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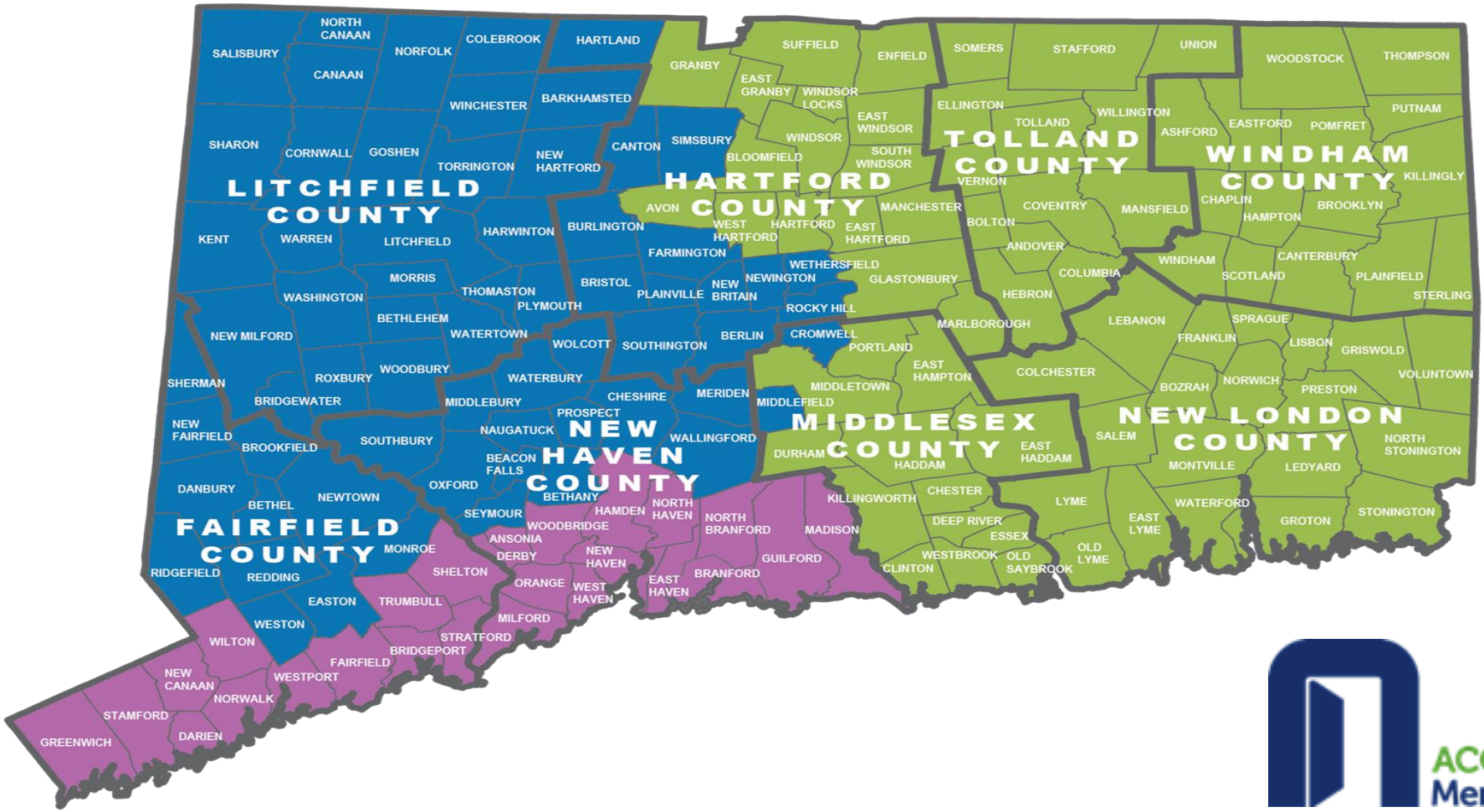
- Wheeler Clinic, Inc. 855.631.9835
- Hartford Hospital 855.561.7135



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ACCESS to:
Addressing Anxiety in Primary Care Settings

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Disclosure

- **RICHARD J. MILLER, MD, FAACAP**
  - Financial disclosure: Contract with ACCESS Mental Health CT
  - No commercial conflicts of interest

- **GURENDER S. SAHANI, MD**
  - Financial disclosure: Contract with ACCESS Mental Health CT
  - No commercial conflicts of interest

- **Off-label use of medications may be discussed**

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Learning Objectives

After attending this session the participants will be able to:

- Describe different ways anxiety problems can present in your office
- Outline strategies to approach anxiety problems in primary care
- Guide families through how they can help and the decision-making process regarding treatment options

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ANXIETY

- **Brain and body's response to threat**
  - Usually adaptive, not typically pathological
  - It is usually healthy and necessary for survival
  - Becomes a "disorder" when interferes with functioning, overly frequent or severe.

