Mindful
Continuing Education

Trends in Children's Mental Health

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Introduction

Children's mental health is in crisis, with many children struggling with the impacts of COVID-19. According to the Center for Disease Control, prior to COVID-19, 1 in 5 children were diagnosed with a mental disorder. Now, post-COVID-19, children face even more mental health difficulties ranging from child abuse, the loss of a family member, anxiety about the virus and unpredictable routines, and depression. All this leads to even more support being required than before the pandemic, which is further complicated by a shortage of mental health services for children. Parents are reporting that the pandemic has taken a toll on their children's mental health. Emergency departments have seen a rise in mental health crises, with a 24% rise in visits for children ages 5-11 and a 31% rise in ages 12-17 between March-October 2020 compared to 2019 emergency room visits for children. In addition, families must use emergency room services due to the shortage of outpatient services, which often have months-long waiting lists. Additional concerns include the lack of child and adolescent psychologists (among licensed psychologists in the United States, only 4,000/100,000 treat children and adolescents) and school psychologists (the recommended ratio of school psychologists to students is 1/500, and the current ratio in the United States is 1/1211). Mental health service ratios are even lower in low socioeconomic communities. While there has always been a disparity in mental health services, it has increased even more dramatically over the last couple of years. (Abramson, 2022). Although there has been a drastic increase in children's mental health needs, the lack of mental health providers and services available has reached a crisis level. Long waitlists, a lack of trained providers, and inadequate access to quality care for low-income individuals and people of color are among the issues faced (DeAngelis, 2022).

Trending Mental Health Disorders in Children

Anxiety and depression are the two most common childhood mental health disorders. Before COVID-19, the estimated global prevalence of depression in children was 8.5% and 11.6% for anxiety. Since then, those numbers have increased substantially, with the most recent global estimates of children experiencing clinically significant depression being 23.8% and 19% for anxiety. Overall, the pandemic safety measures have negatively impacted children's mental health. School adaptations (many shifted to remote learning) and diminished availability or temporary closure of community services and supports

(after-school programs, boys & girls clubs, sports) all impacted children's mental health (Benton et al., 2021).

Anxiety

Even before the COVID-19 pandemic, increasing numbers of young people were experiencing high rates of clinical-level anxiety. Approximately 11.6% of children had anxiety in 2012, up 20% from 2007. During the pandemic, those numbers nearly doubled, with 20.5% of youth worldwide struggling with anxiety symptoms. Issues that have been identified that increase anxiety include COVID-related stressors like social isolation, missed milestones, increased family tension, and background stressors such as school shootings, political unrest, and the war in Ukraine (DeAngelis, 2022).

Anxiety can be viewed as a false alarm of the sympathetic nervous system; it is a fight-or-flight response to something perceived as alarming when it does not need to be. Symptoms can include worried thinking, avoidant behavior, and physiological stress reactions. While the causes of anxiety disorders are not entirely clear, genetics and the environment, including parenting styles, traumatic events, and even one's birth cohort, impact one's anxiety susceptibility. In addition, anxiety can look different among children and teenagers based on their developmental stages. Younger children think in concrete terms and therefore lack insight into how unreasonable their anxiety may be. Older children can see that their level of anxiety is not necessarily warranted, but despite their improved insight, they cannot stop their anxious feelings (DeAngelis, 2022).

The most frequent types of anxiety seen in children are

Generalized Anxiety Disorder: GAD is extreme worry or anxious feelings across all domains of life. Children tend to worry, across the board, about their friend group, their performance, their health, their parents' health, their pet's health, etc. In addition, they may have physiological anxiety symptoms such as upset stomach, muscle tension, difficulty relaxing, difficulty concentrating, difficulty falling asleep, and feeling fatigued or on edge.

