

Appendix C: Manual of procedures and tool kit for implementation

International Committee on Mental Health in Cystic Fibrosis: Cystic Fibrosis Foundation and European Cystic Fibrosis Society's Guide to Implementing Depression and Anxiety Screening in CF Centers

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This guide was adapted from A Guide to Depression Screening developed at the Cystic Fibrosis Center of University at Buffalo at Women & Children's Hospital of Buffalo by Beth Smith, M.D., Carla Frederick, M.D., Danielle Goetz, M.D., Lynne Fries, PA-C, MPAS, DPT, Kimberly Rand, LMSW, Christine M. Roach, RN, BSN, and Drucy S. Borowitz, M.D.

How to Get Started:

Before you get started with depression and anxiety screening, identify a core group of people who are interested. "It takes a village" to move this forward and it's **important that this does not land on the shoulders of just one or two people.**

Identify:

- **Who** are the integral players for depression and anxiety screening and assessment in your center?
- **What** specifically will each of them do and do they have the knowledge and skills to do it?

The Main Ideas:

- **All patients 12 years and older receive annual screening for depression and anxiety.**
- **Parent caregivers of patients aged 0-17 years are *offered* annual screening for depression and anxiety.**
- **A stepped process** for prevention, screening, assessment and intervention is recommended. Please refer to the Cystic Fibrosis Foundation and European Cystic Fibrosis Society Consensus Statements for Screening and Treating Depression and Anxiety Figure 1: Assessing & Treating Depression & Anxiety in CF.

Step 1 Screening:

For Depression: Administer the Patient Health Questionnaire-9 (PHQ-9) to adult patients and parent caregivers (appendix 1) and the PHQ-9 *or* PHQ-9 Modified for Teens to adolescent patients 12-17 years (appendix 2). The PHQ-9 informs on depression severity and diagnostic criteria of major depression based on the Diagnostic and Statistical Manual of Mental Disorders (DSM).

For Anxiety: Administer the Generalized Anxiety Disorder Questionnaire (GAD-7) to adolescents, adults and parent caregivers (appendix 3).

These forms are in the appendix however can also be downloaded free with a full instruction manual at www.phqscreeners.com.

Step 2 Assessment:

Assessment: If the PHQ-9 and/or the GAD-7 score ≥ 10 the patient needs an assessment.

- Assessment should be the shared responsibility of the team however the team must designate who is expected to conduct the assessment per the scope of practice. This may be a mental health specialist on your team or another CF professional with sufficient mental health training and comfort.
- Some teams may decide to refer to psychiatry, psychology, or the patient's primary care physician for further assessment based on the team's resources. For example, teams may choose to refer all patients scoring in the moderate to severe range or patients with certain risk factors.
- An assessment should include risk factors, pertinent history, severity/extent of symptoms and level of impairment, which leads to different interventions using a stepped care approach.
- Patient and parent preference is also considered.

Screening Tools:

- Identify if you will use paper/pencil or computer based questionnaires.
- Who will administer the tools?
- Who will score them?
- Consider when you will screen.

An example could be to screen patients annually in a certain quarter of the year, as many patients are seen quarterly. Here are some tips if you choose this method:

- If a patient is not seen in that quarter of the year, screen them at their next outpatient visit.
 - If a patient is non-adherent to outpatient appointments or was not seen in that quarter of the year consider screening at the end of an inpatient admission.
 - Begin the next cycle in the same quarter so you do not have to track when individual patients are due for their next screen.
 - Additionally, the team may choose to screen patients **any time** significant symptoms of depression or anxiety are reported or observed by patients, caregivers, or members of the CF multidisciplinary team.
 - **All patients, whether or not they had a positive screen the year before, are screened again the following year.**
- **PHQ-9 and GAD-7 total scores, together with an assessment, lead to different interventions using a stepped care approach. Patient and parent preference is also considered.**
 - The **PHQ-9 total score** puts the patient into categories:
 1. **No or minimal depression:** Total Score 0-4
 2. **Mild depression:** Total Score 5-9
 3. **Moderate depression:** Total Score 10-14
 4. **Severe depression:** Total Score ≥ 15
 - The **GAD-7 total score** puts the patient into categories:
 1. **No or minimal anxiety:** Total Score 0-4
 2. **Mild anxiety:** Total Score 5-9
 3. **Moderate anxiety:** Total Score 10-14
 4. **Severe anxiety:** Total Score ≥ 15

- Refer to www.phqscreeners.com for full scoring instructions for the PHQ and GAD-7 and to Appendix 4 for examples of different scoring methods for the PHQ-9 and PHQ-9 Modified for Teens and appendix 5 for scoring the GAD-7.
- **All patients with a positive screen (Score \geq 10) receive a follow-up assessment.**
- The PHQ-9 and GAD-7 total score helps assess depression and anxiety severity; however, an **assessment** provides additional information to help **further categorize the severity** and clinical significance of symptoms based on factors such as prior history of depression and/or anxiety, depression/anxiety treatment, stressors, history of comorbid psychiatric diagnoses, severity of CF, and presence of complications.
- There is an **algorithm** of how to manage each of the categories of depression and anxiety severity for individuals with CF 12 years and older. Please refer to the Cystic Fibrosis Foundation and European Cystic Fibrosis Society Consensus Statements for Screening and Treating Depression and Anxiety Figure 2 (Screening & Treatment for Depression & Anxiety: Algorithm for Individuals with CF ages 12-Adulthood). It is important to confirm a clinical diagnosis prior to initiating treatment and use independent clinical judgment and skills in the context of individual clinical circumstances.
- There is also an **algorithm** for managing parent/caregiver depressive and anxiety symptoms. Please refer to the Cystic Fibrosis Foundation and European Cystic Fibrosis Society Consensus Statements for Screening and Treating Depression and Anxiety Figure 3 (Screening & Treatment for Depression & Anxiety: Algorithm for Parents/Caregivers).
- Remember there is a suicidality question in the PHQ-9 (question #9). This is addressed below.

The work before the work” – The PLAN part of the P-D-S-A Cycle:

1. The key to beginning screening is to have a plan for what you will do with a positive screen:

- You will want to have **educational materials on hand for patients with depression and anxiety**. Offer support, help coping with stress, and provide education and information about depression/anxiety and its management for all patients with a PHQ-9 or GAD-7 score \geq 5. Depression and anxiety education is an important part of ongoing prevention, as well as an intervention for all levels of depression and anxiety severity.
- Examples of sample handouts/educational materials are found in Appendix 5. Some additional resources include:
 - A comprehensive resource for adolescent depression tools can be found in a toolkit that accompanies the Guidelines for Adolescent Depression in Primary Care (GLAD-PC) and can be downloaded free at www.glad-pc.org.
 - Additional educational materials and screening tools for other mental health issues, such as substance abuse, ADHD, oppositional-defiant disorder, and a variety of behavioral health problems are available at www.cappcnny.org.
 - For adolescent patients the American Academy of Child and Adolescent Psychiatry has developed facts for families, which are concise handouts with up-to-date information on a variety of topics that affect children. (www.aacap.org)

- For pediatric patients, the Massachusetts General Hospital School Psychiatry Program/Mood and Anxiety Disorders Institute has developed resources aimed at parents, teachers, and clinicians for implementing school-based interventions for depression, anxiety, and other mental health disorders (www.schoolpsychiatry.org).
 - For adult patients the American Academy of Psychiatry has "Let's Talk Brochures" on psychiatric disorders and their treatments (www.psychiatry.org).
- **You will need to identify available resources in your institution and community for the treatment of depression and anxiety for patients with moderate - severe symptoms**
 - *Even if your CF team already includes a mental health provider/clinician with appropriate skills and training, it is likely that some individual patients, such as those travelling long distances to their CF center, will need to access additional community resources..*
 - **This step must be completed prior to implementing screening and will likely take the most time.**

Here are some thoughts about how to do this:

- Contact Psychology/Psychiatry Departments at your university and ask for resources or contact psychology or consult liaison psychiatry services within your hospital and ask for resources.
 - Contact the local office of mental health in your county or region.
 - It is recommended when referring patients that you educate the patients/parents on what to ask for. For example: evidence based therapies for depression include Cognitive Behavioral Therapy (CBT) and Interpersonal Therapy (IPT) and evidence based treatment for anxiety includes exposure based CBT. Handouts about CBT for depression and anxiety are found in appendix 6 (www.abct.org). Information about IPT can be found at <http://interpersonalpsychotherapy.org>. It is also important to educate our referral resources about CF. Appendix 7 has a general handout about cystic fibrosis for mental health care providers.
- **You will need to develop a plan for patients with suicidality.**
 - For patients or parents/caregivers who screen positive for suicide risk (Question 9 on the PHQ-9), the designated mental health expert on the CF team should follow up immediately to determine how serious the risk is. This should include a clinical interview or further assessment. There are formal assessment tools, such as the Columbia Suicide Severity Rating Scale (C-SSRS; <http://www.ccrs.columbia.edu/ecssrs.html>), which can also be used to evaluate this risk.
 - Appendix 7 has the Columbia Suicide Severity Rating Scale (CSSRS) for assessing and managing patients with suicidal ideation. This scale or an alternate assessment, should be completed on every patient with a positive response to question 9 on the PHQ-9. This scale is administered in person and is not handed to the patient.
 - If using the CSSRS, we recommend members of your team complete the free online training. All members of your team involved in screening are encouraged to complete this training and will receive a certificate of completion.
 - Appendix 8 has POSSIBLE triage responses to the Columbia Suicide Severity Rating Scale and suggested interventions however these need to be modified based on your local practice patterns and resources. Other responses are available on the training web-site and again may differ in your algorithm depending on local practices and resources.
 - Appendix 9 has an example of an Adult Safety Plan.
 - Appendix 10 has an example of a Pediatric Safety Plan.

