

GUIDELINES & PROTOCOLS

ADVISORY COMMITTEE

Anxiety and Depression in Children and Youth – Diagnosis and Treatment

Effective Date: January 1, 2010

Scope

This guideline presents recommendations for early diagnosis, intervention, and maintenance treatment of depression and anxiety disorders in children and youth (18 years and under).

Diagnostic Codes: 300 (Anxiety, dissociative and somatoform disorders)
308 (Acute reaction to stress)
311 (Depressive disorder NOS)
313 (Disturbance of emotions specific to childhood and adolescence)

Routine Screening and Diagnosis

Periodically screen **children and youth** for early signs of depression and/or anxiety. Record these results in the patient's problem list.

Ask questions of the child (or parent where applicable) when there are red flags including: unexplained somatic complaints; unexplained behavioural changes; teenage pregnancy; school absences and family members with depression, anxiety, alcohol or other substance abuse.

Suggested questions

- Do you find yourself sad, irritable or worried a lot?
- Is the child withdrawing from or avoiding their usual activities?

Family involvement is invaluable for assisting with and monitoring treatments as well as providing assurance and emotional support for the child or youth. Assure the family that the questions and fact-finding is not to assign blame but to better understand the situation.

Choose an appropriate diagnostic questionnaire available for download on the internet. If the screen indicates a possible problem then either begin or schedule time to begin a detailed inquiry about anxiety or depressive symptoms, evaluate severity, and the potential for self-harm. Consider that there may be more than one psychiatric disorder when screening because anxiety and depressive disorders are highly comorbid in children and adolescents. Refer to *Appendix A: Diagnosis of Anxiety Disorders in Children and Youth* for descriptions of these disorders.

All youth with mood or anxiety disorders should be screened for alcohol or drug use.

Note red flags for risk of bipolar depression: family history; psychotic depression; mania with Selective Serotonin Reuptake Inhibitors (SSRIs); hyper-sexuality; risk-taking behaviour and pre-pubertal depression. Consider referral if bipolar disorder is suspected. Manage the patient while waiting for referral (see management considerations) and provide follow-up.

Diagnosis

Take a medical history and do a physical examination with attention to conditions that may mimic anxiety or depressive disorders. Consider indications for diagnostic tests such as TSH. Consider the family situation and social stressors.

Refer to Appendix A for descriptions of anxiety disorders, examples of anxiety disorders appearing as another disorder, prevalence, development, and treatment tips.

If post-partum depression is possible, consider referring for treatment. Manage while waiting for referral and provide follow-up.

Management considerations

Remember the basics: regular sleep, eating and exercise routines, along with consistent effective parenting are essential.¹

Enlist the family for help in supporting the child with the treatment plan. Reassure them that they are not being blamed for the problems but that they can provide valuable help with developing and enacting a treatment plan and can help provide reassurance to the child or youth throughout the process. Consider the strengths of the family (and possibly larger community and school), use these and build upon them in the treatment plan.

Make a diagnosis if possible, and then begin to treat or refer as appropriate.

- Refer to *Treatment Algorithm* in this guideline
- Refer to *Appendix A: Diagnosis of Anxiety Disorders in Children and Youth* and *Appendix B: Treatment of Anxiety Disorders and Depression in Children and Youth*
- Provide parents with *A Guide for Parents* (either for Anxiety or Depression) and the *Resource List for Families* included with this guideline which lists pamphlets, books, web-resources and information

Set these treatment goals:

- Work towards both symptom and functional improvement including normal academic and psychosocial development
- Encourage assertiveness: taking charge of daily activities, increasing socialization, avoiding procrastination, developing goals and routines
- Teach healthy thinking: replace “what if” and self-deprecating thinking, with positive appraisals and achievable daily goals

Monitor management regularly:

- Within a week or two after initiation of treatment
- Every 2 weeks until well or is receiving secondary care
- If you are the primary care provider, then every 2 months for 6 months (as necessary)
- Structured monitoring using *Appendix C: Selective Serotonin Reuptake Inhibitor (SSRI) Monitoring Form*, and *Appendix D: Measurement of Functional Change*

Avoid these common pitfalls:

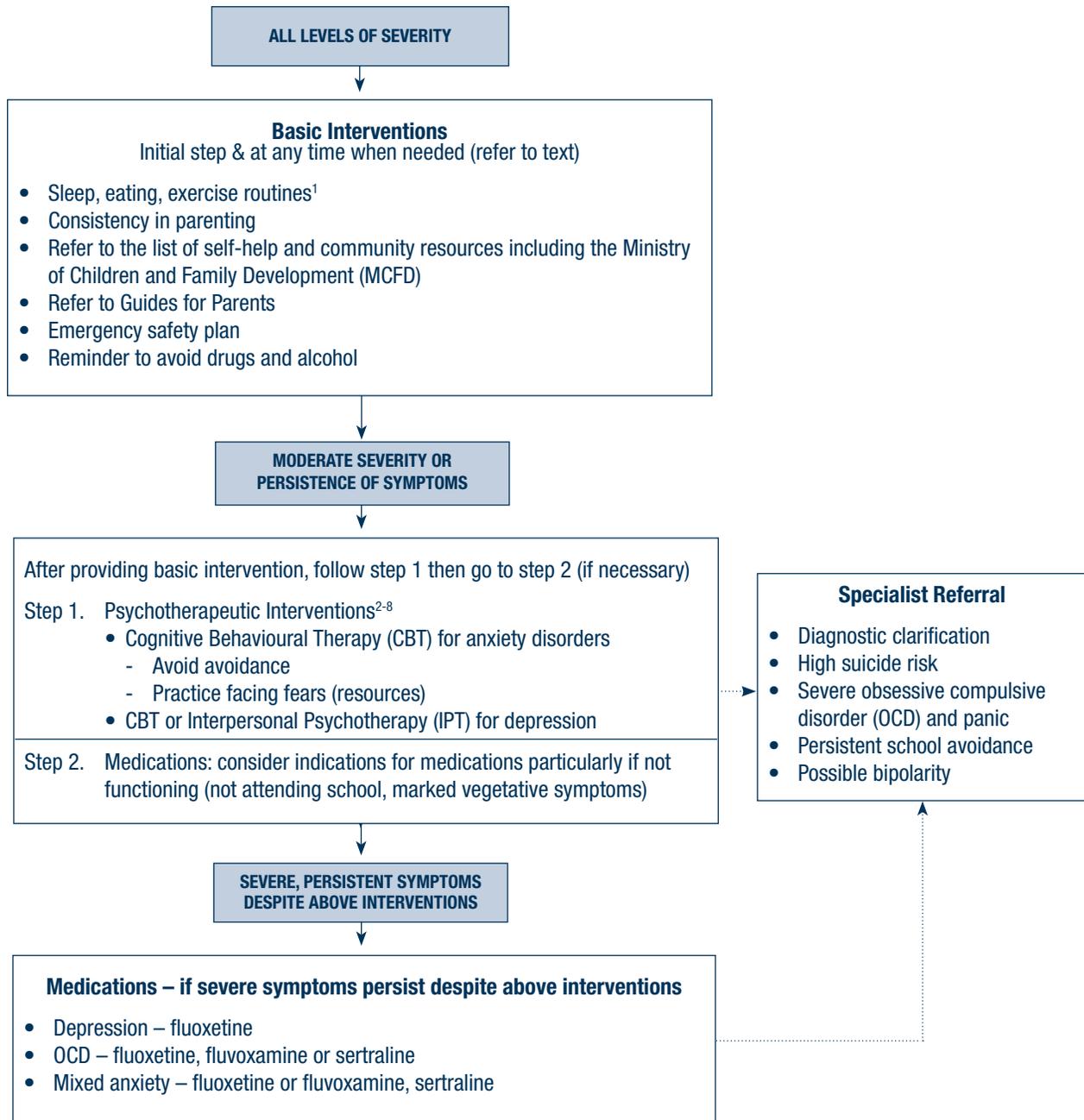
- Failure to address and discourage avoidance of school, friends, work and feared situations - avoidance is instinctive and natural but unhelpful
- Allowing treatment goals to be side-tracked by physical symptoms i.e. encourage the child to continue school and activities

Attempt non-pharmacological management strategies first

Non-pharmacological approaches are essential first-line treatments for both anxiety²⁻⁷ and depression.^{2,3} It is likely that your initial visits along with parent input and books that are read by parent and child will affect a significant response.