Separation Anxiety: This is more common in younger children; it is an intense fear of being separated from a primary caregiver and goes beyond the developmental norm. Children may be reluctant to go to school or participate in an activity, refuse to sleep away from home without their caregiver, and may have nightmares about the separation. They fear something bad might happen to their caregiver, and the person will never return, leaving them alone and unprotected.

Panic Disorder: This condition is more common in teenagers. They experience unexpected panic attacks, have persistent concerns, and worry about another attack. Panic attacks are abrupt surges of extreme discomfort or intense fear that usually peak within minutes. Physical and cognitive symptoms also occur, such as shortness of breath, palpitations, sweating, fear of going crazy, or fear of dying. These can occur unexpectedly with no obvious trigger, or they may be in a known response to a feared object or situation.

Specific phobias: This condition involves strong fears of specific situations or things. These often include needles and injections, dogs and other animals, and vomiting for children. Children with these phobias can become fixated on their fears, which can build into other problems, such as fear of leaving home and social anxiety.

Selective mutism: This disorder usually begins in early childhood. Children with selective mutism can talk in situations where they are comfortable, at home, or with others they feel close to, but with new people or in new places, there is a freeze response, where their anxiety prevents them from being able to use their voices. Children with selective mutism who act normally at home often show behavioral inhibition at school and in community settings, communicating only through gestures, head nods, and pointing (DeAngelis, 2022).

Nierengarten (2019) identifies the following risk factors for anxiety in children:

Sex

Girls are at a greater risk of developing an anxiety disorder, and the ratio of girls to boys with anxiety is 2:1 in children and 3:1 in adolescents.

Genetics

Children have a higher rate of anxiety if a parent has anxiety.

Personality Traits

- Emotionality
- Shyness
- Neuroticism
- Behavioral inhibition temperament (higher physiological response to stimuli)

Family Dynamics

- Overly controlling or overly critical parents
- Parental rejection
- Parental stress
- Family pattern of conflict avoidance
- High levels of stress in a family setting (family conflict, marital strain, divorce, domestic violence)

Environmental

Low Socioeconomic status has a higher prevalence of anxiety disorders.

Depression

Children and adolescents with depression often have impairments in functioning in multiple areas, including decreased school performance, poor social interactions, early pregnancy, frequent physical illness, and substance abuse. Depression can also negatively affect a child's development. Major depressive disorder in youth is strongly associated with depression in adulthood, other mental health diagnoses, and an increased risk for suicidal thoughts and behaviors. Youth die by suicide at a rate of 2.5 deaths per 100,000 persons (younger youth - age 12 and younger) and 16.1 deaths per 100,000 persons (older youth - age 13 and older) (USPSTF, 2022).

The most frequent types of depression seen in children are:

Major Depressive Disorder: this type of depression can be severe where the child has difficulty managing everyday life. The signs of major depressive disorder may include insomnia or hypersomnia, difficulty concentrating, weight loss or gain, loss of interest in previously enjoyable activities such as school or sports, irritability, or feeling sad or worthless. The difference between major depressive disorder and grief (such as the loss of a loved one) is if the predominant symptom is an overwhelming sense of loss or emptiness, which is more typical of grief. With major depressive disorder, the depressed mood prevents the person from anticipating any future enjoyable events (Selph & McDonagh, 2019)

Persistent Depressive Disorder: while this type of depression is chronic, it tends to be less severe. Although children can usually manage their everyday lives, they are not at their best, and they often feel down. In persistent depressive disorder, a child has a depressed mood for more days than not for at least one year (Selph & McDonagh, 2019).

Selph & McDonagh (2019) identify the following risk factors for depression in children and adolescents.