2. Your team will need to figure out how to **communicate with patients and parents/caregivers that screening will be starting**. It is important for patients and parents to be aware of the process.

- Will you send a letter to patients?
- Do you have a newsletter?
- Will you do an educational webinar?
- Other

3. **Establish your process for screening in clinic**. Decide who will do specific tasks.

- Who will hand out the screening tools (PHQ-9 and GAD-7)
- Who will score the PHQ-9 and GAD-7?
- How will the treating clinician know what was completed and the results?
- How do patients with positive PHQ-9 and/or GAD-7 receive an assessment?
- What is the process for looking at question #9 (suicidality) on the PHQ-9 and intervening if necessary? One possibility: The clinician seeing the patient looks at question 9 and if positive intervenes with the help of the social worker/psychologist.
- Who gets the PHQ-9 and GAD-7 forms at the end of clinic?
- Are the forms scanned into the patient's electronic medical record?
- Consider discussing each patient with a positive score at your team's next multidisciplinary team meeting.

Implementing the Program – the “DO” part of the P-D-S-A Cycle:

- Now that you've prepared your team and your patients/parents, **get started!**
- You've decided who is doing what in clinic, but you also need to decide who is doing what after clinic.
 - **How will you keep track of screening scores?**
 - Who will enter this data at your site?
 - **How will you track the patients who screened positive for suicidality**, especially those who have an intervention in clinic?
- **How will you track that the required follow-up and re-assessment has been completed?**
- **How will you track patient adherence with recommendations/treatment?** It is common for patients with symptoms of depression to not follow through on treatment referrals and/or comply with treatment recommendations. One suggestion is calling patients with moderate to severe depression and/or anxiety after their clinic visit to assess follow-through and compliance with recommendations/treatment and any perceived barriers to either the referral or treatment. Alternatively one could assess follow-through at the next clinic visit.
- **Routinely discuss patients who screen positive as part of your weekly pre-clinic/post-clinic team meeting.**

Evaluating the Program: The “STUDY” Part of the P-D-S-A cycle:

- **Examine your tracking tools to see if you are accomplishing your initial goals:**
 - All patients get screened with PHQ-9 and GAD-7 at least once a year.
 - All patients with a positive answer to question #9 (suicidality) have an intervention.
 - All patients with a PHQ-9 or GAD-7 score ≥ 10 have an assessment and an intervention based on their level of depression and/or anxiety.
- **Examine your tracking tools to see if you are achieving longer-term goals:**
 - Are you re-assessing patients and repeating the PHQ-9 and GAD-7 for those with mild depression/anxiety at the next visit?

- Are you ensuring follow-up for patients with PHQ-9 or GAD-7 score ≥ 10 ?
- If the patient is receiving psychological or psychopharmacological treatment within the center more frequent reassessment may be required for optimal management. For those patients who are referred for psychological/psychiatric treatment, are you re-assessing/repeating the PHQ-9 or GAD-7 for those patients with moderate-severe symptoms at the next clinic visit? Consider whether and how you will communicate the initial and regular rescreening results to clinicians providing mental health treatment within or outside your CF team.
- On reassessment, if the PHQ-9 or GAD-7 score is < 5 then rescreen at the next annual assessment period.
- **Will you elicit feedback from patients/parents on your depression and anxiety screening protocol?**
 - If so, how does that alter what you will do next?

Improving your processes: The “ACT” Part of the P-D-S-A cycle:

- **As a team, decide what part of your processes should change.**
 - Work together as a team to put your new processes in place. Meet periodically to review the process and seek feedback from your team to improve the process.
 - Decide if you need to change or improve your protocol or tracking tools so you can continue to measure the effectiveness of your screening.
- **Share your experience, resources and tools generously with other CF Centers**

Appendix 1: Depression Screening Tool - The PHQ-9

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

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

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 2: Depression Screening Tool- PHQ-9: Modified for Teens

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ Clinician: _____ Date: _____

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

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
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?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
 Yes No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
 Not difficult at all Somewhat difficult Very difficult Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?
 Yes No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?
 Yes No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: _____ **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Appendix 3: Anxiety Screening Tool - GAD-7

GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
<i>(Use "✓" to indicate your answer)</i>				
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T_____ = _____ + _____ + _____)

Appendix 4: Depression Scoring Tool
PHQ-9 Scoring Worksheet

Scoring the PHQ-9 and PHQ-9 Modified for Teens

Scoring the PHQ-9 or the PHQ-9 Modified for Teens is easy but involves thinking about several different aspects of depression.

To use the PHQ-9 as a diagnostic aid for Major Depressive Disorder:

- Questions 1 and/or 2 need to be endorsed as a “2” or “3”
- Need five or more positive symptoms (positive as defined by a “2” or “3” in questions 1-8 and by a “1”, “2”, or “3” in question 9).
- The functional impairment question (How difficult...) needs to be rated at least as “somewhat difficult.”

To use the PHQ-9 to aid in the diagnosis of dysthymia:

- The dysthymia question (In the past year...) should be endorsed as “yes.”

To use the PHQ-9 to screen for suicide risk:

- All positive answers to question 9 MUST be followed up by a clinical interview.

To use the PHQ-9 to obtain a total score and assess depressive severity:

- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See Table below:

Total Score	Depression Severity
0-4	No or minimal depression
5-9	Mild depression
10-14	Moderate depression
≥ 15	Severe depression

Appendix 5: Anxiety Scoring Tool
GAD-7 Scoring Worksheet

Scoring the GAD-7

To use the GAD-7 to obtain a total score and assess the severity of anxiety:

- Add up the numbers endorsed for questions 1-9 and obtain a total score.
- See Table below:

Total Score	Severity of Anxiety
0-4	No or minimal anxiety
5-9	Mild anxiety
10-14	Moderate anxiety
≥ 15	Severe anxiety

FACTS *for* FAMILIES

No. 66

May 2005

Helping Teenagers Deal with Stress

Teenagers, like adults, may experience stress everyday and can benefit from learning stress management skills. Most teens experience more stress when they perceive a situation as dangerous, difficult, or painful and they do not have the resources to cope. Some sources of stress for teens might include:

- school demands and frustrations
- negative thoughts and feelings about themselves
- changes in their bodies
- problems with friends and/or peers at school
- unsafe living environment/neighborhood
- separation or divorce of parents
- chronic illness or severe problems in the family
- death of a loved one
- moving or changing schools
- taking on too many activities or having too high expectations
- family financial problems

Some teens become overloaded with stress. When it happens, inadequately managed stress can lead to anxiety, withdrawal, aggression, physical illness, or poor coping skills such as drug and/or alcohol use.

When we perceive a situation as difficult or painful, changes occur in our minds and bodies to prepare us to respond to danger. This "fight, flight, or freeze" response includes faster heart and breathing rate, increased blood to muscles of arms and legs, cold or clammy hands and feet, upset stomach and/or a sense of dread.

The same mechanism that turns on the stress response can turn it off. As soon as we decide that a situation is no longer dangerous, changes can occur in our minds and bodies to help us relax and calm down. This "relaxation response" includes decreased heart and breathing rate and a sense of well being. Teens that develop a "relaxation response" and other stress management skills feel less helpless and have more choices when responding to stress.