- **Developmentally variable**
  - Normal fears present at different developmental stages

Sarvet, B

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Developmentally Normal Worries

- **Infants**
  - 6-9 Months, Stranger Anxiety
  - 8-24 Months Separation Anxiety
- **Toddlers**
  - Fears of imaginary creatures
  - Fears of darkness
  - Normative separation anxiety
- **School-age Children**
  - Worries about injury and natural events
    (e.g., storms, lightening, earthquakes, volcanoes)

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Normal Worries, continued.

- **School Age Children (continued)**
  - In general, girls tend to endorse more anxiety symptoms than boys
  - Younger children are more likely to experience anxiety symptoms than older children

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Normal Worries, continued, continued.

- **Adolescents**
  - Fears related to school
  - Fears related to social competence & rejection
    - Exacerbated by social media
  - Fears related to sexuality
  - Fears related to health issues

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Anxiety – Some Numbers

- 10 – 20% of children and adolescents suffer a diagnosable anxiety disorder (2-3x ADHD)
- Many more children suffer with symptoms that do not meet diagnostic criteria (Walkup et al, 2008)
- ~40% of grade school children have fears of separation from a parent
- ~40% of children aged 6 – 12 years have 7 or more fears that they find troubling
- ~30% of children worry about their competence and require considerable reassurance
- ~20% of grade school children are fearful of heights, are shy in new situations, or are anxious about public speaking and social acceptance (Bell-Dolan et al, 1990)
- Girls report more stress than boys – may be an artifact of social expectations
- Many, if not most of these worries and stresses are transient and outgrown or recede as children mature and develop, but some do not.
- Healthy Anxiety is adaptive or a transient if not exaggerated response to a stressor. A disorder is disruptive, out of proportion and interferes with functioning.

When to Worry about Worrying

Object of Fear:

- Is this something a child of this age should be worrying about?

Intensity of Fear:

- Is the degree of distress unrealistic given the child's developmental stage and the object/event?

Impairment:

- Does the distress interfere with the child's daily life?
- Social functioning: unable to make friends
- Academic functioning: attendance,work avoidance, failing classes
- Family functioning: creating conflicts, limiting family choices

Ability to Recover/Coping Skills:

- Is the child able to recover from distress when the event is not present?
- Tend to worry about future occurrences of event/object
- Distress occurs across multiple settings

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Common Anxiety Symptoms

- Hypervigilance
- Reactivity to Novel Situations
- Avoidance
- Biased perception of experiences as threatening
- Catastrophic Reactions
- Parental Accommodation to anxiety
- Arousal Dysregulation
  - Sleep disturbance
  - **Explosive Outbursts**
    - **Irritability and angry outbursts may be misunderstood as oppositionality or disobedience**
    - **Tantrums, crying, aggression common in children with anxiety**
  - **Inattention (may look like ADHD)**

- **Midline Somatic Symptoms**
  - Often present in PCP office
  - Headache
  - Throat Discomfort
  - Gagging
  - Chest Pain
  - Abdominal Pain & Stomachaches
  - Bowel & Bladder Urgency
  - SOMATIZATION IS NOT MALINGERING

J. Walkup

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Anxiety Presentations

Different Presentations may help sort out different causes and point to interventions

- Temperament vulnerable/chronic
- Acute/sub acute

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Temperament Vulnerable/ Chronic Presentation

- **Temperament (biologic predisposition)**
  - “Shy”, approach avoidant, slow to warm
  - Anxious children interpret ambiguous situations in a negative way and may underestimate their competencies (*attribution bias*)
  - Children who are passive, shy, fearful, and avoid new situations at 3 and 5 years are more likely to exhibit anxiety later in life (Caspi et al, 1995)
  - Children who are characterized as confident and eager to explore novel situations at 5 years are less likely to manifest anxiety in childhood and adolescence
  - At risk to progress from sub-syndromal to syndromal (look for degree of interference in functioning).
  - Family history of anxiety problems

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Temperament Vulnerable/ Chronic Presentation

