

Identification, Diagnosis & Treatment of Childhood Anxiety Disorders

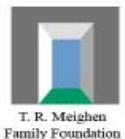
A Package for First Contact Health Providers

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Kathryn A. Weldon
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The Practice Support Program (PSP) is an initiative of the General Practice Services Committee, which is a joint project of the Ministry of Health and the BC Medical Association.



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A Package for First Contact Health Providers

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Acknowledgment: **Pamela Hinada** provided technical assistance and project coordination.

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Introduction

This package is provided as an overview of anxiety disorders in children and how first contact health providers can identify and address this issue in an effective, clinically relevant and best evidence-driven manner.

The package is divided into two parts:

1) Overview

An informational overview to help first contact health providers understand how to identify, diagnose and treat anxiety disorders in children.

2) Toolkit

A toolkit for first contact health providers containing useful resources for assessing and treating anxiety disorders in children.

Throughout this package hyperlinked text is highlighted in [blue underline](#) that, when clicked, will link to either a resource within the package or to an external website where additional information can be found.

This program offers the health care provider a comprehensive, sequential and rational framework for addressing childhood anxiety. Each health care provider will be able to extract from this program those components that they can best apply in their own practice setting. By building on the information presented in this course and by utilizing those components of the toolkit that best meet the realities of their practice each health care provider can customize their approach to the treatment of their patient.

For health care practices in which there exist family care teams, different providers can use the various components of the toolkit, with the team leader being responsible to ensure integrated monitoring of ongoing care.

Primary health care providers can appropriately deliver effective treatment for anxiety disorders to children. Here's how...

Key steps

1. [Identification of youth at risk for anxiety disorders](#)
2. [Useful methods for screening and diagnosis of anxiety disorders in the clinical setting](#)
3. [Treatment template](#)
4. [Suicide assessment](#)
5. [Safety and contingency planning](#)
6. [Referral flags](#)

Step 1. Identification of children at risk for anxiety disorders

Child and Adolescent Mental Health Screening Questions

Historical factors:

1. Parent has a history of a mental disorder (including substance abuse/dependence)
2. Family has a history of suicide
3. Youth has a childhood diagnosis of a mental disorder, learning difficulty, developmental disability, behavioural disturbance or school failure
4. There has been a marked change in usual emotions, behaviour, cognition or functioning (based on either youth or parent report)

One or more of the above answered as YES, puts child or youth into a high risk group. The more YES answers, the higher the risk.

Current situation:

1. Over the past few weeks have you been having difficulties with your feelings, such as feeling sad, blah or down most of the time?
2. Over the past few weeks have you been feeling anxious, worried, very upset or are you having panic attacks?
3. Overall, do you have problems concentrating, keeping your mind on things or do you forget things easily (to the point of others noticing and commenting)?

If the answer to **question 1** is YES – for adolescents, consider a depressive disorder and apply the KADS evaluation and proceed to the [Identification, Diagnosis and Treatment of Adolescent Depression](#).

If the answer to **question 2** is YES – consider an anxiety disorder, apply the SCARED evaluation and proceed to the Identification, Diagnosis and Treatment of [Child](#) or [Youth](#) Anxiety Disorders

If the answer to **question 3** is YES – consider ADHD, apply the SNAP evaluation and proceed to the Identification, Diagnosis and Treatment of [Child](#) or [Youth ADHD](#).

Remember that some cases of anxiety and depression may demonstrate positive scores on the concentration component of the SNAP. If no hyperactivity components are identified on the SNAP review for ADHD please assess for depression and anxiety using KADS and SCARED.

Next steps:

- If patient is positive for depression and either Anxiety or ADHD and the patient is an adolescent, continue to apply the KADS protocol for Depression.

- If positive for Depression, treat the depression and following remission review for presence of continued Anxiety Disorder or ADHD.
- If positive for Anxiety Disorder at that time, refer to specialty mental health services for specific anxiety disorder psychotherapy (CBT) and continue SSRI medication treatment.
- If positive for ADHD at that time, add a psychostimulant medication following the protocol in the ADHD module or refer to specialty mental health services.

Fast Facts about Anxiety in Children

- Childhood is generally considered to be the years from toddlerhood to puberty (~2-12 years of age).
- Anxiety is ubiquitous and is developmentally appropriate in new situations and in response to stressors (such as first day at school, some separations from parents, etc.).
- Normal or expected anxiety must be differentiated from an anxiety disorder.
- Anxiety disorders affect 8-10% of children.
- Most anxiety disorders begin in childhood and adolescent years.
- Many individuals with anxiety disorders complain primarily of physical symptoms and first present to their family physician or health care provider with a “physical” concern.
- An individual can be affected by different anxiety disorders throughout their life course. Separation anxiety disorder is a common childhood anxiety disorder and can be a precursor for other anxiety disorders and depression in adolescents and young adults.
- Onset of an anxiety disorder can lead to poor economic/vocational/interpersonal outcomes and increased morbidity (comorbid anxiety disorders, major depressive disorder, and alcohol and drug abuse) and mortality (suicide).
- Anxiety disorders in children can have a significant impact on family, social and school functioning.
- Chronic anxiety disorder can lead to poorer physical health outcomes and increased cardiovascular morbidity and mortality in mid-life.
- Effective treatments can be provided by first contact health providers are available.
- Early identification and early effective treatment for child onset anxiety disorders can decrease short-term morbidity and improve long-term outcomes (including decreased mortality).

Identification of Children at Risk for Anxiety Disorder

First contact health providers are in an ideal position to identify children at risk to develop an anxiety disorder. The following table has been compiled from scientific literature and can be used by a health provider to identify those children who should be periodically monitored for onset of anxiety.

Anxiety Disorder in Children, Risk Identification Table

Significant risk effect	Moderate risk effect	Possible “group” identifiers (these are not causal for anxiety disorder but may identify factors related to adolescent onset anxiety)
<ol style="list-style-type: none"> 1. Family history of anxiety disorder 2. Severe and/or persistent environmental stressors in early childhood 	<ol style="list-style-type: none"> 1. Children with shy, inhibited and/or cautious temperament (innate personality type) 2. Family history of a mental illness (mood disorder, substance abuse disorder) 3. Have experienced a traumatic event 4. Substance misuse and abuse (early onset of use including cigarette and alcohol) 	<ol style="list-style-type: none"> 1. School failure or learning difficulties 2. Socially or culturally isolated 3. Bullying (victim and/or perpetrator)

What to do if a child is identified as at risk?

Educate about risk

Even with numerous risk factors, an anxiety disorder is not inevitable but it may occur. If it occurs, the sooner it is diagnosed and effectively treated, the better. It is more helpful to check out the possibility that problems may be anxiety related than to ignore symptoms if they occur. Primary care health professionals who provide services to families are well placed to educate parents about potential risks for anxiety in their children. Family members (child included at an appropriate age) should be made aware of their familial risk for mental disorders the same way they are made aware of their family risk for other disorders (e.g.: heart disease, breast cancer, etc.). [Access additional resources for parents about childhood anxiety.](#)

“Many school districts throughout BC are offering the FRIENDS program, which is a school-based early intervention and prevention program, proven to be effective in building resilience

and reducing the risk of anxiety disorders in children.” More information about the program can be obtained at http://www.mcf.gov.bc.ca/mental_health/friends.htm

Obtain and record a family history of mental disorder

Primary health care providers should take and record a family history of mental disorders (including substance abuse) and their treatment (type, outcome) as part of their routine history for all patients. This will help identify young people at risk on the basis of family history.

Agree on a “clinical review” threshold

If a child is feeling very anxious, distressed, sad and/or irritable, and they are not functioning as well (avoidance, poor coping) at home, school or socially, for more than several weeks, this should trigger an urgent clinical review. The onset of suicidal ideation, a suicide plan or acts of self-harm must trigger an emergency clinical review.

Arrange for a standing “mental health check-up”

The mental health check-up could be 15-minute office/clinical visits every 6 months during the childhood years in which a clinical screening for anxiety is applied to the at risk child. Anxiety symptoms are generally worse during the school year and better in the summer months. Some increased anxiety in the few weeks before school is seen in most children, but should not cause severe distress or dysfunction and should improve within the first few weeks of school. The Screen for Child Anxiety Related Emotional Disorders (SCARED) is a 41-item anxiety screen with child and youth self report as well as parent report found in links below.

One potentially useful approach is to ask the parent to bring in the child’s school reports. Check for a pattern of declining grades, frequent late arrival or frequent absences. These patterns may indicate a mental health problem. Children with anxiety also report a lot of physical complaints, particularly on school mornings or before an event. Children who have frequent stomach aches and nausea and/or headaches on school mornings or at the end of the weekend, but have no evidence of being sick (no fever, not vomiting) could have symptoms related to anxiety. These symptoms usually improve once they are in school for the day, but may also occur in school throughout the day in new situations and in response to stressors.

It is useful to ask parents about how their child compares to other children of a similar age regarding such issues as: being away from the parent; need for reassurance; comfort with exploring novel situations; physical complaints. If their child shows substantially more anxiety type symptoms it is useful to assess for the presence of an anxiety disorder or other mental health problem.

Confidentiality and understanding that treatment is by informed consent

Part of the education should include a discussion about risk and benefits in proceeding with anxiety treatment, as well as confidentiality and informed consent to treatment for both the child and the parents. For parents, knowing what they can expect in terms of being informed about their child may help them feel more comfortable about how treatment will occur if it becomes necessary.

As children generally visit health care providers infrequently, screening should be applied to both high risk and usual risk child at scheduled clinical contacts. Routine vaccination and start of school visits provide an excellent opportunity to screen for mental health.

A self-test with good sensitivity and specificity should be used. It is helpful to have parents report as well, particularly when working with children. The SCARED has both a [SCARED child self report](#) and a [SCARED parent report](#) and can be used by clinicians at no cost. This instrument has been studied in clinical and population samples and demonstrated excellent sensitivity and specificity. Ensure that you provide the child and family with feedback on their results.

- It is helpful to evaluate highly anxious children for depression as well, as anxiety disorders increase the risk of developing depression. The [Center for Epidemiological Studies Depression Scale for Children \(CES-DC\)](#) is a useful self report tool that is relatively easy to use and is available at no cost.
- Results should be interpreted in the context of the child, taking into consideration other clinical factors such as history and presentation.
- Depression in children is not as common as in adolescents, but can occur and is an important risk factor for self harm and suicide.

Step 2. Useful methods for screening and diagnosis of anxiety disorders in the clinical setting

An overall mental health screening should be part of general health visits. The anxiety disorders screening has to be especially directed to those children showing frequent worries and fear, diminished participation in social activities, academic underachievement, irritability, as well as frequent physical complaints such as head or stomach aches that can not be explained by a physical illness, but not limited to these clinical presentations. From a developmental perspective the presentation of anxiety symptoms may change over time.

As children generally visit health care providers for specific ailments or for annual checkups, screening should be applied to both high risk and usual risk child at scheduled clinical contacts. Child visits for vaccination or annual checkups are an excellent opportunity to screen for mental health problems.

A recommended clinician assessment and monitoring tool for anxiety is the SCARED. It is a self-report instrument that can be helpful in the diagnosis and monitoring of anxiety disorder in children, and includes both a child and parent version. This can be used either on its own to determine if Anxiety Disorder may be present, or the initial screening questions described above may be used. When using the SCARED tool, ensure the young person, their parents, and their teachers are provided with feedback on the screening results!

Diagnosis of Anxiety Disorders in Childhood

Anxiety for some children may only occur in specific situations or environments and for others can be more generalized. It is important to distinguish between appropriate and adaptive anxiety and stress, and an anxiety disorder. An anxiety disorder is of long duration (usually lasting for many months), significantly interferes with functioning, and is often out of synch

with the magnitude of the stressor. Anxiety disorders will usually require health provider intervention, while stress induced anxiety is usually of short duration (less than a couple of weeks) and is likely to resolve spontaneously or be substantially ameliorated by social support or environmental modification alone.

Diagnosis of Anxiety Disorders in children is currently made using [DSM IV-TR criteria](#).

Distress

- Usually associated with an event or series of events
- Functional impairment is usually mild
- Transient – will usually ameliorate with change in environment or removal of stressor
- Professional intervention not usually necessary
- Can be a positive factor in life – person learns new ways to deal with adversity and stress management
- Social supports such as usual friendship and family networks help
- Counseling and other psychological interventions can help
- Medications should not usually be used

Disorder

- May be associated with a precipitating event, may onset spontaneously, often some anxiety symptoms predating onset of disorder
- Functional impairment may range from mild to severe
- Long lasting or may be chronic, environment may modify but not ameliorate
- External validation (syndromal diagnosis: DSM*/ICD*)
- Professional intervention is usually necessary
- May increase adversity due to resulting negative life events (e.g.: anxiety can lead to school refusal and avoidance of normal developmental steps like independent activities with peers)
- May lead to long term negative outcomes (social isolation, low self esteem, lack of independence, depression, substance abuse, etc.)
- Social supports and specific psychological interventions (counselling, psychotherapy) are often helpful
- Medications may be needed but must be used properly

* DSM- Diagnostic and Statistical Manual

* ICD – International Classification of Diseases

Clinical Screening for Child Anxiety in the Primary Care Setting

Clinical screening can be effectively and efficiently conducted by primary care providers – who are often the first point of contact for concerned parents or school authorities, and who may know the child and family well. Conducting this brief screening question may allow the health provider to recognize if further anxiety investigation is needed or not.

Who to screen?

- Child presenting with symptoms of worries, nervousness, fear, diminished participation in social activities, academic underachievement, irritability or difficulty concentrating.
- Child with numerous somatic complaints, such as tiredness, headache, stomach ache, nausea and light headedness, that are not easily explained by a known physical illness and which vary in duration, frequency and intensity over a long period of time.
- Child at risk. See the [Anxiety Disorder in Children, Risk Identification Table](#) in this document.

Refer to [Child and Adolescent Mental Health Screening Questions](#). These questions can be included in clinic/office registration materials to be completed by parents or patients before visits, or in the waiting room before the evaluation screening.