If physician counseling, parental involvement and use of books does not effect a significant improvement it is appropriate to refer to a specialist or to the Child and Youth Mental Health team for treatment.

Treatment Algorithm for Children and Youth with Anxiety or Depression



Treatment Type

I. Cognitive Behavioural Therapy

Anxiety: The evidence-based psychological treatment for anxiety disorders is Cognitive Behavioural Therapy (CBT), a brief, directive therapy to promote realistic and adaptive thinking patterns and build behavioural competence through graduated exposure.²⁻⁷

Depression: CBT is also considered effective for child and adolescent depression.^{2,3}

- Available through Child and Youth Mental Health teams (phone 250 387-7027 (Greater Victoria) or toll free 1 877 387-7027 or the [website http://www.mcf.gov.bc.ca/mental_health](http://www.mcf.gov.bc.ca/mental_health)) or private specialists trained in CBT.
- Self-help materials based on CBT at the Anxiety Disorder Association of BC (ADABC) (phone (604) 525-7566 or website with videos at: <http://www.anxietybc.com>)
- Self-help materials (e.g. “Dealing with Depression”) designed to help depressed adolescents available through the Ministry of Children and Family Development (MCFD) Child and Youth Mental Health website (http://www.mcf.gov.bc.ca/mental_health) and the Knowledge Network tool (<http://www.knowledgenetwork.ca>)

There is evidence of benefit using Interpersonal Psychotherapy (IPT) but it is not as strong as for CBT.⁸ IPT is similar to CBT but has more focus on interpersonal problem solving. There are fewer professionals trained in IPT treatment.

- Available at some Child and Youth Mental Health teams or through some private specialists trained in IPT

II. Pharmacological Management Strategies

In general, pharmacotherapy alone is not recommended for children and adolescents. Its use should ideally be preceded and complemented by psychotherapy and/or behavioural therapy. **Employ pharmacological management strategies if non-pharmacological interventions are not achieving therapeutic goals.** If required, these are the issues to be considered.

There is very little peer reviewed evidence as to the safety or efficacy of SSRI medications for the treatment of anxiety and/or depression in young children. Approximately two-thirds of randomized placebo controlled pharmacological trials for depressive disorders in children and adolescents consider an age range starting from ages 6-8 through to ages 17 or 18, while the other third of cases consider ages 12-13 through 17-18.⁹⁻¹⁸

Given the above, no SSRIs are approved for marketing in Canada as appropriate medications for patients under age 18. Refer to the Health Canada statement below.²¹

“It is important to note that Health Canada has not approved these drugs for use in patients under 18 years. The prescribing of drugs is a physician’s responsibility. Although these drugs are not authorized for use in children, doctors rely on their knowledge of patients and the drugs to determine whether to prescribe them at their discretion in a practice called off-label use. Off-label use of these drugs in children is acknowledged to be an important tool for doctors. Doctors are advised to carefully monitor patients of all ages for emotional or behavioural changes that may indicate potential for harm, including suicidal thoughts and the onset or worsening of agitation-type adverse events.”

Adding pharmacotherapy to the non-pharmacological approaches needs to be done with careful monitoring, while informing patient and family about risks and benefit. An emergency safety plan should be made when there is moderate to severe symptoms, whether or not pharmacotherapy is used.

Indications for pharmacotherapy include: persistent depression and/or a comorbid anxiety disorder which have not responded to psychosocial interventions.

Anxiety: Drugs most often used are fluoxetine, fluvoxamine, or sertraline for Generalized Anxiety Disorder (GAD) and mixed anxiety, including social anxiety disorders and obsessive compulsive disorder (OCD).⁹⁻¹⁴

SSRIs appear to be generally somewhat effective in randomised control trials in anxiety. Benzodiazepines are not recommended because of anger, disinhibition, habituation and irritability response.

Depression: Psychotherapy can be effective for treating depression, particularly in adolescents. If unavailable, medications may be indicated.¹⁵⁻¹⁸

- The drug most often used is fluoxetine
- If bipolar vulnerability, start with a shorter-acting SSRI (e.g. sertraline)
- If comorbid anxiety, fluvoxamine or sertraline are possible alternatives

The majority of randomised control trials in depression show no significant benefit of SSRI medications over placebo. Spontaneous remission in community diagnosed adolescent depression is 50% within two months. However, those not remitting in this time period have a high risk of chronicity. Refer to a specialist.

Medication Dosing and Follow-Up for Anxiety and Depression

Initiation and Continuation: Pick target symptoms to self-monitor and document weekly (give form to parent or teenager - Appendix C or download from <http://www.cpsbc.ca>). Ask families and caregivers to help by daily monitoring the child or youth for worsening symptoms or any unusual changes or behaviours, particularly any emergence of suicidality. Discuss an emergency plan as well as planned follow-up.

General Dosing Suggestions: Start with ¼ or ½ of the adult dose and wait at least one week to increase dosages. For adolescents, the maximum dose can be similar to adults, while the dose is less than the adult dose for children.¹⁹

- **Anxiety:** Children who are anxious are sensitive to physical sensations. Provide support, reassurance and monitor frequently. Generalized anxiety disorder may respond at lower doses (e.g. 25-50 mg sertraline),²⁰ OCD (100-200 mg sertraline); generally start low and increase slowly. Dosing example: 10 mg daily fluoxetine for an adolescent. For an anxious 6 year old, start with 5 mg daily and use increments of 5 mg every two weeks if needed.
- **Depression:** The response often requires full doses for youth and the response to medication is slower. Example: start the first week with 10 mg daily of fluoxetine and increase to 20 mg daily as soon as tolerated. Increase again up 30 mg daily if not improved after 6 weeks to a maximum of 40 mg daily. If not responding after 10-12 weeks, refer to specialist.

Adverse Effects: In children, SSRIs and other new anti-depressants produce a higher rate of behavioural and emotional adverse effects (such as: agitation, disinhibition, irritability and occasionally thoughts of self-harm). The largest drug-placebo difference in the number of cases of suicidal ideation and behaviour is greatest for the under-24 age group. For all ages, the risk is highest during the first few months of drug therapy, therefore, monitor patients closely during this time. For more information, review the product monograph, Health Canada warnings for SSRIs at <http://www.hc-sc.gc.ca>, and the United States Food and Drug Administration (FDA) website at <http://www.fda.gov>.

Monitoring: Request assistance of the family and/or teenager, to monitor both symptoms and functions. Use the SSRI Monitoring Form (Appendix C and link below) as well as Measurement of Functional Change (Appendix D).

Continuation: For both anxiety and depression the usual length of treatment is 6-12 months before a trial of tapering.

Discontinuation: Anxious patients are very sensitive to physical sensations during discontinuation. So, taper off particularly slowly over 1-2 months by approximately 5 mg per reduction. For slow smooth tapering, capsules can be opened and/or pills divided.

Refer to Pharmacare Plan G if financial assistance is needed for medication coverage. Information is available at <http://www.health.gov.bc.ca/pharmacare> and the form is available at <http://www.healthservices.gov.bc.ca>.

