AACAP OFFICIAL ACTION

Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders

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Anxiety disorders are among the most common psychiatric disorders in children and adolescents. As reviewed in this guideline, both cognitive-behavioral therapy (CBT) and selective serotonin reuptake inhibitor (SSRI) medication have considerable empirical support as safe and effective short-term treatments for anxiety in children and adolescents. Serotonin norepinephrine reuptake inhibitor (SNRI) medication has some empirical support as an additional treatment option. In the context of a protracted severe shortage of child and adolescent–trained behavioral health specialists, research demonstrating convenient, efficient, cost-effective, and user-friendly delivery mechanisms for safe and effective treatments for child and adolescent anxiety disorders is an urgent priority. The comparative effectiveness of anxiety treatments, delineation of mediators and moderators of effective anxiety treatments, long-term effects of SSRI and SNRI use in children and adolescents, and additional evaluation of the degree of suicide risk associated with SSRIs and SNRIs remain other key research needs.

Key Words: clinical practice guideline, anxiety, child psychiatry, assessment, treatment

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The objective of this Clinical Practice Guideline is to enhance the quality of care and clinical outcomes for children and adolescents with anxiety disorders as defined by the *Diagnostic and Statistical Manual of Mental Disorders*.[1] The primary aim of the guideline is to summarize empirically based guidance about the psychosocial and psychopharmacologic treatment of anxiety. A secondary aim is to summarize expert-based guidance about the assessment of anxiety as an integral part of treatment and the implementation of empirically based treatments in clinical practice.

Anxiety disorders are among the most common psychiatric disorders in children and adolescents. At any given time, nearly 7% of youths worldwide have an anxiety disorder[2]; estimated lifetime prevalence in the United States approximates 20% to 30%.[3,4] For specific anxiety disorders among youths 13 to 18 years old, lifetime prevalence rates approximate 20% for specific phobia, 9% for social anxiety, 8% for separation anxiety, and 2% each for agoraphobia, panic, and generalized anxiety.[3]

The median age of onset of anxiety disorders approximates 11 years[5]; however, each anxiety disorder often (but not always) onsets during a specific developmental phase: separation anxiety during the preschool/early school-age years; specific phobias in the school-age years; social anxiety in the later school-age and early adolescent years; and generalized anxiety, panic, and agoraphobia in the later adolescent/young adult years.[6] The development of an anxiety disorder may be foreshadowed by behavioral inhibition,[7] autonomic hyperreactivity,[8] or negative affectivity.[9] Parent/parenting factors,[10] stressful/traumatic exposures,[11] and insecure attachment[12] also may play important etiologic roles. Anxiety disorders (especially generalized anxiety) are highly comorbid with each other and with other psychiatric disorders,[13,14] particularly depression[15] but also bipolar, attention-deficit/hyperactivity disorder (ADHD), learning/language, behavior, obsessive-compulsive, eating, and substance-related disorders. For comorbid occurrences, multifaceted treatment plans likely are necessary.[16]

Although onset can be acute, the course of anxiety tends to be chronic,[17] often with waxing and waning, and exhibits both homotypic (prediction of a disorder by the same disorder) and heterotypic (prediction of a disorder by a different disorder) continuity.[18] Likely reflecting a common underlying vulnerability (eg, "negative valence systems"),[19] examples of heterotypic continuity are the prediction of