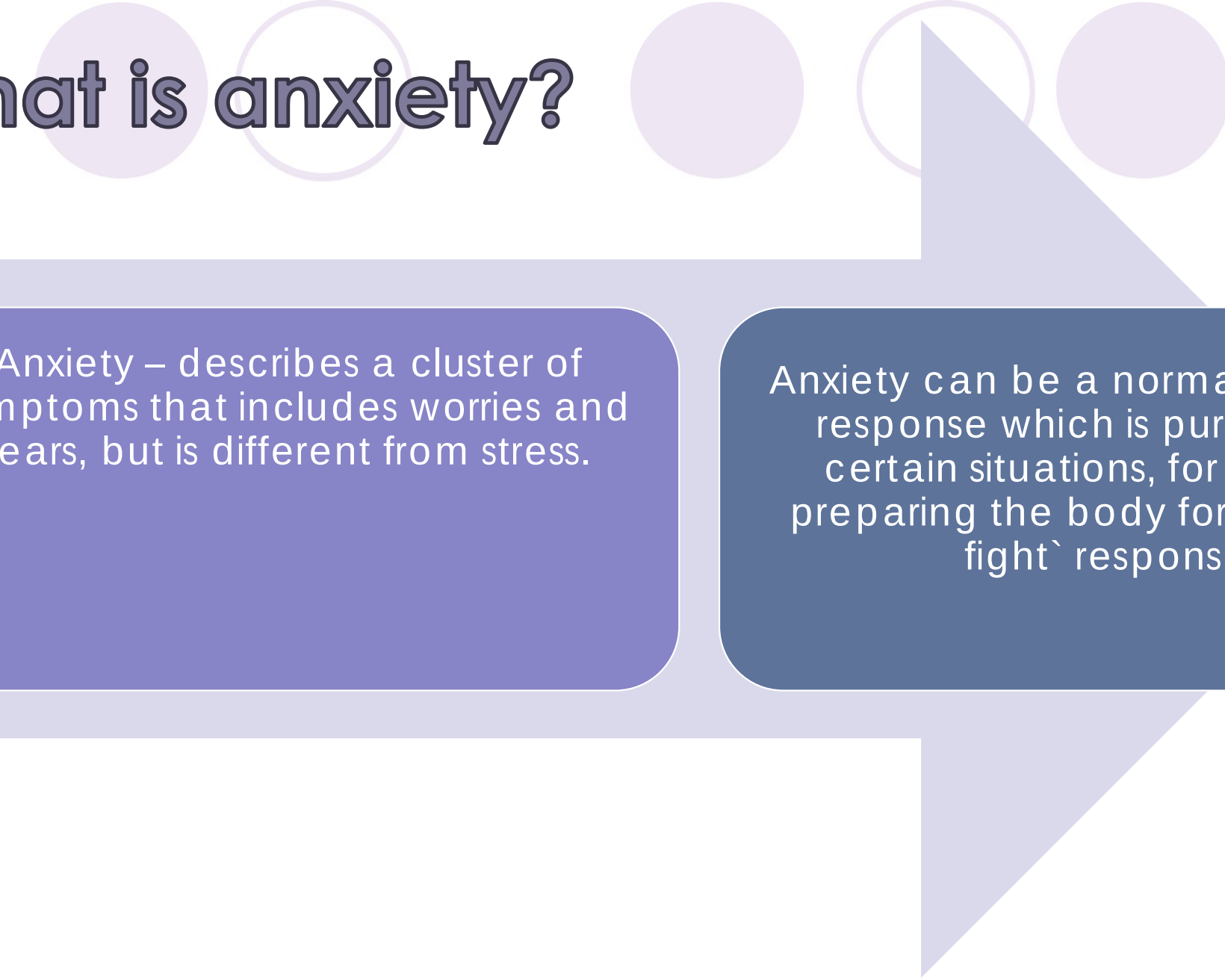


Internalising Disorders

Anxiety and Depression



What is anxiety?



Anxiety – describes a cluster of symptoms that includes worries and fears, but is different from stress.

Anxiety can be a normal emotional response which is purposeful in certain situations, for example preparing the body for a `flight or fight` response.