Referral to Specialist

Indications for referral to a specialist:

- Depression or anxiety that has not responded to primary treatment
- High suicide risk
- Severe OCD and panic
- Persistent school avoidance
- Possible bipolarity
- Postpartum depression

Referral options (also refer to other resources in the Resource List for Physicians)

- Continue to follow the patient until they are seen by the specialist
- For specialist mental health consultation and CBT refer to MCFD - Child and Youth Mental Health (250 387-7027 (Greater Victoria) or toll free 1 877 387-7027); or contact a community or private Psychiatrist
- Community or private psychologist with skills in CBT for children and youth
British Columbia Psychological Association at 604 730-0522 (Lower Mainland) or toll free 1 800 730-0522 or the website <http://www.psychologists.bc.ca/referral.html>
- For treatment resistant cases (aged 6 to 19), refer to the tertiary care Mood and Anxiety Disorders Clinic at BC Children's Hospital, 604 875-2010 or the website at <http://www.bcchildrens.ca/Services/default.htm>

Rationale

Psychiatric disorders in children and youth are under-detected in health care settings. Symptoms are likely to be missed unless they are severe or accompanied by physical illness.²⁵ Under-detection represents a serious omission given the research evidence establishing effective treatments for both anxiety and depression in children.¹⁻¹⁸

The prevalence of anxiety disorders in children aged 5 to 17 is 6.4%.²² The debilitating nature of these disorders is routinely underestimated and the need for help may not be realized until serious impairment in social and academic functioning has occurred.²³ Untreated anxiety disorders in children and adolescents are associated with higher rates of comorbid depression and substance abuse.²⁴

Depression affects 3.5% of children at any given time, impeding healthy psychosocial development.¹ Diminished self-worth, academic struggles, and difficulties in social relations with family and peers exert a heavy toll on youth who are often unable to communicate the nature of their experience. Clinical depression during adolescence represents the strongest risk factor for teenager suicide and is linked to significant psychosocial impairment in adulthood.²³

Periodic screening of children presenting -- for any reason -- to primary care physicians can improve clinical recognition of these disorders and result in improved rates of treatment.²⁶

References

1. Larun L, Nordheim L, Ekeland E, et al. Exercise in prevention and treatment of anxiety and depression among children and young people (Review). *Cochrane Database of Systematic Reviews* 2006;3.
2. Compton S, March J, Brent D, et al. Cognitive-behavioral psychotherapy for anxiety and depressive disorders in children and adolescents: an evidence-based medicine review. *J Am Acad Child Adolesc Psychiatry* 2004;43(8):930-59.
3. Chu B, Harrison T. Disorder-specific effects of CBT for anxious and depressed youth: a meta-analysis of candidate mediators of change. *Clin Child Fam Psychol Rev* 2007;10:352-72.
4. Kendall P, Brady E, Verduin T. Comorbidity in childhood anxiety disorders and treatment outcomes. *J Am Acad Child Adolesc Psychiatry* 2001;40(7):787-794.
5. Soler J, Weatherall R. Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews* 2005;4.
6. O’Kearney R, Anstey K, von Sanden C. Behavioural and cognitive behavioural therapy for obsessive compulsive disorder in children and adolescents. *Cochrane Database of Systematic Reviews* 2006;4.
7. Lumpkin P, Silverman W, Weems C, et al. Treating a heterogeneous set of anxiety disorders in youths with group cognitive therapy: A partially non concurrent multiple-baseline evaluation. *Behavior Therapy* 2002;33(1):163-77.
8. Mufson L, Dorta K, Wickramaratne P, et al. A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. *Arch Gen Psychiatry* 2004;61:577-84.
9. Stein D, Ipser J, van Balkom A. Pharmacotherapy for social anxiety disorder. *Cochrane Database of Systematic Reviews* 2000;4.
10. Kapczinski F, Lima M, Souza J, et al. Antidepressants for generalized anxiety disorders. *Cochrane Database of Systematic Reviews* 2003;2.
11. Hawkrigde S, Ipser J, Stein D. Pharmacotherapy for anxiety disorders in children and adolescents (Protocol). *Cochrane Database of Systematic Reviews*. 2005;1.
12. Geller D, Biederman J, Mullin B, et al. Which SSRI? A meta-analysis of pharmacotherapy trials in pediatric obsessive-compulsive disorder. *Am J Psychiatry* 2003;160(11):1919-28.
13. Clark D, Birmaher B, Axelson D, et al. Fluoxetine for the treatment of childhood anxiety disorders: open-label, long-term extension to a controlled trial. *J Am Acad Child Adolesc Psychiatry* 2005; 44(12):1263-1270.
14. The Research Unit on Pediatric Psychopharmacology Anxiety Study Group. Fluvoxamine for the treatment of anxiety disorders in children and adolescents. *NEJM* 2001;344(17):1279-85.
15. Hughes C, Emslie G, Crismon M, et al. Texas children’s medication algorithm project: update from Texas consensus conference panel on medication treatment of childhood major depressive disorder. *J Am Acad Child Adolesc Psychiatry* 2007;46(6):667-86.
16. Hetrick S, Merry S, McKenzie J, et al. Selective serotonin reuptake inhibitors (SSRIs) for depressive disorders in children and adolescents. *Cochrane Database of Systematic Reviews* 2007;3.
17. Cheung A, Emslie G, Mayes T. Review of the efficacy and safety of antidepressants in youth depression. *Child Psychol Psychiatry* 2005;46(7):735-54.
18. Donnelly C, Wagner K, Rynn M, et al. Sertraline in children and adolescents with major depressive disorder. *J Am Acad Child Adolesc Psychiatry* 2006;45(10):1162-70.
19. Canadian Pharmacists Association. *Compendium of pharmaceuticals and specialties*. Ottawa: Canadian Pharmacists Association; 2008.
20. Rynn M, Siqueland L, Rickels K. Placebo-controlled trial of sertraline in the treatment of children with generalized anxiety. *Am J Psychiatry* 2001;158(12):2008-14.
21. Health Canada. Advisory: Health Canada advises Canadians of stronger warnings for SSRIs and other newer antidepressants. 2004. Available at http://www.hc-sc.gc.ca/dhp-mps/alt_formats/hpfb-dgpsa/pdf/medeff/prozac_hpc-cps-eng.pdf Accessed September 10, 2009.
22. Waddell C, Offord D, Shepard C, et al. Child psychiatric epidemiology and Canadian public policy-making: the state of the science and art of the possible. *Can J Psychiatry* 2002;47:825-832.
23. Roza S, Hofstra M, van der Ende J, Verhulst F. Stable prediction of mood and anxiety disorders based on behavioral and emotional problems in childhood: a 14-year follow-up during childhood, adolescence, and young adulthood. *Am J Psychiatry*. 2003;160(12):2116-21.
24. Lewinsohn P, Rhode J, Seeley P, et al. Psychosocial functioning of young adults who have experienced and recovered from major depressive disorder during adolescence. *J Abnorm Psychol* 2003;112(3):353-363.
25. Cheung A, Zuckerbrot R, Jensen P, et al. Guidelines for adolescent depression in primary care (GLAD-PC: II). Treatment and Ongoing Management. *Pediatrics* 2007;120(5)e:1313-26.
26. Vander Stoep A, Weiss N, McKnight B, et al. Which measure of adolescent psychiatric disorder--diagnosis, number of symptoms, or adaptive functioning--best predicts adverse young adult outcomes? *J Epidemiol Community Health* 2002;56(1):56-65.

List of Abbreviations

ADABC	Anxiety Disorders Association of BC
CBT	Cognitive Behavioural Therapy
FDA	United States Food and Drug Administration
GAD	Generalized Anxiety Disorder
IPT	Interpersonal Psychotherapy
MCFD	Ministry of Children and Family Development
OCD	Obsessive compulsive disorder
SSRI	Selective serotonin reuptake inhibitor
TSH	Thyroid-stimulating hormone or thyrotropin

Appendices

Appendix A – Diagnosis of Anxiety Disorders in Children and Youth

Appendix B – Treatment of Anxiety Disorders and Depression in Children and Youth

Appendix C – Selective Serotonin Reuptake Inhibitor (SSRI) Monitoring Form

Appendix D – Measurement of Functional Change in depressed and/or Anxious Patients

Associated Documents

The following documents accompany this guideline:

- Resource Guide: Information Sources for Physicians
- Resource Guide: Information Sources for Families
- Anxiety in Children and Youth: A Guide for Parents
- Depression in Children and Youth: A Guide for Parents

This guideline is based on scientific evidence current as of the Effective Date.

This guideline was developed by the Guidelines and Protocols Advisory Committee, approved by the British Columbia Medical Association and adopted by the Medical Services Commission.