Temperament Associated Anxiety Problems/Risk of Anxiety Disorder

- Separation anxiety/School Refusal
- Social Anxiety/Selective Mutism
- Generalized Anxiety
- Somatic disorders (recurrent stomach aches, nausea, headache, etc.)
- OCD & Related Disorders (though no longer categorized as anxiety disorders)

Presents an opportunity for early intervention:

- Explaining temperament, encouragement
- Look at level of impairment and progression over time.
- Check for family/environmental barriers & accommodation.
- Early guidance may change progression of anxiety

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Acute/Sub-Acute Presentation

- Sudden Onset/ Change from Baseline
- Situation specific problems/developmental challenges may bring out traits or present de novo
- **Think About WHY NOW**? Look for stressors in school, family, peers, health or environment.
- Psychosocial (domestic issues but also family, health or financial issues)
  - Medical illness/procedures/hospitalization
- Trauma (recent and past)
- Acute Stressors
  - Ex COVID,
- **RED FLAG Presentations- Sudden onset can be high risk**
  - **Always Check for Safety**
  - **Suicidal, self injury, psychosis, severe debilitation**
  - **Needs immediate response, something has happen NOW**

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Anxiety Disorders - DSM 5

Many Different Anxiety Disorders-
Determined by their primary presentation, often co-occur.

- Generalized Anxiety Disorder
- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder
- Panic Attack (Specified)
- Agoraphobia
- Substance/Medication-Induced Anxiety Disorder
- Anxiety Disorder Due to Another Medical Condition
- Other Specified Anxiety Disorder
- Unspecified Anxiety Disorder
- Adjustment Disorder

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Obsessive-Compulsive and Related Disorders DSM 5

- **NOT ADDRESSED IN THIS TALK**
- **DSM 5 Split off OCD and from Anxiety and placed in its own Section**
  - Obsessive-Compulsive Disorder
  - Body Dysmorphic Disorder
  - Hoarding Disorder
  - Trichotillomania (Hair-Pulling Disorder)
  - Excoriation (Skin-Picking) Disorder
  - Substance/Medication-Induced Obsessive-Compulsive and Related Disorder
  - Obsessive-Compulsive and Related Disorder Due to Another Medical Condition
  - Other Specified Obsessive-Compulsive and Related Disorder
  - Unspecified Obsessive-Compulsive and Related Disorder
  - **PANS/PANDAS (Autoimmune Neuropsychiatric Disord**ers)

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Post Infectious Autoimmune Encephalopathies- PANS/PANDAS

PANS (“**Pediatric Acute-onset Neuropsychiatric Syndrome**”)

is a clinically defined disorder characterized by the **sudden onset of obsessive-compulsive symptoms (OCD) or eating restrictions, concomitant with acute behavioral deterioration** in at least two of eight domains.

PANDAS

(“Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections”)

is a subset of PANS and was first reported by a team at the National Institute of Mental Health (part of NIH) in 1998. PANDAS has 5 distinct criteria for diagnosis, including abrupt “overnight” OCD or dramatic, disabling tics; a relapsing-remitting, episodic symptom course; young age at onset (average of 6–7 years); presence of neurologic abnormalities; and temporal association between symptom onset and Group A strep(GAS) infection. The 5 criteria usually are accompanied by similar comorbid symptoms as found in PANS.

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DSM 5
Trauma- and Stressor-Related Disorders

DSM 5 Split off PTSD from Anxiety and placed in its own Section

NOT ADDRESSED IN THIS TALK

- **Reactive Attachment Disorder-** limited emotional responsiveness, follows disruption of early childhood care
- **Disinhibited Social Engagement Disorder-** AD but with a pattern of behavior in which a child actively approaches and interacts with unfamiliar adults.
- **Posttraumatic Stress Disorder**
- **Acute Stress Disorder**
- **Adjustment Disorders**
- Other Specified Trauma- and Stressor-Related Disorder
- Unspecified Trauma- and Stressor-Related Disorder

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What Do You Do In Practice?

How do you currently handle these situations in your practice?