Anxiety

Symptoms

- ◉ Abnormal if it is out of proportion to the situation at hand, persisting or interferes with daily ifor at least one anxiety disorder (Manassis et al, 2010).
- ◉ Anxiety presents as physical, emotional or behaviour disorders.
- ◉ Common childhood anxieties – separation anxiety and specific phobias.
- ◉ Adolescence – GAD, social phobia, panic disorder and agoraphobia.

- **Physical:** heart racing/pounding, sweating, shaking, dizziness, nausea, vomiting, dry mouth, headaches, hyperventilation.
- In younger children – somatic complaints (stomach ache).
- **Emotional:** worry, fear, feeling 'on edge' or under threat, irritability.
- **Behaviour:** avoidance, maladaptive ways of coping with the anxiety.

Aetiology and risk factors

Fear - The first time either the feelings /bad thoughts occur, you may feel scared or worried. If you then worry that you will have the bad thoughts or feelings again, it can lead to them re-occurring. Eventually, you feel fearful of the feelings or thoughts known as the "fear of the fear"

Thoughts – negative thinking, something is seriously wrong with me; I cant cope, people think I`m not normal etc.

Physical feelings: feeling like you might faint, fast heart beat, feeling shaky.

One in six 16- 24 year olds have suffered from an anxiety disorder.

In an average school class, 5 pupils will have experienced anxiety.

2% of 16 – 24 year olds have suffered from a depressive episode. This equates to one person in an average school class.

1-2% of 16- 24 year olds have suffered with obsessive compulsive disorder - see Singleton et al (2001)

Aetiology and risk factors

Genetics

Children of parents with at least one anxiety disorder are at increased risk - risk increases with severity of the parent's condition (Schreier et al, 2008). □ Genetic heritability ranges from 30 to 40 per cent (Beesdo et al, 2009).



Conditioning

Previously neutral stimuli become associated with a frightening experience, subsequently leading to avoidance. The amygdala is involved in learning to fear a previously harmless object.

Temperament

□ Personality traits, including neuroticism and behavioural inhibition (Kagan, 1989), maybe important in its development.

□ Inhibition is associated with shyness around strangers and fear in unfamiliar situations (Biederman et al, 2001).

Aetiology and risk factors

Parenting style

- ☐ Parental overprotection and rejection is associated with higher rates of social phobia (Knappe et al, 2009).
- ☐ Social learning and parental modelling of anxious behaviour or avoidance may play a role (Ollendick et al, 2001).



Trauma and adverse life events

Linked to the onset of later difficulties.
Anxiety is related to threat events and smaller events may have a cumulative effect.

Separation Anxiety

Developmentally inappropriate and excessive anxiety concerning separation from home or those to which the child is linked.

Impacts on child's functioning.

Affects 2-4% of children and is most common pre-pubescent anxiety disorder.

OCD

OCD is found in 1-2% of young people, and can be looked at in two parts:

- (1) obsessions - these are repetitive, obtrusive, unwanted thoughts that are experienced and result in unreasonable fears, and
- (2) compulsions - acts or rituals carried out in response to fears generated by obsessions.

Compulsive hand washing in response to an irrational fear of germs/ contamination.

Excessive cleaning, counting, checking, measuring, and repeating tasks or actions.

Trichotillomania (compulsive hair-pulling) may also be classified under the general umbrella of OCD.

Obsessions are worrying excessively about death, germs, illness - usually AIDS, cancer, etc. (this can also be classified as an 'illness phobia' or health anxiety) having undesirable sexual thoughts, fearing causing harm to others.

Anxieties in childhood

SPECIFIC PHOBIA

A fear associated with a specific object or event that does not have a reasonable basis and interferes with functioning – present for 6months.

Affects 2-4 per cent of children and adolescents, more common in girls. Avoidance is frequent. The focus of the fear is anticipation of harm (dogs-bite).

Beesdo et al. (2009) – different fears peak at different ages;

Fear of animals, thunder and lightning age 2-4,

Fear of the dark and imaginary creatures age 4-5,

Fear of illness and natural disasters age 5-7,

Fear of war and negative social evaluation during adolescence.