Screening Questions for Anxiety and OCD in Primary Care Setting (For parents, but can include older children)

- Does your child worry more than other children you know?
- Do you need to reassure your child excessively and about the same things over and over?
- Does your child have difficulty separating from you to go to school or over to a friend's house?
- What does your child worry about?
- Does worry/anxiety ever stop your child from doing something new or an activity they would enjoy?
- Does your child get a lot of stomach aches and headaches? When do they occur?
- Are there any events/activities/people/places that your child avoids because of fear or anxiety?
- Describe your child's sleep routine (where, when, quality, night routine)?
- Has your child ever missed school or had to come home from school early due to anxiety?
- Has your child ever had an anxiety attack where their heart raced, they couldn't catch their breath, they felt dizzy or lightheaded, and thought they might be dying?
- Does your child have ideas or images that come into their mind and they can't control them?
- Does your child have any routines or behaviours they need to do to that don't seem to make sense or be goal directed? (e.g. ask about germs/dirt worries and handwashing/cleaning, also counting and checking rituals)
- What would be different for your child and for your family if they didn't have anxiety/worry?

Diagnosis of Anxiety Disorder in Childhood Using SCARED

The SCARED is a self-report instrument that can be helpful in the diagnosis and monitoring of anxiety disorders in children. Information on scoring of the SCARED is found on the instrument itself.

An anxiety disorder in a child should be **suspected** if a SCARED score of 25 or higher is found at time of evaluation.

A high SCARED score (25 or higher) does not mean that a patient has a clinical anxiety disorder; it simply suggests a possible diagnosis and the score/items can be used as a guide for further questioning.

If a SCARED score of 25 or higher is found during screening the following is suggested:

- Discussion about important issues/problems in the child's life/environment.
 - Ask about school, home, activities, friends and family. Anxiety disorders interfere in normal developmental tasks and functioning.
- Supportive, non-judgmental problem solving assistance – “supportive strategies” for parents.
 - A child's anxiety can significantly impact the family. Parents will often accommodate their child's anxiety in order to maintain overall family functioning.
 - General self-care of parent and child is important as this decreases overall stress.
 - Strongly encourage and prescribe: regular and adequate sleep; physical activity; healthy eating; positive social activities and supports for primary caregiver.
- Screen for depression – use the [Center for Epidemiological Studies Depression Scale for Children \(CES-DC\)](#).
- Screen for suicide risk, as appropriate. It is important to ask these questions in a developmentally appropriate way. For example, “When you feel sad or scared, do you ever think about not wanting to be alive?”
- Ask the parent to keep a diary of their concerns. They should record the signs and symptoms that their child expresses, how severe they seem, what impact they have (for example, was the tummy ache so strong that the child did not go to school) and what their response to the problem was.
- Schedule a more comprehensive mental health check-up about 1-2 weeks following the initial visit. This second visit could also include a functional assessment, a review of the DSM criteria and supportive education and discussion with parent(s) about possible strategies to deal with problems such as school attendance related anxiety.
- Schedule a third visit 2-3 weeks later to check in, repeat SCARED, and if the anxiety symptoms still persist, review diagnostic criteria (DSM) and make treatment plan as indicated.
 - If concerns about depression persist then the CES-DC should be utilized again. Childhood depression is uncommon and the treatment of depressed children is best applied within a specialty mental health setting or with the guidance of a child psychiatrist.

- If depression is strongly suspected in a child, referral should be made to the appropriate specialty service while treatment for the anxiety disorder is instituted.

Don't get overwhelmed!

There are a number of easy to use clinical tools to assist you with diagnosis and treatment of childhood anxiety disorders. A full assessment of anxiety can be completed in three 15-minute office visits using the suggested framework above. Some clinicians may prefer to integrate the details found in the tools into their assessment interviews rather than use the tools separately. If there is concern about depression and/or suicide risk, then these screens should be done at each visit.

Remember, the onset of an anxiety disorder in children is not an emergency. It is reasonable to conduct the clinical evaluation over a period of time (such as described above). This will allow the clinician to get a clear picture of what is happening and will allow the clinician to determine if the non-specific interventions suggested were enough to address the problems. Persistent signs and symptoms associated with a negative impact on functioning, and little or no response to non-specific interventions is diagnostically indicative of an anxiety disorder.

Types of Anxiety Disorders

Anxiety Disorders are the most common psychiatric illnesses in children, adolescents and adults. Anxiety is a physiological response that is essential to human alertness and survival, involving "fright/flight" neurobiology. In anxiety disorders, this response is no longer adaptive and is either out of proportion to a stressor, or occurs when there is no threat. Some young children are "wired" (brain response) to be more anxious and avoidant in new situations. This is also known as behavioural inhibition. This temperamental style does increase the risk of developing an anxiety disorder in childhood, but some children have no identifiable predisposing factors yet still develop an anxiety disorder.

Anxiety disorders tend to run in families, and this is believed to be related both genetic predisposition and environmental factors. Due to the physiological mechanisms activated through the anxiety and stress response, individuals with chronic anxiety and stress have more risk of both physical and mental health problems. Individuals with anxiety often present to their primary health care provider with frequent physical complaints, and not necessarily reporting anxiety. There are many types of anxiety disorders, and prevalence varies depending on age group. Four of the most common anxiety disorders with onset in children are separation anxiety disorder, specific phobia, generalized anxiety disorder, and obsessive compulsive disorder. Panic disorder and social anxiety disorder usually have onset in adolescence and thus are rarer in children. Obsessive Compulsive Disorder may have onset in childhood or in adolescence.

Social Anxiety Disorder ([Social Anxiety Disorder DSM-IV-TR diagnostic criteria](#))

Social Anxiety Disorder (Social Phobia) is not a common anxiety disorder in childhood, but is the most common anxiety disorder in teens. This change in prevalence is likely linked to the

increased individuation and the importance of peers in adolescent social and emotional development. Onset usually occurs in junior high or middle school years. Socially anxious children are identified as “shy” or “introverted”, which is not accurate. Children who suffer from social anxiety disorder have severe anxiety in social situations that is very distressing and can lead to avoidance and significant deterioration in overall function. Children with social anxiety disorder describe an overwhelming fear of drawing attention to themselves or saying something stupid or embarrassing around others, especially peers. This can lead to not asking questions in class, not talking in front of or to others, or avoiding social events and group activities. When social anxiety disorder is quite severe it can result in isolation to the point where the individual rarely leaves their home, does not have contact with friends and stops attending school. Social anxiety disorder has significant developmental and functional impact on children at a time when they should be developing their own identity and independence.

Separation Anxiety Disorder ([Separation Anxiety Disorder DSM-IV-TR diagnostic criteria](#))

Separation Anxiety Disorder is one of the most common anxiety disorders in children. Separation anxiety is a normal stage of early development, however if it continues into school age, it can cause significant distress and interfere with normal developmental tasks such as going to school and sleeping in one’s own room. Children with separation anxiety disorder fear something bad will happen to them or someone they love (usually parents or caregiver) when they are apart. This fear causes children to avoid being out of sight from the parent or caregiver, or to have significant distress and anxiety when they are separated or anticipate separation. To meet the criteria of separation anxiety disorder, the patient will have experienced this distress for at least 4 weeks. Anxiety symptoms can manifest as physical complaints such as headache and stomach ache on school mornings (that do not occur on weekend mornings), and/or behaviour outbursts, crying, clinging and yelling. Parents with children with separation anxiety disorder will describe their child as not being able to be left with a babysitter, not able to sleep in their own bed (parent falls asleep with them, or they sleep in parents room), and difficult to get them to school in the morning. Often parents will be called from school by children with separation anxiety disorder seeking reassurance that their parent is okay, checking when they will be picked up, or insisting on coming home because they feel sick (due to anxiety). Children with separation anxiety disorder miss out on social opportunities with friends, such as play dates or sleepovers, because they do not want to be away from home or their parent. This disorder can cause significant distress and dysfunction for the child and family, and significantly interfere with development of age-appropriate independence and academic success.

Specific Phobia ([Specific Phobia DSM-IV-TR diagnostic criteria](#))

Many people have fears. Some of the more common things people are afraid of include heights, spiders, snakes, blood, and needles. A specific phobia is fear of an object or situation that is out of proportion to the actual danger, and the anxiety response is extreme and unreasonable. Specific phobias are the most common type of anxiety disorder. This specific fear must be present for at least 6 months and cause the child significant distress and/or impairment in functioning. Children cope with this fear by avoiding the situation or object, or they may have

intense anxiety (possibly panic attack) and distress when faced with it. It is rare for this disorder to cause significant impairment in function in children, as parents will often help their children avoid triggering situations whenever possible. In some cases, such as fear of needles where the child requires blood work or a vaccine, or refusing to go outside due to a fear of a particular trigger such as seeing spiders, the phobia has to be addressed. Fear of choking on certain foods is a common specific phobia which can cause significant physical health concerns if oral intake is restricted. Specific phobias are sometimes preceded by a traumatic event (such as becoming afraid of dogs after experiencing being bitten by a dog) and their onset can also be associated with genetic predisposition, increased stress in environment, and modeling behaviours.

Generalized Anxiety Disorder [\(Generalized Anxiety Disorder DSM-IV-TR diagnostic criteria\)](#)

Generalized Anxiety Disorder (GAD) can begin in both the childhood and adolescent years. Children with GAD are “master worriers”. Their anxiety centers around everyday events and responsibilities in their life, however, their distress and worry is excessive, unrealistic and/or unhelpful, and persists for at least 6 months. GAD sufferers have significant distress both mentally and physically due to their anxiety. Children may report feeling tense, irritable, frequent muscle aches and pains, and difficulty concentrating due to the intensity and chronicity of the worried thoughts and feelings. Other physical symptoms of anxiety common in children are tiredness, headache, stomach ache, nausea, and light headedness. They excessively worry about everyday things such as school, friends, health, future, and finances. However, the intensity and degree of worry is extreme and/or the worries are “adult” type and not developmentally appropriate. These symptoms can make it difficult to fall asleep, or to get restful sleep, and this in turn increases distress. Individuals with GAD may have academic performance anxiety that interferes with starting and completing assignments and taking tests, due to fear of failure. A pattern of avoidance can develop to prevent “failure” or “something bad happening”, and the child may seek excessive reassurance from others that “everything will work out or be okay”. These anxious behaviours lead to increased anxiety, interfere with overall function, and lead to lack of enjoyment and avoidance of everyday activities.

Obsessive Compulsive Disorder [\(Obsessive Compulsive Disorder DSM-IV-TR diagnostic criteria\)](#)

Obsessive Compulsive Disorder (OCD) is an anxiety disorder involving obsessions (distressing intrusive thoughts and/or images) and/or compulsions (repetitive behaviours or rituals performed to relieve distress and anxiety associated with the obsessions) that are unwanted, cause significant anxiety, and interfere with functioning (taking up more than one hour per day). The most common obsession themes are illness and danger related, and the most common compulsions are cleaning and washing rituals, and checking behaviours. Sometimes OCD does not involve any observed compulsions, and the individual could suffer from repetitive images or thoughts (e.g. of violent, religious or sexual nature) which are extremely distressing. The compulsions could be mental rituals such as counting or praying. There could also be avoidance of and distress around things that are associated with or trigger obsessions (e.g. having all the knives removed from the house for someone who has violent obsessive thoughts) and efforts to try and suppress obsessive thoughts. Individuals suffering from OCD often suffer

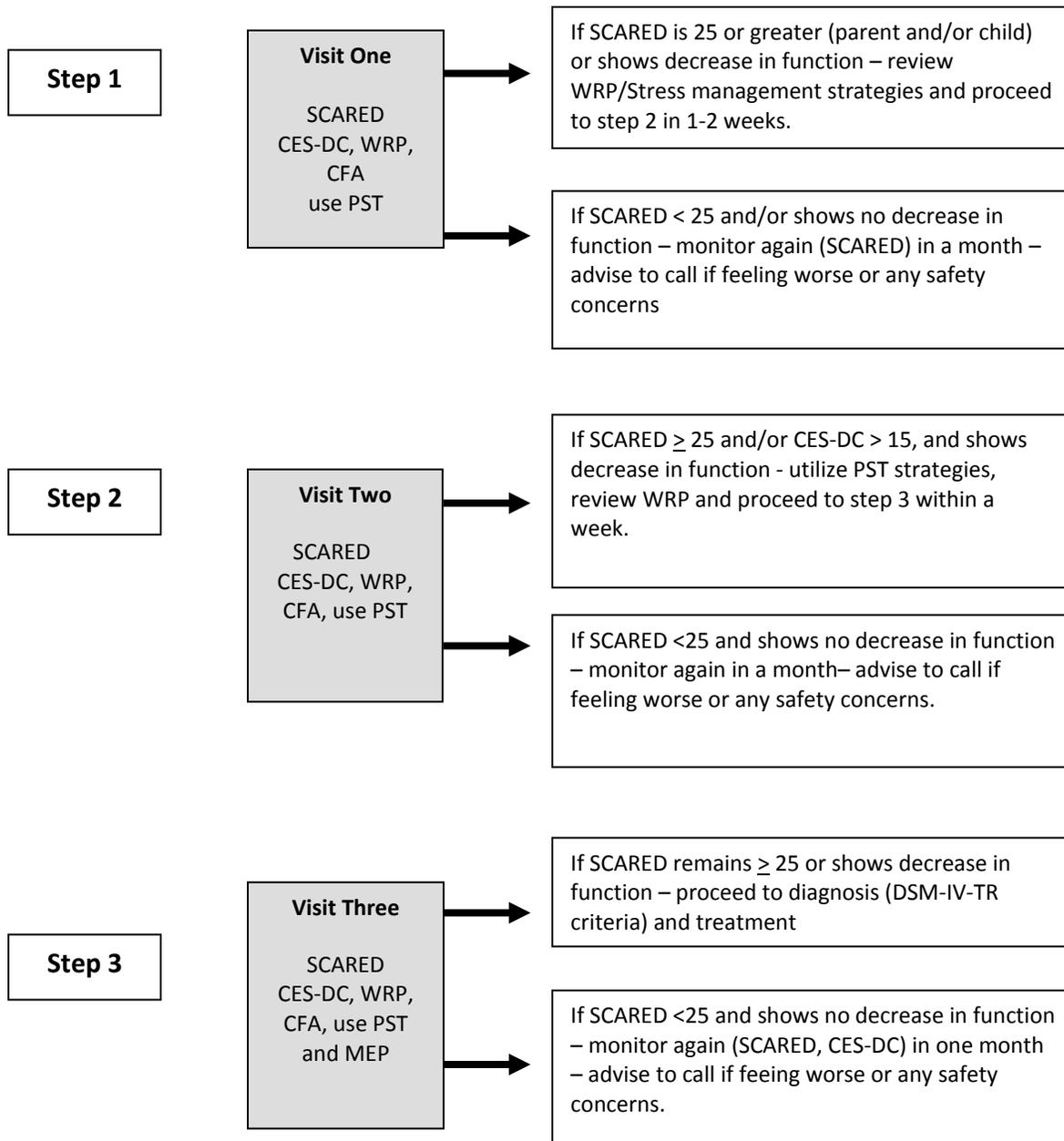
in silence for many years before seeking help. Parents may notice symptoms that are interfering with functioning at home or school, and bring their child or teen to their health care provider to find out what is wrong.