The principles of the Guidelines and Protocols Advisory Committee are to:	Contact Information
<ul style="list-style-type: none">• encourage appropriate responses to common medical situations• recommend actions that are sufficient and efficient, neither excessive nor deficient• permit exceptions when justified by clinical circumstances	Guidelines and Protocols Advisory Committee PO Box 9642 STN PROV GOVT Victoria BC V8W 9P1 Phone: 250 952-1347 Fax: 250 952-1417 E-mail: h1th.guidelines@gov.bc.ca Web site: www.BCGuidelines.ca

DISCLAIMER

The Clinical Practice Guidelines (the "Guidelines") have been developed by the Guidelines and Protocols Advisory Committee on behalf of the Medical Services Commission. The Guidelines are intended to give an understanding of a clinical problem, and outline one or more preferred approaches to the investigation and management of the problem. The Guidelines are not intended as a substitute for the advice or professional judgment of a health care professional, nor are they intended to be the only approach to the management of clinical problems.

Appendix A: Diagnosis of Anxiety Disorders in Children and Youth

Description of Anxiety Disorders

The fourth text revision of the fourth edition of the Diagnostic and Statistical Manual, DSM-IV-TR (APA, 2000), provides diagnostic criteria of anxiety disorders, details the differences between adult anxiety disorders when applied to children and youth and provides specifics for separation anxiety disorder which is unique to this age group. A description of anxiety disorders in children and youth based upon the DSM-IV diagnostic criteria follows:

Specific Phobia – At least 6 months of irrational and persistent fear (e.g. crying, tantrums, freezing, or clinging) and marked avoidance of a specific thing, place or circumstance, **to the extent that it interferes with normal functioning**. The child or youth may not recognize the fear as excessive. Common fears in children are: needles, masks or clowns, dogs, and insects. Common fears in youth are: heights, snakes, choking or vomiting, flying, and enclosed spaces.

Social Phobia – At least 6 months of noticeable and persistent fear of being negatively evaluated for at least one social or performance situation. The child fears appearing anxious or incompetent, resulting in feelings of embarrassment and humiliation and **marked social avoidance of both peers and adults** (e.g. tantrums, crying, freezing or shrinking from social situations with unfamiliar people). Social phobia is often undiagnosed as the child is seen only as shy with strangers. Developmental loss in learning social competence at this age may result in long term vulnerability to leading a marginal life and depression.

Obsessive-Compulsive Disorder (OCD) – Obsessions are recurrent, intrusive, inappropriate and unwanted thoughts, or images, which cause **significant anxiety to the extent they interfere with usual functioning**. The child or youth unsuccessfully tries to suppress, ignore, or counteract these thoughts with another thought or act. Compulsions are repetitive behaviours (e.g., washing, ordering, checking) or mental acts (e.g., praying, counting) that the child does to reduce distress and/or prevent a dreaded outcome. Children may not recognize their behaviour as being unusual and by the time parents are aware the disorder is often well established.

Panic Disorder – At least one panic attack (acute episode of unprovoked, intense fear/distress accompanied by somatic or cognitive symptoms) resulting in worry about having another panic attack and its implications or engaging in significant behavioural avoidance.

Post Traumatic Stress Disorder (PTSD) – Following an exposure to significant trauma, the child or youth shows avoidance or re-experiencing of the trauma for at least one month as illustrated by: intense fear, disturbing dreams, flashbacks, helplessness, physiological agitation upon seeing reminders of the event, or disorganized/agitated behaviour. The child then avoids or responds “numbly” to things associated with the event (e.g., avoids trauma related thoughts, feelings, conversations, people, activities or places, cannot recall important parts of the trauma and withdraws from significant activities).

Generalized Anxiety Disorder (GAD) – At least 6 months of excessive and uncontrollable daily worry about multiple themes (e.g. school, family safety, world issues, natural calamities, friends, personal performance) that results in physical symptoms (e.g. fatigue, irritability, restlessness, poor concentration, muscle tension, sleep disturbance) and functional impairment.

Separation Anxiety Disorder – Developmentally inappropriate and excessive anxiety for at least 4 weeks by a person under 18 years of age that causes **significant distress or functional impairment** concerning separation from home or those to whom the individual is attached as evidenced by 3 or more of the following: (1) distress when separated (2) worry about separation (3) reluctance to leave home (4) avoiding being alone or going to sleep because of fear of separation (5) nightmares involving separation and (6) complaints of physical symptoms (e.g., headaches, upset stomach) when separation occurs.

Distinguishing normal from problematic fears and anxiety from other diagnoses

Normal fears in Children – All children experience fears that spontaneously resolve. The emotional reactions can be protective and the avoidance appropriate. Common fears of small children are strangers, loud noises and parental separation; for preschoolers it is imaginary creatures, the dark and animals; and in older children and young adolescents it is blood, injury and needles, natural disasters, heights and social situations.

Problematic Fears in Children – Fear is problematic when regular routines (school attendance, social engagement, normal milestones of independence and general well-being) are disrupted or compromised due to significant distress and excessive behavioural avoidance. Children will often present with somatic complaints (shortness of breath or difficulty in breathing, stomach aches, heart palpitations). Parents often report the child or adolescent is “jumpy”, “fidgety”, “nervous”, irritable, oppositional or will have a ‘melt down’, when anxious. Behavioural avoidance usually becomes entrenched because parents, compelled by their child’s obvious distress, accommodate the avoidance.

Examples of anxiety disorders incorrectly appearing to represent another disorder

- Anxious children with aggressive behaviours and ‘meltdowns’ may be misdiagnosed with oppositional defiant disorder.
- Inattention and fidgety behaviour can lead a clinician to think about attention-deficit hyperactivity disorder (ADHD).
- Repetitive movement and pre-occupations characteristic of OCD may suggest self-stimulation and preoccupations associated with Autistic Disorder.
- Social avoidance and impairments in social interactions are symptomatic of both social phobia and high functioning Asperger’s Syndrome. In the case of social phobia, their expressions are dependent upon who is present.

Prevalence of Anxiety Disorders in Children and Youth

Anxiety disorders are the most common mental disorders in children and youth. Life time prevalence rates for experiencing any anxiety disorder are between 14-17%. Females are at greater risk of developing an anxiety disorder than are males; except for OCD where they are equal. Both prevalence and gender differences are similar across racial groups. Higher prevalence for anxiety disorders in children and youth are for: specific phobia, social phobia, and separation anxiety disorder. Moderate prevalence is found for: panic disorder, GAD, OCD and PTSD.

Development of Anxiety Disorders

Individual vulnerability to anxiety disorders appears to be mediated by genetic factors (propensity to anxious arousal, often evident in family members) and environmental factors (exposure to fearful situations, humiliation or trauma, parenting styles of excessive worry, parental rejection, stressful events). Excessive fear is maintained and strengthened by avoidance and cognitive distortions. Avoidance is reinforced by relief of distress while cognitive distortions (e.g. selective attention and recall, and catastrophic thinking) contribute to a perception of imminent danger.

¹Swinson, et al., 2006

²Casper, Belanoff, et al., 1996

Appendix B: Treatment of Anxiety Disorders and Depression in Children and Youth

Treatment of Anxiety Disorders

Cognitive behavioural therapy (CBT) is an evidenced-based, psychological treatment that recognizes biological predisposition to fearful responding and the role of environmental experiences in shaping anxiety disorders. Specifically, CBT assumes anxiety disorders are largely learned and therefore, can be unlearned. Although the family physician does not have time to provide elaborate CBT, there are many brief interventions that can be passed on to parents and or youth, in several minutes, that can result in excellent treatment outcomes. In the case of children, the family physician will primarily be training the parent in how to manage their child's anxiety disorder, whereas with adolescents, treatment may be direct.

A list of community, written and web-based resources is available with this guideline in the patient resource guide. As well, parents can liaise with trained therapists, including those available through the Ministry for Children and Family Development--Child and Youth Mental Health for additional support.

There are 4 general treatment elements to CBT:

1. Education: Provide young people and their parents with information on the condition to help normalize the fear of dealing with the illness and whether it will escalate over the long term. This includes:
 - Assuring them that anxiety disorders are highly treatable and that the child or youth can expect to experience remission with some flare-ups over the life course, particularly when experiencing life stressors.
 - Explaining the psychophysiology of anxiety and what they should do. Discussions can include how emotional thinking produces cognitive biases, and how avoidance brings relief from anxiety but thwarts recovery.
 - Reviewing the treatment roles and what is involved for the child, the family and the physician. By using a collaborative approach to seek agreement to the treatment process and treatment goals, the treatment plan becomes explicit and jointly owned.

