

ECCY7007: Presenting issues

Session five

What are the current trends for Children and Young People experiencing Mental Health Diagnoses and Trauma-related diagnoses in the UK?

What do you estimate the statistics to tell us?

The Mental Health of Children and Young People Survey (MHCYP, 2017).

Previously conducted in 1999 with 5 – 15yr olds in England, and with 5 – 16yr olds in 2004.

In 2016 it was conducted with children aged 2 – 19yrs, from the NHS patient register in England.

Children and their parents or teachers were interviewed either face to face or via a self-interview on a computer.

Respondent rates were 52%.

Sadler, K., Vizard, T., Ford, T., Goodman, A., Goodman, R., & McManus, S. (2018). *Mental health of children and young people in England, 2017: trends and characteristics*.

Findings:

Summary of findings:

- 1 in 8 children had at least one Mental Health Disorder (MHD).
- 1 in 20 children met the criteria for two or more MHD's.
- The MHD's were split into four main categories: emotional, behavioural, hyperactivity and other less common disorders.
- Emotional disorders were the most prevalent group of disorders.
- Rates of MHD increased with age: 5.5% of 2 – 4yr olds compared to 16.9% of 17 – 19yr olds.
- Data from this survey revealed an increase over time from 1999 – 2017.
- **HOWEVER... your thoughts?**

The Disorders

Emotional Disorders

- Anxiety disorders (characterised by fear and worry)
- Depressive disorders (characterised by sadness, loss of energy, interest or low self-esteem)
 - Mania
 - Bipolar disorder
- Rates were higher in girls (10%) than boys (6.2%)
- What do you think the issues are here?
- Why was this survey important?

The Disorders

Behavioural / Conduct disorders

A group of disorders characterised by repetitive and persistent disruptive and violent behaviour in which the rights and norms of others are violated.

Rates are higher in boys (5.8%) than girls (3.4%)

Hyperactivity disorders

Disorders characterised by inattention, impulsivity and hyperactivity.

Higher frequency of ADHD than hyperactivity disorder (based on ICD 10 criteria)

Higher in boys (2.6% than girls (0.6%))

The Disorders

Finally, Other less common disorders:

- Autistic Spectrum Disorders (ASD), about 1 in 50 children.
 - Eating disorders (0.4%)
 - Tics or other disorders (0.8%)

No current findings for Wales per se that are more recent than joint UK findings from 2004.

A meta-analysis of eight EU studies of child and adolescent refugees and asylum seekers reported a 22.7% prevalence of PTSD, 13.8% of depression, and 15.8% of anxiety disorders (Morina et al., 2020).

However, findings for Refugee children and young people are particularly problematic – why?

More
specifically...

Emotional Disorders related to Trauma:

In addition to the emotional disorders identified above, there are a number of disorders that specifically relate to Trauma. These are -

- Post Traumatic Stress Disorder (PTSD)
- Reactive Attachment Disorder (RAD)
- Disinhibited Social Engagement Disorder (DSED)

Recognising Post-traumatic Stress Disorder (PTSD)

Clinical Characteristics/Specifiers:

The child must be exposed to the event in one of four ways; directly witnessing an event, directly experiencing the event, by learning that the event happened to a close family member or significant individual or by first-hand exposure to aversive details about the event.

- Presence of one or more 'intrusion symptoms'
 1. Reoccurring, intrusive, involuntary memories.
 2. Recurrent or distressing dreams.
 3. Dissociative reactions (flashbacks).
 4. Intense distress to cues.
 5. Marked physiological reactions to cues.

PTSD

Persistent avoidance of stimuli associated with the traumatic event (one or both of these):

- Avoidance or efforts to avoid memories, thoughts or feelings about the traumatic event.
- Avoidance or efforts to avoid external reminders that may trigger the memory of the traumatic event.

Negative alterations in cognition and mood following the traumatic event (two or more), such as:

- Inability to remember an aspect of the event.
- Persistent negative beliefs or expectations about the self.
- Persistent distorted cognitions about the causes or consequences of the event.
 - Persistent negative or emotional state.
 - Markedly diminished interest in activities.
 - Feelings of detachment.
 - Inability to experience positive emotions.

PTSD

Marked alterations in arousal or reactivity associated with the traumatic event (two or more):

- Irritable behaviour or angry outbursts.
- Reckless or self-destructive behaviour.
- Hypervigilance.
- Exaggerated startle response.
- Problems with concentration.
- Sleep disturbance.

Disturbance needs to be longer than one month.

The disturbance causes significant distress.

The disturbance is not attributable to the effects of any substance.

Diagnosis in children under 6yrs

Exposure to a traumatic event in either (1) directly being involved, (2) witnessing in person the event, particularly if it involves a primary care-giver or (3) learning about an event happening to a care-giver.

