medications. The recommendations for an adequate SNRI trial are the same as those delineated above for SSRIs. For all SNRIs, medical monitoring should include height, weight, pulse, and blood pressure; no specific laboratory tests are recommended.

As with SSRIs, a discontinuation syndrome has been reported[103] following missed doses or acute discontinuation of SNRIs. Accordingly, SNRIs also warrant a slow discontinuation taper.

Areas for Additional Treatment Research

For many important domains of treatment for anxiety (listed below), the AHRQ/Mayo review yielded insufficient information to draw conclusions about the benefits or harms of the treatment. As such, treatment statements for these domains are not offered. Research is urgently needed to support additional treatment statements in these domains for future guidelines.

- Circumstances suggesting preferential use of SSRIs or CBT[d]
- Preferential sequencing of SSRIs and CBT[e]
- Treatment effect modifiers (eg, child/family characteristics, treatment setting, disorder severity, comorbidities)[f]
- Use of non-CBT psychotherapies[g]
- Use of benzodiazepines[h]
- Long-term safety risks of pharmacologic treatment[i]
- Effectiveness of psychosocial and pharmacologic treatments in underserved populations and minorities[j]

LIMITATIONS

The limitations of the Treatment section of this guideline reflect the derivation of the treatment statements from the findings of a single, time-limited, critical systematic review of the literature by the AHRQ-contracted Mayo Clinic Evidence-based Practice Center in which reviewers' judgment played a role in rating the strength of the empirical evidence. Despite the rigor and transparency of the systematic review process as delineated in the AHRQ/Mayo review,[36] differences in professional judgment are possible. However, any differences are deemed unlikely to affect the overall conclusions of the guideline. Other limitations of the AHRQ/Mayo review are as follows:

- Relatively small body of evidence, especially for medication studies
- Brief follow-up of most studies
- Use of different symptom rating scales across studies to assess improvement
- Lacking, sparse, or unstratified descriptions of potentially mediating and moderating variables (eg, intervention components, participant demographics, comorbidities, symptom severity)
- Poor representation across studies of both very young children and young adults
- Poor representation across studies of multiracial youths
- Paucity or lack of medication studies addressing selective mutism, specific phobias, panic, or agoraphobia as the primary disorder
- Variable methods for reporting treatment-emergent adverse events and serious adverse events
- Insufficient data to assess risk of suicidal behavior

The limitations of the Assessment and Implementation sections of this guideline reflect the derivation of the narrative from a single time-limited review by the CQI Guideline Writing Group of published expert opinion and consensus. When expert opinions differed, judgment was exercised by the CQI Guideline Writing Group to select among equally supported opinions. Although differences in professional judgment are possible, any differences are deemed unlikely to affect the overall conclusions of the guideline.

CONCLUSIONS

Congruent with previous national and international guidelines,[62-65] 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. CBT may be considered to be the first-line treatment for anxiety in children and adolescents, particularly for mild to moderate presentations, with SSRI (and possibly SNRI) medication an alternative treatment consideration, particularly for more severe presentations or when quality CBT is unavailable. Combination treatment (CBT and SSRI) may be a more effective short-term treatment for anxiety in children and adolescents than either treatment alone. Because effective treatment outcomes are predicated in part upon accuracy of the diagnosis, depth of the clinical formulation, and breadth of the treatment plan, comprehensive, evidence-based assessment may enhance evidence-based treatment.

[d]AHRQ/Mayo review: equivocal head-to-head comparisons of SSRI vs CBT
[e]AHRQ/Mayo review: no data
[f]AHRQ/Mayo review: equivocal subgroup analyses
[g]AHRQ/Mayo review: excluded from analyses due to heterogeneity of therapies
[h]AHRQ/Mayo review: one poor quality trial of BZP versus placebo
[i]AHRQ/Mayo review: no data
[j]AHRQ/Mayo review: no data