2. Behavioural Exposure: Is the therapeutic 'engine of recovery', accounting for most of the treatment outcome. To ensure that it becomes a central feature of treatment:
 - Behavioural exposure should be introduced early and remain the focus of at least 50% of treatment efforts.
 - Take time to explain why it is so important.
 - For children and youth, it will take courage to systematically face their fears.
 - Discuss with family members that they need to support the child or youth with sustained confidence in the exposure process, despite the likely protestations and pleas to avoid or escape.
 - Throughout the process, provide copious amounts of empathy and faith that sustained exposure will weaken the learned anxiety response to any particular situation, if certain guidelines are followed. These are:
 - Collaborative development of a 'Fear Hierarchy' ('Fear Ladder' for children). Have the parent or youth develop about 10 graded approximations of the feared object or situation, from least to most.
 - Daily homework of planned exposure. Exposure works by (1) fear habituation, and (2) providing evidence that catastrophic expectations did not materialize.
 - The child or youth systematically follows through the Fear Hierarchy, while practicing somatic calming techniques and talking themselves through the experience (rehearsing prepared cognitive corrections to their worry themes). Parents can supervise, motivate, help record and report out on these efforts.
 - Daily sessions six days/week of about 30 minutes each (less for children), or until levels of distress drop by at least 50%. Ensure that exposure is not too brief or infrequent. Physicians can advocate for strong doses of exposure when favourable results are evident.
 - In the case of children, small and instant rewards for exposure are meaningful motivators (e.g., stickers that parents can dispense).

3. Cognitive Self-Control:

- To help children cope, suggest to children to do or say certain things (e.g., "push anxiety off the table", "my brain is hiccupping again", "It's all right for OCD to stay here, I'll do other things"). However, in the case of children seeking reassurance (that something bad will happen), other family members can help by not providing it ("I don't know, let's find out").
- Youth have more awareness and insight into thoughts, beliefs and other cognitive phenomena and can benefit from learning about how emotional thinking differs from critical thinking. For example,

misconceptions arise from overestimating danger, confusing possibility and probability, catastrophic (“what if”) thinking and other cognitive biases introduced by emotional thinking. Learning how to challenge these assumptions and distinguish “internal reality” from “external reality” will help adolescents develop emotional control.

4. Somatic Self-Control: Signs of anxious arousal such as tension validate that there is a reason to be frightened.

- Children can be taught to recognize anxiety by “walking through” times when they felt anxious, and noticing sensations in different parts of the body (e.g. stomach, head, hands) and then learning to relax those particular parts, one at a time and also by building tolerance (e.g. “Lots of kids feel dizzy or have a headache, but they are still able to play and go to school”).
- Youth are able to learn more detailed muscle relaxation techniques.
- Both children and teenagers relate well to controlled breathing (inhaling and exhaling a moderate sized breath volume, then counting 5 seconds before inhaling again – repeat for about 10 cycles).

Treatment Tips for Specific Anxiety Disorders

Specific Phobia

- There are no risks to exposure. It is a graduated exercise in which the patient plays a collaborative role in developing the exposure program and can control entering and staying in the situation.
- In children, fear of dogs is the most common fear. Use concrete approximations of dogs for exposure, starting with outlining one on paper, then have parents view dogs in magazines and books with their child at home, watching friendly dog movies, making trips to a pet store to watch the puppies, watching a non threatening dog confined to its yard, while walking by five times, etc.

Social Phobia

- Role play making ‘light’ conversation to teach and practice what a patient might say when in the community. Encourage good eye contact, correct volume of speech, smiles, and showing appreciation.
- Set up safe experiments for asking questions in class, ordering food in a restaurant, buying a magazine in a store by oneself, etc.
- Have the child or youth practice phoning someone from your office with several things to talk about, and then have them practice the same in the community.
- For children, have parents arrange frequent, short play dates. Ask adolescents to list and engage in at least two social activities per day (e.g. phoning a peer, attending a social event, going out with a friend, reviewing homework with a fellow student at school)
- Encourage age appropriate assertion training.

Separation Anxiety

- Check sleep habits to ensure the child or youth is sleeping in their own bed.
- Remember that separation anxiety can affect adolescents, as well as children.
- Arrange for frequent, short intervals away from mom (e.g. mom goes for a 10 minute walk while the child or youth is alone with an aunt, grandparent).
- Home schooling for a child or youth with separation anxiety is not a good idea.
- Prepare child or youth for coping with and tolerating bouts of anxiousness while in their target environment (e.g. school, camp, overnight at friend’s house) without being “rescued” by parents, or others.
- Focus on daily, graduated exposure that is varied, flexible and rewarded.

Panic Disorder/Agoraphobia

- The magnitude of fear of bodily sensations which are perceived as similar to those of panic is often underestimated. Patients benefit from watching family physicians and parents model interoceptive exposure (i.e. simulation exercises) involving rapid breathing, spinning, etc., and then slowly have the child or youth do the same thing along with the clinician. This helps build tolerance.
- Ensure that young patients understand that panic attacks are safe, painless, private and brief. Encourage them to have them, wherever they are. This helps patients view them as increasingly incidental.
- The treatment of choice for agoraphobia is behavioural exposure. The most common problem in its treatment is that exposure is not daily or focuses only on one theme at a time (e.g. going to the mall). Exposure should be robust and creative. Patients will tolerate exposure better if accompanied at first by a trusted other and then if the trusted other arranges to meet them in the target area after the client has accomplished planned exposure alone.

Generalized Anxiety Disorder

- Children and youth relate well to the concept of chaining of thoughts, where one worry provokes another, and the need to “break the chain”.
- Focus on 2-3 worry themes in the same week, instead of completing one worry hierarchy before addressing another.
- Help children and youth with GAD make frequent “behavioural experiments” to test their worries (“if that were true, what would you predict will happen tomorrow when...? Lets see if it is true.”), collect the evidence for or against the prediction and then modify the prediction and belief accordingly (“Well maybe it doesn’t happen very often”).
- Help patients reframe worries into problem solving (“What could you do to help ensure this doesn’t happen?”).
- Have patients estimate the possibility and probability of a feared event occurring within a particular time frame, and help them draw the appropriate conclusions when their biases are revealed.

Obsessive Compulsive Disorder

- Compulsions often change over time. Prepare and encourage patients and their parents to treat new compulsions the same way they managed the old compulsions.
- Often sexual obsessions are not approached because of embarrassment on everyone’s part, although they are common, even amongst children.
- To help kids know that they are not a “freak”, ask them to calculate the number of kids in their school who have OCD even though they don’t know who they are, by multiplying the number of students in their school by 2%.

Post Traumatic Stress Disorder

- Children who have experienced sexual abuse require significantly more time for development of trust, assessment and preparation for exposure than do older youth.
- Family physicians may avoid exposure because of the myth about re-traumatizing the patient, thus depriving them of treatment gains. Exposure needs to be conducted in a prepared, sensitive and developmentally appropriate manner, but should not be avoided (for detailed recommendations in exposure with children and youth, see Kendall, et. al., 2005; and Bouchard et. al., 2004).

Examples of Common Treatment Errors

Underexposure: Behavioural exposure to feared objects or situations may appear to be harsh as it heightens distress and runs counter to parent’s protective tendencies. Avoiding exposure is to become complicit in maintaining the child’s anxiety disorder. Exposure should be done empathetically:

- Carefully explain how it works (habituation of learned fear responses and demonstrating that feared outcomes don’t occur).
- Break it down into manageable steps.
- Acknowledge the courage required to face one’s fears.
- Model the process, providing encouragement and support/rewards.
- Trouble shoot exposure failures and negotiate renewed exposure trials, while coaching the child or teenager with a sensitive, but can-do approach, utilizing the exposure guidelines.

