Anxiety in Children and Adolescents

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- Approximately 31% of those children that meet diagnostic criteria receive treatment for symptoms of anxiety.
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- Approximately 31% of those children that for diagnostic criteria receive treatment for symptoms of anxiety.
- Following a survey of 10,123 adolescents ages 13-18 years of age, anxiety disorders were the most common condition (31.9%)
  - This was followed by behavior disorders (19.1%) and mood disorders (14.3%)
- Nationally, among youth, the prevalence of anxiety disorders ranges from 2 to 4%.

(Merikangas et al., 2010; Connolly & Nanayakkara, 2009)
Anxiety in Children and Adolescents

- Anxiety disorders can interfere with academic, social, and family functioning.
- Anxiety disorders are associated with an increased risk of failure in school.
- Childhood anxiety is predictive of adult anxiety disorder, major depression, suicide attempts, and psychiatric hospitalization.

(Lalongo et al., 1994; Klein, 1995; Pine et al., 1998)
Anxiety Disorders According to DSM-V

- Separation Anxiety Disorder
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder
Obsessive Compulsive and Related Disorders

- OCD and related disorders is its own category
  - Obsessive-Compulsive Disorder
  - Body Dysmorphic Disorder
  - Hoarding Disorder
  - Trichotillomania (Hair-Pulling Disorder)
  - Excoriation (Skin-Picking) Disorder
- There is also a category of trauma and stress related disorders
Goals of Managing Anxiety in Primary Care

• Equip pediatricians with the tools necessary to identify children who may suffer from anxiety.
• Help with connecting these children to mental health services.
• Increase comfortability prescribing medications for anxiety symptoms.
• Assist with monitoring the impact of therapy and medication on children’s behavioral health.
Anxiety in Primary Care

• Within the context of a well visit:
  – Identify the anxiety and determine severity
  – Obtain complete social and medical history if initial visit / review
    history and obtain additional information regarding problems if follow-
    up appointment
  – Evaluate comorbidities (drug and alcohol use; other psychiatric
    disorders, etc.)
  – Formulate treatment plan
  – Improve motivation of patient and parent to participate in therapy
    services if necessary.
Screening for Anxiety Disorders in Primary Care

• Free to the public:
  – PSC-35 – items 11, 13, 19, 22, and 27 (Internalizing)
  – Screen for Child Anxiety Related Emotional Disorders (SCARED) – parent and youth version
  – Spence Children’s Anxiety Scale (SCAS) – parent, child, and preschool version

• Not free to the public:
  – Revised Children’s Manifest Anxiety Scale (RCMAS-2) – Ages 6 to 19
  – Depression and Anxiety in Youth Scale (DAYS) – Ages 6 to 19
  – Beck Anxiety Inventory (BAI) – Ages 7+
  – State Trait Anxiety Inventory for Children (STAIC) – Ages 9 to 12
Screen for Child Anxiety Related Emotional Disorders (SCARED)

- Ages 8-18
- Both SCARED versions measure five factors: general anxiety, separation anxiety, social phobia, school phobia, and physical symptoms of anxiety.
- It contains 41 items that take about 5 to 10 minutes to complete.
Spence Children’s Anxiety Scale (SCAS)

- Child ages 8-15
- Preschool ages 3-6
- SCAS is designed to evaluate symptoms relating to separation anxiety, social phobia, obsessive-compulsive disorder, panic-agoraphobia, generalized anxiety, and fears of physical injury.
- It contains 45 items that take about 5 to 10 minutes to complete.
Treatment

• Best course of treatment for anxiety disorders in children and adolescents
• One example: A placebo-controlled trial in youths with moderate to severe SAD, GAD, and/or social phobia, compared CBT, medication (sertraline), or placebo with combination treatment with medication and CBT.
  – CBT - 60% improved
  – Medication (sertraline) - 55% improved
  – Placebo - 24% improved
  – Combination of CBT and medication - 81% improved
  – All 3 of these active treatments were recommended with clinicians considering availability, family preferences, and cost in choosing a treatment.

(Walkup et al., 2009)
Cognitive Behavioral Therapy (CBT)

Thoughts: What we think affects how we feel and act.

EMOTIONS: What we feel affects how we think and act.

