15 Anxiety Disorders: Generalized Anxiety, Phobias, and Obsessive-Compulsive Disorder

Essential Concepts
Screening Questions
- Are there things that you are afraid of?
- Do you often feel nervous? Are there particular things that bring this on?
- Do you have thoughts that you can't get out of your head, even though they really bother you? What are they?
- Are there things that you feel that you must do to help you feel less anxious—like washing your hands, checking on something, or counting things?
- Do others consider you a perfectionist?

Do not anticipate trouble, or worry about what may never happen. Keep in the sunlight.

—Benjamin Franklin

CLINICAL DESCRIPTION

Most children experience various fears throughout their childhood, and some of these fears are specific to developmental stage. In contrast to fear, anxiety is defined as an anticipatory response to perceived threat, either internal or external. Both fear and anxiety are characterized by distressing "fight or flight" reactions and a plethora of other physiological responses that may affect multiple systems, such as cardiac, pulmonary, gastrointestinal, and neurological. Anxiety is further characterized by cognitive symptoms, such as feelings of losing control or losing one's mind, unwelcome or intrusive thoughts, inattention, insomnia, and even perceptual disturbances, such as depersonalization or vague visual images. Children who are anxious tend to be frequent doctor

visitors, presenting with a variety of vague aches, pains, and physical symptoms that may frustrate health care providers. Separation anxiety disorder and selective mutism, two anxiety disorders that begin in childhood, have been discussed in Chapters 8 and 9. The present chapter will discuss the anxiety disorders of generalized anxiety, phobias, and obsessive-compulsive disorder.

Generalized Anxiety Disorder

Children with generalized anxiety disorder (GAD) worry excessively about upcoming events and occurrences. This worry has continued mostly unabated for at least 6 months. They worry unduly about their academic performance or sporting activities, about being on time, or even about natural disasters such as earthquakes. The worry persists even when the child is not being judged and has always performed well in the past. Because of their anxiety, children may be overly conforming, perfectionistic, and unsure of themselves. They tend to seek approval and need constant reassurance about their performance and social acceptability. The child may appear restless, tense, irritable, or fatigued. Somatic complaints are common.

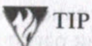
Phobic Disorders

Phobic disorders are heterogeneous, consisting of specific phobias, which involve a single feared object or situation, or social phobia, a more serious and impairing condition. Phobic disorders need to be differentiated from the normal episodes of fear often seen in childhood. The difference between having a phobic disorder or an age-appropriate episode of fearfulness is based on developmental considerations, the length and intensity of fearful affect, and the severity of accompanying impairment of everyday functioning.

Fear and avoidance occur in response to a specific object or situation in specific phobias. The anxiety is intense and immediate. Animals, natural disasters, blood or injury or enclosed places are common examples of fears that are common in specific phobias. However, when the feared object or situation is not present, the child functions normally.

Social phobia is more common in adults than in children, but it can be quite debilitating.

Children suffering from social phobia have a persistent fear of being embarrassed in social situations, during a performance, or if they have to speak in class or in public, get into a conversation with others, or eat, drink, or write in public. Feelings of anxiety in these situations produce physical reactions such as palpitations, tremors, sweating, diarrhea, blushing, and muscle tension. Social phobia can lead to school refusal with subsequent school failure and even truancy charges. Socially phobic youth frequently avoid all meaningful social relationships. These children do not have a primary social disability (as one might see with an autism spectrum disorder). However, severe avoidance of social situations may seriously impede normal social development.

 TIP

Consider the child's developmental stage prior to making a diagnosis of phobia. Developmentally normative fears include toddlers being terrified by being separated from their parents, and preschool and kindergarten children being frightened by the dark or "monsters" under the bed; fear of dogs and getting hurt is common. School-age children may be scared of using public bathrooms, and teenagers are often afraid of undressing for gym class or giving a speech in class. Age-appropriate fearfulness that does not derail development is not considered a disorder.