Presence of one or more intrusion symptoms (the same as for children over the age of 6yrs).

One or more of the two avoidance symptoms, OR one or more of negative alterations in cognitions, from:

1. Increased negative emotional states.
2. Diminished interest in activities.
3. Socially withdrawn.
4. Reduction in expression of positive emotions.

And, alterations on reactivity and arousal :

- Hypervigilance
- Exaggerated startle response
- Problems with concentration
- Sleep disturbance

PTSD

Therefore, PTSD has four defining features:

Behavioural – avoidance behaviours

Emotional – numbing or negative emotions such as anger, guilt, shame

Cognitive – intrusion symptoms

Physiological – over activity of the stress response or fight/flight/freeze response

However, not all children respond to a traumatic event with PTSD. For some children they might experience anxiety, sadness, fear or even excitement. Some children even demonstrate no emotion at all (Sheeringa et al., 2011).

Additionally, some children experience **depersonalisation** or **dissociation**. *What do you know about these?*

Dissociation

DOCS The Woman With 7 Personalities



Acute Stress Disorder

If an individual has the symptoms of PTSD, but they only last between three days and one month, they may be diagnosed with Acute Stress Disorder.

The symptoms overlap with the four main symptoms of PTSD but include a fifth symptom – dissociation.

Therefore, the symptoms associated with acute stress disorder are:

- Intrusion symptoms (cognitive)
- Avoidance symptoms (behavioural)
 - Dissociative symptoms
 - Negative mood (emotional)
- Arousal (physiological) symptoms

Epidemiology of PTSD

As many as 30% of children and young people are exposed to a traumatic event, but only a third go on to develop PTSD.

The prevalence to paediatric PTSD depends on the trauma to which the children are exposed.

Between 40 and 60% of children from war-torn countries, chronic victims of abuse, neglect or domestic violence meet the diagnostic criteria for PTSD.

The course of PTSD is variable; most adults will recover without treatment, however longitudinal studies with children show that the disorder persists over time.

It is essential to treat PTSD in children because there are high co-morbidity rates for depression and suicidal ideation moving into adolescence or adulthood.

Additionally, treatment may prevent acute stress disorder from developing into PTSD. PTSD is detrimental to children's well-being, emotionally, socially and cognitively.

Moreover, adolescents with PTSD often turn to substances to help them deal with the overwhelming symptoms or anxieties that they feel.

Aetiology of PTSD

Functioning BEFORE the Trauma

A child's social-emotional functioning predicts the severity of their PTSD, (many studies, including 9/11 and hurricane Katrina showed that children with elevated levels of anxiety/depressive symptoms were more likely to develop PTSD).

Proximity to the Trauma

In one school shooting (Wending, 2009) a direct relationship was found between the proximity to the shooting and the resultant PTSD symptoms. Similar findings were for the 9/11 event.

Brain and Endocrine functioning

The amygdala plays a role in the development of PTSD. On the next slide the stress response is explained.

The stress response and the HPA AXIS

In some children with acute stress disorder or PTSD they show OVER activity of the HPA at baseline, meaning more cortisol, thus higher BP, HR, hypervigilance and prone to startle.

However, in some children their stress response is downregulated (blunted response) good in the short term but long term leaves them more prone to an exaggerated stress response

Stress response
to threat



Amygdala sends message
to the

Hypothalamus to release
CRF, which is detected by
the

Pituitary which releases
corticotropin. This triggers
the

Adrenal gland to release
cortisol.

Once the stressor is dealt
with the **Amygdala**
inhibits the **hypothalamus**



End of stress
response

Aetiology of PTSD

Cognitive appraisal and coping

We way we feel depends on our evaluation of a situation. If we experience trauma as '**personally relevant**' we will show more distress than if we '**distance**' ourself from it. Again, this was evidenced in children who were associated with 9/11.

Moreover, **coping** determines the relationship between stress and the emotional response – this is more important than the stressor itself! Coping is a way of protecting ourself from psychological distress.

There are two types:

- **Problem** focused – adaptive by changing the way you think.
- **Avoidance** focused – by disengaging or distracting. Effective in the S/T, but damaging in the L.T.

Why?

The family and PTSD

Family functioning

Why is this important?

What can families do to support a child with PTSD?



Case study: Preston

Preston was referred to a clinic for self-harm. He was a tall good looking 17yr old student who excelled at rugby and had many friends. He had not previously shown any behavioural or emotional problems before his car accident three months earlier.

Preston and three friends were driving home from a party and whilst he had not been drinking, his friends had. They were boisterous and distracted Preston.

It veered off the road and into a ditch landing on its roof. Preston broke his arm and clavicle, whilst two friends died instantly. The third died a few days later in hospital.

Preston told the clinician that he felt guilty and that he should be dead instead of his friends. He blamed himself and has lost all interest in his life. He was refusing to go to graduation, taking medication, trying to block out the accident, arguing with his family and finding difficulty concentrating in college.