CHANGING PERCEPTIONS

BEHAVIORS: What we do affects how we think and feel.
Trigger - real or imagined danger

Thoughts:
- I can't cope
- Something terrible is going to happen
- I feel bad so it must be bad

Feelings:
- Anxious, fearful
- Physical sensations of anxiety

Behaviours:
- Avoid, Escape or Freeze
- Try to cope by doing things that help me feel better or keep me safe
Cognitive Behavioral Therapy

- CBT Worksheets for Patient and Family
  - Tools to manage stress (children – ages 5-10, or adolescents – ages 11-18)
  - My Fears
  - My Worry Box
  - Problem Solving
  - Guided Imagery
  - Progressive Muscle Relaxation
  - Stopping Automatic Negative Thoughts (ANTS)
Academic Accommodations

- Seating within classroom
- Following directions
- Class participation
- Class presentations
- Answering questions at the board
- Testing conditions
- Fire/safety drills
- Homework expectations
- Lunchroom/unstructured activities
- Safe person
- Cool down pass
- Assemblies/large group activities
- Return after illness
- Field trips
- Change in routine/substitute teachers
References


Understanding Depression, Anxiety and Suicide prevention
Why talk about depression?

• Recent surveys suggest, according to Mental Health America
  – 1 in 5 teens suffers from Clinical Depression
  – Each year almost 5,000 young people (ages 15-24) commit suicide
  – Rate has tripled since 1960 – 3rd leading cause of death in adolescents and 2nd leading cause of death among college age
What is Depression?

• Sadness is a normal reaction to life’s struggles, setbacks, and disappointments.

• Depression is **different** from normal sadness by:
  – Engulfing your day-to-day life,
  – Interfering with your ability to work, study, eat, sleep, and have fun.

• The feelings of helplessness, hopelessness, and worthlessness are intense and unrelenting, with little, if any, relief.
Common Signs and Symptoms

- Feelings of helplessness and hopelessness
- Loss of interest in daily activities
- Appetite or weight changes
- Sleep changes
- Anger or irritability
- Loss of energy
- Self-loathing
- Reckless behavior
- Concentration problems
- Unexplained aches and pains
Changes in behavior and thinking

• These may include:
  – General slowing down
  – Neglect of responsibilities and appearance
  – Poor memory
  – Inability to concentrate or think clearly
  – Suicidal thoughts, feelings, or behaviors
  – Difficulty making decisions
  – Negative attitude and outlook
Depression in teens

- Some appear sad – most appear irritable
- Poor performance in school
- Withdrawal from friends and activities
- Anger/rage
- Overreaction to criticism
- Suicidal thoughts
- Poor self-esteem or guilt
- Substance abuse or acting out to avoid feelings
Risk factors

- Loneliness
- Lack of social support
- Recent stressful life experience
- Family history
- Early childhood trauma/abuse
- Substance abuse
- Health problems or chronic pain
Link between anxiety and depression

- Anxiety and depression are believed to stem from the same biological vulnerability
- Often go hand in hand
- Depression can make anxiety worse (and vice versa)
- Important to recognize both conditions
TYPES OF DEPRESSION

UNIPOLAR Depression

- Non-melancholic
- Melancholic
  - Psychotic

  • Anhedonia
  • Lack of reactivity
  • Worse in morning
  • Early morning awakening
  • Psychomotor retardation or agitation
  • Anorexia or weight loss
  • Inappropriate or excessive guilt

BIPOLAR disorder

- Manic
- OR
- Hypomaniac

- Mild
- Moderate
- Severe
Depression in Children and Adolescents

Subtypes

- Catatonic depression
- Post-psychotic depression
- Premenstrual dysphoric disorder
- Seasonal depression
- Mood disorder NOS
- Adjustment disorder with depressed mood
- Minor depression
- Unipolar depression
- Bipolar depression
- Psychotic depression
- Melancholic depression
- Dysthymic disorder
- Double depression
Depression in Children and Adolescents

Etiology

- Genetics
- Prenatal factors
- Family relationships
- Parental depression*
- Cognitive style
- Stressful life events
- Lack of parental care
• Anxiety disorders
• Post Traumatic Stress Disorder
• Conduct problems
• Attention Deficit Hyperactivity Disorder
• Obsessive Compulsive Disorder
• Learning difficulties
Suicidal thoughts:
  – 1/6 girls
  – 1/10 boys

100:1 ratio of attempts to completions
60% depressed youth have thoughts of suicide
30% depressed youth make a suicide attempt
Risk factors: family history, previous attempts, comorbidities, aggression, impulsivity, access to lethal means, negative life events
Depression in Children and Adolescents