Parents can help their teen in these ways:

- Monitor if stress is affecting their teen's health, behavior, thoughts, or feelings
- Listen carefully to teens and watch for overloading
- Learn and model stress management skills
- Support involvement in sports and other pro-social activities

Helping Teenagers Deal with Stress, “Facts for Families,” No. 66 (05/05)

Teens can decrease stress with the following behaviors and techniques:

- Exercise and eat regularly
- Avoid excess caffeine intake which can increase feelings of anxiety and agitation
- Avoid illegal drugs, alcohol and tobacco
- Learn relaxation exercises (abdominal breathing and muscle relaxation techniques)
- Develop assertiveness training skills. For example, state feelings in polite firm and not overly aggressive or passive ways: (“I feel angry when you yell at me” “Please stop yelling.”)
- Rehearse and practice situations which cause stress. One example is taking a speech class if talking in front of a class makes you anxious
- Learn practical coping skills. For example, break a large task into smaller, more attainable tasks
- Decrease negative self talk: challenge negative thoughts about yourself with alternative neutral or positive thoughts. “My life will never get better” can be transformed into “I may feel hopeless now, but my life will probably get better if I work at it and get some help”
- Learn to feel good about doing a competent or “good enough” job rather than demanding perfection from yourself and others
- Take a break from stressful situations. Activities like listening to music, talking to a friend, drawing, writing, or spending time with a pet can reduce stress
- Build a network of friends who help you cope in a positive way

By using these and other techniques, teenagers can begin to manage stress. If a teen talks about or shows signs of being overly stressed, a consultation with a child and adolescent psychiatrist or qualified mental health professional may be helpful.

For additional information see *Facts for Families*:

[#4 The Depressed Child](#)

[#47 The Anxious Child](#)

[#24 When to Seek Help](#)

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FACTS *for* FAMILIES

No. 04

July 2013

The Depressed Child

Not only adults become depressed. Children and teenagers also may have depression, as well. The good news is that depression is a treatable illness. Depression is defined as an illness when the feelings of depression persist and interfere with a child or adolescent's ability to function.

About 5 percent of children and adolescents in the general population suffer from depression at any given point in time. Children under stress, who experience loss, or who have attentional, learning, conduct or anxiety disorders are at a higher risk for depression. Depression also tends to run in families.

The behavior of depressed children and teenagers may differ from the behavior of depressed adults. Child and adolescent psychiatrists advise parents to be aware of signs of depression in their youngsters.

If one or more of these signs of depression persist, parents should seek help:

- Frequent sadness, tearfulness, crying
- Decreased interest in activities; or inability to enjoy previously favorite activities
- Hopelessness
- Persistent boredom; low energy
- Social isolation, poor communication
- Low self-esteem and guilt
- Extreme sensitivity to rejection or failure
- Increased irritability, anger, or hostility
- Difficulty with relationships
- Frequent complaints of physical illnesses such as headaches and stomachaches
- Frequent absences from school or poor performance in school
- Poor concentration
- A major change in eating and/or sleeping patterns
- Talk of or efforts to run away from home
- Thoughts or expressions of suicide or self-destructive behavior

A child who used to play often with friends may now spend most of the time alone and without interests. Things that were once fun now bring little joy to the depressed child. Children and adolescents who are depressed may say they want to be dead or may talk about suicide. Depressed children and adolescents are at increased risk for committing suicide. Depressed adolescents may abuse alcohol or other drugs as a way of trying to feel better.

The Depressed Child, "Facts for Families," No. 4 (5/08)

Children and adolescents who cause trouble at home or at school may also be suffering from depression. Because the youngster may not always seem sad, parents and teachers may not realize that troublesome behavior is a sign of depression. When asked directly, these children can sometimes state they are unhappy or sad.

Early diagnosis and treatment are essential for depressed children. Depression is a real illness that requires professional help. Comprehensive treatment often includes both individual and family therapy. For example, cognitive behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are forms of individual therapy shown to be effective in treating depression. Treatment may also include the use of antidepressant medication. For help, parents should ask their physician to refer them to a qualified mental health professional, who can diagnose and treat depression in children and teenagers.

Also see the following Facts for Families:

#8 Children and Grief

#10 Teen Suicide

#21 Psychiatric Medication for Children

#38 Bipolar Disorder in Teens

#86 Psychotherapies for Children and Adolescents

#00 Definition of a Child and Adolescent Psychiatrist

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FACTS *for* FAMILIES

No. 47

November 2012

The Anxious Child

All children experience anxiety. Anxiety in children is expected and normal at specific times in development. For example, from approximately age 8 months through the preschool years, healthy youngsters may show intense distress (anxiety) at times of separation from their parents or other persons with whom they are close. Young children may have short-lived fears, such as fear of the dark, storms, animals, or a fear of strangers. Anxious children are often overly tense or uptight. Some may seek a lot of reassurance, and their worries may interfere with activities. Parents should not dismiss a child's fears. Because anxious children may also be quiet, compliant and eager to please, their difficulties may be missed. Parents should be alert to the signs of severe anxiety so they can intervene early to prevent complications. There are different types of anxiety in children.

Symptoms of separation anxiety include:

- constant thoughts and intense fears about the safety of parents and caretakers
- refusing to go to school
- frequent stomachaches and other physical complaints
- extreme worries about sleeping away from home
- being overly clingy
- panic or tantrums at times of separation from parents
- trouble sleeping or nightmares

Symptoms of phobia include:

- extreme fear about a specific thing or situation (ex. dogs, insects, or needles)
- the fears cause significant distress and interfere with usual activities

Symptoms of social anxiety include:

- fears of meeting or talking to people
- avoidance of social situations
- few friends outside the family

Other symptoms of anxious children include:

- many worries about things before they happen
- constant worries or concerns about family, school, friends, or activities
- repetitive, unwanted thoughts (obsessions) or actions (compulsions)
- fears of embarrassment or making mistakes

The Anxious Child, "Facts for Families," No. 47 (11/12)

- low self-esteem and lack of self-confidence

Severe anxiety problems in children can be treated. Early treatment can prevent future difficulties, such as loss of friendships, failure to reach social and academic potential, and feelings of low self-esteem. Treatments may include a combination of the following: individual psychotherapy, family therapy, medications, behavioral treatments, and consultation to the school.

If anxieties become severe and begin to interfere with the child's usual activities (for example separating from parents, attending school and making friends) parents should consider seeking an evaluation from a qualified mental health professional or a child and adolescent psychiatrist.

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FACTS *for* FAMILIES

No. 10

May 2008

Teen Suicide

Suicides among young people continue to be a serious problem. Each year in the U.S., thousands of teenagers commit suicide. Suicide is the third leading cause of death for 15-to-24-year-olds, and the sixth leading cause of death for 5-to-14-year-olds.

Teenagers experience strong feelings of stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up. For some teenagers, divorce, the formation of a new family with step-parents and step-siblings, or moving to a new community can be very unsettling and can intensify self-doubts. For some teens, suicide may appear to be a solution to their problems and stress.

Depression and suicidal feelings are treatable mental disorders. The child or adolescent needs to have his or her illness recognized and diagnosed, and appropriate treatment plans developed. When parents are in doubt whether their child has a serious problem, a psychiatric examination can be very helpful.

Many of the signs and symptoms of suicidal feelings are similar to those of depression.

Parents should be aware of the following signs of adolescents who may try to kill themselves:

- change in eating and sleeping habits
- withdrawal from friends, family, and regular activities
- violent actions, rebellious behavior, or running away
- drug and alcohol use
- unusual neglect of personal appearance
- marked personality change
- persistent boredom, difficulty concentrating, or a decline in the quality of schoolwork
- frequent complaints about physical symptoms, often related to emotions, such as stomachaches, headaches, fatigue, etc.
- loss of interest in pleasurable activities
- not tolerating praise or rewards

A teenager who is planning to commit suicide may also:

- complain of being a bad person or feeling rotten inside
- give verbal hints with statements such as: I won't be a problem for you much longer, nothing matters, It's no use, and I won't see you again

- put his or her affairs in order, for example, give away favorite possessions, clean his or her room, throw away important belongings, etc.
- become suddenly cheerful after a period of depression
- have signs of psychosis (hallucinations or bizarre thoughts)

If a child or adolescent says, I want to kill myself, or I'm going to commit suicide, always take the statement seriously and immediately seek assistance from a qualified mental health professional. People often feel uncomfortable talking about death. However, asking the child or adolescent whether he or she is depressed or thinking about suicide can be helpful. Rather than putting thoughts in the child's head, such a question will provide assurance that somebody cares and will give the young person the chance to talk about problems.

If one or more of these signs occurs, parents need to talk to their child about their concerns and seek professional help from a physician or a qualified mental health professional. With support from family and appropriate treatment, children and teenagers who are suicidal can heal and return to a more healthy path of development.

For more information, see Facts for Families:

#3 Teens: Alcohol and Other Drugs

#4 The Depressed Child

#37 Children and Firearms

#38 Bipolar Disorder in Children and Teens

#00 Definition of a Child and Adolescent Psychiatrist

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What is Psychotherapy?