When asked why he was cutting himself, what do you think his response was?

Treating PTSD

Talking to a child with PTSD

Initially, Psychological Debriefing was used, but it is no longer recommended by WHO. Rather PFA (Psychological First Aid) is advocated.

How would you talk to a child with PTSD; what strategies/techniques would you use?

Foster safety

Promote calm

Increase self-efficacy

Connect for support

Instil hope

Simple relaxation strategies

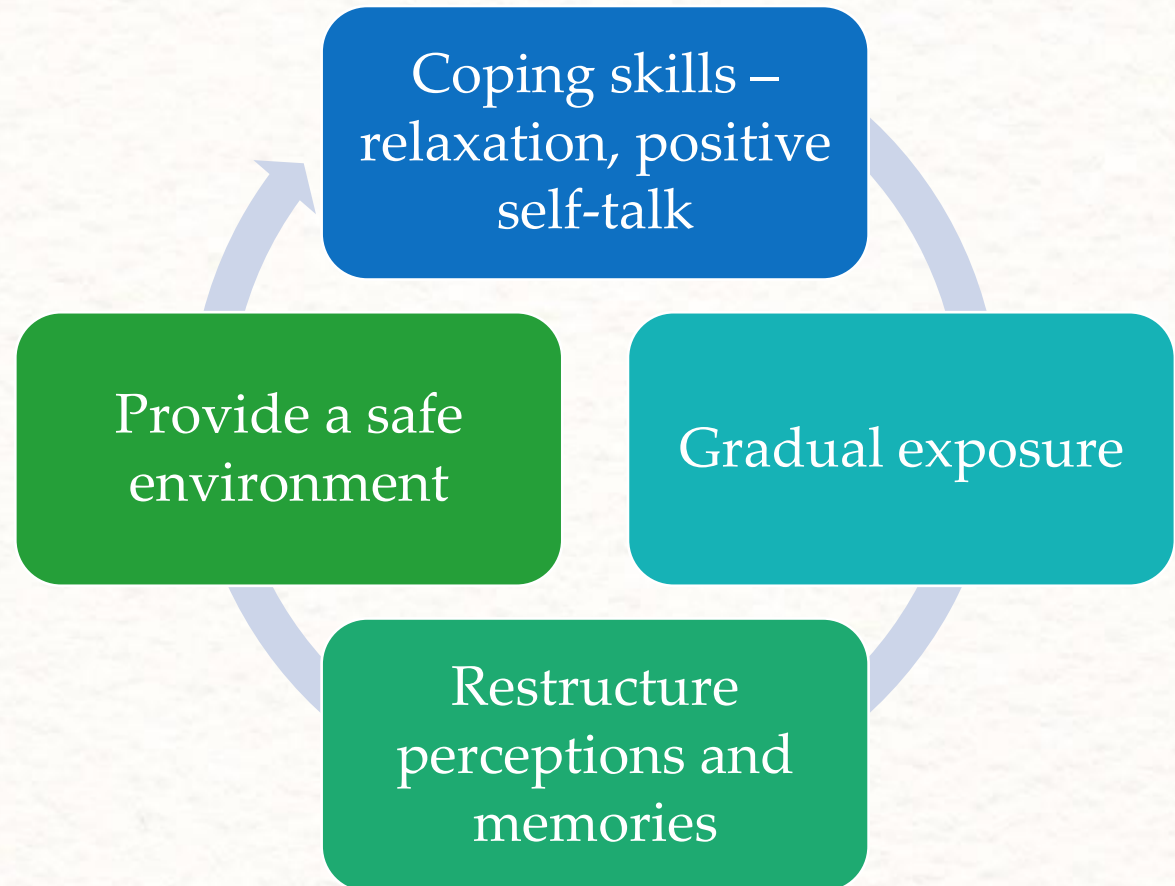
Active listening

Normalise stress response

Treating PTSD

Trauma Focused Cognitive Behavioural Therapy (TF-CBT)

Similar to standard CBT, but with a focus on the traumatic incident. Several steps to negotiate:



Treating PTSD

Eye movement desensitisation reprocessing (EMDR; Sharp, 2001)

Used effectively in adults, with several studies demonstrating success in children, e.g. de Roos et al. (2011).

Main drawback is that we do not know how it works; theorists believe that the saccadic movements somehow help to integrate the traumatic memories into LTM, whereas others believe that it allows the individual to process the information in a non-threatening environment.



