# *Treat Pediatric Anxiety Disorders Aggressively*

BY DAN HURLEY

NEW YORK — Aggressive treatment of child and adolescent anxiety disorders is the key to clinical success, according to Dr. John T. Walkup.

"The biggest mistake you can make is to half treat," Dr. Walkup, vice chair of psychiatry and director of the division of child and adolescent psychiatry at Cornell University, New York, said at a pharmacology update sponsored by the American Association of Child and Adolescent Psychiatry.

The biggest issue in consultation is underdosing. "As long as they're safe, I'm monitoring carefully, and they haven't had full recovery, I increase [the] dose," he said.

Cognitive-behavioral therapy (CBT) for obsessive-compulsive disorder (OCD) also must be done energetically, Dr. Walkup said.

He cited the proactive approach taken largely by investigators at the University of Pennsylvania, Philadelphia, in the Pediatric OCD Treatment Study (POTS). That multisite, placebo-controlled, double-blind trial compared sertraline alone, CBT alone, and combination therapy for the treatment of OCD. The investigators found that CBT alone and sertraline alone did not bring results that were significantly different (JAMA 2004;292:1969-76).

The University of Pennsylvania providers "are not quiet, easygoing therapists. These are tough, fast, energizing, engaging," he said. "But if you're going to be an effective OCD therapist, you have to be."

Whatever the treatment modality, the first step is proper diagnosis. Mistaking the disorder for variants of attention-deficit/hyperactivity disorder (ADHD) or bipolar disorder can lead to lost months and poor outcomes, Dr. Walkup said.

"Both ADHD and anxiety tend to develop around the same age, ages 6-10. But the anxious kids tend to be inattentive because they're worried about their mom; they're worried about the nurse; their mind is just cluttered with worry; and the last thing they can do is pay attention," he said.

A similar case of mistaken diagnosis is sometimes made with bipolar disorder. Dr. Walkup drew applause from the audience when he said: "If you see something affective in a kid before 12, think anxiety, don't think bipolar. The rate of anxiety to bipolar is 20 or 40 to 1."

The stakes are high, he emphasized, when it comes to making an accurate diagnosis and offering adequate treatment for anxiety disorders. "The morbidity is high: suicide, depression, performance," Dr. Walkup said.

Asked by an audience member how quickly he raises an initial dose of sertraline, he said: "When you start a drug trial, get going. You offer hope and encouragement, and a brisk response that make kids and families responsive to treatment. I start at 25 mg the first week, 50 the second week, and hold at 50.

"If the symptoms are nonresponsive, at week 4, I go to 100. If still nonresponsive, after another 2 weeks, I go to 150, and up to 200 if necessary by week 8."

When the highest safe dose is ineffective, he considers switching to a second selective serotonin reuptake inhibitor or lithium, Dr. Walkup said. His protocol is a slow cross-taper, gradually adding the second drug and seeing a benefit before even considering a reduction of the first.

"You're usually recommended to discontinue the first medication before you start the new," he said. "The problem is that even the nonresponders probably had some benefit on that first drug. When you begin to discontinue, those symptoms that got better begin to creep back."

Instead, he prefers what he calls "getting stuck in the middle."

"You've got them on one drug; you add another," Dr. Walkup said. "You want an enhancement on the second medication before you begin to discontinue the first. Within a brief period, you see what seems to be a lithium augmentation.... I stop, I hold, and I do not discontinue. I get stuck in the middle of a cross-taper.

"The process is not 2 or 3 weeks. It's much longer. How long? Families are impatient. Insurers are impatient. You've got to educate, educate, educate."

Once significant relief of anxiety is achieved, he prefers to wait a year before attempting to reduce or eliminate medication. " Those who deteriorate during discontinuation usually do so within 6 weeks. If I can get them through that 6-week period, I know I have a pretty good chance of taking them down another notch," he said. ■

***Disclosures:*** *Dr. Walkup has served on the advisory board of the Tourette Syndrome Association (TSA); received grant support from the TSA; and received honorarium and travel support from AACAP, and additional support from Abbott Laboratories, the Centers for Disease Control and Prevention, Eli Lilly & Co., and Pfizer Inc.*

## CLINICAL GUIDELINES FOR FAMILY PHYSICIANS

# Depression Screening in an Adult Population

BY NEIL S. SKOLNIK, M.D., AND SONA M. GARG, D.O.

