

ANXIETY DISORDERS ACROSS THE LIFESPAN: A CLINICAL UPDATE FOR FAMILY PRACTICE PROVIDERS

PART I: PEDIATRIC ANXIETY DISORDERS

SCOPE & RISK: The "COVID Bump" & The "Triad"



Prevalence nearly doubled during pandemic (~20% youth). Most common, comorbid triad: **GENERALIZED ANXIETY (GAD), SOCIAL ANXIETY, SEPARATION ANXIETY.**



Risk Factors: Heritability (GAD ~35%, Social Anxiety 5x higher), Environment (Bullying, Sleep, ACEs), Externalizing Link (Early ADHD/ODD often precedes).

DIAGNOSIS: The "Irritability Trap"



Anxiety mimics ODD.



Distinction: Suspect Anxiety if anger occurs primarily during **THREATENED SEPARATION** (e.g., bedtime, school mornings).



Tools: SCARED, PARS, HAM-A.



TREATMENT: The "Gold Standard" (CAMS Study)



Hierarchy:

1. COMBINATION (Sertraline + CBT): 80.7% response (Superior).
2. CBT Alone: 59.7%.
3. Sertraline Alone: 54.9%.



First-Line Meds (SSRIs): Escitalopram, Fluoxetine, Sertraline. Improvement begins by 2 weeks, full effect by week 12.



Benzodiazepines: LEAST effective class, not recommended (risks: sedation, disinhibition).

SAFETY & MANAGEMENT



Suicidality: Risk does not differ between SSRIs and placebo in pediatric anxiety trials.

"Activation" Syndrome: Impulsivity/insomnia.



Manage with LOWER starting doses, slow titration.



Genetics: Consider CYP2C19 testing for failed trials (slow metabolizers need lower doses).

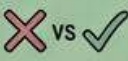


PART II: ADULT ANXIETY DISORDERS



EPIDEMIOLOGY & THE "GAP"

Lifetime prevalence ~34%, median onset age 11.



The "Gap": Without screening, up to 97.8% of cases missed. Systematic screening improves detection to 63.6%.



Comorbidities: Depression (50% of Panic patients), Substance Use Disorders (16.5% of anxiety patients).

SCREENING & DIAGNOSIS: Protocol



Screen with GAD-2 (score ≥ 3 triggers GAD-7) or PHQ-4. Differentiate from stress by severity, frequency, persistence (>6 months).

Rule Out: Hyperthyroidism, arrhythmias, asthma, substance withdrawal.



NON-PHARMACOLOGIC & PROGNOSIS



CBT: Strongest evidence base ($d=1.23$).

Internet-based CBT (iCBT) and Apps (rated via PsyberGuide) critical for rural access.



Lifestyle: Mindfulness (MBSR), high-intensity exercise.



Relapse: Anxiety is chronic. Discontinuing meds leads to 36.4% relapse rate vs. maintenance. Taper slowly over months.



SUMMARY WORKFLOW



1. **SCREEN** (GAD-2/PHQ-4) to close detection gap. →
2. **DIAGNOSE** (Differentiate "Triad," rule out mimics). →
3. **TREAT** (Peds: SSRI+CBT / Adults: SSRI low & slow). →
4. **EDUCATE** (Expect 2-4 week lag; maintain treatment for 1 year).



MANAGING DIFFICULT-TO-TREAT DEPRESSION: A PRACTICAL FRAMEWORK

I. REFRAMING THE GOAL & THE "RULE OF 3s"



1/3 Do Not Respond

Stop calling it "Treatment-Resistant." Call it "**Difficult-to-Treat**": The goal is functional recovery and quality of life, treat like diabetes, not failure.



PSEUDO-RESISTANCE CHECKLIST:

- Medical Mimics (Sleep Apnea, Hypothyroidism),
- Substance Use

II. THE DIAGNOSTIC PIVOT: THREE KEY SUBTYPES



1. BIPOLAR SPECTRUM ("THE GREAT PRETENDER")

40%–60% of "resistant" cases. Screen with Rapid Mood Screener (RMS).

Key Clue: Worsened agitation/insomnia on antidepressants?



2. VASCULAR DEPRESSION ("SILENT" FACTOR >65)

50% of depression > age 65.

Signs: Apathy, executive dysfunction, cognitive slowing.

Action: Aggressively treat BP/lipids. Consider Nimodipine.



3. INFLAMMATORY DEPRESSION

Check hs-CRP > 3mg/L.

Signs: Obesity, autoimmune issues, "brain fog."

Action: Dopamine agents (Bupropion/Pramipexole) or anti-inflammatories.



III. THE "BIG THREE" AUGMENTATION STRATEGIES



Augmentation is 2x as effective as switching.



1. LITHIUM (THE RURAL SAFETY NET)

Target levels 0.6–0.8 mEq/L. Lowers suicide risk by 60%. Start low (150–300 mg/night). Neuroprotective.



2. SECOND-GENERATION ANTIPSYCHOTICS (RAPID RESPONDERS)

Work in 1–2 weeks. Aripiprazole (start low), Quetiapine (insomnia/anxiety), Lumateperone (mixed features).



3. PRAMIPEXOLE ("ANHEDONIA" ANTIDOTE)

Targets dopamine D3. For "the blahs", low motivation. No sexual side effects. Start tiny, titrate slowly.



IV. RAPID RELIEF & MED LIST "CLEAN UP"



RAPID OPTION: AUVELITY

Bupropion + Dextromethorphan. NMDA mechanism, oral pill. Works in ~1 week.



DEPRESCRIBING PROTOCOL

Reduce polypharmacy. Stop: Benzodiazepines (taper very slowly), Stimulants (often fail long-term). Use Hyperbolic Taper.

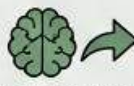
V. LIFESTYLE AS PRESCRIPTION



LIGHT THERAPY: 10,000 lux for 30 mins before 8 AM.



L-METHYLFOLATE: Evidence-based augmentation (15 mg), especially with obesity/inflammation.



THE "MONTREAL MODEL" MINDSET: Action precedes motivation. Set functional goals first.



VI. CONCLUSION

Check for Bipolar and Vascular causes. Augment (Lithium/Pramipexole) rather than switching SSRIs. Deprescribe "downers." You are managing a chronic illness, not failing the patient.