Psychotherapy is a treatment that involves a relationship between a therapist and patient. It can be used to treat a broad variety of mental disorders and emotional difficulties. The goal of psychotherapy is to eliminate or control disabling or troubling symptoms so the patient can function better. Therapy can also help build a sense of well-being and healing.

Problems helped by psychotherapy include difficulties in coping with daily life, the impact of trauma, medical illness, or loss, like the death of a loved one, and specific mental disorders, like depression or eating disorders. Psychiatrists and other mental health professionals can provide psychotherapy.

One out of five Americans will experience a mental illness severe enough to require treatment at some time in their lives. Mental illnesses and emotional distress do not discriminate. They affect men and women of all ages, ethnic groups and socioeconomic statuses. These disorders impair how people feel, think, and act. They can interfere with how people function at work or school and affect their relationships with friends and family.

Therapy Sessions

The goals of treatment and arrangements for how often and how long to meet are planned jointly by the patient and therapist. Most sessions are 45 – 60 minutes long. Psychotherapy can be short-term, dealing with immediate issues, or long-term, dealing with longstanding and complex issues. Therapy may be conducted in an individual, family, couples, or group setting, and can be used by adults, children, or adolescents.

Medication is often used in addition to psychotherapy, and for some disorders the combined treatment is better than either alone. This is a decision to be made by a patient in consultation with the therapist.

Confidentiality is a basic requirement of psychotherapy. Also, although patients share personal feelings and thoughts, intimate physical contact with a therapist is never appropriate, acceptable, or useful.

Does Psychotherapy Work?

Research shows that most patients who receive psychotherapy experience symptom relief and are better able to function in their lives. Psychotherapy has been shown to improve emotions and behaviors and to be linked with positive changes in the brain and body. The benefits also include fewer sick days, less disability, fewer medical problems, and more job stability.

The cost of not treating mental disorders can often be greater personal anguish, substance abuse, poor work performance, broken relationships with family and friends, or death by suicide.

Types of Psychotherapy

Psychiatrists and other mental health professionals use several types of therapy. The choice of therapy type depends on the patient's particular illness and circumstances, and the patient's preference.

Common types of therapy include:

- * **Cognitive behavioral therapy, which helps patients identify and change thinking and behavior patterns that are harmful or ineffective, replacing them with more accurate thoughts and functional behaviors. It often involves practicing new skills in the "real world."**
- * **Interpersonal therapy, which is used to help patients understand underlying interpersonal issues that are troublesome, like unresolved grief, changes in social or work roles, conflicts with significant others, and problems relating to others.**
- * **Psychodynamic therapy, which is based on the idea that behavior and mental well-being are influenced by childhood relationships and experiences, psychological conflicts, and unproductive or inappropriate repetitive thoughts or feelings that are often outside of the person's awareness. It uses the**

relationship with the therapist to work on understanding oneself more fully and to change old patterns so a person can more fully take charge of his or her life.

- * **Psychoanalysis, which is a more intensive form of psychodynamic therapy. Sessions are conducted three or more times a week.**

Choosing a psychotherapist

Psychiatrists, psychologists, social workers, and some others may have specialized training in psychotherapy. However, only psychiatrists are also trained in medicine and are able to prescribe medications.

Psychiatrists are medical doctors who are specially trained to treat individuals for a broad range of emotional and behavioral problems. They are uniquely qualified to diagnose and treat emotional difficulties because they understand the mind, brain and body and their interactions. They are trained to use psychotherapy, medications, and the two in combination.

Finding a psychiatrist or other therapist with whom an individual can work well is important. Good sources of referrals include family physicians, local psychiatric societies, medical schools, and community health centers.

What Is Depression?

Depression is a serious medical illness that negatively affects how you feel, the way you think and how you act.

Depression has a variety of symptoms, but the most common are a deep feeling of sadness or a marked loss of interest or pleasure in activities. Other symptoms include:

- ✱ Changes in appetite that result in weight losses or gains unrelated to dieting
- ✱ Insomnia or oversleeping
- ✱ Loss of energy or increased fatigue
- ✱ Restlessness or irritability
- ✱ Feelings of worthlessness or inappropriate guilt
- ✱ Difficulty thinking, concentrating, or making decisions
- ✱ Thoughts of death or suicide or attempts at suicide.

Depression is common. It affects nearly one in 10 adults each year—nearly twice as many women as men. It's also important to note that depression can strike at any time, but on average, first appears during the late teens to mid-20s. Depression is also common in older adults.

Fortunately, depression is very treatable.

How Depression and Sadness Are Different

The death of a loved one, loss of a job, or the ending of a relationship are difficult experiences for a person to endure. It is normal for feelings of sadness or grief to develop in response to such stressful situations. Those experiencing trying times often might describe themselves as being "depressed."

But sadness and depression are not the same. While feelings of sadness will lessen with time, the disorder of depression can continue for months, even years. Patients who have experienced depression note marked differences between normal sadness and the disabling weight of clinical depression.

Postpartum Depression

Postpartum depression—an illness associated with the delivery of a child—is caused by changes in hormones and

can run in families. It is distinguished from "baby blues"—an extremely common reaction following delivery—both by its duration and the debilitating effects of indifference the mother has about herself and her children. About one in 10 new mothers experience some degree of postpartum depression; women with severe premenstrual syndrome are more likely to suffer from it.

Women with postpartum depression love their children but may be convinced that they are not able to be good mothers.

What Causes Depression?

Depression can affect anyone—even a person who appears to live in relatively ideal circumstances.

But several factors can play a role in the onset of depression:

Biochemistry. Abnormalities in two chemicals in the brain, serotonin and norepinephrine, might contribute to symptoms of depression, including anxiety, irritability and fatigue. Other brain networks undoubtedly are involved as well; scientists are actively seeking new knowledge in this area.

Genetics. Depression can run in families. For example, if one identical twin has depression, the other has a 70% chance of having the illness sometime in life.

Personality. People with low self-esteem, who are easily overwhelmed by stress, or who are generally pessimistic appear to be vulnerable to depression.

Environmental factors. Continuous exposure to violence, neglect, abuse or poverty may make people who are already susceptible to depression all the more vulnerable to the illness.

Also, a medical condition (e.g., a brain tumor or vitamin deficiency) can cause depression, so it is important to be evaluated by a psychiatrist or other physician to rule out general medical causes.

How Is Depression Treated?

For many people, depression cannot always be controlled for any length of time simply by exercise, changing diet, or taking a vacation. It is, however, among the most treatable of mental disorders: between 80% and 90% of people with

depression eventually respond well to treatment, and almost all patients gain some relief from their symptoms.

Before a specific treatment is recommended, a psychiatrist should conduct a thorough diagnostic evaluation, consisting of an interview and possibly a physical examination. The purpose of the evaluation is to reveal specific symptoms, medical and family history, cultural settings and environmental factors to arrive at a proper diagnosis and to determine the best treatment.

Medication: Antidepressants may be prescribed to correct imbalances in the levels of chemicals in the brain. These medications are not sedatives, "uppers" or tranquilizers. Neither are they habit-forming. Generally antidepressant medications have no stimulating effect on those not experiencing depression.

Antidepressants may produce some improvement within the first week or two of treatment. Full benefits may not be realized for two to three months. If a patient feels little or no improvement after several weeks, his or her psychiatrist will alter the dose of the medication or will add or substitute another antidepressant.

Psychiatrists usually recommend that patients continue to take medication for six or more months after symptoms have improved. After two or three episodes of major depression, long-term maintenance treatment may be suggested to decrease the risk of future episodes.

Psychotherapy: Psychotherapy, or "talk therapy," is sometimes used alone for treatment of mild depression; for moderate to severe depression, it is often used in combination with antidepressant medications.

Psychotherapy may involve only the individual patient, but it can include others. For example, family or couples therapy can help address specific issues arising within these close relationships. Group therapy involves people with similar illnesses.

Depending on the severity of the depression, treatment can take a few weeks or substantially longer. However, in many cases, significant improvement can be made in 10 to 15 sessions.

Conclusion

Depression is never normal and always produces needless suffering. With proper diagnosis and treatment, the vast majority of people with depression will overcome it.

Teen Suicide

Adolescence can be a turbulent time. Teenagers deal with a vast array of new experiences during this transitional period, such as new relationships, decisions about the future, and physical changes that are taking place in their bodies.

A considerable number of teenagers are dealing with depression, an illness with significant long-term consequences, including an increased risk for suicide.

Other teenagers are simply overwhelmed by the uncertainties of adolescence and feel they have nowhere to turn. Their search for answers may lead them to begin "self-medicating" their pain by abusing drugs or alcohol. Or they might express their rage and frustration by engaging in acts of violence. They don't want to talk about their emotions or problems because they may think that will make them a burden, or that others will make fun of them. Too often, these troubled teens opt instead to take their own lives.