Distraction by Emotional Circumstances: Often young patients and their families live in volatile circumstances or the client has multiple problems and disorders. This can distract attention from focusing on the treatment plan and can serve as a justification for procrastination. Clinical judgment will allow the family physician to separate out issues and circumstances into a treatment plan which establishes a treatment hierarchy and specifies the order in which various problems will be addressed. Despite such plans, patients and their families often lose sight of what or why they are supposed to do certain things. Clinicians must “stay the course” and draw on considerable skill and experience in helping patients remain focused on therapeutic objectives despite environmental or emotional distractions.

Failure to Measure: In Cognitive Behavioral Therapy (CBT), measurement is an indicator of both treatment compliance and progress toward objectives. It should be relevant and routine and does not need to be complicated. If CBT stalls or fails to achieve one or more treatment goals, the question is why? Was the treatment step too difficult, were the instructions unclear, or are there other reasons why progress was not made? Routine measurement is the easiest way to address these questions. As well as promoting accountability

and shortening the length of treatment, it provides feedback relevant to treatment efforts which can identify roadblocks early or increase momentum and motivation when monitoring indicates objectives are being achieved.

Depression Treatment Tips

Normal Routines: Depressed youth are prone to avoidance, including staying up unusually late, sleeping in, social withdrawal and postponement of many normal activities. They should be strongly encouraged to reestablish normal routines, despite not feeling like it, including social activities and physical exercise.

Being Assertive: When depressed, youth forfeit control over their lives and become passive/non-reactive. They benefit from becoming assertive and taking more control of daily activities and opportunities. Behavioural competence (e.g., starting conversations, organizing one's day, getting small tasks completed as soon as possible) improves mood.

Healthy Thinking: Depression encourages introspection, self criticism, tolerance for rumination and other toxic thinking patterns. It helps when youth can recognize and suppress these bad habits, replacing them with healthy thinking patterns that focus instead on daily goals, problem solving and social support. Depressed youth should be encouraged to focus on their strengths.

Coping with Physical Symptoms of Depression: Depressed youth are distracted by and tend to 'tune into' their physical symptoms using them as the basis for avoidance and procrastination. Building tolerance for symptoms of depression by viewing them as harmless and temporary and as something that should be ignored helps an adolescent become more productive and positive in mood.

Appendix C: Selective Serotonin Reuptake Inhibitor (SSRI) Monitoring Form*

SSRI Medication Monitoring: Rate both symptoms and side effects using a 0 to 3 scale.

0=not present 1=a little 2=a moderate amount 3=severe and/or frequent

Note: It is important that parents or the adolescent do a baseline for both symptoms and “side effects” before treatment to have a comparison. Extra spaces are provided to add individual target symptoms or side effects.

NAME OF PATIENT		MEDICATION				START DATE		
<i>Rate both symptoms and side effects using a 0 to 3 scale. 0 = not present 1 = a little 2 = moderate amount 3 = severe and/or frequent</i>								
DATE:								
DOSE:								
DEPRESSION	BASELINE	2 WEEKS	4 WEEKS	6 WEEKS	8 WEEKS	___ WEEKS	___ WEEKS	___ WEEKS
Depressed mood								
Irritable mood								
Sleep problems								
Fatigue								
Poor concentration								
Appetite problems								
Agitation								
Suicide ideas								
Hopelessness								
Worthlessness								
Social withdrawal								
Slowed down								
ANXIETY	BASELINE	2 WEEKS	4 WEEKS	6 WEEKS	8 WEEKS	___ WEEKS	___ WEEKS	___ WEEKS
Insomnia								
Uncontrollable worry								
Panic attacks								
Avoidance								
Stomach aches								
Fatigue								
Poor concentration								
Compulsive habits								
Obsessive thoughts								
Social anxiety								
SIDE EFFECTS	BASELINE	2 WEEKS	4 WEEKS	6 WEEKS	8 WEEKS	___ WEEKS	___ WEEKS	___ WEEKS
Nausea								
Stomach ache								
Headache								
Shakiness								
Agitation								
Rash								
Can't sleep								
Tired/Sleepy								
Inner restlessness								
Muscle spasms								
Twitching								
Heart racing								
Sexual changes								
Apathy/unmotivated								
Sweating								
Dizzy								
Vivid dreams								
Urinary problem								
Diarrhea								
Appetite decrease								
Appetite increase								
Weight loss								
Weight gain								

Appendix D: Measurement of Functional Change in Depressed and/or Anxious Patients

Depression

For parents or the adolescent to determine the status of **depression** it is important to measure and document change in symptoms as well as to measure changes in functional behaviour.

To measure change in functional behaviors in depression, consider measuring frequency or amount of activities such as:

- School or job attendance
- Social activity (e.g., phoning friends, sleepovers with friends, going to movies or the mall with friends)
- Getting up on time, showering and getting ready for the day
- Number of household chores accomplished
- Homework tasks accomplished
- Time spent talking to family members
- Attendance in planned extracurricular activities (e.g., sport, clubs, music)

Depressed youth can count, on a weekly basis, three or four types of activity that are particularly important to them (perhaps have a parent verify). These can be used to gauge progress in overcoming depression.

Anxiety

Functional measurement of change in an anxiety disorder involves:

- (a) Estimating the degree of behavioural avoidance of a feared object, place or situation (this could be both “how much” and “how often”); and
- (b) Estimating the degree of worry or preoccupation the child or youth has about the source of their anxiety on a 10 point scale (from “none”=1 and “most ever”=10).

To estimate change, compare these measures over time.

RESOURCE GUIDE

INFORMATION SOURCES FOR PHYSICIANS

Physician Resources

- CBT available through Child and Youth Mental Health teams (phone 250 387-7027 (Greater Victoria) or toll free 1 877 387-7027 or the website http://www.mcf.gov.bc.ca/mental_health/pdf/services.pdf)
- Self-help materials based on CBT at the ADABC (phone (604) 525-7566) or website (<http://anxietybc.com/site/> and the video/interactive info <http://www.anxietybc.com/resources/introduction.php>)
- Self-help materials (e.g. “Dealing with Depression”) designed to help depressed adolescents available through the MCFD Child and Youth Mental Health website (http://www.mcf.gov.bc.ca/mental_health/pdf/dwd_printable.pdf) and the Knowledge Network tool (<http://www.knowledgenetwork.ca/>)
- BC College of Physicians and Surgeons Selective Serotonin Reuptake Inhibitor (SSRI) Monitoring Form (see Appendix C) or download from <http://www.cpsbc.ca>
- Pharmacare Plan G if financial assistance is needed for medication coverage. Information on Plan G <http://www.health.gov.bc.ca/pharmacare/sa/criteria/mentalhealth/mentaltable.html> and the form is available at <http://www.healthservices.gov.bc.ca>.

Tools and Skills for Parents and Kids

- Anxiety BC <http://www.anxietybc.com/parent/index.php>
A practical strategies and tools to help you manage your child’s anxiety
Phone (604) 525-7566
- Here to Help BC <http://www.heretohelp.bc.ca/skills/supporting-family>
Understand more, learn skills and connect with others.
Toll free 1 800 661-2121 or (604) 669-7600 (Lower Mainland)
- Youth In BC <http://youthinbc.com/learn-more/mental-health>
Resources for youth including self help, chat room and resources
- Centre of Knowledge an Healthy Child Development http://www.mcf.gov.bc.ca/mental_health/mh_publications/Parent_Info_Bro_BC_Anxiety.pdf
Information on Anxiety Problems in Children and Adolescents, including background information, step-by-step guides, videos and web site references
- Canadian Pediatric Society Caring for Kids <http://www.caringforkids.cps.ca/behaviour&parenting/Fears.htm>
- Dealing with depression: Antidepressant skills for teens http://www.carmha.ca/publications/resources/dwd/DWD_PrintVersion.pdf or phone MCFD at (250) 387-9749 for a printed copy
- The LowDown <http://www.thelowdown.co.nz/#/home> Interactive website on depression from the New Zealand Government