Obsessive-Compulsive Disorder

Obsessive-compulsive disorder (OCD) is characterized by recurrent, time-consuming obsessions or compulsive behaviors that cause distress and/or impairment. The obsessions may be repetitive intrusive images, thoughts, or impulses. Often the compulsive behaviors, such as hand-washing or cleaning rituals, are an attempt to displace the obsessive thoughts. There is a strong familial component to OCD, and there is evidence from twin studies of both genetic susceptibility and environmental influences. Tic disorders and OCD may have similar genetic origins, as they tend to co-occur in families. There is evidence that about 10% of the individuals with OCD may have the symptoms precipitated by pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS). Although evidence remains equivocal, antineuronal antibodies formed against the group A beta-hemolytic streptococcal cell wall antigens may cross-react with caudate neural tissue. This should be considered for children whose symptoms correlate with recurrent strep infections. About half of all adults seeking treatment for OCD report that it began in childhood or adolescence.

Epidemiology

As a group, anxiety disorders affect up to 20% of youth up to age 18 years. Clinically, anxiety disorders are diagnosed equally in men and women, but in epidemiologic samples they are more frequently found in women. Generalized anxiety disorder is thought to affect 3 to 6% of youth. Specific phobias affect about 3% of children. Girls tend to suffer from phobias more commonly than boys, but for both genders the disorder wanes with age. Social phobia has been estimated to affect 1% of children and adolescents at any point in time. Lifetime prevalence may be as high as 13%.

Etiology and Risk Factors

Many investigators postulate that children are born with biologically or constitutionally predetermined temperaments, some of which are a liability for the development of anxiety disorders. Familial factors, both genetic and environmental, contribute to anxiety disorders. General anxiety disorder and major depression seem to have the same genetic risk factors. On the basis of new neuroimaging studies, it is hypothesized than anticipatory anxiety is associated with the cingulated portion of the limbic system, phobic avoidance is associated with the prefrontal cortex, and panic is associated with the brainstem. Serotonin receptor site dysregulation is also posited. The biological vulnerabilities are then variably affected by environmental factors to form clinically significant anxiety symptoms. The environmental factors may be diverse, including neurobiological insults, exposure to trauma, emotionally unavailable parents who are not attuned to the child's needs, or, for the most vulnerable youth, simple uncertainties such as peer teasing or parental discord. Infants who are temperamentally inhibited have higher rates of anxiety disorders in later life. Prospective studies have shown an increased risk of multiple anxiety disorders in middle childhood for children who were classified as behaviorally inhibited as preschoolers.

CLINICAL VIGNETTE

You are called as a consultant to a school to assess Jenn, a 13-year-old eighth-grade girl who has refused to come to school. You find out that Jenn has a long history of multiple absences in school, but this year she came only a few days at the beginning and now is not coming at all. Her mother reports that she has attempted to "drag" her daughter to the car, but Jenn screams and scratches. When she has managed to drive her to school, Jenn will not get out of the car, and even the school social worker and principal cannot persuade her. When you get more history you find that Jenn suffered from separation issues in preschool and kindergarten. The school nurse knows her well, as she visits frequently with complaints of stomachaches and headaches. She refuses to speak in class. She avoids the lunch room and is quiet and nonparticipative in class. Despite this, she had been getting straight As in school until recently, as not coming to school has negatively impacted her grades. Homework sent to her home is done completely and neatly. Jenn has one friend with whom she spends time. You suspect social anxiety with school phobia. What else should you do? First, talk with the primary care doctor. Chances are the girl has been a frequent visitor there with a variety of somatic complaints. Does she have any medical problems? Try to ascertain if she has been traumatized (bullied, etc.) in school as a reason for her refusal. Get a family history and developmental history from the parents. Discuss the course of the difficulties with the school. Interview Jenn and ask about depressive, anxiety, and psychotic symptoms. If she is suffering from school phobia or social anxiety, consider medication (SSRI), psychotherapy, and an intensive, slow but progressive reintegration into school (often starting with tutoring after school). This is one of the few times that benzodiazepines are indicated in child and adolescent psychiatry. Rapid and effective treatment of the anxiety to help the child be able to get back to school will substantially improve prognosis.

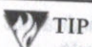
Assessment

When assessing the child or adolescent for whom you suspect an anxiety disorder, it is important to consider other psychiatric disorders, as well as potential for comorbidities (Table 15.1).