Free Rating Scales

- CES-DC: Center for Epidemiologic Studies-Depression Scale
- MFQ: Mood and Feelings Questionnaire
- DSRS: Depression Self-Rating Scale
- KADS: Kutcher Adolescent Depression Scale
- PHQ-A: Patient Health Questionnaires--Adolescent
- SDQ: Strengths and Difficulties Questionnaire
Robust evidence of effectiveness for:

- Medication (moderate and severe depression)
- Psychotherapy (milder depression)
  - Cognitive behaviour therapy (CBT)
  - Interpersonal psychotherapy (ITP)
ALL PATIENTS

CONDUCT A RISK ASSESSMENT

ESTABLISH SEVERITY
[clinical assessment + depression rating scale]

SUPPORTIVE MANAGEMENT
- Build rapport
- Psycho-education
- Self-help
- Healthy lifestyle: exercise, sleep hygiene
- Supportive psychotherapy (problem solving, stress management, pleasant events)

Admission?
Depending on severity:

- Watchful waiting
- Supportive management
- Psychosocial interventions
  - Cognitive Behavioral Therapy (CBT)
  - Interpersonal Psychotherapy (IPT)
- Medication
Common misconceptions about Suicide

• FALSE – People who talk about suicide won’t really do it
• FALSE – People who talk about or attempt suicide want to die
• FALSE – Anyone who tries to kill him/herself must be crazy
• FALSE – If a person is determined to kill him/herself, nothing is going to stop them
• FALSE – Talking about suicide may give someone the idea
Suicide warning signs

- Talking, writing, or joking about suicide or death
- Giving away prized possessions
- Making final arrangements
- Depressive symptoms
- Sudden, unexplained recovery from profound depression
- Marked feelings of helplessness or hopelessness
- Risk-taking behavior
- Self-mutilating behavior (sometimes)
- A suicide plan
- Significant change in behavior
- Previous suicide attempts
- Significant loss
- Chemical (drug or alcohol) abuse
• Mental Health **Does** Matter: Prevalence on College Campuses

Colleges across the country have reported large increases in enrollment [or at least increasing access for students]. At the same time, college counseling centers have also observed an increase in the prevalence and severity of mental health issues experienced by students and an increase in the number of students taking psychotropic medications.
College stressors that can impact mental health

- Relationship breakups
- Homesickness
- Peer Pressure
- Loneliness
- Academic pressure
- Future career stress
- Financial issues
- Lack of sleep
- Taking on too much
- Over-involved

- Body image concerns
- Drug and alcohol use
- Poor diet and lack of exercise
- Sexual identity
- Hazing
- Bullying
- Veteran status
- Death
- Divorce
Mental Health **Does** Matter: Prevalence on College Campuses

75% of lifetime cases of mental health conditions begin by age 24.

1 out of 4 young adults between the ages of 18 and 24 have a diagnosable mental illness. (8,500 X .25 = 2,125 undergrads at SCSU)

More than 11% of college students have been diagnosed or treated for anxiety in the past year.

More than 10% reported being diagnosed or treated for depression.
Mental Health **Does** Matter: Prevalence on College Campuses

**More than 40%** of college students have felt more than an average amount of stress within the past 12 months.

**More than 80%** of college students felt overwhelmed by all they had to do in the past year and... **45%** have felt things were hopeless.

**Almost 73%** of students living with a mental health condition experienced a mental health crisis on campus.

Yet, **34.2%** reported that their college did not know about their crisis.

[Link](http://www2.nami.org/Content/NavigationMenu/Find_Support/NAMI_on_Campus1/Learn_About_The_Issue/Learn_About_The_Issue.htm)
Therapy/Counseling

• This can help many depressed people understand themselves and cope with their problems.
• For example:
  – Interpersonal therapy works to change relationships that affect depression
  – Cognitive-behavioral therapy helps people change negative thinking and behavior patterns
Depression in Children and Adolescents

Barriers to Care

• Shortage of child psychiatrists and allied professionals
• Few training programs
• Stigma
• Few medications
• Minimal inpatient facilities
Depression in Children and Adolescents

Prevention

- Cognitive restructuring
- Social problem-solving
- Interpersonal communication skills
- Coping
- Assertiveness training
Further Information

American Academy of Child and Adolescent Psychiatry (AACAP) 2007 Practice Parameter on depressive disorders
http://www.jaacap.com/article/S0890-8567(09)62053-0/pdf

Depression in Children and Adolescents

Thank You!