Suicide Signals

The strongest risk factors for attempted suicide in youth are depression, alcohol or drug abuse, aggressive or disruptive behaviors, and a previous suicide attempt. If several of the following symptoms, experiences, or behaviors are present, a mental health professional or another trusted adult, such as a parent or a school counselor, should be consulted:

- * Depressed mood
- * Substance abuse
- * Frequent episodes of running away or being incarcerated
- * Family loss or instability; significant problems with parents
- * Expressions of suicidal thoughts, or talk of death or the afterlife during moments of sadness or boredom
- * Withdrawal from friends and family
- * Difficulties in dealing with sexual orientation
- * No longer interested in or enjoying activities that once were pleasurable
- * Unplanned pregnancy
- * Impulsive, aggressive behavior or frequent expressions of rage

Adolescents who consider suicide generally feel alone, hopeless and rejected. They are especially vulnerable to these feelings if they have experienced a loss, humiliation or trauma of some kind: poor performance on a test; breakup with a boyfriend or girlfriend; parents with alcohol or drug problems or who are abusive; or a family life affected by parental discord, separation or divorce. However, a teenager still may be depressed or suicidal even without any of these adverse conditions.

Teenagers who are planning suicide may "clean house" by giving away favorite possessions, cleaning their rooms, or throwing things away. After a period of depression, they may also become suddenly cheerful because they think that by deciding to end their lives they have "found the solution."

Young people who have attempted suicide in the past or who talk about suicide are at greater risk for future attempts. Listen for hints like "I'd be better off dead" or "I won't be a problem for you much longer."

Some Suicide Statistics

While the teen suicide rate has declined by over 25 percent since the early 1990s, suicide is the third leading cause of death among young people ages 15 to 24.

- * It is estimated that depression increases the risk of a first suicide attempt by at least 14-fold.
- * Over half of all kids who suffer from depression will eventually attempt suicide at least once, and more than seven percent will die as a result.
- * Four times as many men as women die by suicide, but young women attempt suicide three times more frequently than young men.
- * Firearms are used in a little more than half of all youth suicides.

What Can Be Done?

Teens aren't helped by lectures or by hearing all the reasons they have to live. What they need is to be reassured that they have someone to whom they can turn—be it family, friends, school counselor, physician, or teacher—to discuss their feelings or problems. It must be a person who is willing to listen and who is able to reassure the individual that depression and suicidal tendencies are treatable.

Treatment is of utmost importance and may involve medications, talk therapy or a combination of the two. Help can be found in a variety of places: through local mental health associations, family physicians, a county medical society, a local hospital's department of psychiatry, a community mental health center, a mood disorders program affiliated with a university or medical school, or a family service/social agency.

In short, simply taking the time to talk to troubled teenagers about their emotions or problems can help prevent the senseless tragedy of teen suicide. Let them know help is available.

DEPRESSION

Depression is a common psychological problem, experienced by many people at some time during their lives. One member of most families has experienced an episode of depression severe enough to require formal treatment. Depressed mood is costly to individuals and society as a whole, both economically as well as in terms of quality of life.

Major Characteristics

The primary feature of depression is a sad mood state, which, in its most severe form, is experienced as a feeling of helplessness, hopelessness, and despair.

When people experience depressed mood, it is common for them also to experience a decrease in social activities, problems with relationships, and an increase in crying or "a desire to cry even if you cannot get the tears out" (called dry tears depression).

Cognitive Characteristics

There are also several cognitive features of depression that may include a loss of concentration and memory; a belief that you are becoming worthless; a belief that things cannot be made better, have gotten bad, and will get worse; and a focus on negative things about yourself without enough attention on positive things about yourself.

Biological Characteristics

The biological characteristics of depression include disrupted sleep (especially trouble falling sleep and a pattern of waking up very early in the morning), loss of appetite, loss of sexual desire or lack of interest in sexual activity, and fatigue or tiredness during the day. It is also important to know that depression may happen along with increased anxiety and feelings of anger or hostility. In about 10% of cases, depression will be followed by problems with alcohol or drugs.

Frequency

Depression severe enough to require formal treatment occurs in about 6% of the women and 3% of the men in this country. Depression can occur, although at lower rates, among children. During adolescence, the rates gradually increase, so that by age 14 or 15 they equal those of adults. Among the elderly, the rates decrease slightly, but depression remains a frequent and serious problem among this age group.

Causes

Life Events

Although no definitive and final answer exists to the question of what causes depression, much is known. Depression may be caused by major negative life events – for example, the death of a loved one, a divorce, a severe financial setback, or even a move to a different neighborhood or part of the country. Other factors that may cause depression include trouble having and keeping social relationships and trouble keeping your everyday life in line with your values in life.

What Is Cognitive Behavior Therapy?

Behavior Therapy and Cognitive Behavior Therapy are types of treatment that are based firmly on research findings. These approaches aid people in achieving specific changes or goals.

Changes or goals might involve:

- **A way of acting:** like smoking less or being more outgoing;
- **A way of feeling:** like helping a person to be less scared, less depressed, or less anxious;
- **A way of thinking:** like learning to problem-solve or get rid of self-defeating thoughts;
- **A way of dealing with physical or medical problems:** like lessening back pain or helping a person stick to a doctor's suggestions; or
- **A way of coping:** like training developmentally disabled people to care for themselves or hold a job

Behavior Therapists and Cognitive Behavior Therapists usually focus more on the current situation and its solution, rather than the past. They concentrate on a person's views and beliefs about their life, not on personality traits. Behavior Therapists and Cognitive Behavior Therapists treat individuals, parents, children, couples, and families. Replacing ways of living that do not work well with ways of living that work, and giving people more control over their lives, are common goals of behavior and cognitive behavior therapy.

HOW TO GET HELP: If you are looking for help with depression, either for yourself or someone else, you may be tempted to call someone who advertises in a local publication or on the Internet. You may, or may not, find a competent therapist in this manner. It is wise to check on the credentials of a psychotherapist. It is expected that competent therapists hold advanced academic degrees and are trained in techniques for treating depression. They should be listed as members of professional organizations, such as the Association for Behavioral and Cognitive Therapies or the American Psychological Association. Of course, they should be licensed to practice in your state. You can find competent specialists who are affiliated with local universities or mental health facilities or who are listed on the websites of professional organizations. You may, of course, visit our website (www.abct.org) and click on "Find a CBT Therapist."

The Association for Behavioral and Cognitive Therapies (ABCT) is an interdisciplinary organization committed to the advancement of a scientific approach to the understanding and amelioration of problems of the human condition. These aims are achieved through the investigation and application of behavioral, cognitive, and other evidence-based principles to assessment, prevention, and treatment.

Thinking Patterns

Depression also may be related to faulty thinking patterns. These might include magnifying how badly things are going for you, drawing negative conclusions from life events even when it doesn't make good sense to do so, and generally having a negative view of oneself, the world, and the future.

Biochemical Imbalances

There are several types of biochemical imbalances that may occur in depression. Depression may develop when a biological predisposition to depression is activated by an event. This predisposition is activated when one experiences a major life event (or a sequence of more minor negative life events) and/or develops a negative cognitive pattern of evaluating oneself and one's life events. It is believed that the biological characteristics of depression (sleep disturbance, appetite loss, loss of sexual interest, and tiredness) are related to this biochemical imbalance.

Treatment

During the past few years, very effective treatments have been developed for depression. The majority of people experiencing depression can expect to experience considerable relief from depression within 3 or 4 weeks of effective treatment, and long-lasting relief within 3 to 6 months of treatment.

Behavioral and Cognitive Behavioral Therapies

Behavior therapy and cognitive behavior therapy are among the treatments that have been most extensively evaluated and that have been shown through research to be effective. Behavioral treatments help a person to engage in healthy life activities, particularly activities that are consistent with one's life values. Behavior therapy also helps people to develop skills and abilities to cope with major life events and to learn social relationship skills when these are missing. Cognitive behavior therapy includes the development of behavioral skills, but focuses more on correcting the faulty thinking patterns of depression. Most people experiencing depression will profit from participating in cognitive behavioral therapy that is widely available from mental health professionals.

Some severe depressions, especially those involving severe biological symptoms, may require antidepressant medications. Such medications are available, and many produce quick and effective relief of depression. When antidepressant medication is necessary, it may be combined with behavior therapy or cognitive behavior therapy to produce effective and long-lasting treatment results. Some people believe that depression will gradually go away, or that if you "just get yourself in gear" you can get over it yourself. Indeed, in some small percentage of cases that may be true. Unfortunately, depression usually does not go away without treatment. Therefore, if you are experiencing a severe, acute depression or a chronic lower level depression, it is best and wise to seek and participate in therapy. Fortunately, there are treatments available to lessen depression and the life difficulties that come along with it.