Anxiety, Depression and Mental Health Information

- Canadian Mental Health Association, BC Division <http://www.cmha.bc.ca/resources> or toll free 1 800 555-8222
- FORCE Society for Kids’ Mental Health Care <http://www.bckidsmentalhealth.org>
- Mood Disorders Association of BC at <http://www.mdabc.net> or phone (604) 873-0103
- Centre for Addictions Research of BC, University of Victoria. <http://www.carbc.ca>
- Jessie’s Hope Society <http://www.jessieshope.org> or phone (604) 466-4877
Promotes positive body image
- Alcohol and Drug Information and Referral Service <http://www.communityinfo.bc.ca/adirs.htm> or toll free: 1-800-663-1441 or (604) 660-9382 (Lower Mainland)

Ministry of Child and Family Development

- Ministry of Children and Family Development http://www.mcf.gov.bc.ca/mental_health/index.htm or toll free 1 877 387-7027 or (250) 387-7027 (Greater Victoria)
- What to expect from community child and youth mental health services http://www.mcf.gov.bc.ca/mental_health/pdf/what_to_expect_mhservices.pdf
- What to expect from your child's school http://www.mcf.gov.bc.ca/mental_health/pdf/what_to_expect_school.pdf
- Ministry of CFD general web site http://www.mcf.gov.bc.ca/mental_health/index.htm

General Assistance

- BC Nurse Line, Dial-A-Dietician Dial **8-1-1**
- BC Ministry of Health Services list of Toll-free Information Lines <http://www.health.gov.bc.ca/cpa/1-800.html>
- BC Health Guide Handbook <http://www.bchealthguide.org>
- BC Ministry of Health Services Guideline Anxiety and Depression in Children and Youth available at <http://www.BCGuidelines.ca>
- BC Primary Health Care web site patient information at <http://www.primaryhealthcarebc.ca>

Book Lists

- MCFD booklists available for physicians on anxiety and depression on prescription pads to give to parents. Requests for paper copies can be made at through MCF.ChildYouthMentalHealth@gov.bc.ca
- Ministry of Children and Family Development booklist on anxiety available to download at: http://www.mcf.gov.bc.ca/mental_health/pdf/anxiety.pdf
- Ministry of Children and Family Development booklist on depression available to download at: http://www.mcf.gov.bc.ca/mental_health/pdf/mood.pdf
- BC Mental Health and Addiction Services online library at: <http://www.bcmhas.ca/Library/default.htm>
- Manassis, K., Keys to parenting your anxious child. New York: Barron's Educational Series, Inc; 1996
- Rapee, R., editor. Helping your anxious child: a step-by-step guide for parents. Oakland, (CA): New Harbinger Publications; 2000.
- Taming Worry Dragons (purchase or borrow from library)
 - o The kid's guide to taming worry dragons. Clark SL, Garland EJ, 2004.
 - o Taming worry dragons: A manual for children, parents, and other coaches. Garland EJ, Clark SL, Earle V, 2000.
 - o Tools for taming and trapping worry dragons: Children's workbook. Clark S, Earle V, 2008.
 - o Worry taming for teens. Garland JE, Clark SL, Earle V, (Illustrator), 2002

RESOURCE GUIDE

INFORMATION SOURCES FOR FAMILIES

Some general suggestions and tips for families are provided from the following sources:

Tools and Skills for Parents and Kids

- Anxiety BC <http://www.anxietybc.com/parent/index.php>
A practical strategies and tools to help you manage your child's anxiety
Phone (604) 525-7566
- Here to Help BC <http://www.heretohelp.bc.ca/skills/supporting-family>
Understand more, learn skills and connect with others.
Toll free 1 800 661-2121 or (604) 669-7600 (Lower Mainland)
- Youth In BC <http://youthinbc.com/learn-more/mental-health>
Resources for youth including self help, chat room and resources
- Centre of Knowledge an Healthy Child Development http://www.mcf.gov.bc.ca/mental_health/mh_publications/Parent_Info_Bro_BC_Anxiety.pdf
Information on Anxiety Problems in Children and Adolescents, including background information, step-by-step guides, videos and web site references.
- Canadian Pediatric Society Caring for Kids
<http://www.caringforkids.cps.ca/behaviour&parenting/Fears.htm>
- Dealing with depression: Antidepressant skills for teens http://www.carmha.ca/publications/resources/dwd/DWD_PrintVersion.pdf or phone MCFD at (250) 387-9749 for a printed copy.
- The LowDown <http://www.thelowdown.co.nz/#/home> Interactive website on depression from the New Zealand Government

Anxiety, Depression and Mental Health Information

- Canadian Mental Health Association, BC Division <http://www.cmha.bc.ca/resources>
or toll free 1 800 555-8222
- FORCE Society for Kids' Mental Health Care <http://www.bckidsmentalhealth.org>
- Mood Disorders Association of BC at <http://www.mdabc.net> or phone (604) 873-0103
- Centre for Addictions Research of BC, University of Victoria. <http://www.carbc.ca>
- Jessie's Hope Society <http://www.jessieshope.org> or phone (604) 466-4877
Promotes positive body image
- Alcohol and Drug Information and Referral Service <http://www.communityinfo.bc.ca/adirs.htm>
or toll free: 1-800-663-1441 or (604) 660-9382 (Lower Mainland)

Ministry of Child and Family Development

- Ministry of Children and Family Development http://www.mcf.gov.bc.ca/mental_health/index.htm
or toll free 1 877 387-7027 or (250) 387-7027 (Greater Victoria)
- What to expect from community child and youth mental health services
http://www.mcf.gov.bc.ca/mental_health/pdf/what_to_expect_mhservices.pdf
- What to expect from your child's school
http://www.mcf.gov.bc.ca/mental_health/pdf/what_to_expect_school.pdf
- Ministry of CFD general web site http://www.mcf.gov.bc.ca/mental_health/index.htm

General Assistance

- BC Nurse Line, Dial-A-Dietician Dial **8-1-1**
- BC Ministry of Health Services list of Toll-free Information Lines
<http://www.health.gov.bc.ca/cpa/1-800.html>
- BC Health Guide Handbook <http://www.bchealthguide.org>
- BC Ministry of Health Services Guideline Anxiety and Depression in Children and Youth available at
<http://www.BCGuidelines.ca>
- BC Primary Health Care web site patient information at <http://www.primaryhealthcarebc.ca>

Book Lists

- Ministry of Children and Family Development booklist on anxiety available at: http://www.mcf.gov.bc.ca/mental_health/pdf/anxiety.pdf
- Ministry of Children and Family Development booklist on depression available at: http://www.mcf.gov.bc.ca/mental_health/pdf/mood.pdf
- BC Mental Health and Addiction Services online library at: <http://www.bcmhas.ca/Library/default.htm>
- Manassis, K., Keys to parenting your anxious child. New York: Barron's Educational Series, Inc; 1996
- Rapee, R., editor. Helping your anxious child: a step-by-step guide for parents. Oakland, (CA): New Harbinger Publications; 2000.
- Taming Worry Dragons (purchase or borrow from library)
 - o The kid's guide to taming worry dragons. Clark SL, Garland EJ, 2004.
 - o Taming worry dragons: A manual for children, parents, and other coaches. Garland EJ, Clark SL, Earle V, 2000.
 - o Tools for taming and trapping worry dragons: Children's workbook. Clark S, Earle V, 2008.
 - o Worry taming for teens. Garland JE, Clark SL. Earle V, (Illustrator), 2002

ANXIETY IN CHILDREN AND YOUTH

A GUIDE FOR PARENTS

Children and youth can suffer from anxiety – which may cause or exist with depression. It is very important for children and youth to have support from their families. Family members can help by making sure the young people can make positive changes in their lives. They can also stand behind strategies that have been recommended to overcome the anxiety, watch for signs of progress, and give the child or teen reassurance.

Therapists have training to help children, youth, and their families deal with anxiety. The BC Ministry of Children and Family Development has therapists available to provide such support. This guideline contains a list of therapists and other organizations parents can contact for help.

