

LECTURE 2

ANXIETY AND DEPRESSION

Internalising disorders

INTERNALISING DISORDERS

- ◉ Internalising problems refer to a set of conditions whose central feature is disordered mood or emotions (Kovacs and Devlin, 1998).
- ◉ Result from behaviours that are *over-controlled* (Cicchetti & Toth, 1991).
- ◉ Problems within the self, without known medical cause and withdrawal from social contact (Achenbach and Rescorla, 2001).
- ◉ Usually high rates of comorbidity.

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 'fight or flight' response.

ANXIETY

Abnormal if it is out of proportion to the situation at hand, persisting or interferes with daily functioning or quality of life

Between 8 and 27% of children will meet criteria for 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

<http://www.youngminds.org.uk/assets/0001/0610/children-and-young-people.pdf>

SYMPTOMS

- 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/RISK FACTORS



Demographics

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)

Wittchen et al (1988)
-around twice as frequent in females, gender differences increasing with age.

Higher rates -reduced education status and low household income.

http://www.moodcafe.co.uk/media/19579/cyp_parents_1_2_web.pdf

HOW ANXIETY IS MAINTAINED?

Fear - The first time either the feelings or the 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 happening again. This is known as the "fear of the fear"

Feelings (Physical) E.g. fast heart beat, feeling shaky, feeling like you might faint

Thoughts (Negative Thinking) E.g. I might die, I might have something seriously wrong with me, I'm not normal, I can't cope, I can't manage this feeling, I will only get worse, other people think I'm strange



AETIOLOGY/RISK FACTORS

Genetics

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



AETIOLOGY/RISK FACTORS

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)

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.

AETIOLOGY/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

AETIOLOGY/RISK FACTORS

Separation anxiety

- ◉ Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached
- ◉ Impacts on the child's functioning
- ◉ This affects 2-4% of children and is the most common anxiety disorder in pre-pubertal children.



Attachment theory

- ◉ Separation anxiety arises from actual or threatened separation from attachment figures

THE FEAR OF NEW FOODS



Some children, mainly boys, can only eat a very narrow range of foods, and show extreme anxiety if they are expected to try new foods.

The foods that they usually are able to eat are usually beige, dry carbohydrates, such as biscuits, crisps, cereals or bread; dairy products such as milk or yoghurt; and chocolate.

The fear of trying new foods stems from a normal development stage that occurs at around the age of two years (the neophobic stage). At this age children narrow down the range of foods accepted and commonly refuse foods that don't look the same as foods that they have learned to like.

Most children grow out of this stage, and are able to try and accept new foods into their diet. Some children do not move on from this stage; whatever the parents try to do.

The reluctance to try new foods becomes a fear, and all new foods trigger a disgust response in the child. If the child is forced to eat foods that they cannot accept then they will often vomit, or show a gag (disgust) response.

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 6mnths
- 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.

ANXIETIES IN ADOLESCENCE

Panic
disorder
with or
without
agoraphobia

- Age of onset is typically 15-19 years
- Panic attacks occur, with or without identifiable triggers.
- Agoraphobia consists of anxiety in situations where escape would be difficult or embarrassing. It typically has a prevalence of up to 5.2 per cent and panic disorder up to 1.6 per cent.

Break



DEPRESSION

<http://www.youtube.com/watch?v=9L7kBM-oQ9c>

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

MAIN FEATURES OF DEPRESSION IN CHILDREN AND ADOLESCENTS

- ◉ 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

- ◉ 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

DIAGNOSIS

- ⦿ Depressive disorder for children is different from that for adolescents. 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

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
 - Algorithms for mental health comorbidities that might be seen in primary care
(Generalized Anxiety Disorder, Panic Disorder, Substance Abuse or Dependence, Alcohol Abuse or Dependence, Nicotine Dependence, and Eating Disorders).

SEVERITY MEASURE FOR DEPRESSION—CHILD AGE 11-17* *PHQ-9 MODIFIED FOR ADOLESCENTS (PHQ-A)—ADAPTED

Name: _____ Age: _____ Sex: Male ☐ Female ☐
Date: _____

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

Item score (0) Not at all (1) Several days (2) More than half the 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?