Biological

- Being overweight
- Chronic illness
- Early puberty
- Family history of depression
- Female gender
- High-functioning autism
- LGBTQ identifies
- Polymorphism in the serotonin, dopamine, or monoamine oxidase genes

Psychological

- Body dissatisfaction and early dieting
- Sweetened beverage consumption
- Dysfunctional emotional regulation
- Internet gaming disorder or video game addiction
- Less attachment to parents and peers or problems with peers
- Low self-esteem and lack of self-kindness
- Negative thinking and recall styles
- Other mental health and behavioral problems (including previous depression, cannabis use, and tobacco use)

- Problematic use of social media
- Frequent worry about school grades and standardized tests

Environmental

- Academic difficulties
- Being victimized or bullied or witnessing violence
- Physical, sexual, or emotional abuse or neglect
- Exposure to natural disasters
- Few opportunities for physical activity and sports, low physical activity (greater than 2 hours/day of leisure-time screen use)
- Foreign-born or perceived discrimination
- Loss of a loved one
- Low socioeconomic status
- Prenatal rejection or low parental involvement
- Poor family functioning or caretaker depression

One aspect that needs to be considered when discussing trends is that COVID-19 has had a disproportionate effect on disadvantaged and marginalized families. The pandemic has highlighted the disparities for youth linked to discrimination, racism, preexisting inequities, poorer access to care, increased exposure to risk, underrecognizing of illness, poor-quality treatment, limited economic resources, and crowded living conditions. In addition, youth from marginalized and minority groups are more likely to experience grief and loss of family members to COVID-19, secondary to the overrepresentation of the virus in communities that have been historically marginalized. Therefore, how minority populations are psychologically affected by COVID-19 and access to mental health care must be thoughtfully considered (Benton et al., 2021).

Treatment Best Practices

Despite children's increasing mental health needs, Lebrun-Harris et al. (2022) found no significant improvement in the receipt of mental health treatment or counseling over

the past five years. As of 2020, only 80% of children who needed mental health care received any services. While participation in evidence-based treatments for depression and anxiety is effective, outcomes are poor without treatment.

Cognitive Behavioral Therapy is the gold standard of evidence-based therapies to treat anxiety and depression in children. Grist et al. (2019) reviewed multiple studies and found that CBT should be delivered in face-to-face sessions for the best results. While internet and computer-based CBT was more effective than control groups on wait lists receiving no treatment, it had lower success rates than in-person CBT. Internet and computer-based CBT had slightly better results for adolescents than for children.

Anxiety

The treatment modality with the most evidence for successful results is cognitive behavioral therapy (CBT). Anxiety-specific CBT treatment usually consists of 12-20 sessions exploring the difference between thoughts, feelings, and behaviors and how they interact to impact anxiety. The treatment goals are addressing unrealistic or exaggerated anxious thoughts and exposing youth to what they fear until they experience and learn that the anticipated catastrophe does not occur. As a result, they become less triggered when they enter similar situations.

These are effective treatments; for example, 60% of young people who completed a tailored anxiety-specific cognitive behavioral therapy program improved significantly, and those numbers rose to 80% when they also took sertraline (Zoloft). The tailored CBT program in this study was Coping Cat (DeAngelis, 2022). Coping Cat is for children ages 7-13, and there is a version for older children ages 13-17 called the CAT Project. Coping Cat targets four skills areas:

- Recognizing and understanding emotional and physical reactions to anxiety
- Clarifying thoughts and feelings in anxious situations
- Developing plans for effective coping
- Evaluating performance and giving self-reinforcement (CEBC, 2022).

Treatment is important as untreated anxiety can escalate into depression, substance use, and suicidality. With treatment, children can learn the coping skills they need to find success in all aspects of their lives, including family and peer interactions, and school experiences. (DeAngelis, 2022).

Depression

Treatment options for children with depression include psychotherapy and antidepressant medications. Cognitive behavior therapy is a form of talk therapy focusing on changing behaviors by correcting faulty or potentially harmful thought patterns over time. CBT also focuses on improving interpersonal relationships, and treatment generally lasts between 12 and 16 sessions.