OCD generally has two peaks of onset, in childhood (pre-puberty) and in later adolescence. Children with OCD generally have poor insight into their illness and may not recognize that the obsessions and compulsions are irrational. They may truly believe they need to carry out the compulsions or something very bad will happen, and they can become frustrated and angry if they are not able to complete rituals properly or control their environment to keep OCD “satisfied”. OCD can have a sudden onset of symptoms, but generally has a gradual onset with worsening of symptoms over time. Children suffering from OCD may have trouble going to school, find they are unable to concentrate in class, have difficulty getting out of the house or getting dressed, and have decreased food intake related to obsessions and compulsions. In children, it is quite common for parents and other family members to be involved in OCD routines and compulsions, and this illness can have a significant negative impact on family functioning. Children and youth with OCD have higher rates of developing depression as the illness progresses.

Panic Disorder ([Panic Disorder DSM-IV-TR diagnostic criteria](#))

Panic disorder usually has onset in adolescent years, but sometimes occurs in children. Although not the most common anxiety disorder, this illness can become debilitating quite rapidly. Patients with panic attacks ([Panic Attacks DSM-IV-TR diagnostic criteria](#)) most commonly first present to an emergency room or urgent care clinic because the physical symptoms are acute and escalate quickly. Individuals may think they are having a heart attack, asthma attack or even a stroke or seizure. The individual becomes extremely afraid and believes they are dying or that something terrible is going to happen. Panic attacks can occur in any anxiety disorder or high distress situation. However, in panic disorder these attacks occur “out of the blue” without clear precipitants or warning. This causes extreme fear and anxiety of having another attack, particularly in a place where others might see them or where escape or help might not be possible. Individuals with panic disorder will avoid any situation they associate with feeling panicky, or places where they fear that if they did have an attack they would not be able to manage or get help. In many individuals this can lead to staying closer to home to the point where they will not go to places where there may be groups of people or crowds (agoraphobia). In teens with panic disorder, they may stop all extracurricular activities, refuse to go anywhere without their parent, and may stop going to school (or have extreme distress with school attendance). This deterioration can happen quite rapidly for some individuals after only one or two panic attacks. Individuals with panic disorder can develop depressive symptoms quite rapidly and have a higher associated risk of suicide than other anxiety disorders.

Clinical Approach to Possible Childhood Anxiety Disorder in Primary Care*



* Alternatively, some health care providers may choose to “flush out” the child’s entrance complaint, determine if any safety or immediate referral issues are present (for example: not eating; not leaving house; suicidal – see below for more details), provide the SCARED and CES-DC to the parent and child to complete and then schedule a longer visit in the near future to complete the assessment. The key issue here is to ensure patient safety while providing a long enough assessment period to allow for distress to be better differentiated from disorder.

Step 3. Treatment Template

Treatment of childhood anxiety includes both specific and non-specific factors. Specific factors are evidence-based treatments for anxiety disorders and include: structured psychotherapies (Cognitive Behaviour Therapy (CBT)) and medication. Non-specific factors include activities which decrease stress, improve mood and general well-being PLUS supportive psychological interventions (use the PST in the toolkit as a guide) given by the health provider.

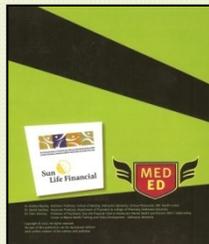
When initiating treatment it is necessary to start by educating the patient or caregiver about the disorder and about the treatment. This should be done over two visits about a week apart with the time between visits spent by the patient and parent or caregiver in self-study and research. To initiate the self-study, direct them to websites in section [Suggested Websites](#) and encourage them to search wherever they want (e.g. to “Google” the specific anxiety disorder) and then bring a list of the questions and concerns to the next visit for discussion.

When providing information about a mental disorder:

- 1) Determine what the child and caregivers know already – about the disorder and the treatment.
- 2) Identify areas of misinformation and provide correct information.
- 3) Identify gaps in knowledge and provide information.
- 4) Be knowledgeable, realistic, clear and helpful.
- 5) Provide written materials to take away or refer parent to [Useful resources for parents.](#)

If prescribing a medication:

- 1) Go over the risks and benefits of medication. Review side effects and Health Canada Warning in detail with parents/caregivers, and give brief overview to child.
- 2) Discuss anticipated duration of medication use, if relevant. For initial treatment of anxiety this will be for about 6-9 months after they get well.
- 3) Discuss how taking medicine will impact their child (e.g.: substances that interact with medication)



Check out MedEd ©

MedEd © is a novel interactive manual that has been designed to optimize psychopharmacologic treatment in young people

Non-specific Interventions

Recent neuro-biological research has provided more clues on how environmental changes may balance brain functioning in those domains known to be associated with control of stress, anxiety and mood such as: serotonin systems; dopamine systems; noradrenaline systems, neurotropic factors (particularly brain derived neurotropic factor (BDNF)); and endorphin systems.

These non-specific interventions include:

- 1) **Exercise** – particularly a minimum of 30 minutes of aerobic exercise daily. Discuss ways the child could incorporate this in their existing routine (e.g. walking to and from school, joining in school program, family activity, playing with friends outside).
- 2) **Sleep** – school-aged children need 10 hours of sleep per night to function optimally. Most children get only 8 to 9 hours per night, due to staying up late and having to wake up for school. Encourage a regular bedtime routine for the child and family. Try to keep the same routine even on weekends and holidays. Ask them to try this for a few weeks and see if they notice any difference.
- 3) **Routine** – children do better when they know what to expect and when. Anxious children in particular have more trouble with uncertainty and change. Keeping to a regular and predictable routine at home and school as much as possible can be helpful in reducing stress and anxiety.
- 4) **Social support** – friend and family interactions – particularly associated with pleasurable activities – should be incorporated in the weekly schedule.
- 5) **Nutrition** – a healthy diet and eating regular meals. Skipping meals, particularly breakfast, can increase stress and anxiety. Snacks are important for younger children who are active throughout the day, encourage them to have something healthy to eat and drink mid morning and mid afternoon between meals. Caffeine and sugar-rich drinks (soda, iced tea, sport and energy drinks) can increase anxiety and agitation. Overall, a balanced diet and regular meals is recommended.
- 6) **Music and movement** – particularly rhythmic “upbeat” music and dance can help with stress and improve mood.

While it is unlikely that application of the above strategies in the absence of medication or psychotherapy will fully “treat” an anxiety disorder “prescribing” a wellness strategy that incorporates most or all of these interventions is concrete, doable and helpful. At the very least, the tendency for an anxious child to be more stressed, to have trouble falling asleep, to experience decreased appetite, and to avoid daily activities and friends should be actively discouraged.

Applying the strategies above in the absence of medication or psychotherapy will not be sufficient treatment for an Anxiety Disorder. However, prescribing the above wellness strategies may be helpful to improve the overall outcome.

Eat Breakfast!

Breakfast is the most important meal of the day, and studies show that eating a healthy breakfast decreases stress and improves how you perform at school and work.

Suggestions: Yogurt plus fruit (berries, bananas, peach etc), fruit smoothie, granola bar, wholegrain cereal/toast.

Engaging the School

It is essential to engage the school when addressing mental disorders in a child. This engagement is important for the following reasons:

1. **Diagnosis** – symptoms of the mental disorder are present in the school setting. Information from the child’s teachers is essential for diagnostic purposes.
2. **Treatment** – treatment of anxiety disorders requires monitoring of outcomes in various domains, including the school.
3. **Adjustments** – Some adjustments in classroom activities, courses or learning engagement styles may be needed to optimize the chances for academic success. This requires the input of teachers and guidance counsellors.

Once a positive diagnosis of an Anxiety Disorder is made, (see [Clinical Approach to Possible Child ADHD in Primary Care](#)) it is time to contact the school. Prior to contacting the school, ensure that the child and the parent or guardian give informed written consent. Although schools may differ in their contact protocols, it is useful to enlist the assistance of the parent or guardian in identifying the school contact person. Usually this will be a member of the senior administrative team, such as a Vice-Principal or a school counsellor. Depending on the school’s policy, the parent or guardian may also have to give consent to the school to speak with the physician. Ensure that this issue is clarified and has been appropriately addressed prior to speaking with the school representative.

It is important to ensure that there is a single contact person in the school for all issues related to addressing the interventions planned. In some cases it may be necessary to meet with the school contact person (and others as indicated) to ensure that the intervention plan is clear and all issues have been considered. Schools usually have a protocol to follow when medical interventions are underway and it is important for you to be informed about how this protocol is applied and what role you will have in its application.

Schools and school contact persons will differ in their familiarity with addressing a mental disorder. It is important to take a little more time at the beginning to ensure all parties are comfortable with what needs to be done, as over time this collaborative relationship will become more established and simpler to navigate.

Love and Affection	<ul style="list-style-type: none"> • Spending quality time with the child individually; demonstrating physical affection; words and actions convey support and acceptance
Stress Management	<ul style="list-style-type: none"> • Parents learn how to manage their own stress and try not to let their stress drive relationships with their children
Strong Relationships	<ul style="list-style-type: none"> • Demonstrate positive relationships with a spouse or partner and with friends. Good modeling with individuals not related is especially relevant in that it can encourage a heavily stigmatized child/youth to reach out to others and establish their own health/balanced social network in preparation for adulthood
Autonomy/ Independence	<ul style="list-style-type: none"> • Treat child with respect and provide environment to promote self-sufficiency
Education/ Learning	<ul style="list-style-type: none"> • Promote and model lifelong learning and encourage good educational attainment for the child
Life Management	<ul style="list-style-type: none"> • Provide for the needs of the child and plan for the future. Teach comprehensive life skills, especially for youth; avoid enabling and instead focus on youth's strengths, gradually targeting what could be improved upon in terms of personal hygiene, interpersonal skills, cooking, cleaning, organization and goal setting
Behaviour Management	<ul style="list-style-type: none"> • Promote positive reinforcement and punish only when other methods have failed and then consistent with the severity of the negative behavior and not in a harsh manner
Self Health	<ul style="list-style-type: none"> • Model a healthy lifestyle and good habits
Spirituality	<ul style="list-style-type: none"> • Provide an appropriate environment in which spiritual or religious components can be addressed
Safety	<ul style="list-style-type: none"> • Provide an environment in which your child is safe, monitor your child's activities; friends; health

**Modified from Epstein, R. What Makes a Good Parent? Scientific American Mind. November/December. 2010: 46 – 49.*

Worry Reducing Prescription (WRP)

It is useful to provide the child with a simple outline developed in collaboration with them and the caregiver that clearly specifies what self-regulatory activities they could pursue during the

diagnostic and treatment phases of their contact with their health provider. The [Worry Reducing Prescription](#) is a useful and time-efficient tool for managing stress that can be used to help the child identify and plan their daily activities. It is embedded below and also provided in the clinician’s [Toolkit](#) as well. In practice, the clinician can review the WRP with the patient, complete the form and then review it at the next office visit.

Worry Reducing Prescription

There are many things that you can do to help decrease stress and improve your mood. Sometimes these activities by themselves will help you feel better. Sometimes additional help (such as psychotherapy or medications) may be needed. This is your prescription for what you can do to help decrease stress and feel better. For each activity “write in” your plan (include what you will do, how often and with whom). This can be done by a health team member or the parent together with the child.

Activity	Plan (what, how often, other supports)
Exercise	
Eating Well	
Sleep	
Problem Solving	
Planning / Organizing	
Social Activity	

Enrolling the Help of Others

Family members could be involved in helping with worry reducing strategies. Other significant persons in the child’s life may also be able to play a role (e.g. teacher, school counsellor, coach, neighbour, etc.). It is a good idea to ask the child about who else can help out and, whenever possible, get the family involved. Always inquire about school performance. Some children with anxiety disorders may need certain interventions or a modified academic approach, since school stress can make some anxiety disorders worse. Discussion with a school counsellor (with permission from the patient and parent) is recommended.

Remember that parental or caretaker involvement is essential during the assessment and treatment of anxiety disorders in a child. Whenever possible, information about the child's emotional state and function should be obtained from the parent or guardian. It is not uncommon for children and parents or guardians to have different opinions about the mental state and activities of the child. When this occurs, joint discussion of the issue will be necessary for clarification and optimal intervention planning. However, it is essential to ensure that appropriate confidentiality is being maintained during this process.

Assessment and Monitoring of Functioning

Functional impairment is an essential component of an Anxiety Disorder diagnosis. In young people, a functional assessment across three domains is an essential component of treatment monitoring. Functional improvement is a necessary target for treatment outcome.

The three functional domains that need to be addressed are:

School	Grades, teacher relationships, attendance
Home	Parental/sibling relationships, home activities
Friends	Peers, down time activities, intimate relationships (when appropriate)

The [Child Functional Assessment \(CFA\)](#) has been developed to assist the primary care provider in the evaluation of each of these components. It is embedded below and also provided in the clinician's Toolkit.