Depression affects more than 13% of U.S. adults during their lifetime. The prevalence of major depressive disorder ranges from 5% to 13% in primary care settings. One-third to two-thirds of adult patients with depression have their depression managed by their primary care physicians. When primary care physicians see patients with depression, the patients usually have the same severity of depression as those seen by psychiatrists.

Depression is the leading cause of disability in patients older than age 15 years. Given that depression is common and causes serious morbidity, it qualifies as a disease for which screening may be considered.

Evidence suggests that treating depression in adults identified through screening in a primary care setting improves patient outcomes and decreases morbidity. The caveat here is that depression care must be available within the primary care setting or screening becomes of questionable value. Here is a look at guidelines issued last year by the U.S. Preventive Services Task Force (Ann. Intern. Med. 2009;151:784-92), as well as the findings of a systematic evidence review (Ann. Intern. Med. 2009;151:793-803).

### Screening

Many screening tools for depression exist, but studies show that about the same degree of case finding and accuracy can be achieved with the use of two simple questions: "Over the past 2 weeks, have you felt down, depressed, or hopeless?" and "Over the past 2 weeks, have you felt little interest or pleasure in doing things?"

If the patient's answer to either of these two questions indicates the possibility of depression, a more comprehensive evaluation should be undertaken.

It is essential to have the resources in place to support the diagnosis, treatment, and follow-up of patients with depression. Trained support staff includes office staff members who are able to ask initial questions and make appointments, a case manager who follows the patient and recommends appropriate interventions, and a mental health provider who counsels patients and performs cognitive-behavioral therapy. A well-organized system of care would also have ready educational materials written for patients and providers. Regular follow-up visits with the primary care physician are essential.

For screening to be worthwhile, treatment and follow-up must be available or coordinated by the primary care physician's office.

### Treatment

Evidence supports the nearly equal efficacy of antidepressants or psychotherapy, and both approaches are readily available within the primary care setting or by referral.

Pharmacologic approaches to depression most commonly utilize selective serotonin reuptake inhibitors (SSRIs) or other second-generation antidepressants. SSRIs function by blocking the reuptake of serotonin at the presynaptic receptor, increasing the level of serotonin in the synapse. Typical side effects include nausea, headache, dry mouth, sexual dysfunction, and rash.

Discontinuation rates on antidepressants are estimated to be 20%-23% in primary care practices over the first few months of treatment. Therefore, an important component of competent depression care involves scheduling regular and frequent follow-up visits to encourage adherence to medications, as well as to titrate treatment doses. It is important to remind patients that it may take up to 6 weeks to begin feeling an effect.

### Adverse Effects

Young adults aged 18-29 years were found to have an increased risk of suicidal behavior on SSRIs. Patients younger than age 25 years in particular had double the risk of suicidal behavior on SSRIs compared with those not on antidepressants. These risks were associated with patients diagnosed with major depressive disorder, those on the SSRI paroxetine, and those within the first month of treatment. Thus, frequent follow-up visits and monitoring are crucial in young patients early in their treatment course.

The risk of suicidal behavior in adult populations younger than 45 years of age is low and no significant change was noted with the use of SSRIs. Adults older than 65 years of age had a decreased risk of suicidal behavior but were at an increased risk for upper gastrointestinal bleeding on SSRIs. This risk is significantly increased in patients on both SSRIs and nonsteroidal anti-inflammatory drugs.

### The Bottom Line

In offices that are structured to provide diagnosis, treatment, coordination, and follow-up for patients with depression, screening is valuable and appears to improve outcomes compared with populations that do not receive screening. There are no adverse effects of screening. A simple, two-question approach to screening is recommended and is nearly as effective as more complicated screening tools.

DR. SKOLNIK *is an associate director of the family medicine residency program at Abington (Pa.) Memorial Hospital.* DR. GARG *is a second-year resident in the program. A handheld computer version of this guideline is available at www.redi-reference.com.*