General Approach

1. Screen
2. If positive, Symptom Focused Assessment
3. Triage and Teach
4. Follow up

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Screening for Anxiety

- **When**
  - Routine Office Visits
  - When Other Behavioral Concerns Present
    - Example. Anxiety is about 2-3x more prevalent that ADHD
  - Recurrent, Indistinct or Unexplained Physical Complaints
- **How**
  - Ask about problems or worries that interfere with activities or relationships. Avoidance? Unexplained Physical Complaints?
  - Administer Broad Screening Tools
    - PSC 17 (Cut off 15 TOTAL, 5 INTERNALIZING)
    - Mini Scared (Cut off 3 anxiety, 6 PTSD)
    - Vanderbilt – check anxiety screening questions (whether or not the scale suggests ADHD)
- **Schedule Focused Assessment if Screen is**

  Positive or interview is otherwise concerning

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Schedule Targeted Assessment Visit

Dispense the following and have family fill out ahead of time

- **Parent Packet**
  - General Rating scales (PSC17, Vanderbilt) if not already obtained
  - History forms (if your practice uses any BH history forms)
- **Symptom Specific tools**
  - SCARED (Screen for Child & Adolescent Related Disorders) Parent and Child Versions
  - GAD 7 (General Anxiety Disorder Scale)
  - SCAS (Spence Children's Anxiety Scale) Free DSM Sx. checklist
  - Kutcher General Anxiety Screen
  - PHQ-9 or PHQ 9-A (checking for comorbid depression)
  - SBIRT/CRAFFT(Substance use is common in anxious
  - adolescents and adults)
- **School Packet**
  - Release of information, request any assessments
  - Vanderbilt (has anxiety depression & disruptive beh. screening questions)

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Next Step – Focused Assessment Visit

- **Review reports and rating scales**
  - **SCARED SCALES (General cut off point 25 and above)**
  - **GAD7 (10 moderate, 15 severe)**
- **General Medical Assessment**
  - R/O hyperthyroidism, arrythmias, caffeine and energy use, sleep issues
  - Medication side effects (stimulants, steroids, decongestants)
- **Further Interview of Caregivers and CHILD (**and school and other sources if available)
  - Problem focused history of how problem evolved over time, what was done to help and how it worked.
  - Obtain family history of anxiety, depression, substance abuse and stressful events
  - Assess substance abuse including vaping –SBIRT(Nicotine, cannabis, alcohol etc.)
  - Check for other triggers, trauma, co morbid conditions (OCD, depression, Etc.)
  - Social stressors (bullying, social media)
  - Consider Co-Morbid Conditions, especially depression, trauma
  - Dramatic, sudden, severe onset without trauma or other overt event (especially with OCD, eating issues or following acute illness) Consider possible PANS.
  - **Always assess for safety and self harm**. Anxiety is high risk for this

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Sample Questions & Topics for Interview.

- Most people have worries or fears that occur from time to time, What kinds of things do you worry about? How scared do you get? Does it stop you from doing things? Do others help you with it? What do they do? Does it work?
- Do you ever have scary feelings that come on all of a sudden, do they ever occur for no special reason?
- Use the answers on the screening tools to focus follow up questions

- *Has there ever been a time when really bad thing happened to you where you were afraid you or someone else would die or be badly hurt (like a fire, car accident, being hit, injured or touched in a private place? (Trauma?)*
- *Do you ever have to do things or repeat thing over and over again? washing checking touching etc. (OCD?)*

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Main Criteria of Different Anxiety Disorders

Generalized Anxiety Disorder

- Excessive frequent worry about numerous events or activities

Separation Anxiety Disorder

- Excessive fear of separation from major attachment figures without more generalized worries

Social Anxiety Disorder

- Excessive fear of social situations where they may be exposed to scrutiny of others

Panic Attacks

- Intense sudden onset of fear, palpitations, SOB physical distress need to leave situation. Can be associated with other anxiety disorders or predominant symptom

Adjustment Disorders

- Emotional or behavioral response related to specific stressors that is out of proportion to the severity of the stressor.

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Other Diagnoses to Consider

Substance Use Related Disorder
- Nicotine, Cannabis, Caffeine, Alcohol, Energy Drinks

Post Traumatic Stress Disorder
- Intrusive memories, dissociative reactions, Intense psychological or physical distress from cues related to traumatic event

Bipolar Disorder and other mood disorders
- People with Bipolar Disorder present with more intense moods and can first present with depression or anxiety disorders.