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

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

DEPRESSION SCREENING SCALES

- 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, good concurrent validity in adolescent samples
- Moods and Feelings Questionnaire (30)
 - Brief format—13; 11/8 clinical cut-off
 - <http://devepi.duhs.duke.edu/instruments/MFQ%20%20Child%20Self-Report%20-%20Long.pdf>
- Achenbach Youth Self-Report Form (103+)
 - Assesses social function, mood, anxiety, and behavioral problems

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
 - 0 I do not feel sad.
 - 1 I feel sad
 - 2 I am sad all the time and I can't snap out of it.
 - 3 I am so sad and unhappy that I can't stand it.

2.
 - 0 I am not particularly discouraged about the future.
 - 1 I feel discouraged about the future.
 - 2 I feel I have nothing to look forward to.
 - 3 I feel the future is hopeless and that things cannot improve.

3.
 - 0 I do not feel like a failure.
 - 1 I feel I have failed more than the average person.
 - 2 As I look back on my life, all I can see is a lot of failures.
 - 3 I feel I am a complete failure as a person.

PROBLEMS IN REDUCING MDD IN CHILDREN AND ADOLESCENTS

Problems of diagnosis

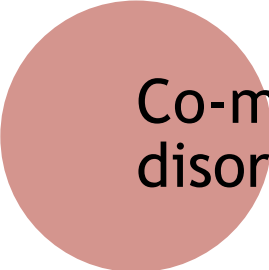
Developmental variations

Co-morbidity

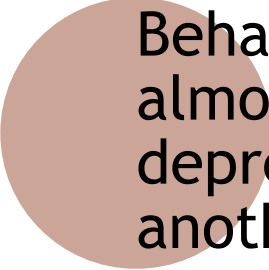
Complexity of factors associated with clinical course

Need specificity of treatments

CO-MORBIDITY



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 (NICE)

- ◉ 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 (anx and dep) (Meltzer et al, 2000).

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

VULNERABILITY - NEUROBEHAVIORAL DEVELOPMENT IN ADOLESCENTS

Early Adolescence

Puberty stimulates changes in brain systems regulating arousal and appetite that influence intensity of emotion and motivation



Middle Adolescence

adolescent emotional and behavioural problems 2nd to poor regulation skills-- particularly when gap between pubertal arousal and consolidation of cognitive skills is extended

Late Adolescence

With age and experience comes maturation of frontal lobes which facilitates regulatory competence