Fluoxetine (Prozac) and escitalopram (Lexapro) are the only two U.S. Food and Drug Administration-approved medications to treat children and adolescents with major depressive disorder. Fluoxetine is approved for children aged eight years and older, and escitalopram is approved for children aged 12 years and older. There are concerns about the potential for increased suicide risk with the use of fluoxetine and escitalopram. Clinical trials found an increase in suicidal thoughts and behaviors when the antidepressant was compared to a placebo (4% vs. 2%). Therefore children and adolescents taking antidepressants should be monitored for suicide ideations. The frequency of monitoring should be based on the individual's risk, and may consist of weekly monitoring at the beginning of treatment which transitions to monthly monitoring as the child shows improvement on antidepressants (Selph & McDonagh, 2019).

School Roles

Abramson (2022) discusses the school's role in addressing children's mental health. Federal funding has been provided to schools to support students' mental health. As a result, many schools are building mental health into the curriculum and training teachers in prevention strategies to support students' psychological health. Unfortunately, hiring full-time staff may not be sustainable because federal aid is temporary. However, there are ways schools can address the mental health of their students.

Bringing Mental Health into the Classroom

Some districts are having their school psychologists train teachers in social and emotional skills to help students deal with stress and anxiety at the moment they are experiencing it in the classroom. Equipping students with coping skills in the classroom can reduce the strain on school psychologists while at the same time improving the student's ability to learn. Teachers are also immediately available to students, while

school psychologists may not be available when students need to implement a coping skill they have learned.

Some teachers are building mental health lessons into their curriculum on their own, while other schools have their psychologists work with teachers to incorporate pandemic-relevant topics like anxiety, trauma, and warning signs of suicide into their classes. Other schools invest in formal social and emotional health training programs. For example, Yale University's RULER program teaches the five emotional intelligence skills of recognizing, understanding, labeling, expressing, and regulating. Schools that have implemented the RULER program have seen positive results not just among students but also teachers and administrators (Yale, 2022).

Training Teachers to Address Trauma

In addition to teachers having more students with mental health and behavioral issues, more students have trauma. Many teachers do not feel they can or know how to address trauma. One study found that only 15% of teachers felt comfortable addressing grief and trauma linked to the pandemic. Helping teachers identify trauma is essential, as too frequently student behaviors that are triggered by trauma are incorrectly labeled and students are punished for behaving inappropriately. Additionally, they do not receive the support they need as it is seen as a behavioral issue instead of a trauma response. Curriculum that shows teachers how to recognize, support, and refer students with trauma is available. For example, the Coalition for Psychology in Schools and Education has developed Mental Health Primers to help teachers identify behaviors that are symptomatic of mental health struggles, with the goal of directing teachers to appropriate resources for their students (Abramson, 2022).

Ensuring Long-term Resilience

While short-term emergency funding can temporarily help communities and schools, advocates recognize that a more permanent solution is needed. There are pending federal policies to increase mental health education in schools, implement a student mental health helpline, and increase funding for in-school mental health providers (Abramson, 2022).

Parental Roles

Parental involvement is key in any child's treatment. Parents are crucial in helping their children buffer everyday stress, teaching them to manage their feelings effectively, and providing a stable and secure environment. Research has consistently shown a correlation between parental mental health and children's well-being, suggesting that caregivers' mental health is important to protect children's well-being (Spiteri, 2021).

Parents can play a pivotal role in their children's mental health at home by helping them engage in school work, assigning chores, and encouraging them to exercise daily (Spiteri, 2021). There has unfortunately been a significant decline in the number of school-age children who have 60 minutes of physical activity daily (24.2% down to 19.9%) (Lebrun-Harris et al., 2022). Physical activity is known to help reduce symptoms of anxiety and depression.

Sometimes, parents unintentionally promote a child's anxiety by offering too much reassurance or protection. While this is a natural parental response, it can perpetuate anxiety in the long term because children are not learning how to handle difficult situations themselves. Other parents may invalidate or ignore a child's anxious reactions, which can leave the child feeling unsettled and strain the parent-child relationship. Parents can support their children by acknowledging and empathizing with their children's feelings while at the same time promoting their autonomy and not giving too much credence to their anxiety. Parents can facilitate behavioral experiments at home to help kids practice facing anxiety-provoking situations (DeAngelis, 2022).

