Werry Workforce WHĀRAURAU

Anxiety Disorders

Evidence Based Intervention

Practitioner Expertise | Best Available Evidence | Lived Experience Expertise

Fast facts

- Anxiety disorders are one of the most common mental health concerns of childhood and adolescence, and include a wide range of presentations.
- In DSM-5, new criteria were introduced describing the symptoms of PTSD in children aged 6 and under.
- Both CBT and medication (SSRIs) are effective interventions when used alone, and become more effective when used in combination.
- For PTSD, Trauma-focussed CBT is the most effective intervention.

Interventions that work – at a glance

This table represents a compilation of information from several different sources (including Fonagy et al. (2015), Kendall et al. (2015), The Matrix (2015), and Dunnachie (2007) and is designed to provide an overview only. Directly consulting these sources will provide considerable additional information.

		Gold	**Silver**	**Bronze**	**Not recommended**
Specific Phobia		Exposure-based therapy, including systematic desensitisation			
Generalised Anxiety Disorder (GAD), Separation Anxiety Disorder (SAD), and Social Phobia (SP)	*Mild to moderate*	Bibliotherapy / self-help Computerised CBT Brief CBT School-based prevention and intervention programmes	General parent training approaches		Benzodiazepines or antipsychotic medication
	Moderate to severe	Specific CBT programmes – individual or group **And** SSRI medication			

Obsessive-Compulsive Disorder (OCD)		SSRI medication **And** CBT – exposure and response prevention			
Posttraumatic Stress Disorder (PTSD)		Trauma-focussed CBT (TF-CBT)	EMDR		Medication for PTSD.

The fine print

1. Selective Serotonin Reuptake Inhibitors (SSRIs) have produced improvements in children and adolescents with GAD, SAD, and SP that are substantially better than a placebo medication (Kendall et al., 2016; Fonagy et al., 2015). Psychological interventions and SSRIs are roughly equivalent in effectiveness when used alone, but are even more effective for GAD, SAD and SP when used together (Fonagy et al., 2015).
2. Specific Cognitive Behavioural Therapy programmes that are supported by research evidence for children and adolescents with GAD, SAD and SP include Coping Cat, Coping Koala, and FRIENDS (Fonagy et al., 2015; Kendall et al., 2016). Group CBT appears to be as effective as individual CBT, and involving parents is important - particularly for younger children, or where parents themselves are anxious (Fonagy et al., 2015).
3. Benzodiazepines are associated with dependence issues, and antipsychotic medications with several adverse side effects. Neither should be used routinely to treat anxiety disorders (NICE, 2014) however may be considered for short-term care or crisis support.
4. Relapse rates are high when children and young people stop taking the SSRI medication (Fonagy et al., 2015).
5. As with other anxiety disorders, while CBT and SSRI medication are equally effective when given alone, they are more effective when combined in the treatment of OCD (Fonagy et al., 2015; The Matrix, 2015).
6. Trauma-focussed CBT has repeatedly been shown to be an effective treatment for PTSD, particularly in treating children and adolescents who have been sexually abused (Fonagy et al., 2015).
7. Research is not clear on whether Eye Movement Desensitisation and Reprocessing (EMDR) is an effective intervention for children and adolescents with trauma symptoms (Fonagy et al., 2015). It is recommended in treatment of adults with PTSD (Forbes at al., 2007).
8. There is evidence that self-guided bibliotherapy may be helpful, and it is certainly not harmful (Kendall et al., 2016). Kendall and his colleagues (2016; refer to this paper for more information) have recommended several books for parents and families including “Freeing Your Child From Anxiety: Powerful, Practical Solutions to Overcome Your Child’s Fears, Worries, and Phobias” (Chansky, 2004), “Helping Your Anxious Child: A Step-by-Step Guide for Parents” (Rapee, Wignall, Spence, Cobham, & Lyneham, 2008); “Keys to Parenting Your Anxious Child” (Manassis, 2008) and “You and Your Anxious Child: Free Your Child From Fears and Worries and Create a Joyful Family Life” (Albano & Pepper, 2013).
9. Effective computerised CBT programmes include BRAVE-ONLINE, Cool Teens, Think Feel Do (see Kendall et al., 2016 for more information) and New Zealand’s SPARX (Merry et al., 2012).
10. Effective school based programmes include FRIENDS for Life (The Matrix, 2015).

Description and demographics

Worries and fears are very common in children and adolescents, and only become a ‘disorder’ when they are chronic and impacting detrimentally on daily life. In fact, up to 40% of adolescents will experience a panic attack, without necessarily meeting criteria for panic disorder (Norton et al., 1988; cited in RANZCP, 2003). In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), there are a number of different anxiety disorders which are applicable to children and adolescents, and to adults. These include Generalised Anxiety Disorder (excessive apprehensive expectation related to a number of events or activities), Separation Anxiety Disorder (excessive anxiety or fear related to separation from attachment figures or the home environment), Agoraphobia (intense anxiety or fear brought on by the real or anticipated exposure to several different situations, such as public places or being outside of home), Panic Disorder (unexpected and recurring panic attacks), Specific Phobia (the anxiety or fear is related specifically to the presence of a particular object or situation), Social Anxiety Disorder (formerly Social Phobia in DSM-IV; intense anxiety or fear of social situations where the child or young person might be scrutinised by other people), and Selective Mutism (not reciprocally responding or initiating speech when interacting with others). Obsessive-Compulsive Disorder (OCD; where obsessive thoughts are present and compulsive behaviour is performed in response) and Post Traumatic Stress Disorder (PTSD; the development of a cluster of symptoms after exposure to a traumatic event) are included elsewhere in DSM-5. In DSM-5, the PTSD description now includes specific diagnostic criteria for children 6 years of age and under. A few conditions, such as Over-anxious Disorder and Avoidant Disorder are not retained in DSM-5. There are other small changes to diagnostic criteria for the anxiety disorders, but most of these do not relate to children and adolescents.

Anxiety disorders are among the most commonly diagnosed difficulties in childhood and adolescence, and prevalence rates increase as children mature. For example, the Christchurch and Dunedin longitudinal studies identified that around 7% of New Zealand children met criteria for an anxiety disorder at eleven years of age, with this rising to around 11% at age fifteen, and around 20% at age eighteen (Fergusson et al., 1997). However discrepancies in reports of prevalence rates are characteristic of anxiety disorders (Fonagy et al., 2015). A reasonably representative estimate of the overall prevalence of anxiety disorders in childhood and adolescence is 5-10% (Pine & Klein, 2008; cited in Fonagy et al., 2015).

No interventions for anxiety which were developed by Māori, or in partnership with Māori were able to be identified. Neither were there interventions targeted specifically at Pacific children and young people with anxiety.

References

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