Clinicians can copy and use the CFA without written permission from the author. Some clinicians may choose to incorporate the essential features of the CFA into their standard patient monitoring interviews rather than using the tool itself.

Child Functional Assessment (CFA)

The CFA is a self-report tool, but in some cases it may require the caregiver to help. It is meant to be completed by the patient/caregiver and should take no more than three minutes to complete for most children. The health care provider can use the information obtained on the CFA to probe for further information – especially in those areas where the young person noted worse or much worse than usual and in those domains that the child/caregiver identifies as either self or parental worry.

This form is meant to let your health provider know about how you are doing. All information you give is confidential. Please write your answers to the items on the form.

For each of the following categories, write down one of the following options in the space provided – “much better than usual”; “better than usual”; “about the same as usual”; “worse than usual”; “much worse than usual”. You can also give an example if you would like.

Over the last week how have things been at:

School: _____

Home: _____

Friends: _____

Write down the two things in your life that either worry you the most or are causing you the most problems.

1) _____

2) _____

Write down the two things about you that cause your parents or other adults to be concerned about or that you think might concern them if they knew about these things.

1) _____

2) _____

Sleep Assessment

Sleep is often disturbed in children with anxiety disorders and sleep problems can be a side effect of medication treatment. Therefore it is a good idea to assess sleep during the functional assessment and before treating.

A useful method for assessing quality and quantity of sleep in a child is by asking the parent or guardian the following simple questions:

- What time is the child getting in bed?
- Does the child have troubles falling asleep?
- How long does it take the child to fall asleep?
- Once the child falls asleep, does he/she sleep throughout the night?
- What time does the child wake up?
- Does the child have troubles to waking up?
- Is the child irritable or cranky most mornings?
- Does the child feel tired during the day?
- Does the child nap during the day?

Sleep Hygiene

Good sleep hygiene is an important part of healthy development for all children. Children with anxiety disorders often require greater attention to sleep hygiene due to the disturbances of sleep commonly seen with anxiety disorders. Here are a few helpful sleep hygiene suggestions.

- Set a reasonable bedtime for both week and weekend days
- Get some exercise after school or before homework but not in the hour before going to bed
- No caffeine containing drinks (such as cola, tea, etc.) after dinner
- 30 to 45 minutes of quiet time (no video games and no TV) prior to going to sleep

Psychosocial Interventions

Standard anxiety disorder treatment guidelines recommend the use of cognitive behavioural therapy (CBT) as first line treatment for children with anxiety disorders. CBT is a strong evidence-based practice whereby children often have improvement in their anxiety with CBT alone, and do not require medication intervention. However, if waiting lists for these therapies are long, these psychotherapies are not available, or the family is not able to access services, treatment may need to be implemented with medications, wellness-enhancing activities and supportive rapport. There are also some CBT strategies that can be provided through primary care (see Psychotherapeutic Support for Children and Parents in the next section below). Additionally, there are some [cognitive behavioural self help resources for parents of children with anxiety](#) that provide helpful education and practical skills and tools for parents to help their child better manage anxiety.

Remember that although suicidal ideation and suicide attempts are not as common in childhood anxiety disorders, they may occur, and should be monitored in any treatment modality.

Additionally, evidence suggests that CBT has additional positive effects when combined with a medication treatment in severe anxiety disorders. For example, the addition of SSRI to CBT increases the numbers of children in treatment that no longer meet criteria for an anxiety disorder.

An Important Clinical Point:

Medications should not be used to treat children who have mild to moderate symptoms of anxiety or stress. They should be used only for treating moderate to severe anxiety disorders, and usually in those children with significant impairment in functioning. If you are not sure if it is an anxiety disorder, it is reasonable to offer supportive rapport, suggest wellness-enhancing activities and stress management strategies, and monitor carefully for symptom change and suicide risk. Do not rush into medication prescribing. Use medications for where they are clinically indicated: in severe and unremitting anxiety disorders.

Psychotherapeutic Support for Children and Parents: Practical Pointers for Primary Care Health Providers Treating Childhood Anxiety

This tool provides clinicians with guidelines/suggestions that they can use to direct their clinical interactions with the child and family. It includes some basic cognitive behavioural therapy strategies.

- Approach** Create a supportive and safe space
- Compassionate and non-judgmental attitude with parents and child
 - If parents are very distressed, may be helpful to meet with them without child for part of appointment
 - Give parents a chance to talk and tell the story
 - Ask the child to tell you what they think is the problem
 - Clarification (“help me understand”, “how were you feeling”, etc.)
 - Emotional identification (“seems as if you are feeling frustrated”, “it sounds like both of you are exhausted”, etc.)
 - Show understanding of the situation (“anxiety is tough for everyone in the family, and you have been trying your best to help”)
 - Include a discussion of the child’s strengths and interests
 - If you do not know an answer to a question – admit it and tell them how you will find out
 - Establish confidentiality and limits of confidentiality (abuse, self-harm, danger to others, etc) and be very CLEAR about these
- Provide Education** Provide education about anxiety and education about the treatment (review SCARED and function)
- Anxiety is a necessary feeling for all human beings to survive. It helps protect you in dangerous situations and helps you prepare for challenges. The fright/flight response in your brain is like an alarm that signals danger and gets your body ready to react quickly and run away or fight. For example, if you see a big dog barking that you don’t know, you might run to the other side of the street.
 - The reasons for children developing an anxiety disorder are complex, but family history, temperament (how the child is “wired” to respond to their environment from an early age), modeling, and exposure to psychosocial and environmental stressors can all contribute.
 - Anxiety disorders are disorders caused by changes in the fright/flight alarm signalling in the brain. This leads to the alarm mechanism being activated in situations that are not a threat, or over responding (alarm is too loud) in reaction to the stressor. This then leads to release of stress hormones and adrenaline in your body, and is what causes the physical symptoms of anxiety (e.g. stomach aches, nausea and headaches).
 - Anxiety disorders lead to extreme distress and changes in behaviour to avoid or decrease the anxiety reaction. Your child is in survival

mode when they are anxious, and thus they do not react as you would expect given the situation. It is difficult to reason with someone in the height of anxiety, any discussion needs to take place when they are feeling calmer. The avoidance and reliance on others may temporarily help to decrease anxiety, but can become extreme and interfere with functioning at home, school, socially and in activities.

- Anxiety gets worse over time the more a child avoids or relies on others to help manage anxiety and worry. Anxiety improves when the child learns they can handle their anxiety and worry on their own successfully.
- Anxiety is very treatable and the best treatments include therapy to help your child understand and manage anxious thoughts, worries and behaviours. Occasionally children require medications to help decrease their overall anxiety/panic response, so they use the strategies to manage their anxiety. By helping to change thoughts and behaviours associated with anxiety and worry, the feeling of anxiety and distress improves, physical symptoms lessen, and the child becomes more confident and independent in handling these triggering situations.
- Without treatment, anxiety disorders usually get worse and cause more distress and impairment in function. Untreated anxiety disorders put your child at higher risk of developing later depression and substance abuse.

In OCD, thoughts and images (obsessions) that many children without OCD have and discard (garbage thoughts) become recurring and intrusive in children with OCD (recycled thoughts). This leads to significant anxiety and distress, and compulsions or rituals are performed to temporarily relieve anxiety and distress. The same alarm system (fright/flight) is activated in OCD with the obsessions, and the compulsions help to turn off or quiet the alarm. However, this cycle then strengthens OCD brain communication patterns and makes the obsessions and compulsions stronger (alarm bell louder and more distressing) and more difficult to ignore.

Coping Skills Children and parents develop both helpful and unhelpful ways of dealing with anxiety. Review the current skills and try to increase coping skills.

- What are your current coping strategies? Identify whether they are helpful or unhelpful in the long term. (Helpful: increase child self-reliance and independence. Unhelpful: avoidance and excessive reassurance seeking.)
- Review wellness strategies for stress management above (healthy eating, regular activity, good sleep, daily routine) and make plan for how to make them work.
- Teach relaxation and strategies for calming down (slow, deep, full breathing, progressive muscle relaxation, visual/mental imagery, talk to someone helpful, distraction, warm baths, exercise, doing something engaging or pleasurable).

Cognitive Strategy

Help identify the most important problem at present and identify unhelpful thoughts associated with it. One of the keys in cognitive behavioural therapy is that the child comes up with their own helpful solutions and says them or writes them down. Parent coaching and suggestions are good, but the child has to practice challenging anxious/worried thoughts on their own or it will not work.

- What is anxiety getting in the way of most right now? (e.g. separation anxiety – not able to sleep in their own room at night)
- What does anxiety stop you from doing? What does anxiety have you do more of?
- What are you afraid of? If that happened what would happen next?
- What is the worst thing that could happen?
- What do you worry about the most? What do you think about? (e.g. someone will break into the house in the middle of the night)
- How realistic is this worried thought? Ask the child to give evidence for and against, need to give specifics, what is the most likely outcome, if the worst happened what would you do? How likely do you think this would happen? Can you give me an example of when it did happen?
- Can you come up with a more realistic thought? (e.g., “My house is a safe place and no one has ever broken in before, this is my worry and it will be hard to sleep in my own room at first, but I will feel better and have less worry if I learn to do this”). What would your parents say is more likely to occur? What would you like to be able to think (or believe is true)?

In OCD the child may not have insight that the obsessions do not make sense, and thus they may believe they need to do the compulsions because they may believe the obsessive thoughts are real. The cognitive strategies are to have them understand and identify what is OCD (i.e. separate OCD from the child, have the child name OCD) and try to gain insight (e.g. What is the evidence that what OCD tells you is real?). This may also require motivational help in fighting OCD by having them identify the pros and cons of having these thoughts and behaviours. What would their life and their family life be like without OCD?

Behavioural Strategy

Identify anxiety-related behaviours and avoidance. The goal is to **gradually*** expose the child to anxious situations and manage their anxiety to decrease avoidance.

- What are you currently avoiding or very distressed by (upset/worried terms for younger kids)? (e.g. asking a question in class)
- Is this behaviour causing you any problems or difficulties? (e.g., “Yes, because I don’t understand something and I can’t complete homework”.)
- Are there any times you have been able to face your fear and not

avoid these situations?

- What would be a next step you could try to face your anxiety/fear and not avoid? (e.g., “I could ask the question of the teacher after class or go to extra help”)
- When could you try this?

****Children need to take small steps in decreasing avoidance of anxiety situations. The goal is to tolerate the anxiety they feel and make it through the situation successfully on their own. If the step is too challenging and they are not able to do it on their own, then the next time find an easier step.***

(In OCD this technique is called Exposure and Response Prevention; it is the core component to CBT in OCD. Youth are exposed to a feared situation related to their obsession and are then not to engage in any rituals or compulsions. This technique requires a clinician trained in this field.)

Medication Intro

If medication is to be initiated, provide rationale for medication trial, what they can expect, and education about medication.

- Explain how medication works to treat anxiety.
- Give information about potential side effects and Health Canada Warning regarding increase risk of suicidal thoughts and behaviours in youth 18 and under taking antidepressant medication.
- Provide time line for titration of medication and treatment response.

Be Realistic

Discuss expectations and potential obstacles in treatment course.

- Anxiety has the best chance of improving when children and family are both aware of anxiety disorder and there is support of treatment plan.
- Anxiety can wax and wane over time, and it is not unusual for anxiety to improve overall while still having brief recurrences often in higher stress times.
- The goal with treatment of anxiety is not to eliminate anxiety, but to lessen it so the patient can function in all areas of their life (i.e. anxiety does not make decisions for you or control your life).

Be Responsive

- Be available for urgent matters within office hours (this depends on individual practitioners preference and can include phone, email or text messaging)
- Schedule frequent brief face to face visits at times that do not conflict with school (15-20 minutes)
- Monitor and support teen wellness activities (exercise, sleep, healthy diet, etc.)
- Ensure access to professional care during the off hours for

emergencies and review crisis plan with teen and parents (as appropriate).

Initiating Pharmacological treatment for Childhood Anxiety Disorders

Both CBT and pharmacological management are evidence-based treatments in childhood anxiety disorders. In moderate to severe anxiety disorders, and when children are not able to engage or utilize CBT strategies, the addition of medication can be helpful. The best level one evidence for medication treatment of childhood anxiety disorders is the selective serotonin reuptake inhibitors (SSRI). There is minimal evidence for use of medication in children under the age of 7 years. Cognitive behavioural therapy in combination with SSRI is the recommended first line treatment for moderate to severe anxiety disorders (including OCD). Either fluoxetine or sertraline is recommended as the first line medication treatment for childhood anxiety in primary care based on scientific evidence base, side effects and half life profile, and ease of use. If a child does not tolerate an initial trial or there is no improvement, the child should be referred to secondary/tertiary mental health services.

Not all anxiety disorders require treatment with medication, and it is strongly recommend medication not be used alone. Medication should be viewed as helping the child decrease overall anxiety so they can successfully learn and utilize anxiety management strategies, with the long term goal of no longer needing medication. Given the side effects and risks of SSRI medication in children, and the limited long term safety data of these medications in the developing brain, medication intervention should be combined with CBT, wellness enhancement activities and supportive rapport. Alternatively it could be combined with anxiety disorder education (and [parent self help strategies](#)), wellness enhancement activities and supportive rapport.

Fluoxetine and sertraline can significantly improve anxiety symptoms and improve depressive symptoms if they are also present. However, some children may experience suicidal ideation and self harm behaviour or have these increased when treated with antidepressant medication. Therefore systematic assessment of suicide risk must be completed as part of the ongoing treatment with antidepressants (see [Health Canada Advisory for antidepressant medication](#)).

Further information on SSRI use and children suicide can be accessed below. If fluoxetine, sertraline or another SSRI is used, the following 12 steps of treatment should be considered, customized and integrated into a practical approach that is feasible in your practice.

