Table 17-6	Criteria for Diagnosis of Specific Phobia
A. Marked and persistent fear that is excessive or unreasonable, cued by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection, seeing blood)	
B. Exposure to the phobic stimulus almost invariably provokes an immediate anxiety response, which may take the form of a situationally bound or situationally predisposed panic attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or clinging.	
C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.	
D. The phobic situation is avoided or else is endured with intense anxiety or distress.	
E. The avoidance, anxious anticipation, or distress in the feared situation interferes significantly with the person's normal routine, occupational (or academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.	
F. In children <18 years, the duration is at least 6 months.	
G. The anxiety, panic attacks, or phobic avoidance associated with the specific object or situation are not better accounted for by another mental disorder, such as obsessive-compulsive disorder, posttraumatic stress disorder, separation anxiety disorder, social phobia, panic disorder with agoraphobia, or agoraphobia without history of panic disorder.	
Specify type:	
• Animal type is fear elicited by animals or insects.	
• Natural environment type (e.g., heights, storms, water).	
• Blood/injection/injury type is fear related to seeing blood, injuries, injections, or having an invasive medical procedure.	
• Situational type is fear caused by specific situations (e.g., airplanes, elevators, enclosed places).	
• Other type (e.g., fear of choking, vomiting, or contracting an illness; in children, fear of loud sounds or costumed characters)	

Table 17-7	Criteria for Diagnosis of Social Phobia
A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people, and the anxiety must occur in peer settings, not just in interactions with adults.	
B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed panic attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations or unfamiliar people.	
C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.	
D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.	
E. The avoidance, anxious anticipation, or distress in the feared social or performance situation interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.	
F. In children <18 years, the duration is at least 6 months.	
G. The fear or avoidance is not due to the direct physiologic effects of a drug of abuse, a medication, or a general medical condition and is not better accounted for by another mental disorder (e.g., panic disorder with or without agoraphobia, separation anxiety disorder, body dysmorphic disorder, pervasive developmental disorder, or schizoid personality disorder).	
H. If a general medical condition or another mental disorder is present, the fear in criterion A is unrelated to it (e.g., the fear is not of stuttering or exhibiting abnormal eating behavior in anorexia nervosa or bulimia nervosa).	
Specify the following:	
Generalized: if the fears include most social situations (e.g., initiating or maintaining conversations, participating in small groups, dating, speaking to authority figures, attending parties). Note: Also consider the additional diagnosis of avoidant personality disorder.	

In the **management of anxiety disorders,** likely medical conditions, including hyperthyroidism, medication side effects, substance abuse, or other medical conditions, should be ruled out. The patient should be screened for comorbid psychiatric disorders, such as mood disorders, psychosis, eating disorders, tic disorders, and disruptive behavior disorders. A history from multiple sources is important because the child may be unable to effectively communicate symptoms. A detailed history that includes the nature of the anxiety triggers; psychosocial history; and family history of tics, anxiety disorders, depression, and other mood disorders should be taken. The younger child may better communicate his or her anxieties through drawings or play.

Treatment consists of psychotherapy and psychopharmacology. For mild to moderate anxiety, evidence-based psychotherapies and psychoeducation should be used first. Combined therapy usually has better efficacy than psychotherapy and psychopharmacology alone. Cognitive and behavioral therapy (including systematic desensitization, exposure, operant conditioning, modeling, and cognitive restructuring) can be beneficial in a variety of anxiety disorders. Patients with anxiety disorders are often less tolerant of medication side effects, and supportive therapy helps them maintain treatment regimens.

Family and individual psychotherapy and care coordination with a patient's school is helpful. Reassurance that the patient does not have a life-threatening illness is important. Other psychosocial treatments include stress management, supportive therapies, and biofeedback. Emphasis is placed on decreasing morbidity through proper treatment. Panic disorder tends to be chronic but usually is responsive to treatment. In PTSD trauma-focused cognitive behavioral therapy has shown efficacy. Critical-incident stress debriefing and "psychological first aid," soon after the event, greatly reduce distress and involve discussing the nature and impact of the trauma event in a group format.

Selective serotonin reuptake inhibitors (SSRIs) are the medication of choice. The SSRIs approved for children by the U.S. Food and Drug Administration (FDA) are fluoxetine, sertraline, and fluvoxamine. They can initially exacerbate anxiety or even panic symptoms. Clomipramine requires electrocardiographic and blood level monitoring but may be effective and is approved by the FDA for obsessive-compulsive disorder. Tricyclic antidepressants have also shown efficacy. Benzodiazepines (alprazolam and clonazepam) include a risk of causing disinhibition in children. Alpha-2a-agonists (guanfacine and