For more information or to find a therapist:

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ANXIETY DISORDERS

Anxiety is a normal emotion and common experience, and it represents one of the most basic of human emotions. At one time or another, all of us are likely to be “stressed out,” worried about finances or health or the children, fearful in certain situations (such as when on a ladder or just before an operation), and concerned about what other people think. In general, anxiety serves to motivate and protect an individual from harm or unpleasant consequences.

For many people, however, constant or excessive anxiety disrupts their daily activities and quality of life; for others, panic, which seems to come out of nowhere, can cause terrible physical symptoms, such as faintness, chills, and even extreme chest pains. Anxiety disorders are so common that more than 1 in every 10 Americans will suffer with one at some point in their lives. Fortunately, anxiety disorders can be treated, generally with short-term, effective, and cost-efficient methods.

Types of Anxiety Disorders

There are a number of different disorders that fall under the category of anxiety. They include Panic, Generalized Anxiety, Obsessive-Compulsive Disorder (or OCD), various Phobias (including Social Phobia and Agoraphobia), and Posttraumatic Stress Disorder (or PTSD). Each of these is described below.

PANIC DISORDER

On his way home from work, John is driving through his neighborhood when suddenly a child darts out into the street in front of the car. John slams on the brakes and swerves, just missing the child. As he pulls over, John’s heart is beating furiously, and he is breathless, sweating, and shaking. He could have killed that child. It is several long minutes before he is able to continue home. This is a normal reaction to a potentially catastrophic situation. Our nervous systems are equipped with an alarm system, much like a fire alarm, that alerts us to danger. This system is triggered by impending danger, and it instantaneously prepares our body to “fight or flee” and ultimately protects us from harm. For some individuals, the alarm system rings at inappropriate times, when there is no danger present. Imagine sitting at home, watching television, and, from out of nowhere, this alarm reaction occurs. A panic attack is the physical sensations of the alarm system and includes sensations such as a racing heart, rapid breathing, tingling or numbing sensations, hot or cold flashes, sweating, trembling, and similar sensations. Individuals who experience unexpected alarms develop a fear of these sensations, and often attribute the attacks to major medical problems, such as a heart attack or stroke. When no physical cause is identified, the individual begins to fear losing control, or even think that he or she is going crazy. The more a person fears these intense sensations, the more aware he or she becomes of the sensations. The fear of the panic attacks ultimately can cause the attacks to become more intense and frequent. Fear of panic attacks, then, often becomes the cause of the panic attack.

What Is Cognitive Behavior Therapy?

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Changes or goals might involve:

- A way of acting, like smoking less or being more outgoing
- A way of feeling, like helping a person to be less scared, less depressed, or less anxious;
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- A way of coping, like training developmentally disabled people to care for themselves or hold a job.

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SOCIAL PHOBIA

Giving a talk in front of a group, walking into a room full of strangers, or meeting with the boss can make anyone somewhat anxious, but for the person with social phobia, such situations cause intense fear and even panic attacks. Individuals with social phobia fear being evaluated negatively by others, and worry excessively about embarrassing themselves. This overwhelming fear often leads the person to avoid social situations. Social phobia is not the normal nervousness a person has before meeting new people, it is an intense fear that causes that person to avoid that situation, significantly disrupting the person's life. Social phobia is one of the most common forms of anxiety disorder, and is often accompanied by depression. In addition, some individuals with social phobia develop alcoholism or other substance abuse problems. Social phobia may be present in all social situations or it may appear in only certain situations, such as speaking in public.

GENERALIZED ANXIETY DISORDER (GAD)

Everyone worries from time to time about finances, the job, health, or family matters. For individuals with GAD, the worry is excessive, difficult to control, and unrealistic. In addition, GAD is accompanied by a range of physical symptoms, such as muscle aches, tension, soreness, sleepless nights, irritability, concentration difficulties, and restlessness. The worry and physical symptoms of GAD can persist for six months or longer, thus reinforcing the person's feelings of helplessness and anxiety. Individuals with GAD are also more likely to develop additional anxiety disorders and depression.

SPECIFIC PHOBIAS AND AGORAPHOBIA

Dogs, spiders, injections, small rooms, thunderstorms, blood, elevators, crowds, driving, heights, and deep water can all cause a certain degree of unease in most individuals. It is relatively easy for most individuals to think about a particular situation or object that they would prefer to avoid. However, when that fear is persistent, or the individual's life is disrupted when trying to avoid the cause of that fear, this is considered a specific phobia. Although individuals with specific phobias recognize that their fear is way out of proportion to the actual threat of the situation, they are unable to control the fear and may experience an anxiety attack when encountering the feared situation or object. As an example, individuals with a specific phobia of blood often faint when they see blood; the anxiety and, especially, fainting, make simple medical or dental procedures overwhelming. Agoraphobia, which is closely linked with panic attacks, is particularly disruptive because the person fears most any open space, thereby making simple tasks, such as grocery shopping, or even seeing a therapist, anxiety-provoking.

OBSESSIVE-COMPULSIVE DISORDER (OCD)

Ever wonder if you locked the doors or left the stove on? Ever have the feeling that something terrible was about to happen? Do you have certain routines that you follow in the morning or evening? These thoughts and simple routines are not unusual. However, for the person with OCD, these thoughts and routines occur repeatedly, and the individual feels unable to stop them. Moreover, these thoughts and behaviors cause significant distress and interference in the individual's life. When "checking behavior" or other compulsive

sions take hours, not minutes, of a person's day, therapists consider this to be OCD. Typical obsessions include fears of contamination or poisoning, religious themes, doubts, and thoughts of sex. Compulsions are often desperate attempts to "neutralize" the obsession and anxiety, and involve repeating some behavior such as washing, checking, counting, tapping or touching things repeatedly.

POSTTRAUMATIC STRESS DISORDER (PTSD)

Terrible events can cause extreme feelings of helplessness, horror, and fear. These events might include physical or sexual assault, car accidents, natural disasters, robbery, and war. People with PTSD develop anxiety and intrusive thoughts about the event, and may feel at times as though the event were happening again. Classic symptoms of PTSD include nightmares, being easily startled, anger outbursts, feelings of detachment, and hopelessness about the future. PTSD can occur within one month of the event, or may be delayed for many years after the trauma.

How Can Cognitive and Behavior Therapy Help People With Anxiety Disorders?

There is hope for individuals with anxiety disorders, because these problems can be effectively treated with cognitive therapy and behavior therapy. In some cases, treatment of a specific phobia takes only one session, while most programs for the other anxiety disorders take, on average, 12 to 18 sessions. Cognitive behavioral treatments typically involve four main components.

Education about the nature of anxiety helps the individual understand his or her responses and teaches the individual ways to more effectively cope with anxiety. **Somatic management skills** teach relaxation and breathing techniques, which help the individual manage the physical symptoms and discomfort of anxiety. **Cognitive skills** address the individual's beliefs and thoughts, and focus on teaching more adaptive, realistic thinking styles. And, all treatments for anxiety involve some form of **behavioral exposure**, a gradual, step-by-step confrontation of the fear with mastery and skill.

For many people, behavior therapy and cognitive therapy alone will be enough to overcome or manage the various anxiety disorders. For some individuals, however, medication, in combination with cognitive behavioral therapy, can foster a return to a full and satisfying life. Programs combining pharmacology and behavior therapy are available for the range of anxiety disorders.

For more information or to find a therapist:

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**ASSOCIATION for BEHAVIORAL
and COGNITIVE THERAPIES**

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Appendix 7: Educational Tool for Mental Health Providers.

This handout was provided by Carla Frederick, M.D. You can use this, modify/update this template, or create your own.

Overview of Cystic Fibrosis

What Is Cystic Fibrosis?

Cystic fibrosis (CF) is an inherited chronic disease that affects the lungs and digestive system of about 30,000 children and adults in the United States (70,000 worldwide). Patients with CF have two copies of a defective gene located on chromosome 7. The defective gene results in a defective protein called CFTR (cystic fibrosis transmembrane regulator) which cause the body to produce unusually thick, sticky mucus that:

- clogs the lungs and leads to life-threatening lung infections; and
- obstructs the pancreas and stops natural enzymes from helping the body break down and absorb food.

In the 1950s, few children with cystic fibrosis lived to attend elementary school. Today, advances in research and medical treatments have further enhanced and extended life for children and adults with CF. Many people with the disease can now expect to live into their 30s, 40s and beyond.