Reactive Attachment Disorder (RAD)

As a result of extreme deprivation – the disturbance must be observed between 9 months and 5 yrs of age

Diagnostic criteria:

Consistent inhibited and emotionally withdrawn behaviour which is characterised by –

1. Rarely seeking comfort when distressed
2. Rarely responding to comfort when distressed

It is a persistent social and emotional disturbance characterised by two or more of the following:

- Minimal social or emotional responses to others
 - Limited positive affect
- Unexpected irritability, sadness or fear during a non-threatening interaction

In a child that has experienced extremes of insufficient care in one or more of the following:

1. Social neglect or deprivation
2. Repeated changes of caregiver
3. Reared in unusual circumstances

Case study: Eve

Reactive Attachment Disorder or Autistic Spectrum Disorder?

Eve is a moderately intelligent, unusually beautiful child with big blue eyes and golden curls. At the end of the 11th month Eve, who has never been very active, began to lose interest in playing in her surroundings. In the following two weeks the behaviour was more marked. She was not only passive, but she refused to touch toys and sat in a sort of daze by the hour staring silently into space. She did not show apprehensiveness of a stranger and if a toy was put in front of her she would withdraw into the furthest corner and sit there wide eyed and absent, without contact and with an immobile rigid expression on her beautiful face.

What is your diagnosis and why?

Disinhibited Social Engagement Disorder (DSED)

Also as a result of early deprivation the child demonstrates socially and developmentally inappropriate behaviour from around 6 – 7 months.

Diagnostic criteria:

The child actively engages and interacts with unfamiliar adults along with two or more of the following:

- Absent or reduced reticence in approaching and interacting with adults
 - Inappropriate and overly familiar verbal or physical behaviour with strangers
 - Not checking back with care giver for reassurance
 - No hesitation to go with strangers

The behaviours are not limited to impulsivity and the child must have experienced a pattern of extremes in insufficient care as indicated by one or more of the following:

- Social neglect or deprivation
- Repeated changes in care givers
 - Reared in unusual settings.

Aetiologies of both RAD and DSED

The Bucharest Early Intervention Programme (BEIP) compared three groups of children –

- (a) Children raised in an orphanage
- (b) Children raised in an orphanage but fostered before the age of 24 months
- (c) Children raised in a normal family home

The findings at 24 months revealed that all of the children raised at home had developed an attachment, however of the children raised in the orphanage 9.5% had not formed an attachment at all and 3.2% had formed an attachment.

The children fostered before 24 months had also formed attachments and those with RAD gradually improved over time.

Eventually the majority of the children raised in the orphanage formed some type of attachment, but not necessarily a discriminate one.

What are the implications of this?

The BEIP continued

A significant number of children demonstrated DSED (31.8%) suggesting that there may be a 'sensitive' period for the development of social inhibition. Usually during the early months, parents provide cues to their infants about self-regulatory behaviour, what is acceptable and not.

This is a time when infants also learn self-control (think Freud!). This suggests that social inhibition is related to impulse control rather than attachment per se. Attachment just provides the opportunity for this to occur.

Moreover, because relatively few children go onto develop RAD or DSED, there must be an alternative explanation other than the environment. Early deprivation and genotypes likely interact to influence the likelihood of a child developing them.

One answer is the role of the serotonin transporter gene. We have two alleles for this gene; they can either be short-short, short-long or long-long.

It appears that the short-short version of this gene places individuals at risk from developing attachment problems, whereas the long-long combination provides a protective factor.

Children`s head circumference

In addition to genetic influences and heredity, children raised in institutions or those suffering extreme deprivation, had head circumferences between one and two standard deviations below their neurotypical peers.

However, if fostered, they will catch-up with their peers by the age of six.

In addition, many institutionalised or deprived children also are found to have a dysfunctional HPA axis (recall the stress response).

In addition, deprived or institutionalised children have an IQ score one standard deviation below their neurotypical peers (15points). The BEIP found that children fostered out before 24 months did improve with time but remained below the average score for their age group.

Behavioural and Emotional Problems

Furthermore, early deprivation raises the risk of other mental health conditions later on in childhood. However, if fostered before 24 months, the risk is significantly reduced.

Mental health conditions at 54 months			
Disorder	Institution-alised / deprived	Adopted before 24 months	Never institutional-ised / deprived
Any disorder	61.5%	45.8%	22%
Externalising disorder	28.8%	25.4%	6.8%
Internalising disorder	44.2%	22%	13.6%

Treatments for RAD and DSED

Treatments for RAD:

Dozier – the ABC therapy model – Attachment Behaviour Catch-up. Ten one-hour sessions where parents are encouraged to support their child in a nurturing environment, allowing the child autonomy to lead the sessions and for parents to overcome their own barriers.

The Circle of Security (next slide)

Treatment for DSED:

Unfortunately, if the child is not fostered by the age of six months, problems with impulsivity, hyperactivity and social disinhibition may persist into childhood.

For children fostered after 24 months the outcome is slightly better, but again problem behaviours may remain.

What does this imply?

Circle of Security®

Parent Attending To The Child's Needs