CAUSES AND FACTORS

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

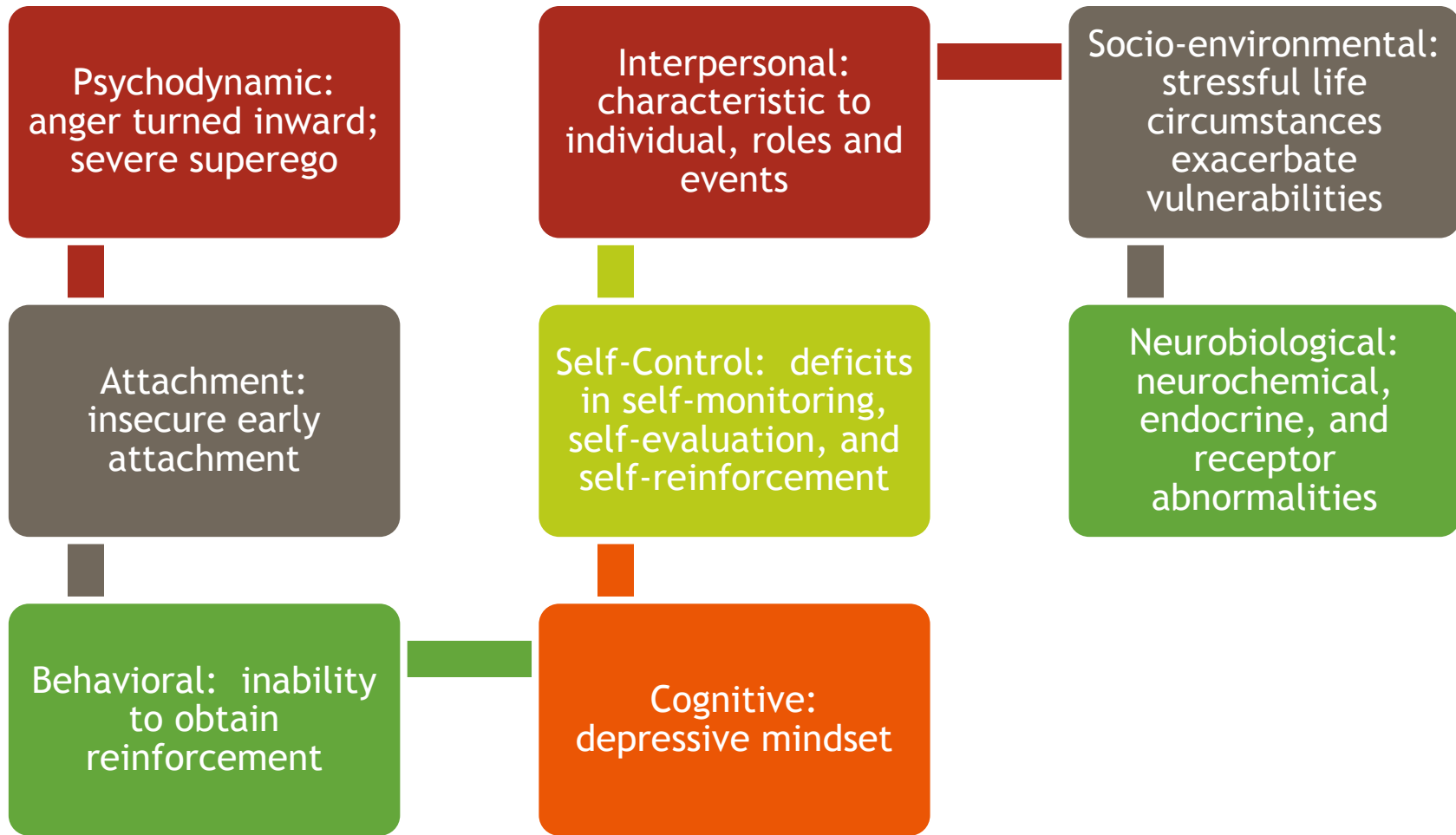
Biochemical- monoamine hypothesis; under-activity in brain amine systems cause depression. Carlson and Garber (1986) - too little serotonergic activity resulted in agitated depression and too little noradrenergic activity results in lethargic depression.

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).

ETIOLOGY: THEORIES OF DEPRESSION



INTERVENTIONS

In the UK

Psychologists

Clinical Psychologists, Counselling Psychologists and Educational Psychologists.

Psychiatrists

Psychiatrists are medical doctors who have chosen to specialise in mental health.

Counsellors and Therapists

BACP

BABCP

CAMHS Workers and Primary Mental Health Workers

BPS

Psychiatric Nurses

UKCP

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)



ANTIDEPRESSANTS

Depression in childhood and adolescence has similarities and differences to adulthood

Response to medication is different

Tricyclics ineffective in Childhood depression

SSRI controversy: suicidality and mood lability in early treatment

NICE guidance:

- Psychological therapies first
- If medication indicated only Fluoxetine first line

Is it bad enough?

Is it pervasive?

Have psychological strategies or environmental modification been tried?

Is it part of a wider treatment package?

Do parents and adolescent give consent?

Is it licensed/unlicensed or off indication?

Is it an emergency?

