of comorbidity. Inattention, for example, may be present in anxiety, ADHD, depression, learning disorders, and substance abuse.

3. A common clinical phenomenon is the recognition of a comorbid diagnosis once the primary diagnosis is treated and additional symptoms become more evident.

H. **Prevention**

**Recommendation 11. Early Assessment and Intervention May Be Considered in Treatment and Prevention of Childhood Anxiety Disorders.**

1. Older age, increased severity of symptoms, parental psychopathology, and family functioning difficulties as significant predictors of poorer treatment outcome.

2. Early intervention, and prevention offer a proactive method for alleviating anxiety symptoms in youths.

3. Group interventions with CBT in school and other community settings can provide effective early treatment for children with mild to moderate anxiety disorders, which may improve longterm functioning.

4. Adaptation of protocol-based CBT interventions to fit diverse populations and take into account the limitations of community resources, including those of inner-city minority youths, can make evidence-supported treatments feasible and transportable.

5. Parent skills-training programs that teach parents anxiety management and foster healthy parent-child relationships may reduce the development of anxiety disorders in young children at risk.