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Specific Phobia vs Panic Disorder in Children: A Unique Case Report and Review of Literature

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Abstract

Background: Specific phobia is defined as marked fear or anxiety about a specific object or situation. The phobic object or situation almost always provokes immediate fear and anxiety, is actively avoided, or endured with intense fear or anxiety that is out proportion to the actual danger posed by the specific object/situation and to the sociocultural context. These symptoms are persistent and last for at least six months. The prevalence of specific and social phobia in children and adolescents is 2.9 and 0.3%. Panic disorder is defined as recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes and is accompanied by at least 4/13 symptoms. One of these panic attacks must be followed by at least one month of constant worry about additional panic attacks and their consequences. There is a significant maladaptive change in behavior related to the attacks. Such disturbances are not attributable to physiological effects of other substances, medical conditions, or other mental disorders. The prevalence of panic disorders is 5 – 15 percent in adolescents and 5 percent in children.

Case Presentation: We present a case of a 3-year old male with panic attacks for over one year which started after an incident of smoke detector alarm followed by three more episodes of panic attacks at the daycare center. The recent episode was 4 weeks ago. After the last incident, the patient stopped eating and refused food which worsened over the past 2 weeks. The patient was evaluated and diagnosed with panic disorder, specific phobia, eating disorder, and referred to outpatient Psychologist.

Objectives:

- Learn about anxiety disorders in children.
- Management options for anxiety in children.
- Etiopathogenesis of anxiety in children.

Conclusion: To the best of our knowledge, this is the first case reported in the literature of panic disorder below the age of 4. We conducted a literature review and found no cases published. This is an interesting case for psychiatrists, therapists and pediatricians to learn as there is a lack of evidence in treating children under the age of 4. No medication recommendations were available for this age group; however, off-label use of selective serotonin reuptake inhibitor (SSRI) medication was discussed with the patient's mother who refused. We agreed with the primary care team's recommendations and the case was referred to an out-patient psychotherapist.

Keywords: Specific Phobia; Panic Disorder; Anxiety; Eating Disorder; Avoidant Restrictive Food Intake Disorder (AFRID); Children & Adolescents

Introduction

Specific phobia is marked fear or anxiety about a specific object or situation. In children, fear or anxiety may be expressed by crying, tantrums, freezing, or clinging. The phobic object or situation almost always provokes immediate fear and anxiety, is actively avoided or endured with intense fear or anxiety, is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context, is persistent and typically lasting for six months or more, or causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. This disturbance cannot be associated with any other substance or be attributed to any other medical/mental disorder.

Panic disorder is defined as recurrent unexpected panic attacks. A panic attack is an abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four or more of the following symptoms occur: palpitations, sweating, trembling, sensation of shortness of breath, feelings of choking, chest pain/discomfort, nausea/abdominal distress, dizziness/light-headedness, chills/heat sensation, paresthesia, derealization, fear of losing control, or fear of dying. In order to be diagnosed with panic disorder, individuals that experience a panic attack must be followed by one month of persistent worry of additional panic attacks and its related consequences or have a significant maladaptive change in

behavior due to the attack. These symptoms cannot be associated to any other substance or medical/mental disorder [1-6].

Avoidant restrictive food intake disorder (ARFID; previously referred to as selective eating disorder) is an eating or feeding disturbance that results in persistent failure to meet appropriate nutritional needs and is associated with significant weight loss, significant nutritional deficiency, dependence on supplementation, or marked interference with psychosocial functioning. ARFID differs from anorexia nervosa and bulimia nervosa because individuals do not have any distress regarding their body shape or size. ARFID cannot be attributed to any other medical or mental condition.

Post-traumatic stress disorder (PTSD) is a disorder that develops in some individuals that have experienced a shocking, scary, or dangerous event. In other cases, it can follow the sudden unexpected death of a loved one. It is natural to be afraid during and after a traumatic event, however, it is not natural for every traumatized individual to develop acute or chronic PTSD. The onset of symptoms can occur within the first three months of the event or can begin years later. In order to meet the diagnostic criteria of PTSD, individuals must experience the following symptoms for one-month duration: at least one re-experiencing symptom, one avoidance symptom, two arousal/reactivity symptoms, and two cognition/mood symptoms. Symptoms present differently in children less than 6 years of age. They can wet the bed after being toilet trained, forget how to talk, or act unusually clingy with parent/guardian.

Method

The Consultation and Liaison service evaluated this case thoroughly. The case was discussed among the authors and a thorough review of the related literature was done in "PUBMED" and "up-to-date" to formulate the discussion.