Issues to Consider When Monitoring SSRI Treatment

First
Do no harm. This does not mean—do not treat. This means do a proper risk benefit relationship analysis of the situation. And make sure that your evaluation of these risks and benefits has been fully discussed with your patient/ family.
Second
Make sure the patient has an anxiety disorder. This means that the diagnostic criteria are clearly met and that there is clear-cut functional impairment and/or significant distress. Medications should not be used to treat anxiety symptoms, they should be reserved for the treatment of moderate to severe anxiety disorders. Remember that threshold for diagnosis is not only within the total number of criteria met in the syndrome, but also within each criterion. For example, anxiety about upcoming move without any change in function would not qualify as excessive worry of at least 6 months duration.
Third
Check carefully for other psychiatric symptoms and stressors that might suggest a different disorder or different treatment approach. For example, does the child have a major depressive disorder, are the symptoms indicative of a learning disorder or bullying that can present with severe anxiety and isolation in the school setting.
Fourth
Check for symptoms of agitation, panic and impulsivity. If the patient has these symptoms they may be at greater risk for the behavioural adverse effects of an SSRI.
Fifth
Check for a past history of mania and for a family history of bipolar disorder. Many children who develop bipolar disorder report a preceding anxiety disorder diagnosis in childhood or teen years. Also, remember that up to two-thirds of teen onset bipolar disorders present to a mental health professional first with depression. Young people with this background may be more at risk for the behavioural activation effects of SSRIs.
Sixth
Measure the patient’s current somatic symptoms, paying careful attention to such items as restlessness, agitation, stomach upset, irritability and the like—before you begin treatment. A side effects scale (see below for an example) can be used to address this issue.

Seventh

Measure the symptoms of anxiety, depression and pay special attention to suicidality. The SCARED is a self report scale for anxiety (see above link) and the CES-DC is a self report scale for depression (see below). Both are easy to use, validated in this population and can provide not only baseline but also treatment outcome information. Remember that SSRI's may occasionally increase suicidal ideation so it is very important for your risk–benefit analysis to determine if there is suicidal ideation at baseline.

Eighth

Provide comprehensive information about the illness and the various treatment options to the patient and family. Appropriate literature should be available in your office and you should have a list of good websites to which you can direct their attention. Remember, the pharmacotherapy of anxiety is not emergency medical treatment. There is time for substantial research followed by frank and open discussion with the patient and family.

Ninth

If an SSRI is chosen make sure that you provide the patient and family with appropriate information about possible side effects (both behavioural and somatic) and the expected timelines to improvement. Ideally this should be in written form and if you are concerned about litigation have the patient and family sign one form and keep it in the patient record. Also make a note in the record as to the discussions and decision.

Tenth

After doing the necessary laboratory workup as indicated by medical history and review of systems (for an SSRI there are no required blood tests, but some recommend a pregnancy test for females), start with a small test dose of the medication, preferably given at a time when the child is with a responsible adult who knows about the test dose and who can contact you if there is a problem. Following that begin treatment with a very low dose (often you can cut the smallest dose pill in half or you can have the parent separate a capsule's contents, some medication comes in liquid form) and ask the patient and parent to monitor for adverse behavioural effects daily. Remember to provide a phone number where you can be reached if any problems develop and arrange to see the patient within about a week of initiating treatment. The medication should be kept by the parent in a safe place away from the child's access.

Eleventh

Increase the dose slowly at no more than 1-2 week intervals until your initial therapeutic dose is reached (the expected minimally effective daily dose), then wait for the required 6–8 weeks at this dose to determine efficacy. Never prescribe medication without at least offering supportive wellness and stress management support, as well as some basic CBT strategies (if CBT is not available through services in your community). See the patient **weekly for the first month** and allow for telephone check–in whenever the dose is increased or between visits if concerns arise. Once stable on a dosage and no side effects over a month, then visits can

decrease to every 2 weeks and gradually go to every month if doing well. If there is a dosage increase, the risk of side effects increases, and frequency of visits should go back to every week for a few weeks. Always check for and record possible adverse events at each visit (use the form that you used at baseline so that you can compare symptom changes over time) and assess improvement at Weeks 2, 4, 5 and 6.

Twelfth

Take advantage of the placebo response (found to be high in most child medication trials) That is, invoke a similar approach to patient care as done in studies including frequent face-to-face contact early in the course of therapy, the development of a trusting and supportive relationship, efforts to measure response objectively and subjectively, and careful elicitation of side effects, overall tolerance, ongoing concerns, and satisfaction with treatment.

This approach represents good clinical care that is consistent with the “careful monitoring” advocated by the FDA and other organizations. This approach will not necessarily totally ameliorate the occurrence of behavioural side effects but it may cut down their prevalence and will help you quickly identify when they occur so that you can intervene appropriately.

The 12 steps appear in Kutcher, S., Gardner, D. & Virani, A. (2004) *A Suggested Careful Monitoring to SSRI Treatment*. Child and Adolescent Psychopharmacology News, 9 (4): 3-4.

CAPN is published by [Guilford Press](#) and at the time of this guide was edited by Dr. Stan Kutcher.

Initiating and Continuing Fluoxetine Treatment *

- Start low and go slow.
- Begin at 5-10 mg daily (fluoxetine comes in liquid form so younger and smaller children can be started at as low as 2.5 mg to 5 mg per day and can be titrated more gradually and at smaller increments).
- Continue 10 mg for one to two weeks then increase to 20 mg.
- Continue 20 mg for a minimum of 8 weeks (response is usually at 2-4 weeks but some have delayed response, expect continued improvement of a few months at same dosage if initial response positive).
- If side effects are a problem with any increase or initial start at 10 mg- decrease the dosage by 5 mg (example: to 20 mg – decrease the dose to 15 mg daily for 1 week and then increase to 20 mg. If substantial side effects occur again continue the dose at 15 mg for a minimum of 8 weeks).
- OCD treatment may require higher dosages 20-60 mg/day (we recommend referring child to secondary/tertiary mental health services with severe OCD not responding to 30 mg/day). Treatment response in OCD is not as fast, usually around 12 weeks, and then gradual improvement over many months.
- Children may try taper off medication after doing well (anxiety in remission) for 6 to 12 months. The taper should occur gradually over several months, preferably in a time of lower stress such as summer vacation.

Initiating and Continuing Sertraline Treatment *

- Start low and go slow
- Begin at 25 mg daily (if significant side effects can decrease to 12.5 mg- pharmacy can help with packaging in smaller dosage)
- Continue 25 mg for one to two weeks then increase to 50 mg
- Continue 50 mg for a minimum of 6-8 weeks
- Increase to 75 mg at 6-8 weeks if tolerating well, anxiety improving, but significant anxiety symptoms remain.
- Maximum recommended dosage of sertraline is 200 mg per day, but anxiety disorders in children generally respond to dosage of between 50-100 mg per day. (if not responding to 75-100 mg per day then refer to secondary/tertiary mental health care services)
- OCD treatment may require higher dosages 100-200 mg/day, and treatment response is not as fast, usually around 12 weeks, and then gradual improvement over many months (however, in primary care if child not responding to 100 mg per day, then refer to secondary/tertiary mental health care services)
- Children may try taper off medication after doing well (anxiety in remission) for 6 to 12 months. The taper should occur gradually over several months, preferably in a time of lower stress such as summer vacation.

* The [PSC based supportive rapport](#) model should be used at every visit as a framework within which you can structure your interaction with your patient.

Referral – Red Flag If the child presents with severe anxiety and/or depression with active suicide intent, immediate referral to specialty mental health services is warranted. The presentation of psychosis or the presence of a suicide plan necessitates emergency referral.

The symptoms of severe anxiety and panic are unlikely to show significant improvement before 2-4 weeks (10-12 weeks for OCD response) following the initiation of either fluoxetine or sertraline intervention or Cognitive Behavioural Therapy. If the patient is markedly distressed by their symptoms small doses of a moderately long-acting benzodiazepine such as clonazepam (0.25 mg – 0.5 mg twice daily) can be used in the short term (up to 6 – 12 weeks). Clonazepam is not recommended to treat anxiety disorders or OCD as a primary treatment, but it can help to control some anxiety symptoms and it can provide some relief to the patient as the SSRI is titrated to the optimal target dose and anxiety and/or OCD symptoms show improvement. Once that has occurred clonazepam can be tapered gradually (decrease by 0.25 mg per daily dose every week). A similar pattern of use can be applied if CBT alone is being used as the initial treatment of choice, but this medication should not be maintained long term. If long term medication is indicated along with CBT, then an SSRI should be initiated.

Clonazepam

- Initiate dose at 0.25 mg BID for three days
- Increase to 0.5 mg BID for three days
- If response not adequate, increase to 0.75 BID in one week

- If symptoms not substantially improved and minimal side effects increase to 1.0 mg BID for one week .
- If no symptomatic improvement gradually discontinue the medication and refer for specialty consultation. If partial symptomatic improvement with minimal side effects increase to 1.5 mg BID.
- If inadequate clinical response at 3.0 mg daily gradually discontinue the medication and refer for specialty consultation.
- When discontinuing clonazepam remember to taper very slowly – decrease the total daily dose by 0.25 mg weekly.

Benzodiazepines (including clonazepam) have a potential risk for addiction and abuse and are not recommended to be used long term. Children should be warned of the risk of combining alcohol and benzodiazepines.

Monitoring Treatment

Outcomes and side effects should be monitored regularly during treatment*. The following chart is suggested as a guideline. For treatment outcome evaluation use the SCARED and the TeFA. For side effects assessment use the **Short Chehil-Kutcher Side Effects Scale (sCKS)** as illustrated in the following section.

Tool	Baseline	Day 1	Day 5	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8
SCARED	✓				✓		✓		✓		✓
CES-DC	✓				✓		✓		✓		✓
sCKS	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Another Way to Monitor Treatment Outcomes

Some clinicians like to use the Clinical Global Impression Scale (CGI) to monitor outcomes. This scale can be used in evaluating treatment for **any** mental disorder.

Clinical Global Impression – Improvement Scale (CGI)

Compare how much the patient has improved or worsened relative to a baseline state at the beginning of the treatment?

- 0 = Not assessed
- 1 = Very much improved
- 2 = Much improved
- 3 = Minimally improved

- 4 = No change
- 5 = Minimally worse
- 6 = Much worse
- 7 = Very much worse

Side Effects

Treatment emergent adverse effects (side effects) are those problems that arise during medication treatment and are caused by the medication. Side effects can include physical, emotional or behavioural problems. In order to best evaluate side effects a systematic baseline assessment of common problems should be conducted using a combination of structured and semi-structured evaluations.

Semi-structured: A useful question that may elicit side effects is *“Have there been changes in your body that you think may be a side effect?”*

Structured: A useful side effects scale that could be used at every clinic visit is found below.

Suicidal ideation or behaviours (Health Canada Warning)

Suicidal thoughts or behaviours with onset or exacerbation once started on medication can be a side effect and requires stopping the medication due to the safety risk of this side effect. This side effect is most common in the first several months of initiating medication.

Short Chehil-Kutcher Side Effects Scale (sCKS)* (modified for Children)

Item	None	Mild	Moderate	Severe
Headache				
Irritability/Anger				
Restlessness				
Diarrhea/Stomach Upset				
Tiredness				
Suicidal Thoughts				
Self Harm Attempt	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes describe: Was this a suicide attempt (intent to die) <input type="checkbox"/> No <input type="checkbox"/> Yes			
Any other problem?	1. 2.			

Clinicians who would like to use the short Chehil Kutcher Side Effects Scale in their individuals or group practice may do so without obtaining written permission from the authors. The short Chehil Kutcher Side Effects Scale may not be used for any other purpose (including publication) without expressed written consent of the authors.

Hypomania

One rare side effect of medication treatment is the induction of hypomania. This presents symptomatically as:

1. Decreased need for sleep – subjective feeling that sleep is not needed
2. Increase in goal directed activity (may be idiosyncratic or inappropriate)
3. Increase in motor behaviour (including restlessness), verbal productivity, and social intrusiveness

If hypomania is suspected the medication should be discontinued and urgent mental health referral initiated. Remember that a family history of bipolar disorder increases the risk for hypomania.

You Have Reached the Recommended Dosage– Now What? *

There will be three possible outcomes – each with a different intervention strategy.

ALWAYS CHECK ADHERENCE TO MEDICATION TREATMENT!!

One	Outcome	Strategy
	Patient not better or only minimally improved. SCARED \geq 25 and little or no functional improvement.	<ul style="list-style-type: none"> • Increase medication gradually (fluoxetine to 20 mg or sertraline to 100 mg) and refer to specialty child/adolescent mental health services • Continue weekly monitoring and all other interventions until consultation occurs
Two	Outcome	Strategy
	Patient moderately improved. SCARED < 25. Some functional improvement	<ul style="list-style-type: none"> • If medication is well tolerated, increase slightly (fluoxetine to 20 mg daily or sertraline to 100 mg per day) and continue monitoring and interventions for two to four weeks then reassess. If no substantial improvement then refer. • If medication is not well tolerated or increase not tolerated continue at current dosage with monitoring and intervention for two more weeks then reassess. If no substantial improvement then refer for specialty mental health treatment.
Three	Outcome	Strategy
	Patient substantially improved. SCARED < 25 and major functional improvement.	<ul style="list-style-type: none"> • Continue medication at current dosage • Gradually decrease monitoring and interventions visits to once every two weeks for two months and then monthly thereafter • Educate patients/caregivers about need to continue medications and how to identify relapse if it occurs • If first episode continue medications for 9-12 months before jointly deciding to discontinue. If discontinuing choose a suitable window (low stress period) and decrease gradually (over a period of four to six weeks) monitoring every two weeks. • Agree on “well checks” (for example, once every three months) and how to identify relapse if it occurs • If second or further episode obtain mental health consultation on treatment duration

* Treatment response in OCD is not as fast, usually around 12 weeks for response, and then gradual improvement over many months. OCD treatment may require higher dosages (refer child to secondary/tertiary mental health services with severe OCD as best treatment response is medication

in combination with OCD specific cognitive behavioural therapy. Refer if not responding to fluoxetine 30 mg/day or sertraline 100 mg/day).

Medication doses used in specialty mental health services may occasionally exceed those usually found in primary care. Physicians monitoring youth who have been treated by specialists should discuss medication dose requirements prior to initiating dose changes.