Even prior to the pandemic, decreases were seen in parents or caregivers reporting they had excellent or good mental health (69.8% in 2016, down to 66.3% in 2020). There was also a decrease in parents who reported they were doing very well with the demands of raising children (67.2% in 2016, down to 59.9% in 2020). Two additional concerning statistics were the rise in the number of children who had lived with someone with mental illness (7.8% in 2016 increased to 8.3% in 2020) and who experienced ethnic or racial discrimination (3.7% in 2016 to 5.4% in 2020) (Lebrun-Harris et al., 2022).

Parents experienced high stress, fear, anxiety, emotional distress, and financial difficulties during the pandemic. Addressing a caregiver's mental health and well-being is two-fold. First, there is a reciprocity between parent and child mental health. Second caregivers' capacity to support and protect their children ultimately depends on their own coping abilities and well-being. Therefore, mental health providers should assess

caregivers' mental health and make referrals as they see necessary to give their young clients the best outcomes possible (Fong & Iarocci, 2020).

Mental Wellness & Prevention

Barriers to accessing mental health services need to be decreased. Low-income families are less likely to access services due to transportation difficulties, lack of insurance, and lack of internet/technology to access telemental health. Providing psychoeducational resources to parents and teachers is critical to help them identify early warning signs of mental health decline in children so that they may receive timely referral for support. Identifying areas of resilience and supporting parents and professionals working with children is essential to strengthening both child and family mental health and wellbeing. Identifying families at risk due to high levels of stress, even before the pandemic, may have worsened since the pandemic. Examples of potentially at-risk families include those coping with domestic violence, youth protection issues, mental health concerns, and disabilities. Other at-risk families, such as healthcare providers, may not be as obvious; 70% of healthcare workers are women and parents. These findings highlight a critical need to support children and their caregivers to improve families' mental and emotional well-being (Fong & Iarocci, 2020).

Prevention

The U.S. Preventive Services Task Force recommends that children ages 8-18 be screened for anxiety and those ages 12-18 be screened for major depressive disorder (USPSTF, 2022).

Understanding impairment levels among youth with depression and anxiety symptoms will allow for targeted and appropriate interventions. When youth's symptoms are considered during screenings, and not just their impairment in functioning, the rate of mental health diagnosis increases. Identification is an important consideration, as youth who may not meet the full criteria of symptoms are likely to need less intensive interventions than those who meet the full symptom criteria for a diagnosis and are experiencing impairments in their daily functioning. In contrast, identifying youth with severe symptoms can facilitate planning for closer monitoring and follow-up for adherence to appointments and treatment guidelines to assure safe and effective care (Benton et al., 2021). See Appendix A for Anxiety & Depression screening tools.

Hoagwood et al. (2021) highly advocate for early childhood interventions due to the long-term impacts they can have on the individual child, families, and communities. For example, children and their parents who receive early intervention services have achieved better academic and health outcomes. In addition, community-level changes are seen in the use of emergency rooms, special education services and reductions in incarceration and unemployment rates.

Hoagwood et al. (2021) identify four key non-mental health areas to target to improve children's mental wellness and potentially prevent difficulties in the future. Their goal in targeting non-mental health areas recognized how overburdened the mental health system is and the necessity to find other ways mental health could be targeted without increasing demands on an over-taxed system. Their recommended areas to target are:

Early Education

Children's brain development begins in utero, and critical brain pathways and cognitive processes develop during the first years of life.

- Prevent Disruptions to Early Brain Development and Promote Early Learning

Adverse childhood experiences can derail early childhood development and lead to costly lifetime healthcare spending. On the other hand, early education (from birth through age 5) has provided long-term benefits, including educational attainment, income, and criminal activity.