Case Presentation

This is a 47-month-old male, full term normal born child, enrolled in day care without any past psychiatric or significant medical history. He was admitted to the pediatric floor for dehydration and the inability to gain weight. The consultation and liaison team were requested to evaluate the patient for anxiety. The patient was born in Spain and migrated to the United States at the age of one with his parents. Since coming to the States, he has been following with a Pediatrician for general wellness checks and is up to date on all vaccinations. He has not been hospitalized in the past or required any medical intervention.

As per mother, when the patient was 18 months old, the smoke alarm went off at their private house. At this time the patient was inconsolable, and the mother had to run outside with him to get away from the sound and console him. The next incident was at the age of 36 months old. He was at daycare when the fire alarm went off for a fire drill and his teacher stated that he appeared to be more frightened and anxious compared to the other children. The teacher recorded a video which showed the patient turning pale, trembling, sweating, and quivering his lips. The fire drill occurred two more times prior to this hospitalization, the last one being two weeks prior. During the most recent incident, the patient's peer had an episode of epistaxis which further distressed the patient. Each fire drill was followed by the same symptoms: paleness, trembling, sweating, quivering, and the need for his mother to come to daycare to console the child. After the last episode, the patient refused to go to daycare and eat which resulted in him getting dehydrated. His mother states that during this two-week period, the patient lost five pounds. At this time, he weighs 30 lbs. which is the same weight that was recorded at his last doctor's visit 7 months prior.

His mother also reported an episode of social anxiety during a school performance. As per mother, the patient had learned all the dance moves for a performance and practiced confidently at home but froze when he got on stage. She showed videos where the patient just stood still and yawned while his peers danced on stage.

When his mother was 15 years old, she moved from Ecuador to Spain. At that time, she was diagnosed with anxiety and depression and treated with sertraline but stopped after a year because she felt better. There is no other family history of psychiatric disorders or eating problems. Mother is employed in odd job, but father lost his job recent past. Parents talk about financial issues in front of the patient. No hx of domestic violence or ACS involvement.

During the evaluation, the patient was talkative, playful and preoccupied with Jurassic park toys especially dinosaurs. Pt appears well-mannered and related to parents. Both parents were caring but mother appears anxious at times.

The patient's appetite improved throughout the hospitalization. After discussing options for medications, risks, benefits, side effects, and age limitations, his mother refused the off-label use of medication. He was referred by his PCP for therapy outside of hospital because our clinic does not accept children below 5.

Discussion

Specific phobias tend to develop in early childhood primarily before the age of 10. The median age of onset is 7-11 years with the mean around 10 years [3]. Although many phobias can come and go from childhood into adolescence, if they persist into adulthood, they tend to remain for life. There are many risk factors for developing specific phobias including neuroticism, behavioral inhibition, parental overprotectiveness, parental loss/separation, physical/sexual abuse, or even a genetic susceptibility [3]. Specific phobias typically increase physiological arousal before or during exposure to the phobic situation or object [1]. Responses can vary to sympathetic nervous system arousal, vasovagal fainting or near -fainting [5]. Individuals with specific phobia have an increased risk for the development of other anxiety disorders, depression, bipolar disorders, substance related disorders, somatic disorders, and personality disorders [4,7]. It is suspected that multiple genes increase vulnerability to panic disorder however the specific details are unknown. There is an increased risk for panic disorder among offspring of parents with anxiety, depressive, and bipolar disorders [4].

"In the general population, the 12-month prevalence estimate for panic disorder across the United States and several European countries is about 2-3% in adults and adolescents" [3]. The prevalence of panic disorder is low before the age of 14 and is less than 0.4% [1]. Panic disorders tend to increase during adolescence especially in females [8]. There are many risk factors for panic disorders including neuroticism, anxiety sensitivity, childhood sexual/physical abuse, smoking, physical health or other stressors like death of a close relative [6].

Conclusion

We presented an interesting case of specific phobia versus panic disorder which started at 36 months of age. Anxiety disorders are not

uncommon in children. Specific phobias are more common in children versus adults and adolescents. There are no approved medications below the age of 6 including SSRIs. Therapy is the only option. Parental education and follow up until the patient reach the age of 6. The patient should be ruled out for medical reasons and treat accordingly for underlying medical issues if any. To conclude, careful and judicious decision should be made on case-by-case basis after discussing the risks, benefits, and consequences with the patient's parents.

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