Checking Adherence to Medication Treatment

Determining medication adherence can be difficult. It may be useful to predict the likelihood of medication non-compliance in advance. Openly recognizing that it is probable that the patient may miss one or more doses of medications is not only consistent with reality, but it allows the patient to miss the occasional dose without guilt, and to return to medication use without seeking permission to do so. Pharmacologically, if this happens occasionally there will be little if any substantive change in fluoxetine serum levels due to the long half-life of fluoxetine and its major metabolite (5 to 7 days). There can be a difference noticed in missing a dosage of sertraline as this medication has a shorter half life (just over 24 hours).

There are three methods that can be used to monitor and assess treatment adherence.

- 1) Enquire about medication use from the child and parent. Using such prompts as: “How have things been going with taking the medicine?” or “As we talked before, it is not uncommon to forget to take your medicine sometimes. How many times since we last talked do you think you may have not taken your medicine?” It is important not to admonish the child/parent who self-identifies occasional medication non-adherence. When do they take the medication? Simply acknowledge the difficulty in remembering and ask if there is anything you can help with to improve their remembering. If the compliance with medications is poor it is important to address the issue openly, trying to understand what the reasons for the adherence difficulties may be. Once these have been identified they can be collaboratively addressed.
- 2) Enquire about medication use from the parents. Children should have parents dispense the medication. However, dispensing is not the same as taking. So, even if the parents are dispensing the medication it is important to ask the child about medication use as described in method one above. Pill swallowing is sometimes difficult for children and causes distress with taking medication. Changing to liquid form (fluoxetine) or opening capsule (sertraline) can be helpful in improving compliance.
- 3) A pill count may sometimes be useful. Simply ask the child or parent to bring the pill bottle to each appointment. It is important to ask the child and parent about medication use as described in method one above and to check in about medication compliance in different settings if the child is moving between homes.

Duration of Treatment

Once substantial improvement or recovery has occurred, the issue of duration of continued treatment arises. Maintaining treatment for a defined length of time is undertaken for the following reasons:

1. To allow for further, perhaps longer to develop, improvements in symptoms and functioning to take place
2. To allow for additional or alternative therapeutic interventions to occur: for example the addition of cognitive behavioural therapy to a initial treatment with medication alone
3. To decrease the risk of relapse
4. To decrease the risk of developing a co-morbid mental disorder (for example: another anxiety disorder or major depressive episode)

Currently, there exists insufficient substantive research to allow for good evidence-driven guidelines for the duration of ongoing treatment following recovery from the index anxiety disorder episode. Given the data (including clinical experience) currently available the following suggestions can be reasonably made:

1. Continue with the same dose of medication that was used to achieve recovery
2. Continue with the same treatment that was used to achieve recovery for a minimum of six to twelve months
3. Educate the patient about signs and symptoms that may suggest relapse and encourage immediate clinical review should these occur
4. Encourage scheduled mental health monitoring visits (“check up from the neck up”)
5. If a decision to discontinue medication is made, do not discontinue medication during times of increased stress (such as examinations at school or moving to a new city)
6. If a decision to discontinue medication is made, decrease dose gradually over a substantial period of time (for example: three months) and monitor closely for signs or symptoms of relapse
7. Advise adherence to mental wellness activities that include appropriate diet, exercise, and sleep hygiene; discuss risks of substance use in older children.

If a patient relapses while on an adequate treatment regime evaluate the following:

1. Compliance with treatment
2. Medical illness
3. Onset of recent stressors that challenge the patient’s ability to adapt
4. Onset of substance abuse
5. Emergence of an alternative diagnostic possibility (such as: depression, bipolar disorder)

Referral to a mental health specialist is indicated if relapse occurs despite adequate ongoing treatment.

Step 4. Suicide Assessment

In young people, unrecognized and untreated mental illness, especially depression, is the single strongest risk factor for suicide. Suicide risk is increased if the following factors are additionally present.

- Family history of suicide
- Substance abuse
- History of impulsivity
- **Hopelessness**
- Legal difficulties
- A previous suicide attempt
- Access to lethal means (such as firearms)

Suicide is more common in males, while self harm attempts are more common in females.

Suicide assessment should occur whenever severe anxiety/panic and/or depression is suspected and at specific points during treatment. Particular attention to suicide risk during treatment and monitoring of depression should occur if:

- A major life stressor occurs
- A friend or acquaintance commits suicide
- A public figure commits suicide
- The media reports on a successful suicide

In these situations, exploration of the impact of the occurrences on suicide risk in your patient must be part of the monitoring and intervention visit.

Assessment of Suicide Risk in Children

Suicide in children is rare and the assessment of suicide risk in children is neither well developed nor well standardized. Research into pre-pubertal suicide is limited. It is useful, however, to screen for suicide ideation and plans if the clinical situation warrants it. A family history of suicide or parent/child reports of self-harm behaviours or substantial depressive symptoms could suggest that the clinician gently inquire about suicide. This must be done in an age-appropriate manner. Here is a suggested approach.

- When you are feeling this way do you ever wish that you were dead?
- Can you tell me what you mean by being dead?
- Have you thought of doing something that would make you dead?
- Can you tell me about what you are thinking or planning?

If the answer to the first question is positive, it is essential to probe to understand what the child means by dead. If the child does mean death then further questions are needed. If there is doubt about child suicide risk, the parents need to be informed and given simple suggestions about what to do (remember that anxious children often have anxious parents, so do not stoke the fires of parental anxiety over this issue) and immediate referral should be made to a specialty child mental health service provider.

Assessing Suicide Risk

Suicide risk should be assessed at baseline and throughout the treatment period. Particular attention to suicide risk should be paid if any of the items identified as risk enhancers noted above occur. Not all young people who have decided to commit suicide will admit to their plan when asked, so no suicide assessment is completely preventive of suicide. However, the assessment of suicide ideation and suicide plans will often identify young people who are at increased suicide risk and appropriate interventions (including hospitalization if suicide plans are in place) can be instituted.

Suicide ideation

- Ask about ideas of dying, not wanting to live and of ending their life
- Ask about feeling hopeless, not seeing any future – A DEPRESSED YOUNG PERSON WHO FEELS HOPELESS IS AT INCREASED RISK.
- Remember that not everyone who has a diagnosis of anxiety or depression feels hopeless.

Suicide plan

- If the child admits to suicide ideation or hopelessness ALWAYS ask about suicide plan

If in your clinical judgement the child is at high risk for suicide, this is a medical emergency. In such a case the parent/caregiver must be informed and the child must be taken by a responsible adult for immediate psychiatric assessment. Please ensure that a copy of your assessment plus information on how to contact you is made available for the mental health specialist conducting the emergency consultation. Many clinicians find that personal contact of the assessing clinician prior to the assessment will facilitate a more useful consultation.

Child with persistent suicidal ideation and frequent self-harm attempts should be referred to specialty mental health services for ongoing treatment.

Step 5. Safety and Contingency Planning

The patient's safety is of paramount importance. Safety concerns trump all other considerations. Here are some suggestions for helping the patient stay safe. If the first contact health care provider is concerned about safety, mental health consultation should be obtained (see below).

Emergency Contact Cards – this consists of emergency contact numbers (for example: mental health services, emergency child mental health services, emergency room service, etc.). Often this is written on a “wallet card” that can be carried by the child and parent at all times. Other methods such as electronically saved messages can also be used.

Rapid Health Provider Availability – often suicide and other safety issues arise in the context of stressful events. Allowing the young person or their caregiver to have easy access to a first contact health care provider (for example: by phone) can be a useful strategy. Clinical experience suggests that most young people or their caregivers rarely overuse this access.

Help Phone – while crisis telephone “hot-lines” have not been demonstrated to reduce suicide rates, they can be a valuable resource for young people in crisis. The child and parents should be provided with the phone number for the appropriate service in their area.

No Suicide Contract – this intervention although popular amongst some clinicians has not demonstrated effect on suicide rates. Its use is not recommended.

Step 6. Referral Flags

Referral of the child with an anxiety disorder to specialty mental health services can occur at three different points. The following referral points are suggestions only. Each first contact care provider must identify their own comfort level with treatment and management of childhood anxiety disorders and act accordingly. These suggestions are:

Emergency Referral (prior to treatment initiation by first contact care provider):

- Suicidal ideation with intent or suicide plan
- Major depressive episode with psychosis (presence of delusions and/or hallucinations)
- Presence of delusions or hallucinations

Urgent Referral (treatment may be initiated but referral should be made concurrently):

- Symptoms severe and function significantly deteriorated (e.g. severe OCD, severe panic)
- Relapse from previous positive treatment response
- Persistent suicidal ideation with no intent or suicide plan
- Comorbid major depressive episode or family history of Bipolar Disorder
- History of suicide attempts
- Hypomania

Usual Referral:

- Referral for Cognitive Behavioural Therapy if available
- Persistent school avoidance
- Anxiety disorder not responding to adequate first contact treatment trial

Suggested Websites

- Resources for children and families can be found on Anxiety BC website.
www.anxietybc.com.

The Anxiety BC group has also developed a couple of DVD's, including one on separation anxiety in children.

- Treatment guideline algorithm for health care providers in treatment of anxiety disorders and depressive disorders in child.
www.bcguidelines.ca/gpac/guideline_depressyouth.html#algorithm
- American Academy of Child and Adolescent Psychiatry - www.aacap.org
- Sun Life Financial Chair in Adolescent Mental Health – www.teenmentalhealth.org
- Collaborative Mental Health Care - <http://www.shared-care.ca/toolkits-anxiety>
- Healthy Living Toolkits, families and health professional versions, contain information, resources, and tools to help children and youth with mental health challenges develop healthy living habits <http://kelymentalhealth.ca/toolkits>.
- Child and Adolescent Needs and Strengths (CANS)
<http://www.praedfoundation.org/About%20the%20CANS.html>

Suggested Reading

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Reinblatt, S.P. & Riddle, M.A. (2007) *The Pharmacological Management of Childhood Anxiety Disorders: A Review*. *Psychopharmacology*, 191: 67-86.

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Child Anxiety Toolkit

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- **Child and Youth Mental Health Screening Questions**
- **Risk Identification Table**
- **SCARED – Child and Parent versions**
- **Worry Reducing Prescription (WRP)**
- **Child Functional Assessment (CFA)**
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- **Short Chehil-Kutcher Side Effects Scale (sCKS)* (modified for Children)**
- **The Center for Epidemiological Studies Depression Scale for Children (CES-DC)**
- **Clinical Global Improvement (CGI)**
- **Medication Monitoring Algorithm**
- **Sample letter requesting psychoeducational testing**
- **Sample letter regarding school support and accommodation**

Child and Adolescent Mental Health Screening Questions

Historical factors:

1. Parent has a history of a mental disorder (including substance abuse/dependence)
2. Family has a history of suicide
3. Youth has a childhood diagnosis of a mental disorder, learning difficulty, developmental disability, behavioural disturbance or school failure
4. There has been a marked change in usual emotions, behaviour, cognition or functioning (based on either youth or parent report)

One or more of the above answered as YES, puts child or youth into a high risk group. The more YES answers, the higher the risk.

Current situation:

1. Over the past few weeks have you been having difficulties with your feelings, such as feeling sad, blah or down most of the time?
2. Over the past few weeks have you been feeling anxious, worried, very upset or are you having panic attacks?
3. Overall, do you have problems concentrating, keeping your mind on things or do you forget things easily (to the point of others noticing and commenting)?

If the answer to **question 1** is YES – for adolescents, consider a depressive disorder and apply the KADS evaluation and proceed to the [Identification, Diagnosis and Treatment of Adolescent Depression](#).

If the answer to **question 2** is YES – consider an anxiety disorder, apply the SCARED evaluation and proceed to the Identification, Diagnosis and Treatment of [Child](#) or [Youth Anxiety Disorders](#)

If the answer to **question 3** is YES – consider ADHD, apply the SNAP evaluation and proceed to the Identification, Diagnosis and Treatment of [Child](#) or [Youth ADHD](#).

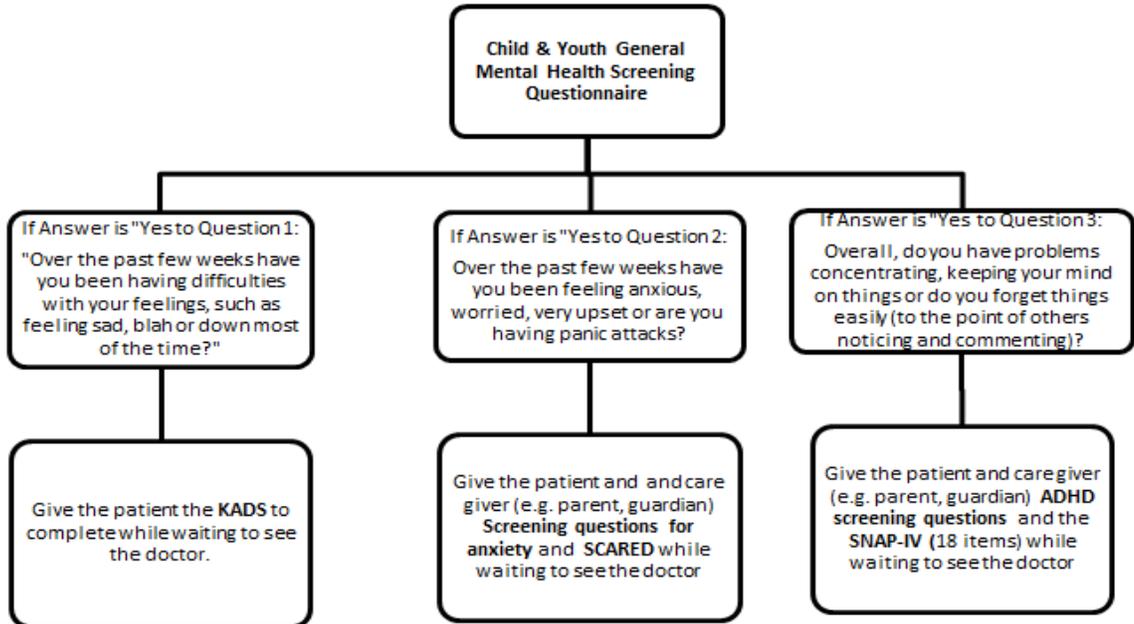
Remember that some cases of anxiety and depression may demonstrate positive scores on the concentration component of the SNAP. If no hyperactivity components are identified on the SNAP review for ADHD please assess for depression and anxiety using KADS and SCARED.