- Protect and Preserve

Early education programs strengthen and empower parents to provide high-quality interactions with their children. These programs have been shown to reduce child maltreatment and child out-of-home placements.

- Provide Services that Build Early Learning into the Continuum of Programming

Home visitation programs during pregnancy have some of the best evidence to improve child development. In addition, many states are implementing early childcare and preschool interventions as they see the benefits to children in achieving early learning gains.

Maternal and Child Health

Maternal and child health from conception through two years of age is critically important to healthy brain development and overall mental, emotional, and behavioral wellness. Rates of maternal and infant mortality in the U.S. are among the highest of all developed countries.

- Prevent Premature Births

Various interventions can be made to reduce premature birth, one of the keys being smoking cessation during pregnancy. Pregnant women who receive smoking cessation support have higher birth rates and fewer preterm births than women who continue smoking during their pregnancy.

- Preserve the Maternal-Child Bond

Maternal postpartum depression occurs in 10% of women and is associated with children's cognitive and emotional delays and disorders. Conversely, maternal depression screening and treatment are associated with improved child development and emotions.

- Provide Services to Young Families

Well-child visits with healthcare providers are provided to most children where they can be screened for speech, auditory, language, cognitive, and emotional problems. Again, early intervention is more effective than later treatment, which is not identified until the child is enrolled in school.

Child Welfare

Services and supports empower parents to improve interactions with their children, contribute to their health and well-being, and ensure safe home environments that can prevent removal from their homes. Abuse and neglect alter both physiological (brain development) and psychological development (impacting attachment and relationship skills).

- Prevent Removal

In 2018 The Family First Prevention Services Act was passed, allowing funds for foster care to go toward evidence-based programs for families so children can safely stay with their parents or relatives.

- Preserve Family Unity

Children in foster care (even those as young as 12-18 months) often have severe and complex behavioral and mental health problems that put them at higher risk for poorer long-term outcomes. Evidence-based programs can help support families and reduce unnecessary out-of-home placement.

- Provide Services

Children enrolled in Early Head Start (EHS) had fewer child welfare encounters and lower child maltreatment rates than non-EHS-enrolled children. Finding ways EHS programs and child welfare services can partner to target families in need and enrolling them in EHS is critical.

Corrections

In the past 40 years, the number of people incarcerated has jumped from 500,000 to 2.3 million, with disparities in race, ethnicity, and income. It is estimated that 5 million children experience parental incarceration with negative consequences of increased homelessness, dependence on public aid, residential instability, school failure, and mental, emotional, and behavioral disorders.

- Preventing Parental Incarceration

Mental health and substance abuse diversion programs provide alternatives to incarceration, and they have lower rates of recidivism and costs.

- Preserve Parent-Child Relationships

Despite a parent being incarcerated, there can still be ways to maintain consistent contact with their children. One program involves inmates participating in parental training classes and maintaining communication through email, mail, or phone.

- Provide Services

The stigma associated with incarceration makes it difficult for the custodial parent or the children to identify themselves. Providing easily-seen information at key places, informal screening procedures, and offers of help may increase identification.

Wellness

Research continues to show the benefits of physical activity, nutrition, and sleep in improving mental health. Physical activity has both neurobiological and psychosocial

effects that particularly help improve depression (in some studies as significantly as antidepressants and CBT) and moderately reduce anxiety. Neurobiologically, physical activity modifies the stress response, promotes brain development, and regulates serotonin, dopamine, norepinephrine, and endorphins. Psychosocial benefits include promoting social connection and autonomy, skills mastery, building confidence through achievement, and learning distress tolerance.