Symptoms of Cystic Fibrosis

People with CF can have a variety of symptoms, including:

- very salty-tasting skin
- persistent coughing, at times with phlegm
- frequent lung infections
- wheezing or shortness of breath
- poor growth/weight gain in spite of a good appetite
- frequent greasy, bulky stools or difficulty in bowel movements

Statistics

- About 1,000 new cases of cystic fibrosis are diagnosed each year.
- More than 70% of patients are diagnosed by age two.
- More than 45% of the CF patient population is age 18 or older.
- The predicted median age of survival for a person with CF is in the mid-30s.

The Cystic Fibrosis Foundation

Since 1955, the Cystic Fibrosis Foundation has been the driving force behind the pursuit of a cure. Thanks to the dedication and financial backing of our supporters--patients, families and friends, clinicians, researchers, volunteers, individual donors, corporations and staff, we are making a difference.

CF Foundation-Accredited Care Centers

- The Cystic Fibrosis Foundation provides funding for and accredits more than 110 cystic fibrosis care centers and 55 affiliate programs nationwide, including 96 programs for treating adults with CF.

- The high quality of specialized care available throughout the care center network has led to the improved length and quality of life for people with CF. Located at teaching and community hospitals across the country, these care centers offer the best care, treatments, and support for those with CF.

Much more information can be found on www.cff.org. There are articles, videos, and a variety of other links meant for patients, caregivers, and CF providers. Check it out!

Treatment of Cystic Fibrosis

A CF care center is made up of physicians, physician's assistants, nurses, respiratory therapists, dietitians, social workers, pharmacists, and medical assistants. Everyone truly plays a critical role in giving each patient with CF the best possible care. At each clinic visit and while patients are in the hospital, these CF team members each perform their specific role of expertise as they see the patient.

CF is multisystem disease. It's not just the lungs that are affected – the GI tract, endocrine system, sinuses, muscles and joints and sometimes mental health of each patient also have problems related to the disease that need to be monitored regularly. Below are the main treatment categories that we pay attention to every time we see a patient with CF.

Pulmonary

End stage lung disease is the eventual cause of death in most patients with cystic fibrosis. The disease has seen great advances over the last 20 years allowing our patients to live longer and healthier lives. Advances and adherence to pulmonary therapies that are proven to be effective are responsible for a large part of this improvement in the health of patients with CF. Pulmonary treatment consists of airway clearance, bronchodilators, inhaled medications, and antibiotics.

Airway Clearance Techniques

Airway clearance techniques (ACTs) are treatments that help people with cystic fibrosis (CF) stay healthy and breathe easier. ACTs loosen thick, sticky lung mucus so it can be cleared by coughing or huffing. Clearing the airways reduces lung infections and improves lung function. There are many ACTs. ACTs move mucus from small to large (more central) airways to be coughed or huffed out.

Types of ACT

- **Coughing** is the most basic ACT. It is a reflex. It clears mucus with high-speed airflow. But sometimes mucus cannot be cleared just with a lot of coughing. Coughing a lot can make you feel more short of breath and worse, not better. **Huffing** is a type of cough. It also involves taking a breath in and actively exhaling. It is more like “huffing” onto a mirror or window to steam it up. It is not as forceful as a cough but can work better and be less tiring.
- **Oscillating Positive Expiratory Pressure (Oscillating PEP)** is an ACT where the person blows all the way out many times through a device. Types of Oscillating PEP devices include the Flutter™, Acapella™, Cornet™ and Intrapulmonary Percussive

Ventilation (IPV). Breathing with these devices vibrates the large and small airways. This vibration thins, dislodges and moves mucus. After blowing through the device many times, the person coughs or huffs. This cycle is repeated many times.

- **High-frequency Chest Wall Oscillation** also is called the Vest or Oscillator. An inflatable vest is attached to a machine that vibrates it at high frequency. The vest vibrates the chest to loosen and thin mucus. Every five minutes the person stops the machine and coughs or huffs.

A little more about mucus...

The lungs make mucus to help defend against germs. CF changes the mucus, making it thick and hard to clear. This mucus is where infections can occur. Infections cause inflammation or swelling of the lungs. Both infections and inflammation cause more mucus to be made. More mucus in the lungs can lead to more infections. This cycle of infection, inflammation and more mucus can hurt the lungs and lower lung function. Antibiotics treat infections. They make you feel better but, over time, the damage builds. This is why your CF care team may say to do ACTs even when you are well. When you get sick, do them more often.

How does mucus move out of the lungs?

Mucus moves three ways:

- Tiny hairs, called cilia, line bronchi. Cilia move back and forth. Mucus is carried on top of cilia. Cilia cannot carry thick, extra mucus as well.
- Mucus builds and lines the bronchi walls. ACTs increase air flow through the bronchi. As air rushes over the mucus in the bronchi, the mucus is pulled toward the large airways. This is like wind on the water making a crest on waves, or wind across a dry plain blowing dust. The faster the air flows, the better it moves mucus.
- If air gets behind thick mucus, it can push it into larger airways. More air behind mucus means more air flowing over it, pulling the mucus along. If air does not get behind mucus, mucus is hard to move.

Bronchodilators

Albuterol is a medication called a bronchodilator. It is inhaled and acts on the small muscles in the respiratory tract (bronchioles) to cause them to dilate or get bigger. This medication is used prior to inhaled medications to open the airways as much as possible, prevent bronchospasm or irritation that can be caused by some inhaled medications. Some patients use their albuterol aside from treatments if they have a component of their cystic fibrosis that is like asthma. (Asthma and CF are similar in that they both affect the respiratory tract and are treated in part by albuterol but overall are very different diseases.)

Inhaled Medications

Inhaled drugs are commonly used in cystic fibrosis care because they reach the airways quickly and easily. Inhaled treatments can be given by aerosol—a mist made from liquid medicines. The medicines go into a cup (nebulizer) that is attached to a small air compressor. The compressor blows air through the cup and makes a mist. People with cystic fibrosis breathe the mist in through a mouthpiece or mask for several minutes. Some medicines can also be given as metered dose inhalers (MDI), which deliver one dose of medicine at a time.

There are several kinds of inhaled medications used to treat CF symptoms:

- Mucolytics like **Pulmozyme® (DNase)** to thin mucus so people can cough it out easier.
- Antibiotics to treat infections. Inhaled **TOBI®** (tobramycin solution for inhalation) is a widely used antibiotic treatment. TOBI can be effective against the most common source of chronic lung infections, a bacterium called *Pseudomonas aeruginosa*. **Cayston** (aztreonam for inhalation solution) also is used to improve respiratory symptoms in people with CF who have *Pseudomonas aeruginosa*. A third inhaled antibiotic is called **Coly-Myxin** (colistin).
- **Hypertonic saline** to draw more water into the airways and make it easier to cough out the mucus.

Antibiotics

Antibiotics are used to fight infection-causing bacteria. Infections are common in the lungs of people with cystic fibrosis, so antibiotics are an important part of regular care. The most common bacteria that colonizes (lives in) the lungs of patients with CF are *pseudomonas aeruginosa* and *staphylococcus aureus*. The antibiotic drug, the dosage, and the length of time to take the drug, all vary from person to person. The infection-causing bacteria can become **resistant** to some drugs.

Antibiotics come in three different forms:

- **Oral antibiotics** – liquids, tablets or capsules that must be swallowed.
- **Intravenous (IV) antibiotics** – liquid medicine that goes directly into the blood through an IV catheter. An IV may require a hospital stay, but can also be done at home.
- **Inhaled antibiotics** – an aerosol or mist that can reach the airways directly.
- [Azithromycin](#), a common antibiotic, was shown to have special benefits for some people with cystic fibrosis. It does not kill the bacteria in the lungs but helps to reduce chronic inflammation that is present in the airways. The drug helped to preserve and improve lung function in research trials as well as reduced the number of hospital stays.

Gastrointestinal

Nutrition & Eating Right

- Nutrition needs change with age—especially for people with cystic fibrosis. Dietitians at cystic fibrosis [care centers](#) offer specially tailored dietary programs for each stage of life.
- All patients should eat a high-calorie diet, including supplements when needed
- Children and teens with cystic fibrosis need extra calories to grow and develop. Everyone with CF, no matter their age, needs good nutrition to stay strong against lung infections and other challenges. Occasionally, patients need to take nutrition through a tube ("[tube-feeding](#)") to provide extra calories that help the body grow and stay strong.
- Body Mass Index, or “BMI” is a calculation used to assess how healthy an individual’s weight is relative to their height. It has been shown in numerous investigations that patient’s with a BMI that is at goal have better lung health.
- Good nutrition can help to prevent or lessen the impact of other health problems like CF related diabetes and osteoporosis.

Pancreatic Enzyme Replacement

The pancreas is responsible for producing enzymes to digest fats, carbohydrates, and proteins as well as making insulin for the body. Both of these functions are affected in many patients with CF. More than 90 percent of people with CF take pancreatic enzymes with every meal and snack they eat to improve digestion and growth because their body does not make secrete the proper amount of enzymes. About 40% of patients with CF have a problem secreting insulin and have what is called CF related diabetes.