ASD
- High rick and incidence of co morbid anxiety of comorbid

PANS/PANDAS
- Consider if sudden onset and OCD

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Triage

Assess General Level of Impairment and Distress

- **Subclinical or Mild**- Causes discomfort but minimal impairment
  - Office based education, supportive therapy, guided self management, schedule F/U, if no progress, refer for therapy.
- **Moderate**- Some impairment in functioning, multiple stressors or self management unsuccessful
  - Above plus refer for outpatient therapy interventions (AMHCT), schedule F/U. Consider medication if therapy alone is unsuccessful
- **Severe-** Significant distress, unable to function in school, home or family
  - Rapid referral for therapy and consider medication interventions, consider higher level of care. Schedule Follow up
- **If Concerned for safety or danger to self or others**

211-1/911 or CONSULT WITH AMHCT AS NEEDED

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Office Based Counseling

Listen

- How does the family talk about fears?
- Does the family accommodate, organize or adjust to avoid the child being afraid?
- What are they asking for when they ask for a school note?

Encourage coping and overcoming the fears rather than avoiding.

- Help Parents move from protection to support
- Bravery = doing what you need to do even though you are afraid
- “Yes, it is scary, but you can do this”
- Encourage parents to **Model Calm Coping**
- Reward coping despite being afraid
- “Feeding vs Starving the Beast”

If parent has an anxiety disorder, encourage treatment.

- Anxious parents accommodate to avoid their anxieties.

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ADDRESS PARENTAL ACCOMODATION

- **Well intended accommodating of fears promotes progression of anxiety**
- **Teach Parents To Change from Protection to Support**
- **PROTECTION=** Decreasing anxiety by relieving distress or avoiding the stress
  - We are hard wired to do this
  - Leads to limiting child's adaptation, seeing the world as dangerous, family organizes around fears
  - Fosters progression of disorder
- **SUPPORT**= Helping to overcome fears
  - Acknowledging fears and feelings
  - Confidence in the child's ability to cope
  - Noticing and encouraging brave behaviors
  - ("Courage is the resistance to fear, mastery of fear not the absence of fear")- M. Twain)

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Reframing the Message

PROTECTION/ACCOMODATION	SUPPORTIVE
It’s too upsetting for them	It’s difficult but they can learn to handle these challenges.
“There is nothing to be afraid of”	“It’s scary but you will be okay.”
Its my job to protect my child	I will help my child learn to deal with challenges and confront fears

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Other Office Based Interventions

- **Education about anxiety disorders**
  - Handouts, library, web resources, CT Clearing house
  - Identify and address Accommodation.
- **Refer for Therapy as Indicated**
  - Accessing therapy - ACCESS Mental Health CT
- **Medication Management-** To be discussed in December Zoom
  - In the meantime call your ACCESS MH team and we will consult and assist.

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Treatment: Community-Based Interventions

- Psychotherapy, CBT most recommended but also others (Ex ERP)
  - Often includes relaxation and mindfulness training
- Where
  - Community based behavioral practitioners
  - Clinics, Mental Health Centers, may have higher levels of care
- Parent Support Groups
- Social Skills Groups (for social anxieties, may be at school)
- School-system
  - Establish COLLABORATION & COMMUNICATION
  - Consider School-based assessment
  - Accommodations and specialized services
  - School Based Counseling-individual & group

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Medical/Medication Treatment: Provider-Based

- **TO BE DISCUSSED IN DECEMBER AMHCT ZOOM (Dr Basu)**
- Primary Care Providers
  - Office Based individual and Family Reassurance & Counseling
  - Discuss findings, recommendations, expectations of treatment, Psychopharmacology (SSRIs are drug of choice, see chart)
  - Treatment monitoring, counseling, reassurance and case management (Medical Home)
  - Leave time for questions
- Referral Providers
  - Psychiatry
  - Psychiatric Nurse Practitioners
  - Developmental-Behavioral Pediatrics (if available)
- Referral services
  - Assessment with recommendations
  - Assessment and treatment

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Practice Change to consider

- “Practice Readiness” (AAP Mental Health Task Force)
  - Parent and School Packets
  - Behavioral Health Screening tools
- Identify resources in your community
  - Prepare handout packets ready to give out.
- **ACCESS Mental Health CT**
  - **Call us at any point in the process to help advise and consult as needed.**

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Summary: Don’t be scared of anxiety

- Anxiety wears many faces
- Be prepared to conduct initial assessment
- Provide guidance to caregiver and child through the assessment, treatment and ongoing monitoring of anxiety

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ANXIETY DURING COVID

- Validate their Feelings
  - Listen before you speak
  - Do not minimize concern
  - Correct misconceptions
- Set the Tone
  - “We can handle this”
- Think Positive
  - Focus on what you can do
  - How to address and mitigate risk
    - Safety measures. Education, Planning
- Establish as much routine and predictability as possible