TABLE 15.1. Assessment Essentials for Anxiety Disorders

1. Rule out physical causes such as hyperthyroidism, side effects to medications (allergy/asthma medications, etc.), substance abuse, or other medical conditions.
2. Get data from multiple sources. Children are often reluctant to talk about their worries. Be sure to get a family genetic history of anxiety disorders, as well as depression and other mood disorders and tics.
3. Younger children may better communicate their anxieties through drawings or play techniques.
4. Determine the trigger(s) for the anxiety. Does the anxiety only occur in a specific situation? Does it occur "out of the blue"? Does it occur in anticipation of something? Is it pervasive?
5. Understand the environmental and family factors that may affect the youth's anxiety. How do the parents react? Are there family conflicts or other stresses contributing to the anxiety?
6. Screen for comorbid psychiatric disorders: mood disorders, psychosis, eating disorders, tic disorders, and disruptive behavior disorders.
7. Consider the use of symptom rating scales to better categorize, understand, and monitor the child's anxieties. Yale-Brown Obsessive Compulsive Scale (Y-BOCS), the Screen for Child Anxiety Related Emotional Disorders (SCARED), the Social Phobia and Anxiety Inventory for Children (SPAI-C), and the Revised Children's Manifest Anxiety Scale (RCMAS) are suggestions.

Children may suffer from both internalizing and externalizing disorders. Co-occurrence of the inattentive type of ADHD and anxiety disorder is not infrequent. If using a stimulant, "start low and go slow" to minimize the risk of increasing anxiety.



TIP

Inquire about caffeine intake and counsel to minimize it. Caffeine is a known cause of anxiety.

Treatment

Treatment is multimodal and requires a thoughtful, stepwise intensive treatment of the child and adolescent. Table 15.2 gives the essentials of treatment, elaborating on the types of

TABLE 15.2. Essentials of Multimodal Treatment of Anxiety

1. Psychoeducation of parent and child about the nature of anxiety, how it can affect family relationships, how family members can inadvertently perpetuate the symptoms through their own anxiety, and how the family can support the child in overcoming his or her anxiety.
2. Cognitive-behavioral therapy should comprise first-line treatment. There are evidence-based treatments for OCD (exposure and response prevention), phobias, and other anxiety disorders.
3. School intervention when the anxiety is seriously impairing school functioning.
4. Medications

   1st line: SSRIs—remember that SSRIs can induce anxiety or even panic symptoms in vulnerable individuals so "start low and go slow." Sometimes, benzodiazepines are started concurrently with an SSRI and later tapered once the SSRI confers therapeutic benefits. The SSRIs that are FDA approved for OCD in children include fluoxetine, sertraline, and fluvoxamine (chlomipramine, a TCA, is also approved).

   2nd line: benzodiazepines such as alprazolam, lorazepam, and clonazepam can be useful in the short-term treatment of anxiety, e.g., to reintegrate the child into school. Remember to taper slowly to avoid rebound anxiety.

   3rd line: alpha-2a-agonists—guanfacine and clonidine may be useful for symptoms of hyperautonomic arousal such as palpitations and tachypnea.

   Others: tricyclic antidepressants (TCAs)—requires EKG and blood level monitoring, but may be effective.

   Buspirone—a few case reports of effectiveness in mild anxiety.

   Anticonvulsant agents—case reports for the use of gabapentin, topiramate, and oxcarbazepine. Consider using when other agents have been ineffective.

   Antipsychotic agents—may be useful when all other medications have not been successful or in children with borderline reality testing and high levels of agitation.

psychosocial and medication treatment options available. For mild to moderate anxiety, evidence-based psychotherapies and psychoeducation should be used first, with adjunctive medication if necessary. There is evidence that some milder forms of anxiety may have a more prolonged course if medications are started initially. However, for disabling anxiety, consider concomitant psychotherapy and medication.

Anxiety disorders affect a large portion of children and adolescents, causing them tremendous suffering and interfering with optimal development in many domains (social, academic, and life skills). Currently, cognitive behavioral treatments are the best supported interventions and should comprise the first line of treatment. Pharmacotherapy can augment psychosocial treatments individualized to each youth's circumstances and response to psychotherapeutic interventions. Early and effective treatments may improve long-term prognosis.