Risk/Benefit analysis



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PRESCRIBING TO CHILDREN: LICENSED OR UNLICENSED IN UK

Antipsychotic	Child (<12)	Adolescent (12-18)
Chlorpromazine	Yes	Yes
Haloperidol oral	Yes	Yes
Haloperidol IM	No	Yes
Pimozide	No	Yes
Trifluoperazine	Yes (anxiety)	Yes
Sulpiride	No	Yes (>14)
Zuclopenthixol IM	No	No
Amisulpiride	No	Yes(>15)
Clozapine	No	Yes(>16)
Olanzapine oral	No	No
Olanzapine IM	No	No
Risperidone oral	No	Yes(>15)
Risperidone IM	No	No

THE LIMITED PLACE FOR ANTIDEPRESSANTS

Should only be prescribed following assessment by a psychiatrist

Should only be offered in combination with psychological treatments

First-line treatment is fluoxetine

Do NOT use: tricyclic antidepressants, paroxetine, venlafaxine, St John's wort

Monitor for agitation, hostility, suicidal ideation and self-harm and advise urgent contact with prescribing doctor if detected

Sertraline or citalopram* as second-line treatment

Continue for 6 months if remission, then phase out over 6-12 weeks

INTERVENTIONS

Interpersonal therapy

- ◉ 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.

INTERVENTIONS

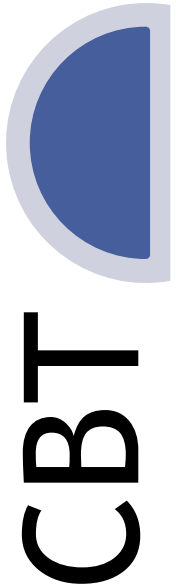
Psychodynamic therapies

- ◉ Psychodynamic therapies can take many different forms. However, many people now feel that these therapies are rather old fashioned, and based on old theories, such as those put forward by Freud and Jung, rather than modern scientific theories of what is happening in the depressed or anxious mind.
- ◉ Traditional psychodynamic therapy has been a long term therapy, with weekly sessions (or even more often) for anything up to several years. However, more recently, shorter forms of psychodynamic psychotherapy have been developed which offer weekly sessions for six months or less. NICE have acknowledged that there is very little evidence for psychodynamic therapy being useful in treating depression - last resort.

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.

WHAT TECHNIQUES MIGHT THEY USE?



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.

Cognitive Behaviour Therapy (CBT) aims to help people to change the way that they view themselves and the world. Current thinking suggests that when people are anxious or depressed, this is because they have developed a complex system of beliefs that make them think that the world is dangerous, difficult and unmanageable. If we think these things, then it is not surprising if we feel scared or miserable. It seems that children also have these sets of beliefs, although they may be less crystallised than they are in adults. We know that when we change these beliefs, using CBT, people start to feel better.

CONCERNS ABOUT TREATMENT

Treatment research is relatively sparse in children and adolescents

Varied opinions about whether psychotherapy or pharmacotherapy, or a combination should be the first-line treatment

Initial acute treatment depends on: severity of symptoms, number of prior episodes, chronicity, age, contextual issues in family, school, social, negative life events, compliance, prior treatment response, motivation for treatment

TASK

- In groups of 3 or 4 create a leaflet/poster that outlines the interventions available for children who suffer with anxiety or depression.

CBT

Read the following paper

- ⦿ Cognitive-behavioural therapies for children and adolescents by Veira Bailey
- ⦿ <http://apt.rcpsych.org/content/7/3/224.full>

RESOURCES FOR CHILDREN

- ⦿ <http://www.therapistaid.com/>
- ⦿ These are some of the tasks therapists may use to help children

ANXIETY AND PHOBIAS – USEFUL WEBSITES

- ◉ <http://www.moodjuice.scot.nhs.uk/phobias.asp> A 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 aimed at teenagers.
- ◉ <http://www.rcpsych.ac.uk/pdf/Sheet13.pdf> Information leaflet from the Royal College of Psychiatrists on helping children to cope with anxieties.
- ◉ <http://www.anxietyuk.org.uk/> General information on anxieties

CAMHS

Anxiety UK

Youngminds

Parentline Plus

Mind

Parent Lifeline

Depression Alliance