Parents can help a child or teen to overcome anxieties:

- Encourage regular routines in sleeping, eating and exercising.
- Be calm and confident role models.
- Talk to the child or teen about logical ways to deal with scary thoughts and worries.
- Teach relaxation techniques such as slow breathing.
- Stop the child or teen from avoiding their fears:
 - Make sure you are firm but understanding.
 - Use gradual exposure to help them face their fears.
 - Develop a ‘fear ladder’ using steps to increase exposure to the object they are afraid of.
 - In a fear ladder, the steps begin with mild exposure (an example for fear of dogs is below).
 - Practice exposure for about 30 minutes a day (less for children), 6 days a week, or until the child or teenager seems about half as afraid during any exposure practice.
- Reward courageous behaviour with praise, perhaps treats (e.g. stickers), and ‘talk it up’ in the family.

Suggestions for parents to help children deal with different kinds of anxiety disorders

Specific Phobias: (in other words, fear of certain situations, places or things)

- Practice the exposure techniques described above (facing one’s fears).
- Children are often afraid of needles, masks or clowns, insects and dogs.
- With fear of dogs for example, exposure could include these steps:
 - Look at the outline of a dog on paper.
 - Look at dogs in magazines and books at home.
 - Watch friendly dog movies.
 - Go to a pet store to watch the puppies.
 - Walk past a ‘safe’ dog that is confined to its yard.
 - Pet and play with a ‘safe’ dog.

Social Phobias: (in other words, being afraid of social situations or being watched by others)

- At home, practice what a child might say when interacting with others at school or in the community. This could involve making eye contact, speaking clearly, smiling or showing appreciation (if appropriate).
- Practice situations like asking questions in class, ordering food in a restaurant, and buying a magazine in a store by oneself.
- Practice phoning a friend. Be prepared to have several things to talk about. Then practice for similar face-to-face interactions away from home.
- Arrange frequent, short play dates for children. For youth, ask them to list and carry out at least two social activities every day. Examples are phoning a friend, going to a social event, and reviewing homework with a classmate.
- Practice assertion training that fits a child’s age group. Examples are speaking up for one self, asking others for help, and expressing opinions.

Separation Anxiety: (in other words, severe distress about being away from home or apart from people who are important to them). Both youth and children can experience this.

- Make sure that the child sleeps in his or her own bed.
- Have the child spend short periods away from parents as often as possible. For example, mom could go for a 10 minute walk while the child is with an aunt or grandparent.
- Gradually increase the length of time the child and parent are apart. Use different situations and give rewards.
- Home schooling is not a good choice for dealing with this disorder because a child can miss out on normal social development. If home schooling is used, expose the child to lots of different social settings.
- Help a child or teen to cope with stress in uncomfortable situations (like school, camp, or staying overnight with a friend) without being rescued by parents.

Panic Disorder: (in other words, severe and unexpected attacks of fear that also cause physical symptoms)

- Panic disorder can cause physical symptoms (like increased heart rate, feeling dizzy and stomach aches) that are scary but harmless.
- Parents can make sure that a child understands that panic attacks are safe, painless, and private (nobody else can see them), and they only last a few minutes.
- With practice, the symptoms will eventually go away. Parents can help children plan how to choose situations where they might panic and then practice coping with panic symptoms.

Generalized Anxiety Disorder: (in other words, frequent, intense worry about many things, such as school, the safety of their family, or world events)

- Explain to the child or teen that worry is not useful. What works better is to try to solve the problem. For example, ask what he or she could do to make sure that the scary situation doesn't happen.
- Children and youth usually understand what it means when one worry brings on another. They can then understand the need to "break the chain" of worrisome thoughts.
- Worries are usually every day concerns that are magnified. Examples are being worried about the health of parents, being accepted by peers, and performance at school.
 - o Parents can help by testing a child's worries. For example, a parent might say, "If that were true, what do you think will happen tomorrow? Let's see if it really happens."
 - o Parents can also collect the evidence for and against the worry and try to change the child's belief. For example, a parent might say "Maybe it doesn't happen very often after all, would you agree?" Parents should also be careful not to tell a child that an event they are afraid of can never happen.
- Young people with generalized anxiety disorder have trouble dealing with uncertainties – in other words, it's not clear what will happen next. Parents can help by exposing a child to situations with uncertain outcomes as often as possible. When a child wants to be reassured, the parent can say something like "I don't know, I guess we'll find out".

Obsessive Compulsive Disorder (OCD): (in other words, thoughts, images, ideas or impulses that are not welcome and that interfere with their lives.)

- Children with OCD usually need the help of a trained therapist.
- Parents can support the treatment in a number of ways:
 - o Help the child or teen deal with the worries or obsessions that they fear by separating the fears into categories. Examples of worries are contamination by dirt or germs and anxiety about whether something is turned off.
 - o Once the worries are organized they can be put into 'fear ladders' that arrange the worries from those that are feared the least to those that are feared the most.
 - o Coach the child through exposure to the feared situations or events. When you do this, make sure the child or teen cannot reduce the anxiety this causes by using OCD behaviours such as rituals of washing, checking or 'fixing'. If this behaviour is allowed it will undo any gains that have been made. Children and youth with OCD can be very strong-willed about their rituals and parents must be even more strong-willed.
 - o Exposure should happen every day and should be practiced. Start with low-level exposure and gradually build up.
 - o Give rewards to help motivate the child or youth to progress.
- If worries or compulsions change over time, treat the new ones the same way.
- Reassure the child or teen that they are not "freaks". Tell them that one out of every 50 kids in their school has OCD. To get a concrete number, ask them about how many kids are in their school and then work out how many may have OCD.

DEPRESSION IN CHILDREN AND YOUTH

A GUIDE FOR PARENTS

When a child or youth is depressed, support from their family is very important. Family members can help by making sure the young people have opportunities to make positive changes and choices. They can also watch for improvements, reward positive behaviour, and give lots of reassurance.

Parents can help a child or teen by encouraging them to:

Follow Normal Routines

Children and youth who are depressed often postpone activities and withdraw from friends and social situations. They may stay up too late and sleep too much.

- Help your child or teen get into normal routines.
- Make sure they get lots of physical exercise. Even if they say they don't feel like it, exercise will help them feel better.

Set Goals

Depression may cause children and youth to give up on their goals.

- Talk to your child or teen and help them to list some personal goals. Then break these goals down into small tasks they can do each day. This will give them a sense of accomplishment.

Act with Confidence

Depressed children and youth may seem passive and emotionless. They may feel that they have no control over their lives.

- Help your child or teen to become more assertive and take responsibility for daily activities. For example, encourage them to start conversations and organize a daily schedule.

Think Positively

Depression causes children and youth to think negatively about themselves and others. Parents can help them to recognize and avoid these negative thoughts.

- Boost your child's or teen's self esteem. Help them to see their strengths.
- Teach them to focus on daily goals and achievements rather than negative thoughts.

Increase Socialization

Depressed children and youth withdraw and lose contact with friends and family.

- Encourage them to spend time with their friends.
- Keep the children and youth busy. Make sure they don't spend too much time alone. Try to get them to take initiative and set up social activities themselves.

Cope with Physical Symptoms of Depression

Depression causes physical symptoms like tiredness. Children and youth may use these symptoms as excuses to avoid tasks and activities.

- Help children and youth understand that these symptoms are temporary and harmless.
- Teach them to cope by not allowing the symptoms of depression to interfere with activities.

Post Traumatic Stress Disorder (PTSD): After an upsetting event a child or teen may have disturbing dreams. They may re-live the trauma, avoid things related to the event, and have physical symptoms of anxiety.

- Prepare a child or teen by asking permission to talk about what they've been through. Make sure they feel safe, respected and in control of when and how much they talk.
- It will not harm the child or teen if they willingly talk about their experience. Sharing their feelings in a safe setting can free them of the emotional responses that are causing the anxiety. For young children, sharing may start with drawings followed by talking.
- Parents can start by letting a child describe the experience in general and then slowly move on to more detail, including a description of the child's feelings.
- Make sure to offer support and encouragements. After a bit of sharing, the session can end until the next time – like closing a book after reading a few pages.
- Parents can help a child or teen to make sense of the memories by letting them know that sometimes the world is not safe. Parents can talk to a child about what can be learned from the experience. Make sure a child does not blame himself or herself. The child or teen should be recognized as a survivor and praised as someone who is brave enough to cope when difficult things happen.