Next steps:

- If patient is positive for depression and either Anxiety or ADHD and the patient is an adolescent, continue to apply the KADS protocol for Depression.
- If positive for Depression, treat the depression and following remission review for presence of continued Anxiety Disorder or ADHD.

- If positive for Anxiety Disorder at that time, refer to specialty mental health services for specific anxiety disorder psychotherapy (CBT) and continue SSRI medication treatment.
- If positive for ADHD at that time, add a psychostimulant medication following the protocol in the ADHD module or refer to specialty mental health services.

MOA's Child and Adolescent Mental Health Screening



Attach a copy of TASR-A to the clinical file if an adolescent answered YES to any of the General Mental Health Screening Questions (To be filled out by the clinician)

Since comorbidity is frequently found, some children or adolescents and/or their caregivers may respond YES to more than one question. If that is the case, provide them with the screening questions or clinical tools regarding each question.

Anxiety Disorder in Children, Risk Identification Table

Significant risk effect	Moderate risk effect	Possible “group” identifiers (these are not causal for anxiety disorder but may identify factors related to adolescent onset anxiety)
<ol style="list-style-type: none"> 1. Family history of anxiety disorder 2. Severe and/or persistent environmental stressors in early childhood 	<ol style="list-style-type: none"> 1. Children with shy, inhibited and/or cautious temperament (innate personality type) 2. Family history of a mental illness (mood disorder, substance abuse disorder) 3. Have experienced a traumatic event 4. Substance misuse and abuse (early onset of use including cigarette and alcohol) 	<ol style="list-style-type: none"> 1. School failure or learning difficulties 2. Socially or culturally isolated 3. Bullying (victim and/or perpetrator)

Screen for Child Anxiety Related Disorders (SCARED) – Child Version

Pg. 1 of 2 (To be filled out by the CHILD/TEEN)

(Birmaher, Kheterpal, Cully, Brent and McKenzie, 1995)

Name:

Date:

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

	0 Somewhat True or Sometimes True	1 Not True Hardly Ever True	2 Very True or Often True
1. When I feel frightened, it is hard to breathe.			
2. I get headaches when I am at school.			
3. I don't like to be with people I don't know well.			
4. I get scared if I sleep away from home.			
5. I worry about other people liking me.			
6. When I get frightened, I feel like passing out.			
7. I am nervous.			
8. I follow my mother or father wherever they go.			
9. People tell me that I look nervous.			
10. I feel nervous with people I don't know well.			
11. I get stomachaches at school.			
12. When I get frightened, I feel like I am going crazy.			
13. I worry about sleeping alone.			
14. I worry about being as good as other kids.			
15. When I get frightened, I feel like things are not real.			
16. I have nightmares about something bad happening to my parents.			
17. I worry about going to school.			
18. When I get frightened, my heart beats fast.			
19. I get shaky.			
20. I have nightmares about something bad happening to me.			

Screen for Child Anxiety Related Disorders (SCARED) – Child Version

Pg. 2 of 2 (To be filled out by the CHILD/TEEN)

	0 Not True Or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. I worry about things working out for me.			
22. When I get frightened, I sweat a lot.			
23. I am a worrier.			
24. I get really frightened for no reason at all.			
25. I am afraid to be alone in the house.			
26. It is hard for me to talk with people I don't know well.			
27. When I get frightened, I feel like I am choking.			
28. People tell me that I worry too much.			
29. I don't like to be away from my family.			
30. I am afraid of having anxiety (or panic) attacks.			
31. I worry that something bad might happen to my parents.			
32. I feel shy with people I don't know well.			
33. I worry about what is going to happen in the future.			
34. When I get frightened, I feel like throwing up.			
35. I worry about how well I do things.			
36. I am scared to go to school.			
37. I worry about things that have already happened.			
38. When I get frightened, I feel dizzy.			
39. I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport.)			
40. I feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well.			
41. I am shy.			

SCORING:

A total score of ≥ 25 may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED) – Parent Version

Pg. 1 of 2 (To be filled out by the PARENT) (Birmaher, Kheterpal, Cully, Brent and McKenzie, 1995)

Name:

Date:

Directions:

Below is a list of sentences that describe how people feel. Read each phrase and decide if it is “Not True or Hardly Ever True” or “Somewhat True or Sometimes True” or “Very True or Often True” for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

	0 Somewhat True or Sometimes True	1 Not True Hardly Ever True	2 Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe.			
2. My child gets headaches when he/she is at school.			
3. My child doesn't like to be with people he/she doesn't know well.			
4. My child gets scared if he/she sleeps away from home.			
5. My child worries about other people liking him/her.			
6. When my child gets frightened, he/she feels like passing out.			
7. My child is nervous.			
8. My child follows me wherever I go.			
9. People tell me that my child looks nervous.			
10. My child feels nervous with people he/she doesn't know well.			
11. My child gets stomachaches at school.			
12. When my child gets frightened, he/she feels like he/she is going crazy.			
13. My child worries about sleeping alone.			
14. My child worries about being as good as other kids.			
15. When he/she gets frightened, he/she feels like things are not real.			
16. My child has nightmares about something bad happening to his/her parents.			
17. My child worries about going to school.			
18. When my child gets frightened, his/her heart beats fast.			
19. He/she gets shaky.			
20. My child has nightmares about something bad happening to him/her.			
21. My child worries about things working out for him/her.			
22. When my child gets frightened, he/she sweats a lot.			

Screen for Child Anxiety Related Disorders (SCARED) – Parent Version

Pg. 2 of 2 (To be filled out by the PARENT)

	0 Not True Or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
23. My child is a worrier.			
24. My child gets really frightened for no reason at all.			
25. My child is afraid to be alone in the house.			
26. It is hard for my child to talk with people he/she doesn't know well.			
27. When my child gets frightened, he/she feels like he/she is choking.			
28. People tell me that my child worries too much.			
29. My child doesn't like to be away from his/her family.			
30. My child is afraid of having anxiety (or panic) attacks.			
31. My child worries that something bad might happen to his/her parents.			
32. My child feels shy with people he/she doesn't know well.			
33. My child worries about what is going to happen in the future.			
34. When my child gets frightened, he/she feels like throwing up.			
35. My child worries about how well he/she does things.			
36. My child is scared to go to school.			
37. My child worries about things that have already happened.			
38. When my child gets frightened, he/she feels dizzy.			
39. My child feels nervous when he/she is with other children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sport.)			
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.			
41. My child is shy.			

SCORING:

A total score of **≥ 25** may indicate the presence of an **Anxiety Disorder**. Scores higher than 30 are more specific.

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**For children ages 8 to 11, it is recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in case they have any questions.*

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., Western Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

Worry Reducing Prescription (WRP)

It is useful to provide the young person with a simple outline developed collaboratively with them and caregiver that clearly specifies what self-regulatory activities they should pursue during the diagnostic and treatment phases of their contact with their health provider. The Worry Reducing Prescription is a useful and time efficient tool for managing stress that can be used to help the young person identify and plan their daily activities. It is embedded below and provided in the Clinician’s Toolkit as well. In practice, the clinician can review the WRP with the patient, complete the form and then review it at the next office visit.

Worry Reducing Prescription

There are many things that you can do to help decrease stress and improve your mood. Sometimes these activities by themselves will help you feel better. Sometimes additional help (such as psychotherapy or medications) may be needed. This is your prescription for what you can do to help decrease stress and feel better. For each activity “write in” your plan (include what you will do, how often and with whom). This can be done by a health team member or the parent together with the child.

Activity	Plan (what, how often, other supports)
Exercise	
Eating Well	
Sleep	
Problem Solving	
Planning / Organizing	
Social Activity	

Enrolling the Help of Others

Family members should be involved in helping with worry reducing strategies. Other significant persons in the young person’s life may also be able to play a role (e.g. teacher, school counsellor, coach, neighbour, etc.) It’s a good idea to ask the young person about who else can help out and whenever possible get the family involved. Always inquire about school performance. Some young people with Anxiety Disorders may need certain interventions or a modified academic approach, since school stress can make Anxiety Disorders worse. Discussion with a school counsellor (with permission from the patient) is recommended.

Child Functional Assessment (CFA)

The CFA is a self-report tool, but in some cases it may require the caregiver to help. It is meant to be completed by the patient/caregiver and should take no more than three minutes to complete for most children. The health care provider can use the information obtained on the CFA to probe for further information – especially in those areas where the young person noted worse or much worse than usual and in those domains that the child/caregiver identifies as either self or parental worry.

This form is meant to let your health provider know about how you are doing. All information you give is confidential. Please write your answers to the items on the form.

For each of the following categories, write down one of the following options in the space provided – “much better than usual”; “better than usual”; “about the same as usual”; “worse than usual”; “much worse than usual”. You can also give an example if you would like.

Over the last week how have things been at:

School: _____

Home: _____

Friends: _____

Write down the two things in your life that either worry you the most or are causing you the most problems.

1) _____

2) _____

Write down the two things about you that cause your parents or other adults to be concerned about or that you think might concern them if they knew about these things.

1) _____

2) _____

Parenting Overview

- Love and Affection**
 - Spending quality time with the child individually; demonstrating physical affection; words and actions convey support and acceptance
- Stress Management**
 - Parents learn how to manage their own stress and try not to let their stress drive relationships with their children
- Strong Relationships**
 - Demonstrate positive relationships with a spouse or partner and with friends. Good modeling with individuals not related is especially relevant in that it can encourage a heavily stigmatized child/youth to reach out to others and establish their own health/balanced social network in preparation for adulthood
- Autonomy/Independence**
 - Treat child with respect and provide environment to promote self-sufficiency
- Education/Learning**
 - Promote and model lifelong learning and encourage good educational attainment for the child
- Life Management**
 - Provide for the needs of the child and plan for the future. Teach comprehensive life skills, especially for youth; avoid enabling and instead focus on youth's strengths, gradually targeting what could be improved upon in terms of personal hygiene, interpersonal skills, cooking, cleaning, organization and goal setting
- Behaviour Management**
 - Promote positive reinforcement and punish only when other methods have failed and then consistent with the severity of the negative behavior and not in a harsh manner
- Self Health**
 - Model a healthy lifestyle and good habits
- Spirituality**
 - Provide an appropriate environment in which spiritual or religious components can be addressed
- Safety**
 - Provide an environment in which your child is safe, monitor your child's activities; friends; health

**Modified from Epstein, R. What Makes a Good Parent? Scientific American Mind. November/December. 2010: 46 – 49.*

Short Chehil-Kutcher Side Effects Scale (sCKS)* (modified for Children)

Item	None	Mild	Moderate	Severe
Headache				
Irritability/Anger				
Restlessness				
Diarrhea/Stomach Upset				
Tiredness				
Suicidal Thoughts				
Self Harm Attempt	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes describe: Was this a suicide attempt (intent to die) <input type="checkbox"/> No <input type="checkbox"/> Yes			
Any other problem?	1. 2.			

The Center for Epidemiological Studies Depression Scale for Children (CES-DC) (Weissman et al, 1980)

Instructions for Use

The Center for Epidemiological Studies Depression Scale for Children (CES-DC) is a 20-item self-report depression inventory with possible scores ranging from 0 to 60. Each response to an item is scored as follows:

0 = "Not At All"

1 = "A Little"

2 = "Some"

3 = "A Lot"

However, items 4, 8, 12 and 16 are phrased positively, and thus are scored in the opposite order:

3 = "Not At All"

2 = "A Little"

1 = "Some"

0 = "A Lot"

Higher CES-DC scores indicate increasing levels of depression. Weissman et al. (1980), the developers of the CES-DC, have used the cutoff score of 15 as being suggestive of depressive symptoms in children and adolescents. That is, scores over 15 can be indicative of significant levels of depressive symptoms.

Remember that screening for depression can be complex and is only an initial step. Further evaluation is required for children and adolescents identified through a screening process. Further evaluation is also warranted for children or adolescents who exhibit depressive symptoms but who do not screen positive.

Instructions:

Below is a list of the ways you might have felt or acted. Please check how much you have felt this way during the past week.

	<i>During the Past week</i>	<i>Not At All</i>	<i>A Little</i>	<i>Some</i>	<i>A Lot</i>
--	-----------------------------	-------------------	-----------------	-------------	--------------

1 *I was bothered by things that usually don't bother me.*

_____	_____	_____	_____
-------	-------	-------	-------

2 *I did not feel like eating, I wasn't very hungry.*

_____	_____	_____	_____
-------	-------	-------	-------

3 *I wasn't able to feel happy, even when my family or friends tried to help me feel better.*

_____	_____	_____	_____
-------	-------	-------	-------

4 *I felt like I was just as good as other kids..*

_____	_____	_____	_____
-------	-------	-------	-------

5 *I felt like I couldn't pay attention to what I was doing.*

_____	_____	_____	_____
-------	-------	-------	-------

	<i>During the past week</i>	<i>Not At All</i>	<i>A Little</i>	<i>Some</i>	<i>A Lot</i>
--	-----------------------------	-------------------	-----------------	-------------	--------------

6 *I felt down and unhappy.*

_____	_____	_____	_____
-------	-------	-------	-------

7 *I felt like I was too tired to do things.*

8 *I felt like something good was going to happen.*

9 *I felt like things I did before didn't work out right.*

10 *I felt scared.*

During the past week

Not At All

A Little

Some

A Lot

11 *I didn't sleep as well as I usually sleep.*

12 *I was happy.*

13 *I was more quiet than usual.*

14 *I felt lonely, like I didn't have any friends.*

15 *I felt like kids I know were not friendly or that they didn't want to be with me.*

During the past week

Not At All

A Little

Some

A Lot

16 *I had a good time*

17 *I felt like crying.*

18 *I felt sad.*

19 *I felt people didn't like me.*

20 *It was hard to get started doing things.*

Reproduced from *Bright Futures in Practice, Volume II, Mental Health Tool Kit*. Jellinek, Michael, M.D.; Patel, Bina P., M.D.; Froehle, Mary, Ph.D., editors. National Center for Education in Maternal and Child Health, Georgetown University, Arlington, VA.

