Depression and Anxiety Disorders in Children and Adolescents

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Learning Objectives:

• Recognize common signs and symptoms of depression and anxiety problems and how they might impact a child/adolescents’ functioning
• Screen for suicidal and provide support
• Understand evidence-based treatments for depression and common types of anxiety
• Explore resources for parents, healthcare providers, school personnel and other professionals that work with and adolescents
Review of Depression and Anxiety Disorders
Clinical Depression in Children and Adolescents

• According to National Institutes of Mental Health- 11% of adolescents have a depressive disorder by the time they are 18

• World Health Organization- depression is the leading cause of disability among people ages 15-44

• Depression can lead to suicide, which is the 3rd leading cause of death among ages 10-24
Prevalence numbers of depression in kids

• Prevalence research
  • Adolescents: up to 8.3% point prevalence
  • Preadolescents: up to 2.5% point prevalence
  • Preschool: up to 1% point prevalence

• Gender ratio
  • Preadolescents: boys = girls
  • Adolescence: girl : boy = 2 : 1
Key signs of depression in teenagers

• Adolescents can have significant fluctuations in mood that fall within normal
• Depression is substantial, persistent, and causes impairments in functioning at home, school, and social
• Key signs and symptoms
  • Changes in attendance at school
  • grades dropping
  • peer group shifts
  • physical symptoms or ailments (especially headaches, stomachaches)
  • Irritability and defiance more than sadness
  • Sleeping in class or fatigue and low energy
  • Loss of interest in fun stuff - not motivated by reward
  • Low motivation and drive
  • Extreme sensitivity to social criticism or negative feedback
  • Start or increase in substance use
Social presentation of teenage depression

• With high motivation to gain approval of others and to “save face”...they may appear happy and well at school- but at home and in private may be significantly effected by depression
Depression in preschool and school age children

Research validation of clinical depression in children as young as age 3. Limited research on how to guide treatment.

Intense irritability- Although irritability is nonspecific and can come with variety of problems (ADHD, anxiety, adjustment, trauma, normal), when it presents with social withdrawal and anhedonia and or excessive guilt or self negativity, early depression should be considered

Other Signs/ Symptoms:
• Changes in play,
• changes in social functioning and withdrawal,
• changes in sleep and appetite,
• extended periods to calm down,
• Reacting to minor frustrations with intense sadness and despair, lasting hours,
• Lack of interest in activities and play,
• Preoccupation with negative play and pessimistic thoughts.
Major Depressive Episode (MDE)

• 5 or more of the following present during the same 2-week period, change from previous functioning; at least one of the symptoms is either **depressed mood** or **loss of interest or pleasure (in kids irritability and defiance)**.
  • Depressed mood most of the day, nearly every day, (subjective or observed)
  • Diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day
  • Weight loss or weight gain, increased/decreased appetite (in kids, failure to make expected wt gains)
  • Insomnia or hypersomnia
  • Psychomotor speeding up or slowing down
  • Fatigue or loss of energy
  • Feelings of worthlessness or excessive or inappropriate guilt, self-negative
  • Diminished ability to think or concentrate, or indecisiveness
  • Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
Dysthymic Disorder

• Usually an early and sneaky onset, chronic course
• Depressed mood for most of the day, for more days than not for 2 year duration- (In kids, mood can be irritable and duration must be at least one year)
• While depressed 2 or more of the following
  • Poor appetite or overeating
  • Insomnia or hypersomnia
  • Low energy or fatigue
  • Low self-esteem
  • Poor concentration or difficulty making decisions
  • Feelings of hopelessness
Models of depression

• Both heritability/vulnerability (physiological) and environmental factors

• Diathesis-stress model
  • Children/Adolescents whom are vulnerable and have circumstances that may trigger
Prevalence of Anxiety Disorders in Children and Adolescents

- All anxiety diagnoses
  - 3-13% point prevalence in community samples
  - 6-16% of clinical samples

- Generalized Anxiety Disorder
  - 3-12% point prevalence in community
  - 6-12% clinical

- Obsessive Compulsive Disorder
  - 1-3% point prevalence in community samples
  - Subclinical OCD (absence of distress or impairment) in up to 20% of kids
Prevalence of Anxiety Disorders in Children and Adolescents

• Specific phobia ranges from 1.7-12%, variable depending on type of phobia

• Social phobia
  • 3-16% point prevalence in community, more prevalent in teens

• Panic
  • 2-18% of adolescents have experienced at least once a 4-symptom plus panic attack (based on structured interview)
  • Adolescent self report questionnaires show much higher prevalence, between 43-60%
Worry versus Anxiety Disorder

• 70% of children report worrying
• Girls report more fears and worries than boys
• Intensity more than specific content serves to differentiate
• Functional impairment is important determining factor
• Do they feel in charge, can they turn it off?
• Is it developmentally appropriate?
Developmental Typical Worry

• Preschool: Separation from caregivers and imaginary and supernatural characters

• 5-6 years old: threats to physical well being and still imaginary

• Older school age: personal and social performance, school performance and physical well being

• Adolescents: personal and social performance, physical well being, war, money, disasters
Anxiety Disorders

• **Common features across all anxiety disorders:**

  • Avoidance of objects, situations, events or they are endured with distress

  • Maladaptive thoughts or cognitions

  • Physiological arousal or reactions
Why do kids get anxiety?