New research supports the link between healthy eating and improved mental health. One study found poor diets linked to lower left hippocampal volume, and ongoing research explores how the gut biome impacts mental health. Areas to target that have shown positive improvements in mental health include increased intake of fruits and vegetables, whole grains, seafood, nuts, and legumes; moderate consumption of dairy products; low intake of red and processed meat; and minimal intake of processed foods. Food insecurity can play a part in this, and mental health providers should consider this when evaluating and making nutrition recommendations.

Quality sleep has several positive outcomes for children, including improvements in attention, academic performance, memory, cognition, behavior, emotional regulation, enhanced self-esteem, and levels of optimism. In contrast, inadequate sleep has been linked to increased self-criticism, risk-taking behaviors, and increased risk of suicidality and other mental health disorders. On average, adequate sleep amounts are considered to be nine or more hours for children aged 6-12 and 8 or more hours for adolescents aged 13-18, with younger children under the age of six requiring even more sleep time. Nearly 60% of middle schoolers and 75% of high schools do not get adequate sleep. Factors that contribute to poor sleep include electronic media exposure, caffeine consumption, early school start times, chronic medical conditions, neurologically based sleep disorders, and pressures to achieve good grades, participate in extracurricular activities, and maintain an active social life (Hosker et al., 2019).

Conclusion

The impacts of the pandemic on children's overall well-being are significant and go beyond the physical risk of becoming infected with a severe acute respiratory virus. The repercussions for children must be addressed, or they are likely to become longstanding problems with even worse outcomes in the future. Therefore, interventions with children and families should be considered to prevent the potential negative effects of the COVID-19 pandemic and overall stressors that children and families face. To achieve

this, mental health providers need to work with children and their parents to help them with strategies to reduce the negative impact of the pandemic, trauma, and other hardships on their mental health. (Spiteri,2021).

This mental health crisis requires more than just a mental health services response. A targeted community approach that considers other areas to target, such as those recommended by Hoagwood et al. (2021), may be the most successful approach. Children are not independent entities; therefore, their whole environment should be targeted to address their mental health, including family, school, and community.

Children ages 0-17 comprise 22% of the United States population. They make up a significant portion of the population, and addressing physical and mental health issues at younger ages helps set them up for success and health as they mature.

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Appendix A: Screening Tools

Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 1 of 2 (To be filled out by the CHILD)

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 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1.	When I feel frightened, it is hard for me to breathe	O	O	O
2.	I get headaches when I am at school	O	O	O
3.	I don't like to be with people I don't know well	O	O	O
4.	I get scared if I sleep away from home	O	O	O
5.	I worry about other people liking me	O	O	O
6.	When I get frightened, I feel like passing out	O	O	O
7.	I am nervous	O	O	O
8.	I follow my mother or father wherever they go	O	O	O
9.	People tell me that I look nervous	O	O	O
10.	I feel nervous with people I don't know well	O	O	O
11.	I get stomachaches at school	O	O	O

12.	When I get frightened, I feel like I am going crazy	O	O	O
13.	I worry about sleeping alone	O	O	O
14.	I worry about being as good as other kids	O	O	O
15.	When I get frightened, I feel like things are not real	O	O	O
16.	I have nightmares about something bad happening to my parents	O	O	O
17.	I worry about going to school	O	O	O
18.	When I get frightened, my heart beats fast	O	O	O
19.	I get shaky	O	O	O
20.	I have nightmares about something bad happening to me	O	O	O

Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 2 of 2 (To be filled out by the CHILD)

		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	O	O	O
22.	When I get frightened, I sweat a lot	O	O	O
23.	I am a worrier	O	O	O
24.	I get really frightened for no reason at all	O	O	O
25.	I am afraid to be alone in the house	O	O	O

26.	It is hard for me to talk with people I don't know well	o	o	o
27.	When I get frightened, I feel like I am choking	o	o	o
28.	People tell me that I worry too much	o	o	o
29.	I don't like to be away from my family	o	o	o
30.	I am afraid of having anxiety (or panic) attacks	o	o	o
31.	I worry that something bad might happen to my parents	o	o	o
32.	I feel shy with people I don't know well	o	o	o
33.	I worry about what is going to happen in the future	o	o	o
34.	When I get frightened, I feel like throwing up	o	o	o
35.	I worry about how well I do things	o	o	o
36.	I am scared to go to school	o	o	o
37.	I worry about things that have already happened	o	o	o
38.	When I get frightened, I feel dizzy	o	o	o
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)	o	o	o
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	o	o	o
41.	I am shy	o	o	o

**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.*

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SCORING

0 = not true or hardly true

1 = somewhat true or sometimes true

2 = very true or often true

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**.

