Comorbid Conditions Important

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Other studies have examined the benefits of adding a family component to CBT. For example, researchers at Griffith University in Nathan, Australia randomly assigned 79 children aged 7-14 years with separation anxiety, a comorbid disorder, or social phobia to receive CBT or CBT plus family management, or to be on a waiting list. Almost 70% of the children who were in the CBT groups did not meet diagnostic criteria for an anxiety disorder, compared with 26% of the children on the waiting list.

At the 12 month follow up, CBT combined with family management performed better than CBT alone. About 70% of the children in the CBT-only group did not meet criteria for an anxiety disorder, compared with 96% in the CBT plus family management group (J. Consult. Clin. Psychol. 1999;64:333-42). “That’s certainly helpful information about delivery of these treatments,” Dr. Rynn said.

With strong evidence to support the use of both medication and CBT, clinicians have wondered whether a combined approach from the outset would have the greatest benefit for patients. Researchers are beginning to address that question, Dr. Rynn said. The Pediatric OCD Treatment Study (POTS) team, of which Dr. Rynn was a member, assessed the efficacy of sertraline (Zoloft), CBT, and combination therapy among 112 children aged 7-17 years. The project was a multisite, placebo-controlled, double-blind study.

During the first phase, patients were randomized to receive sertraline, CBT, combination therapy, or placebo for 12 weeks. Results of the intent-to-treat random regression analyses showed that all the active treatments were significantly more effective than placebo and that combination therapy outperformed either of the single active treatments. The results with treatments using CBT alone and sertraline alone were not significantly different from one another (JAMA 2004;292:1969-76).

Another study compared the use of imipramine plus CBT with placebo plus CBT among adolescents who refused to attend school. Sixty-three students were randomly assigned to the two groups and 47 students completed the study. The mean attendance rate in the final week of the study was about 70% in the imipramine plus CBT group, compared with about 28% in the placebo plus CBT group. Depression and anxiety rating scales decreased in both groups but decreased significantly faster in the imipramine plus CBT group (J. Am. Acad. Child Adolesc. Psychiatry 2002;41:111-2).

Researchers also have recently completed the Child/Adolescent Anxiety Multimodal Treatment Study, which examined the efficacy of sertraline with CBT alone, combination treatment, and placebo. The analysis of that data is almost complete, said Dr. Rynn, who participated in the research.

“I still think there’s a lot that we’re struggling with in how to tailor treatment to children in a specific way,” Dr. Rynn said.

An individualized approach that respects the wishes of the patient is the best approach, Dr. Rynn said. She finds that her patients and their families often have the best instincts about what medication, psychotherapies, or a combination will work best for them.

The main CBT manual for treating anxiety in children and adolescents using CBT is the Coping Cat manual, which has several sections that describe how to work with parents, Dr. Rynn said. In addition, there are manuals to complement the Coping Cat that include a parent piece, she said.

Regardless of the treatment approach, remember to treat comorbid conditions, Dr. Rynn advised. Children and adolescents with anxiety disorders often have comorbid attention-deficit/hyperactivity disorder or depressive symptoms. And treatments of the child should be done in the context of the family situation, looking at whether the anxiety has developed because of negative events in his or her life, such as parental illness or stress.

One of the most important facets of anxiety management, however, is medication education, Dr. Rynn said. “I know from experience to take the time because we’re really busy, but I just think the more time we can spend to explain to parents and families the possible adverse events and the expectations for long-term treatment, it goes a long way in terms of being compliant and tolerant.”

It’s important to develop a team approach with the child and parents with respect to medication. Children need to understand the purpose of the medication, she said; otherwise, they might decide not to take it.

Understanding family expectations for medication treatment also can make a difference in terms of adherence. If an aunt or uncle did poorly on a particular medication, the family might not feel comfortable with that choice. Everyone who is influencing this child will affect the child’s view of the medication, she said.

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