SELECTIVE MUTISM

First recognised in people aged between 3 to 8 years.

Symptoms - an inability to speak in certain places such as school or when children have to meet people they don't know because of feeling so anxious and stressed that they can't respond.

They are usually able to speak normally when they are at home or in other places where they feel comfortable and safe.

As well as finding it hard to talk, young people may also find it hard to make eye contact or feel frozen and unable to move when people are talking to them.

They have a tendency to find certain situations extremely uncomfortable.

ANXIETIES IN ADOLESCENCE

Generalized anxiety disorder

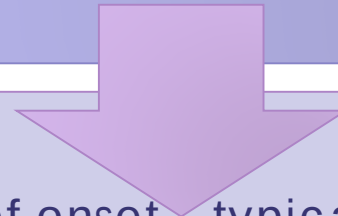
fearful and worried most days, about various topics or minor events, or about topics outside of conscious awareness.

Prevalence is up to 0.8 per cent, with later onset in boys.

Social Phobia

Prevalence is between 0.5 and 3.7 per cent.
Typically emerges in late childhood and through adolescence with very few cases starting after age 25.

Panic Disorder – with or without agoraphobia



Age of onset – typically 15 - 19 years.

Panic attacks occur, with or without identifiable triggers.

Anxiety occurs in places where escape is difficult or embarrassing.

Prevalence of agoraphobia is 5.2%, panic disorder 1.6%.

Interventions

One of the main factors that keeps anxiety going is avoidance of a feared stimulus.

help them to challenge this avoidance - step by step plan that gradually exposes them to the thing that they fear.

This should not push them into an anxiety provoking situation - the point is to build on the success of the last step and help them to grow in confidence each time.

◉ Exposure ladders

- ◉ ☐ Step 1 - look at a photo of a dog.
- ◉ ☐ Step 2 - When the child is comfortable doing this, perhaps try looking at a toy dog.
- ◉ ☐ Step 3 - Holding a toy dog.
- ◉ ☐ Step 4 - Being in the same garden as a very small dog in a cage.
- ◉ ☐ Step 5 - Moving closer to the cage.
- ◉ ☐ Step 6 - Being in the same garden as a dog on a lead.
- ◉ Step 7 - Moving closer to the dog.
- ◉ ☐ Step 8 - Touching the dog for one second, etc., etc. (systematic desensitisation).

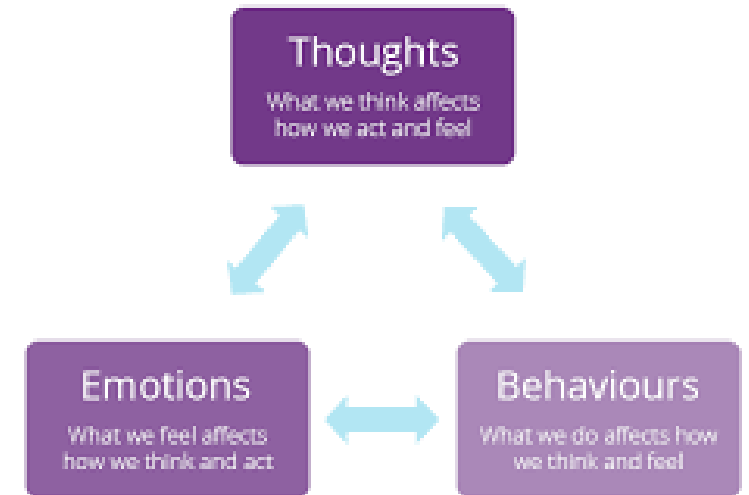
Psychopharmacology & Therapy

- ◉ SSRI's and venlafaxine were more effective than placebo for anxiety disorders.
- ◉ A combination of both CBT and medication showed significant reductions in anxiety symptoms.

- ◉ Psychologists –
 - ◉ Clinical Psychologists,
 - ◉ Counselling Psychologists and
 - ◉ Educational Psychologists.
- ◉ Psychiatrists –
 - ◉ Psychiatrists are medical doctors who have chosen to specialise in mental health.
- ◉ Counsellors and Therapists.
- ◉ CAMHS Workers and Primary Mental Health Workers.
- ◉ Psychiatric Nurses.

