

Correspondence

Addressing anxiety and avoidance in food-induced anaphylaxis

To the Editor:

We read the article by Dahlsgaard et al¹ with interest and appreciate the authors' focus on "unhelpful avoidance" in the context of excessive anxiety as an underrecognized response to allergic reactions to food in children. We agree with the premise of the article and many of its recommendations and conclusions. We especially agree that some forms of exposure therapy may be valuable in alleviating unhelpful avoidance. Under the aegis of the EMPOWER (Enhancing, Managing, and PrOmoting WEll-being and Resiliency) program at the Jaffe Food Allergy Institute, we have undertaken randomized trials of self-injection exposure to relieve anxiety and avoidance associated with self-injection of epinephrine, and of education and allergen contact exposure to reduce anxiety about casual allergen exposure, both with positive outcomes.^{2,3} Although we were very pleased to see the important topic of recognizing and addressing anxiety expertly reviewed, we would like to highlight a few points that we believe were not sufficiently emphasized.

1. Definitions: Although we appreciate that opinions may vary, and agree with much of the characterizations in the article, we do not prefer the term "phobia of anaphylaxis." The current *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* criteria for specific phobia⁴ are not easily applied to anaphylaxis: anaphylaxis is neither an object nor a situation—it is an event. We believe that posttraumatic stress, which is characterized by a set of symptoms (including avoidance) related to the experience of a potentially life-threatening event,⁵ is the better designation in most cases. This is not just a semantic difference—this view leads to a specific modality of effective treatment (prolonged imaginal exposure).⁶

2. Exposure treatment: We recognize that the authors do not intend to "expose" patients to anaphylaxis. In speaking of "brave practices" it will be important to carefully consider implied allergen exposure. In our own application of the "exposure" paradigm, therefore, the clinician applying it was an allergist, not a mental health professional, to ensure that safety is not compromised.³ The authors correctly recognize that an allergist should be involved, and we suggest in addition that the mental health professional's role, unless very closely paired with that of the allergist, should be restricted to "imaginal" exposure techniques,⁷ for those who need them.

3. Application of cognitive-behavioral therapy: Dahlsgaard et al mention some of the following, but we believe that it should be emphasized that prevailing research and diagnostic criteria show that "avoidance" and anxiety symptoms are entirely appropriate in the immediate aftermath of a traumatic event (eg, anaphylaxis). The *Diagnostic and Statistical Manual of Mental*

Disorders requires at least 1 month of persistent symptoms for the diagnosis of posttraumatic stress disorder,⁵ and 6 months for phobia.⁶ Therefore, in the immediate aftermath of a reaction, we usually offer supportive treatment, rather than recommend "exposure"/cognitive-behavioral therapy. Our study suggested that discussion/education about the low risk of casual exposure (touch, smell) was effective even without including actual exposure.³

With parents' input, we have developed 2 information sheets that address many of the issues that were brought about in this article. We offer them for use by interested programs/parents (see <https://bit.ly/3aOaI78>).

Eyal Shemesh, MD^a

Scott H. Sicherer, MD^b

From ^athe Division of Behavioral and Developmental Health, Department of Pediatrics, Kravis Children's Hospital, and ^bthe Division of Pediatric Allergy and Immunology, Jaffe Food Allergy Institute, Department of Pediatrics, Kravis Children's Hospital, Icahn School of Medicine at Mount Sinai, New York, NY. E-mail: scott.sicherer@mssm.edu.

Disclosure of potential conflict of interest: E. Shemesh reports royalty payments from UpToDate and grants to his institution from the National Institutes of Health. S. H. Sicherer reports royalty payments from UpToDate and from Johns Hopkins University Press; grants to his institution from the National Institute of Allergy and Infectious Diseases, from Food Allergy Research and Education, and from HAL Allergy; and personal fees from the American Academy of Allergy, Asthma & Immunology as Deputy Editor of the *Journal of Allergy and Clinical Immunology: In Practice*, outside of the submitted work.

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<https://doi.org/10.1016/j.jaci.2020.11.039>