Screening for Pediatric Anxiety Disorders

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In this issue of JAMA, the US Preventive Services Task Force (USPSTF) presents a Recommendation Statement on screening for anxiety in children and adolescents, based on an Evidence Report and Systematic Review by Viswanathan et al that summarized the evidence for screening and treatment. The USPSTF recommends screening for anxiety in children and adolescents aged 8 to 18 years (B recommendation) and concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for anxiety among children 7 years or younger ([I statement]).

The success of a screening initiative depends on the availability of a sensitive and specific screening process for detecting a disorder and safe and effective treatments for persons identified. On both counts, the Evidence Report supports both screening for anxiety disorders in children and adolescents 8 years or older and, importantly, the efficacy and the safety of cognitive behavioral therapy (CBT) and antidepressant medications (eg, selective serotonin reuptake inhibitors). As a high-quality, up-to-date review, it is encouraging that the available evidence supports identifying and treating children with anxiety disorders.

The Evidence Report by Viswanathan et al focused on the benefit of screening and the evidence base for treatment but did not provide specific, actionable guidance for how anxiety screening should occur in primary care. There are also several outstanding questions, such as what measure is best for screening and whether screening has benefits. While future research efforts are needed to address the gaps in the evidence base, the available evidence appears to support moving forward with implementing screening and treatment for anxiety disorders in pediatric primary care settings.

This is very good news because the majority of psychiatric disorders, including the anxiety disorders, first present in childhood and adolescence. Psychiatric disorders are high-prevalence conditions, with up to 1 in 5 youth aged 18 years or younger experiencing a mental health condition at some point in their lives. Despite high prevalence, increasing awareness, and reduced stigma related to mental health conditions, many children with psychiatric disorders still remain unidentified and untreated, resulting in symptomatic distress, accumulated functional impairment, and other sequelae (eg, suicidal behavior and substance misuse). Thus, screening in the pediatric primary care setting is important for early identification and offers the potential for earlier and more effective treatment to reduce distress, impairment, and morbidity associated with delayed recognition and treatment.

Regardless of the specific approach used to screen for pediatric anxiety disorders, identifying a family history of an anxiety disorder early in a child’s life (eg, first “well-child check”) may enhance screening efficacy. Early discussion of family history establishes the child’s and family’s mental health as central to routine pediatric care and sets the stage for a review of the strong genetic and environmental factors associated with risk of childhood anxiety disorders. Parents with anxiety disorders confer genetic risk to their children but also may have parenting beliefs and approaches that inadvertently support the development or maintenance of anxiety disorder symptoms in children.

Matching family history risk with the age of onset for most psychiatric disorders can inform a screening and monitoring strategy specific to the child and family. For example, even before the child enters the age of onset risk for an anxiety disorder, the pediatric clinician could provide guidance to parents on getting treatment for their own anxiety; share
positive parenting practices to mitigate anxiety disorder symptoms and impairment; and engage parents in ongoing monitoring to facilitate the earliest identification of an anxiety disorder in their child. Such early engagement may help prevent the development of an anxiety disorder and could empower the family to intervene promptly should their child develop an anxiety disorder.

The USPSTF B recommendation for screening for anxiety in children and adolescents aged 8 to 18 years is a positive step, yet it reflects the piecemeal approach with which pediatric mental health screening has been developed. While medical screening can focus on the appropriateness and benefit of a screening approach for a specific disease, approaches to screening for individual psychiatric disorders may cause harm. For example, even though anxiety disorders have a prepubertal onset and are the highest-prevalence psychiatric disorder, screening guidance for pediatric anxiety disorders has only recently been proposed, years after pediatric screening recommendations for lower-prevalence conditions including autism spectrum disorders, depression, and postpartum depression.

The sequential implementation of disorder-specific mental health screening means that a large number of children with anxiety disorders either have not been identified or could have been mischaracterized as having a medical condition or another mental health condition that may symptomatically overlap with anxiety disorders (eg, anxiety-related social inhibition leading to an autism spectrum disorder diagnosis, anxiety-related inattention misdiagnosed as ADHD or anxiety-related demoralization misdiagnosed as depression). A comprehensive pediatric mental health screening strategy, focusing on the identification of family history and family risk factors, in anticipation of the age of onset risk could represent a more holistic approach across childhood and adolescence for identifying the common psychiatric disorders that are amenable to prevention, preemption, or early intervention (ie, autism, ADHD, anxiety disorders, and depression).

Screening strategies align with the goal of improving disease recognition and measurement-based care, but some caution is warranted. A focus on screening instruments as stand-alone methods for assessment neglects the importance of the clinical history, the longitudinal course of symptoms, and the integration of such objective measures with a clinician’s knowledge of disease processes. Rating scales, at their best, reflect the pattern of symptoms but lose their relevance if the clinician does not integrate the rating scale data with the child’s clinical history. Pediatric clinicians are ideally positioned to address this challenge. Their early and longitudinal patient and family engagement, combined with their knowledge of the risk factors, characteristic ages of onset, symptom patterns, course, and known patterns of comorbidity, will help ensure that rating scale data are appropriately contextualized.

Importantly, the discussion of treatment in the Evidence Report by Viswanathan et al indicates that “consistent, precise, statistically significant differences for most anxiety outcomes for CBT and pharmacotherapy led to strength-of-evidence ratings of moderate for benefit for nearly all outcomes.” However, context is important with regard to the 2 evidence-based treatments for pediatric anxiety. CBT is considered the most effective psychotherapeutic intervention but regrettably has not yet become standard practice in the community. In addition, “pharmacotherapy” suggests that a broad range of medications are useful, although only selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors have consistently demonstrated efficacy.

Pediatric clinicians have a central role in the early, longitudinal, family-based approach to screening, prevention, preemption, and treatment of medical and mental health conditions in children. Training of current and future pediatric clinicians and facilitating their collaboration with mental health clinicians and integration with mental health systems hold promise to address the gap in mental health evaluation and treatment services involving children and adolescents. For the potential of screening to be fully realized, research focused on the process of screening from evaluation to treatment needs to be a priority. Perhaps most critical is developing a smart and sophisticated process of screening aligned with evidence-based treatment strategies that brings added value to routine pediatric medical care and that improves physical and mental health outcomes for children and adolescents.

ARTICLE INFORMATION

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Conflict of Interest Disclosures: Dr Walkup reported serving as an unpaid member of the scientific council of the Anxiety and Depression Association of America; serving on the scientific advisory board of the TLC Foundation for Body-Focused Repetitive Behaviors; serving on the board of directors of the Tourette Association of America; and receiving royalties for anxiety-related continuing medical education activities from Wolters Kluwer and honoraria for anxiety presentations from the American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics. Dr Green reported receiving personal fees from the American Board of Pediatrics as a consultant and content expert to conduct research in mental health training in pediatrics; receiving speaking honoraria from the REACH Institute; and receiving royalties from a textbook (American Academy of Pediatrics). Dr Strawn reported receiving research support from the National Institutes of Health (National Institute of Mental Health/Eunice Kennedy Shriver National Institute of Child Health and Human Development/National Institute of Environmental Health Sciences), Abbvie, and the Yung Family Foundation; receiving material support from Myriad Genetics and honoraria from Intracellular Therapeutics and Cerevel; receiving royalties from the publication of 2 texts (Springer); serving as an author for UpToDate; and serving as an associate editor for Current Psychiatry.

REFERENCES


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