Techniques used: CBT

- ◉ An effective treatment in just over 50 per cent of cases (James et al, 2007).
- ◉ It can be adapted for the age of 6 and upwards.
- ◉ It can be delivered in individual, group and family formats.
- ◉ It can be combined with relaxation techniques, including deep breathing, meditation and muscle relaxation.



Techniques used: IPT

◉ Interpersonal therapy (IPT)

- ◉ Interpersonal therapy is an offshoot of CBT. It has been found to be useful in some cases of depression where the problem seems to be associated with making relationships with other people (but it is not widely used in this country).

• Family therapy

- Good choice if you are worried about any of the relationships in your family. □
- The focus of family therapy is to subtly change the way family members interact with, and feel about, each other to produce a calmer and more harmonious family life. □
- Sometimes several therapists.
- Not always in the room, but are watching behind a screen.
- They are there to observe, and to give the main therapist extra advice.

Other techniques/interventions:

- ◉ **Parent training**

- ◉ This may result in improved global functioning.
- ◉ Khanna and Kendall (2009) showed that it did not improve specific measures of child anxiety.
- ◉ Rapee et al. (2006) showed that compared to children on a waiting list, use of written materials for parents resulted in around 15 per cent more children being free of an anxiety disorder diagnosis after 12 and 24 weeks.
- ◉ <http://www.therapistaid.com/> (resources for children)

Useful resources

- ◉ <http://www.moodjuice.scot.nhs.uk/phobias.asp> (self help guide for phobias)
- ◉ <http://childanxiety.net/> (The child Anxiety Network)
- ◉ http://kidshealth.org/teen/your_mind/mental_health/phobias.html (information on anxiety and phobias for teenagers)
- ◉ <http://www.rcpsych.ac.uk/pdf/Sheet13.pdf> (Information from the Royal College of Psychiatrists on helping children cope with anxiety)
- ◉ <http://www.anxietyuk.org.uk/> (general information on anxieties)

Depression

The term depression is used to describe a cluster of symptoms involving significant changes in mood, in thinking and in activity.

Persistent over at least 2 weeks and result in changes in personal and social functioning.

Depressed mood may be accompanied by tearfulness and includes sadness/irritability with a loss of enjoyment of everyday Activities.

- ◉ **Mood changes**
- ◉ Sadness, misery
- ◉ Irritability
- ◉ Negative styles of thinking
- ◉ Low self-esteem
- ◉ Feelings of helplessness and hopelessness
- ◉ Suicidal thinking
- ◉ Difficulties with social relationships
- ◉ Social withdrawal
- ◉ Social skills problems
- ◉ Social problem solving difficulties
- ◉ **Physical symptoms**
- ◉ Sleep disturbance
- ◉ Appetite disturbance
- ◉ Inactivity
- ◉ Loss of interest, apathy

Diagnosis

Children are more likely to have depression with another disorder (Alpert et al., 1999) and the diagnosis is commonly associated with major family dysfunction (Harrington et al, 1997).

Depression is often encountered in young people following traumatic events such as assault or rape, where there are chronic family problems, where there is drug or alcohol misuse, aggressive behaviour or chronic school attendance problems.

Diagnostic and statistical manual of mental disorders (DSM-V: APA, 2013).

International Classification of Diseases (ICD-10; WHO, 2016).

Both categorise depression as mild, moderate and severe.

ICD-10 puts emphasis on symptoms whereas DSM-V considers symptoms and functional impairment.

Symptoms must be present for at least 2 weeks.

Depression screening scales

- ◉ Patient Health Questionnaire for Adolescents (PHQ-A)- 5 minutes to complete, easy to score algorithms based on DSM-IV criteria for Major Depressive Disorder.
- ◉ Achenbach Youth Self-report Form (103+)Assesses social function, mood, anxiety, and behavioural problems.
- ◉ Children's Depression Rating Scale (27) Measures distress; clinical cut-off 20.
- ◉ Beck Depression Inventory for Primary Care (BDI-PC is a 9-item self-report measure of depressive symptoms, The primary care version has been shown to have high internal consistency and good concurrent validity.