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Resources:

- AACAP Facts for Family
- AACAP Anxiety Resource Center
- AAP Mental Health Toolkit
- www.healthychildren.org (AAP website for families)
- www.schoolpsychiatry.org
- www.medicalhomeinfo.org (AAP -National Center for Medical Home implementation)
- Child-Adolescent Multimodal Study(CAMS), Walkup et al, NEJM 2008
- CHDI(Child Health and Development Institute) Modules
- **ACCESS MENTAL HEALTH CT 866-631-9835**

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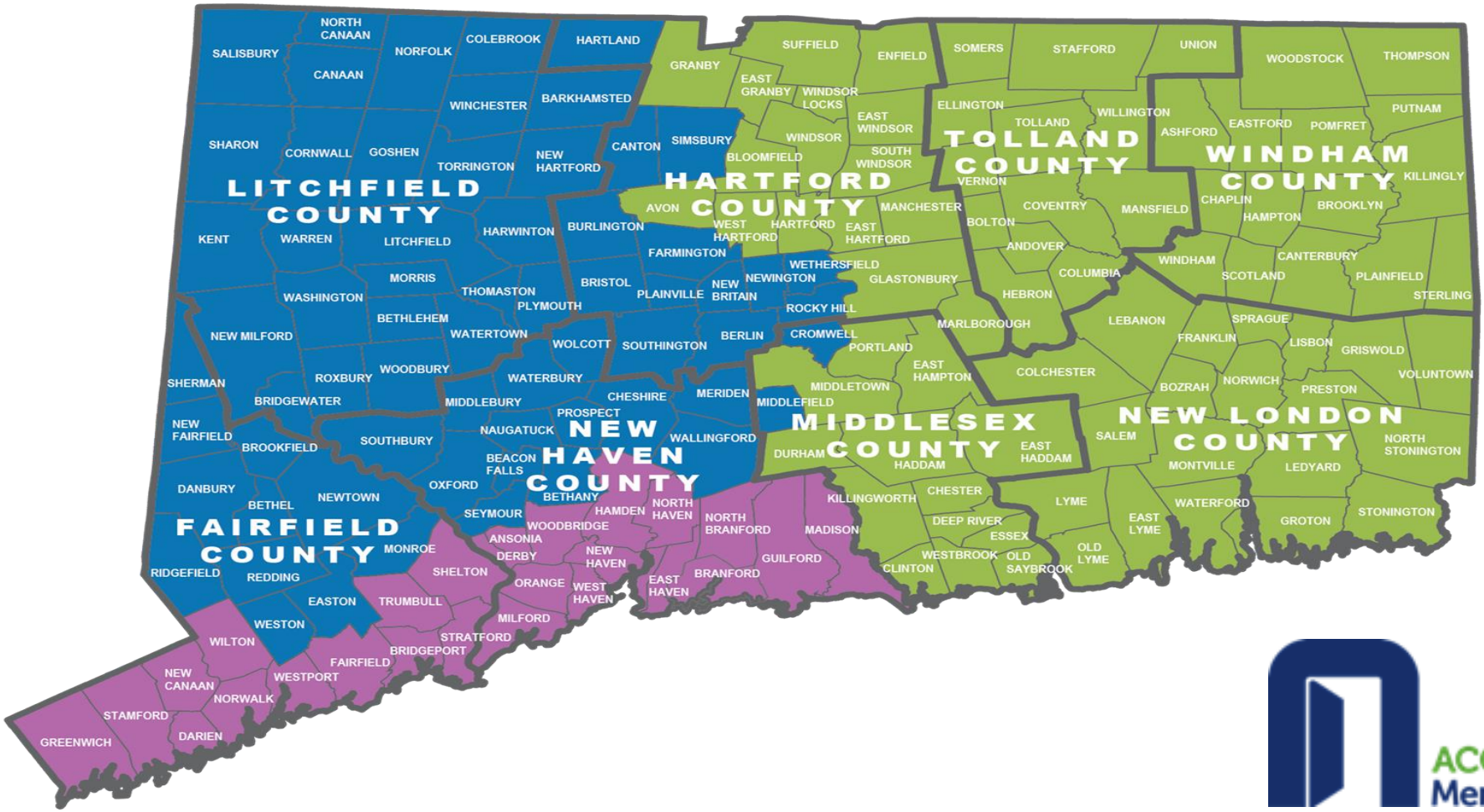

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