Clinical Global Improvement (CGI)

Some clinicians like to use the Clinical Global Impression Scale (CGI) to monitor outcomes. This scale can be used in evaluating treatment for **any** mental disorder.

Clinical Global Impression – Improvement Scale (CGI)

Compare how much the patient has improved or worsened relative to a baseline state at the beginning of the treatment?

0 = Not assessed

1 = Very much improved

2 = Much improved

3 = Minimally improved

4 = No change

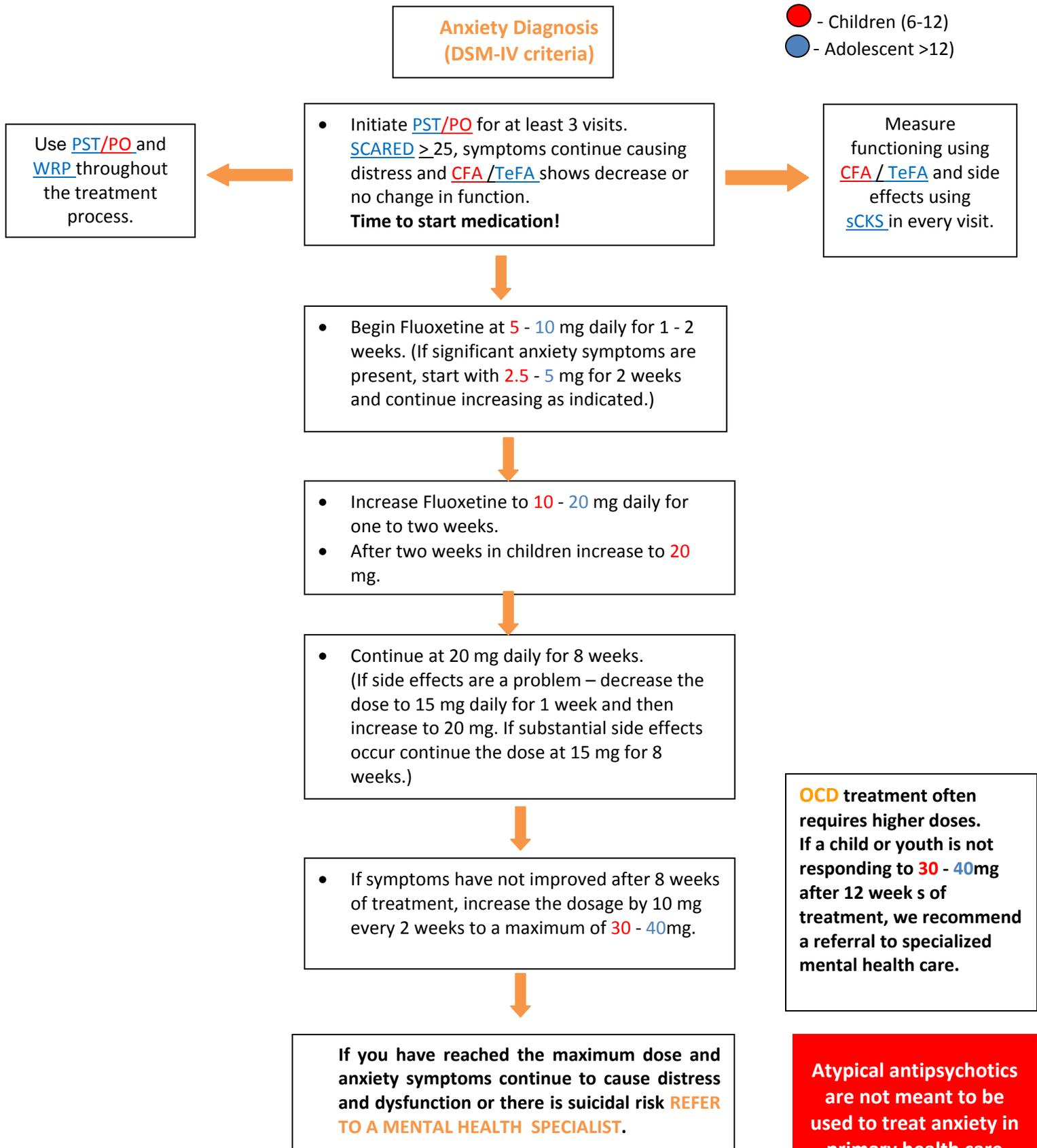
5 = Minimally worse

6 = Much worse

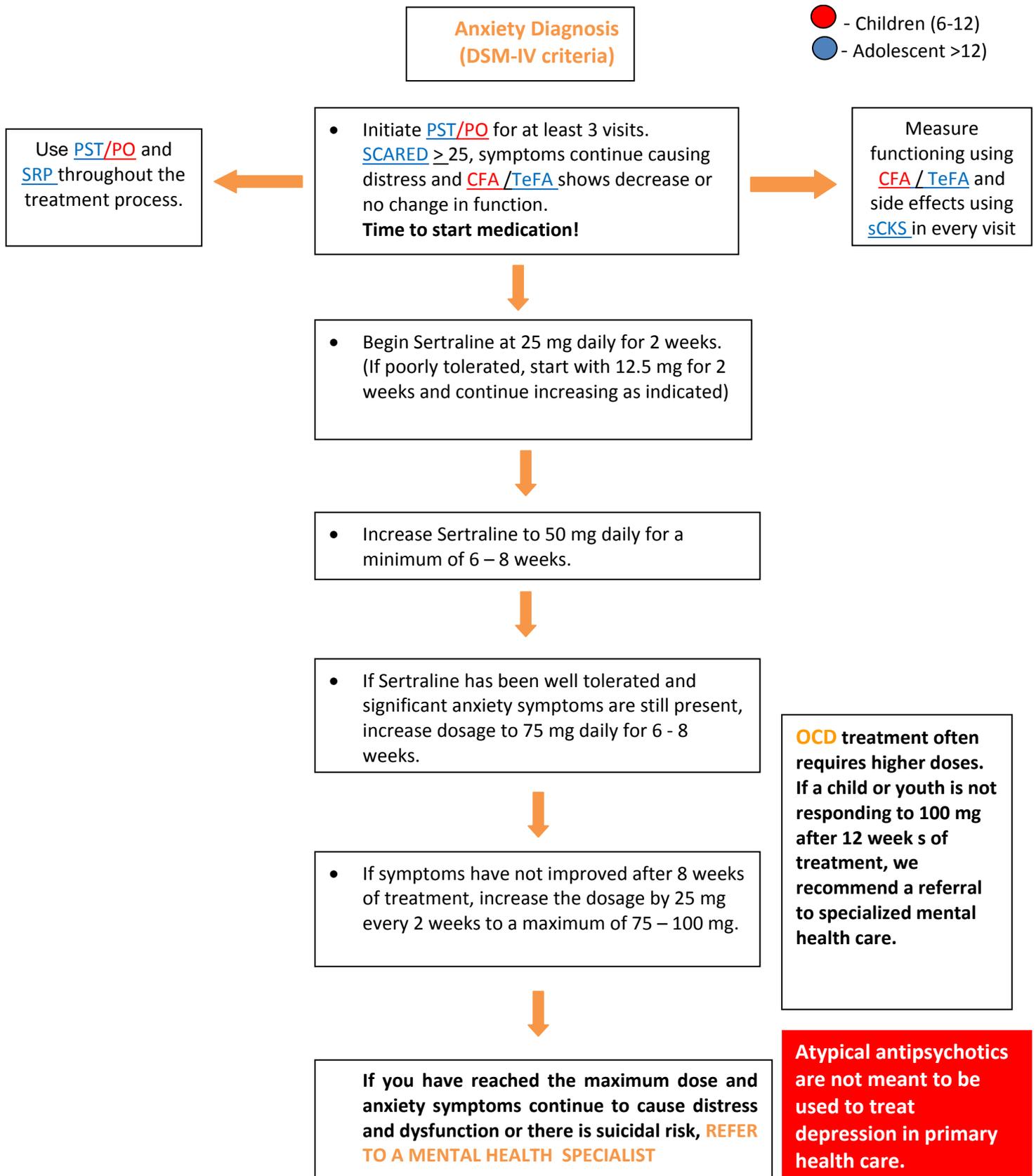
7 = Very much worse

Medication Monitoring Algorithm

Initiating and Monitoring Medication for Anxiety Disorders in Children / Youth



Initiating and Monitoring Sertraline for Anxiety Disorders in Children / Youth



SAMPLE LETTER REQUESTING PSYCHOEDUCATIONAL TESTING

Date:

Salutation:

Re: Patient name ; Request for psychoeducational testing

With the permission of _____ (parent/guardian) of _____ (patient name), I am writing to request psychoeducational testing regarding the possibility of a learning problem concurrent with the diagnosis of ADHD.

I would be pleased to discuss this matter more fully with the appropriate school representative and with the individual who will do the assessment. I can be reached at: _____ (telephone or by email address).

I look forward to hearing from you soon.

Sincerely;

(Physician name)

Cc: Parent/guardian

SAMPLE LETTER REGARDING SCHOOL SUPPORTS AND ACCOMODATIONS

Date:

Salutation:

Re: Patient name ; Request for School Support and Accommodation

With the permission of _____ (parent/guardian) of _____ (patient name), I am writing to discuss possible issues of school support and accommodation arising from my recent assessment and concurrent with the diagnosis of ADHD.

I would be pleased to discuss this matter more fully with the appropriate school representative(s). I can be reached at: _____ (telephone or by email address).

I look forward to hearing from you soon.

Sincerely;

(Physician Name)

Cc: Parent/guardian

DSM-IV Criteria for Anxiety

Separation Anxiety

A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:

1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation
5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
7. repeated nightmares involving the theme of separation
8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated

B. The duration of the disturbance is at least 4 weeks.

C. The onset is before age 18 years.

D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.

E. The disturbance does not occur exclusively during the course of a [Pervasive Developmental Disorder](#), [Schizophrenia](#), or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by [Panic Disorder](#) With [Agoraphobia](#).

Specify if:

Early Onset: if onset occurs before age 6 years

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(s) is avoided or else is endured with intense anxiety or distress.

E. The avoidance, anxious anticipation, or distress in the feared situation(s) 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 individuals under age 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](#) (e.g., fear of dirt in someone with an obsession about contamination), [Posttraumatic Stress Disorder](#) (e.g., avoidance of stimuli associated with a severe stressor), [Separation Anxiety Disorder](#) (e.g., avoidance of school), [Social Phobia](#) (e.g., avoidance of social situations because of fear of embarrassment), [Panic Disorder with Agoraphobia](#), or [Agoraphobia Without History of Panic Disorder](#).

- Specify type:
 - Animal Type
 - Natural Environment Type (e.g., heights, storms, water)
 - Blood-Injection-Injury Type
 - Situational Type (e.g., airplanes, elevators, enclosed places)
 - Other Type (e.g., phobic avoidance of situations that may lead to choking, vomiting, or contracting an illness; in children, avoidance of loud sounds or costumed characters)

Generalized Anxiety

Excessive anxiety about a number of events or activities, occurring more days than not, for at least 6 months. The person finds it difficult to control the worry. The anxiety and worry are associated with at least three of the following six symptoms (with at least some symptoms present for more days than not, for the past 6 months):

- Restlessness or feeling keyed up or on edge
- Being easily fatigued

- Difficulty concentrating or mind going blank
- Irritability
- Muscle tension
- Sleep disturbance

The focus of the anxiety and worry is not confined to features of an Axis I disorder, being embarrassed in public (as in social phobia), being contaminated (as in obsessive-compulsive disorder), being away from home or close relatives (as in separation anxiety disorder), gaining weight (as in anorexia nervosa), having multiple physical complaints (as in somatization disorder), or having a serious illness (as in hypochondriasis), and the anxiety and worry do not occur exclusively during posttraumatic stress disorder. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social or occupational functioning. The disturbance does not occur exclusively during a mood disorder, a psychotic disorder, pervasive developmental disorder, substance use, or general medical condition.

Obsessive-Compulsive Disorder

Obsessions

- Recurrent and persistent thoughts, impulses, or images that are experienced as intrusive and inappropriate, causing anxiety or distress.
- The thoughts, impulses, or images are not simply excessive worries about real-life problems.
- The person attempts to ignore or suppress such thoughts, impulses, or images or to neutralize them with some other thought or action.
- The person recognizes that the obsessional thoughts, impulses, or images are a product of his or her own mind.

Compulsions

- Repetitive behaviours or mental acts that the person feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
- The behaviours or mental acts are aimed at preventing or reducing distress or preventing some dreaded event or situation.
- These behaviours or mental acts either are not connected in a realistic way with what they are designed to neutralize or prevent, or they are clearly excessive.
- At some point during the course of the disorder, the person has recognized that the obsessions or compulsions are excessive or unreasonable.
- The obsessions or compulsions cause marked distress, take up more than 1 hour a day, or significantly interfere with the person's normal routine, occupation, or usual social activities.
- If another Axis I disorder, substance use, or general medical condition is present, the content of the obsessions or compulsions is not restricted to it.

Social Anxiety Disorder

A fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others and feels he or she will act in an embarrassing manner. Exposure to the feared social situation provokes anxiety, which can take the form of a panic attack. The person recognizes that the fear is excessive or unreasonable. The feared social or performance situations are avoided or are endured with distress. The avoidance, anxious anticipation, or distress in the feared situation interferes significantly with the person's normal routine, occupational functioning, or social activities or relationships. The condition is not better accounted for by another mental disorder, substance use, or general medical condition. If a general medical condition or another mental disorder is present, the fear is unrelated to it. The phobia may be considered generalized if fears include most social situations.