Problems with reducing depression in children

- ◉ Problems of diagnosis
- ◉ Developmental variations
- ◉ Co-morbidity
- ◉ Complexity of factors associated with clinical course
- ◉ Need specificity of treatments

Co-morbidity with other emotional and conduct disorders is common.

Behaviour problems or anxiety will be present in almost all cases and between 50% and 80% of depressed young people will also meet criteria for another disorder.

About 25% will have conduct or oppositional defiant disorder (Angold and Costello, 1995).

The presence of multiple problems challenges successful intervention.

Prevalence

- ◉ At any one time, the estimated number of children and young people suffering from depression:
 - ◉ 1 in 100 children
 - ◉ 1 in 33 young people
- ◉ Prevalence figures exceed treatment numbers:
 - ◉ about 25% of children and young people with depression detected and treated
- ◉ Suicide is the:
 - ◉ 3rd leading cause of death in 15– 24-year-olds
 - ◉ 6th leading cause of death in 5– 14-year-olds

Increased prevalence associated with social disadvantage (lone parent, parental unemployment, parents with emotional disorder) (Myers, 2000)

4% of 5 to 15-year-olds had emotional disorder (anxiety and depression) (Meltzer et al., 2000).

Estimated that 75% with mood disorder are untreated in the community (Coyle et al., 2003).

Causes and factors

Biochemical- monoamine hypothesis;

Under-activity in brain amine systems cause depression.

Carlson and Garber (1986) – too little serotonergic activity resulted in agitated depression and too little noradrenergic activity results in lethargic depression.

Long standing family and social difficulties (with or without precipitating life events)

Genetic- genetic predisposition plays a more sig role in bipolar than in unipolar (Kendler et al, 1995). Children who develop major depression are more likely to have a family history of the disorder.

- ◉ Psycho-social – Acute life events like bullying (Harrington, 1992).
- ◉ Maternal depression (Fergusson et al, 1995).
- ◉ Socio-economic – parental unemployment, poor housing, poor support networks, poor standards of living (mental health foundation, 1999).

UK interventions

Tiers 1-2	
TIER 1 Primary care services	• GPs and paediatricians • Health visitors and school nurses • Social workers, teachers, juvenile justice workers • Voluntary agencies and social services
TIER 2 CAMHS Professionals relating to primary care Workers	• Clinical child psychologists and educational psychologists • Paediatricians with training in mental health • Child and adolescent psychiatrists and psychotherapists • Counsellors and community and specialist nurses • Family therapists
TIER 3 CAMHS Services for more severe, complex or persistent disorders	• Child and adolescent psychiatrists and psychotherapists • Clinical child psychologists • Community and inpatient nurses • Occupational therapists and speech and language therapists • Art, music and drama therapists and family therapists
TIER 4 CAMHS Tertiary-level services	• Day units • Specialised outpatient teams • Specialised inpatient units

When to use medication

Have psychological strategies/environmental changes been tried?

Is it part of a wider treatment?

Do parents and adolescents give consent?

Is it licensed, unlicensed or from indication?

Is it an emergency?

Cost – benefit analysis

- Is it bad enough?
- Is it pervasive?

- Monotherapy is better
- than polypharmacy.
- Develop a range of
 - familiar drugs.
- Start low and go slow.

Monitor and review frequently!

Range of treatments

- ◉ Anxiolytics - Trifluoperazine.
- ◉ Sedatives and Melatonin.
- ◉ Antipsychotics – chlorpromazine, Haloperidol.
- ◉ Antidepressants - Fluoxetine, Sertraline or citalopram.
- ◉ Mood stabilisers.



Antidepressants



- ◉ Depression in childhood and adolescence has similarities and differences to adulthood, therefore, response to medication is different.
- ◉ Tricyclics ineffective in Childhood depression.
- ◉ SSRI controversy:
 - ◉ suicidality and mood
 - ◉ lability in early treatment
- ◉ CSM and NICE guidance:
 - ◉ Psychological therapies first
 - ◉ If medication indicated only
 - ◉ Fluoxetine first line

CBT for Depression

- ◉ Read the following paper by Vera Bailey

- ◉ <http://apt.rcpsych.org/content/7/3/224.full>

