

A multimodal approach with or without pharmacotherapy is the treatment of choice. The child should not be removed from the classroom for initiation of treatment. Cognitive-behavioral therapy is the primary intervention aimed at reducing the child's anxiety inhibiting speech and positively reinforcing the child for speaking. An attitude of expectation for normal speech and reinforcement for efforts to speak are important. Behavioral treatments are time consuming, requiring persistence and the cooperation of parents, teachers and other professionals. The child should never be removed from the classroom setting during treatment.

Psychosocial interventions utilizing modeling and peer pressure may be used to reinforce incremental or successive approximations of speech (e.g., hand raising, whispering) in the context of small groups of adults or peers. Family therapy may be helpful.

Pharmacotherapy for selective mutism includes the use of SSRI's, such as fluoxetine and sertraline and the monoamine oxidase inhibitor phenelzine. Given the complexity of using an MAOI agent, this should be reserved for use by psychiatrists. Evidence is preliminary at best, but a trial of an SSRI, or phenelzine failing that, should be considered when the symptoms of selective mutism are debilitating, of long duration or refractory to other interventions.

WHEN TO REFER?

Unfortunately, there is a dearth of child and adolescent psychiatrists in this country. Given this, primary care physicians will be required to diagnose and treat a sizable majority of the patients suffering from anxiety. There are bound to be cases in which specialty referral will be necessary. The primary care physician should keep in mind that the wait list to be seen by child and adolescent can be several months long in certain communities and this wait requires the initiation of treatment.

"First do no harm" applies in the treatment of anxiety disorders. If one is uncomfortable in the treatment of a certain disorder then that case should be referred to specialty care. If a child has multiple co-morbidities whether psychiatric or medical then this complicates the treatment and this might warrant referral. Many times a primary care clinician might just need a specific question to be answered and a simple phone call to a child and adolescent psychiatrist might be effective without referring the patient to specialty care. If a patient has failed pharmacological treatment and a course of the appropriate psychotherapy then they should be referred. When elucidating whether or not a course of psychotherapy has failed it is imperative to make sure that the psychotherapy given is an evidence based treatment. Just because a patient is in therapy does not mean that it is the appropriate modality. For example, if a patient with obsessive compulsive disorder has not had proper CBT then one cannot say they have failed a course of psychotherapy. Keep in mind that we "practice" medicine and the more one treats anxiety disorders the more comfortable and proficient one becomes.

PATIENT AND FAMILY EDUCATION

American Academy of Child and Adolescent Psychiatry facts for families:

The anxious child:

http://www.aacap.org/galleries/FactsForFamilies/47_the_anxious_child.pdf

OCD:

http://www.aacap.org/galleries/FactsForFamilies/60_obsessive_compulsive_disorder_in_children_and_adolescents.pdf

Panic Disorder:

http://www.aacap.org/galleries/FactsForFamilies/50_panic_disorder_in_children_and_adolescents.pdf

School Refusal

http://www.aacap.org/galleries/FactsForFamilies/07_children_who_wont_go_to_school.pdf

National Institute of Mental Health

Anxiety Disorders booklet:

<http://www.nimh.nih.gov/health/publications/anxiety-disorders/nimhanxiety.pdf>

GAD:

http://www.nimh.nih.gov/health/publications/generalized-anxiety-disorder/nimh_generalizedanxietydisorder.pdf

Panic Disorder:

<http://www.nimh.nih.gov/health/publications/when-fear-overwhelms-panic-disorder/complete.pdf>

PTSD:

http://www.nimh.nih.gov/health/publications/post-traumatic-stress-disorder-ptsd/nimh_ptsd_booklet.pdf

Social Phobia:

http://www.nimh.nih.gov/health/publications/social-phobia-social-anxiety-disorder/nimh_socialphobia_publication.pdf

OCD:

<http://www.nimh.nih.gov/health/publications/when-unwanted-thoughts-take-over-obsessive-compulsive-disorder/complete.pdf>

CLINICAL TOOLS

American Academy of Child and Adolescent Psychiatry practice parameters

Anxiety Disorders:

http://www.aacap.org/galleries/PracticeParameters/JAACAP_Anxiety_2007.pdf

OCD:

<http://www.aacap.org/galleries/PracticeParameters/Ocd.pdf>

PTSD:

<http://www.aacap.org/galleries/PracticeParameters/PTSDT.pdf>

Screen for Child Anxiety Related Disorders (SCARED):

<http://www.wpic.pitt.edu/research/ScaredChild-final.pdf>

<http://www.wpic.pitt.edu/research/ScaredParent-final.pdf>

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