PHQ-9 modified for Adolescents (PHQ-A)—Adapted

Severity Measure for Depression—Child Age 11–17

Name:_____ **Age:** _____ **Sex: Male ❑ Female ❑**
Date:_____

Instructions: How often have you been bothered by each of the following symptoms during the past **7 days**? For each symptom put an "**X**" in the box beneath the answer that best describes how you have been feeling.

						Clinician Use
						Item score
		(0) Not at all	(1) Several days	(2) More than half the	(3) Nearly every	
1.	Feeling down, depressed, irritable, or hopeless?					
2.	Little interest or pleasure in doing things?					
3.	Trouble falling asleep, staying asleep, or sleeping too much?					
4.	Poor appetite, weight loss, or overeating?					
5.	Feeling tired, or having little energy?					
6.	Feeling bad about yourself—or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Trouble concentrating on things like school work, reading, or watching TV?					
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you were moving around a lot more than usual?					
9.	Thoughts that you would be better off dead, or of hurting yourself in some way?					

Total/Partial Raw Score:	
Prorated Total Raw Score: (if 1-2 items left unanswered)	

Modified from the PHQ-A (J. Johnson, 2002) for research and evaluation purposes

Instructions to Clinicians

The Severity Measure for Depression—Child Age 11–17 (adapted from PHQ-9 modified for Adolescents [PHQ-A]) is a 9- item measure that assesses the severity of depressive disorders and episodes (or clinically significant symptoms of depressive disorders and episodes) in children ages 11–17. The measure is completed by the child prior to a visit with the clinician. Each item asks the child to rate the severity of his or her depression symptoms **during the past 7 days**.

Scoring and Interpretation

Each item on the measure is rated on a 4-point scale (0=Not at all; 1=Several days; 2=More than half the days; and 3=Nearly every day). The total score can range from 0 to 27, with higher scores indicating greater severity of depression. The clinician is asked to review the score of each item on the measure during the clinical interview and indicate the raw score in the section provided for "Clinician Use." The raw scores on the 9 items should be summed to obtain a total raw score and should be interpreted using the table below:

Interpretation Table of Total Raw Score

Total Raw Score	Severity of depressive disorder or episode
0-4	None
5-9	Mild
10-14	Moderate
15-19	Moderately severe
20-27	Severe

Note: If 3 or more items are left unanswered, the total raw score on the measure should not be used. Therefore, the child should be encouraged to complete all of the items on the measure. If 1 or 2 items are left unanswered, you are asked to calculate a prorated score. The prorated score is calculated by summing the scores of items that were answered to get a partial raw score. Multiply the partial raw score by the total number of items on the PHQ-9 modified for Adolescents (PHQ-A)—Modified (i.e., 9) and divide the value by the number of items that were actually answered (i.e., 7 or 8). The formula to prorate the partial raw score to the Total Raw Score is:

$$\frac{\text{(Raw sum x 9)}}{}$$

Number of items that were actually answered

If the result is a fraction, round to the nearest whole number.

Frequency of Use

To track changes in the severity of the child's depression over time, the measure may be completed at regular intervals as clinically indicated, depending on the stability of the child's symptoms and treatment status. Consistently high scores on a particular domain may indicate significant and problematic areas for the child that might warrant further assessment, treatment, and follow-up. Your clinical judgment should guide your decision.