Endocrine

What is Cystic Fibrosis-Related Diabetes?

Cystic Fibrosis-Related Diabetes (CFRD) is a unique type of diabetes. It is not the same as diabetes in people without CF. The diagnosis and treatment are not exactly the same. CFRD is extremely common in people with CF especially as they get older. CFRD is found in 35 percent of adults aged 20 to 29 and 43 percent for those over 30 years old.

Causes of CFRD

There are two types of diabetes in the non-CF population - **Type I diabetes** (known as “insulin-dependent diabetes”) and **Type II diabetes** (known as “non-insulin dependent diabetes”).

CFRD has some features of both types of diabetes. People with CF do not make enough insulin. This is a result of scarring in the pancreas.

Insulin resistance is another reason people develop CFRD. Insulin resistance means your body does not use insulin normally.

Symptoms of CFRD

Common symptoms, such as increased thirst and increased urination, are caused by high blood sugar levels (hyperglycemia). Other symptoms of CFRD are excessive fatigue, weight loss and unexplained decline in lung function.

Screening and Diagnosis

Many people with CFRD do not know they have it until they are tested for diabetes. Since many people with CF have no symptoms, this is the best way to find out if someone has CF-related diabetes.

People with CFRD who receive treatment for diabetes often start to feel better, gain weight and improve their lung function.

Treatment of CFRD

Insulin is the medication used to treat CFRD. It allows sugars and proteins to move from the blood into the body’s cells. It is used for energy and to build muscle.

Keeping blood glucose levels at a normal or near-normal level helps you gain weight, feel better and have more energy. It also lowers the risk of problems caused by diabetes.

Mental Health

Individuals with chronic diseases are at increased risk for symptoms of depression and anxiety. The connection between cystic fibrosis and depression has been studied in over 6000 patients (12

years of age and older) and 4000 parent caregivers in an epidemiological study across nine countries.

How many people with CF experience depression and anxiety?

Depression and anxiety are common in individuals with CF. One in three patients twelve years and older have high levels of anxiety and 17% have symptoms of depression. Specifically, in adult patients, 32% are anxious and 19% have elevated symptoms of depression. In adolescents, symptoms of anxiety are found in 22% of patients and depression found in 10% of adolescents.

For parent caregivers, the statistics are even higher. Half of mothers of children (0-17 years) with CF have elevated levels of anxiety, and 37% of moms have elevated symptoms of depression. One third of fathers have elevated rates of anxiety and depressive symptoms. These rates are much higher than in the general population.

What are the causes of anxiety and depression in people with CF and their caregivers?

There is no single cause of depression — for the general population — or for people with cystic fibrosis. However, some of the issues that people with CF and their caregivers face may be contributing factors. In any complex chronic condition that requires a time consuming treatment regimen and the potential for health to worsen, symptoms of anxiety and depression are more common. In CF, treatments can take up to 2 to 4+ hours per day, making it difficult to balance the things they want to do and also manage the disease. Because CF is a deteriorating condition, people with the disease and their families often struggle to cope with the uncertainty of the future. Some level of stress or anxiety is, at times, to be expected. In other words, it is not a sign of a medical condition, but a normal response to a very difficult situation.

What do higher rates of anxiety and depression mean for those with CF?

A person who feels overwhelmed, anxious or sad may not adjust well to the CF diagnosis. Individuals with CF who are depressed are less likely to adhere to their treatments. In addition, if you have a lot of anxiety, you may be less able to take care of yourself or your loved one. Too much anxiety, particularly in caregivers, can be very draining and exhausting.

Lung Transplantation

- Lung transplantation is a difficult and personal decision. The Cystic Fibrosis Foundation has prepared the following general information about lung transplantation to help guide discussions between people with cystic fibrosis (CF) and their CF care teams.
- **When is it time for a lung transplant? What is involved in the evaluation process?**
- When someone with CF develops severe lung disease, the CF care team may discuss the option of lung transplantation with the person. The doctor can refer the person to a lung transplant center for evaluation. The transplant center evaluates the person's health to determine if a lung transplant is necessary and timely. Tests examine how well the lungs, heart, and kidneys function, the types of bacteria in the lungs, and, because of the serious health care implications of transplantation, the person's psychological well-being. The transplant center also will evaluate the person's social support system including family, friends, and professional support. Most components of the evaluation are standard, but

each center can have some specific requirements. The staff's decision to accept a person for a transplant is specific to that center.

Appendix 8: Columbia Suicide Severity Rating Scale

SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past month	
Ask questions that are bolded and underlined.	YES	NO
Ask Questions 1 and 2		
<p>1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u></p>		
<p>2) Suicidal Thoughts: General non-specific thoughts of wanting to end one’s life/commit suicide, <i>“I’ve thought about killing myself” without general thoughts of ways to kill oneself/associated methods, intent, or plan.</i> <u>Have you actually had any thoughts of killing yourself?</u></p>		
<p>If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.</p>		
<p>3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. <i>“I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.”</i> <u>Have you been thinking about how you might kill yourself?</u></p>		
<p>4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having <u>some intent to act on such thoughts</u>, as opposed to <i>“I have the thoughts but I definitely will not do anything about them.”</i> <u>Have you had these thoughts and had some intention of acting on them?</u></p>		
<p>5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u></p>		
<p>6) Suicide Behavior Question <u>“Have you ever done anything, started to do anything, or prepared to do anything to end your life?”</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If YES, ask: <u>How long ago did you do any of these?</u> <input type="checkbox"/> Over a year ago? <input type="checkbox"/> Between three months and a year ago? <input type="checkbox"/> Within the last three months?</p>		

Appendix 9: Responses to Columbia Suicide Severity Rating Scale

Administer this scale if there is a score of 1 or greater on question 9 of PHQ-9 (the suicide item).

Item 1 – Safety Plan and Mental Health Referral

Item 2 – Safety Plan and Mental Health Referral

Item 3 – Safety Plan and Urgent Referral

Item 4 – Emergent Referral

Item 5 – Emergent Referral

Item 6 –

- If one week ago or less- Emergent Referral
- If between 1 week and 3 months- Urgent Referral
- Over 3 months ago- Routine Mental Health Referral

Disposition: You should consider having these things in your “toolbox”

- Safety Plan (See examples of an adult and teen safety plan in appendix 10 and 11 respectively)
- Urgent Mental Health Referrals
- Contact information for Local Crisis Services and a suicide hotline
- Know how to make a referral for an Emergency Evaluation (e.g., Psychiatric Emergency Room)

Appendix 10: Adult Safety Plan

If I begin to have thoughts or intentions of hurting or killing myself, or if I am at risk of being in an unsafe situation, I will take the following steps:

1. Things I can do to calm down or keep myself safe:

2. Talk about my feelings with someone that I trust. Specifically, I can talk to the following people:

3. I or someone else will call (_____) at (_____).

4. If I am unable to find someone to talk with, I can contact:
My therapist/psychiatrists if I have one at _____.
The Crisis Hotline at 1-800-273-TALK.
Crisis Services at _____.

5. If I am not able to stay safe, then I will go immediately to the Psychiatric Emergency Program at _____.
The address is _____. The Phone number there is _____.

6. Patients/Families should be sure that all firearms are either removed from the home or are locked away and secured. Access to medications and sharp objects (e.g., kitchen knives) should also be monitored and restricted.

7. Families should also be sure patients are not left alone if they are having suicidal thoughts.

8. Other considerations:

9. I agree to follow the above actions as necessary to maintain my safety:

Patient: _____ Date: _____

Provider: _____ Date: _____

Appendix 11: Teen Safety Plan

Safety Plan for Adolescent Patient: _____

If I begin to have thoughts and/or intentions of hurting or killing myself, or if I am at risk of being in an unsafe situation, I will take the following steps:

1. Talk about my feelings with someone that I trust. Specifically, I can talk to the following people:

2. I or someone else will call (_____) at (_____).

3. If I am unable to find someone to talk with, I can also call the Crisis Hotline number which is 800-273-TALK or _____ (ADD YOUR RESOURCES HERE).

4. If I am not able to stay safe, then I will go immediately to the Psychiatric Emergency Room (or another emergency resource in your area). The address _____ (Again add your resources here).

5. Parents should be sure that all firearms are either removed from the home or are locked away and secured. Access to medications and sharp objects (e.g., kitchen knives) should also be monitored and restricted.

6. Parents should also be sure children are not left alone if they are having suicidal thoughts.

7. Other considerations:

8. I agree to follow the above actions as necessary to maintain my safety:

Adolescent: _____ Date: _____

Parent: _____ Date: _____

Provider: _____ Date: _____