

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

### Treatment of Anxiety Disorders

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

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

There are 4 general treatment elements to CBT:

1. Education: Provide young people and their parents with information on the condition to help normalize the fear of dealing with the illness and whether it will escalate over the long term. This includes:
  - Assuring them that anxiety disorders are highly treatable and that the child or youth can expect to experience remission with some flare-ups over the life course, particularly when experiencing life stressors.
  - Explaining the psychophysiology of anxiety and what they should do. Discussions can include how emotional thinking produces cognitive biases, and how avoidance brings relief from anxiety but thwarts recovery.
  - Reviewing the treatment roles and what is involved for the child, the family and the physician. By using a collaborative approach to seek agreement to the treatment process and treatment goals, the treatment plan becomes explicit and jointly owned.
  
2. Behavioural Exposure: Is the therapeutic 'engine of recovery', accounting for most of the treatment outcome. To ensure that it becomes a central feature of treatment:
  - Behavioural exposure should be introduced early and remain the focus of at least 50% of treatment efforts.
  - Take time to explain why it is so important.
    - For children and youth, it will take courage to systematically face their fears.
    - Discuss with family members that they need to support the child or youth with sustained confidence in the exposure process, despite the likely protestations and pleas to avoid or escape.
  - Throughout the process, provide copious amounts of empathy and faith that sustained exposure will weaken the learned anxiety response to any particular situation, if certain guidelines are followed. These are:
    - Collaborative development of a 'Fear Hierarchy' ('Fear Ladder' for children). Have the parent or youth develop about 10 graded approximations of the feared object or situation, from least to most.
    - Daily homework of planned exposure. Exposure works by (1) fear habituation, and (2) providing evidence that catastrophic expectations did not materialize.
    - The child or youth systematically follows through the Fear Hierarchy, while practicing somatic calming techniques and talking themselves through the experience (rehearsing prepared cognitive corrections to their worry themes). Parents can supervise, motivate, help record and report out on these efforts.
    - Daily sessions six days/week of about 30 minutes each (less for children), or until levels of distress drop by at least 50%. Ensure that exposure is not too brief or infrequent. Physicians can advocate for strong doses of exposure when favourable results are evident.
    - In the case of children, small and instant rewards for exposure are meaningful motivators (e.g., stickers that parents can dispense).
  
3. Cognitive Self-Control:
  - To help children cope, suggest to children to do or say certain things (e.g., "push anxiety off the table", "my brain is hiccupping again", "It's all right for OCD to stay here, I'll do other things"). However, in the case of children seeking reassurance (that something bad will happen), other family members can help by not providing it ("I don't know, let's find out").
  - Youth have more awareness and insight into thoughts, beliefs and other cognitive phenomena and can benefit from learning about how emotional thinking differs from critical thinking. For example,

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

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

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

### **Treatment Tips for Specific Anxiety Disorders**

#### **Specific Phobia**

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

#### **Social Phobia**

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

#### **Separation Anxiety**

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

#### **Panic Disorder/Agoraphobia**

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

### Generalized Anxiety Disorder

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

### Obsessive Compulsive Disorder

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

### Post Traumatic Stress Disorder

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

### **Examples of Common Treatment Errors**

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

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

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

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

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

### **Depression Treatment Tips**

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

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

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

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