• Strong genetic predisposition, heritability rates estimated at 30% for anxiety

• Stress-diathesis model- physiological systems permanently set on high by neuroendocrine mechanisms

• Behavioral inhibition precursor

• Having anxious parents-environmental and social learning mechanisms, models of maladaptive coping
Separation Anxiety Disorder

• Difficulty separating from home/attachment figures is normal & expected for children between 7 months and 6 years

• When distress lingers and is developmentally inappropriate or is abnormally intense, may meet criteria for SAD
  • Recurrent distress with separation or anticipation, worry about lose or harm to parent, getting lost or kidnapped, school refusal, can’t be alone, etc…
Generalized Anxiety Disorder

- Excessive anxiety/worry more days than not for at least 6 months, about a number of events or activities
- Can’t control the worry
- One or more physical symptoms:
  - Restlessness/keyed up
  - Easily fatigued
  - Difficulty concentrating
  - Irritability
  - Muscle tension
  - Sleep disturbance
GAD as the “Basic” Anxiety Disorder

• features may represent the fundamental processes of all emotional disorders

• “anxious apprehension”

• High negative affect and chronic over-arousal

• Sense of uncontrollability

• Attentional focus on threat related stimuli
Specific Phobia

• Marked fear or anxiety about a specific object or situation that:
  • Is out of proportion to actual danger
  • Consistently occurs with exposure to stimulus
  • Persistent, typically lasting 6 months or more
  • Causes clinically significant distress or impairment
  • Specify type: Animal, Natural Environment, Blood-injection-injury, Situational, Other, SCHOOL?
Obsessive-Compulsive Disorder

- Obsessions:
  - Intrusive thoughts, impulsive, or images
  - Not simply excess worries about real-life problems
  - Ignoring, suppression, or neutralizing with other thoughts or actions
  - Product of own mind

- Compulsions:
  - Repetitive behaviors or mental acts the person feels driven to perform
  - Behaviors or mental acts aimed at preventing or reducing distress

- Causes distress and interferes with normal routine or functioning
- Many types- contamination, germs, order, symmetry, counting, harm to others, magical thinking
Social Anxiety Disorder

• Fear of social/performance situations

• Must be evidence of capacity for age-appropriate social relationships and anxiety must occur in peer settings

• Avoid social situations- avoid assertive behavior

• Would like to develop friendships but struggle with social skills and lack confidence
Selective Mutism

- Consistent failure to speak in specific social situations (expectation of speaking)
- Disturbance interferes with educational achievement or with social communication
- Duration of at least 1-month
- Not due to communication problem or language development
Panic Disorder

• Panic attacks can occur within any anxiety condition
• Panic disorder is “fear of fear” and of having further attacks
• Unexpected panic attacks followed by at least one month of one or more of the following:
  • Concern about additional attacks
  • Worry about the implication/consequences of attacks
  • Change in behavior related to the attacks (refusing to go places)
Panic Attack Defined

• A discrete period of intense fear or discomfort that has an abrupt onset, reaches a peak in 10-minutes, and accompanied by at least 4 of 13 somatic symptoms.

• Situationally cued

• Uncued

• Kids can definitely have panic!
Decreased School Functioning

- Depression and Anxiety Disorders can lead to severe impairments in school functioning

- Often underappreciated as a impairing condition that may need formal supports and accommodations

- Problems in school functioning can be one of the more stressful things for families

- Some of the most active treatment components could and should be implemented at schools
Decreased School Functioning

- Both depression and anxiety can create increased problems with concentration/attention, organization, working memory, task completion, problem solving, and decision making

- Many students have been found to not even be able to start basic school tasks
  - Paralyzed by fear or depression

- Once functioning goes down, being behind in school is now a new stressor

- Apprehension about coming back after being gone - because of academics, fear of teacher response, fear of peer response
Suicide in Kids and Teens

• Centers for Disease Control and Prevention (CDC) 2013
  • Death by suicide rare in kids younger than 14-years
  • Ages 15-24- 10.9 suicides per 100,000
  • Suicide rates 4 times higher in young men than in women

• Suicide is the 3rd leading cause of death among teenagers
• 1 out of 6 teens seriously consider suicide
• 1 out of 13 attempt suicide one or more times
Know the Signs of Suicide Risk

• Suicide rarely occurs without warning signs
• IS PATH WARM
Suicide/Crisis warning signs in schools and other community settings

- Teachers and school staff are in unique position to see early warning signs and differentiate form normal teen behaviors

- Suddenly deteriorating academic performance
- Evidence of cutting or self-mutilation
- Fixation with death/violence- poetry, essays, doodling, texts, social media posts
- Drastic change in peer groups- unhealthy peer groups- appearing socially isolated
- Mood swings or a sudden change in personality- including withdrawal
- Evidence of abuse in relationships- bruises, refusal to talk about family
- Increased risk taking behaviors
- Dramatic changes in weight OR sleeping more in class

National Center for Mental Health Promotion and Youth Violence Prevention
Warnings signs that need immediate action

- Talking or writing about death or suicide (including Facebook, Twitter, texts)
- Direct verbal- “I wish I were dead”, “I’m going to end it all”
- Less direct verbal- “You will be better off without me”, “What’s the point of living”
- Isolating themselves
- Expressing belief life is meaningless
- Giving away possessions to others
- Sudden, dramatic IMPROVEMENT in mood after depression
- Suddenly neglecting hygiene or appearance
- Dropping out of school activities, teams, events
- Evidence of obtaining weapons, medications, pills
Intervening with Teens At Risk of Suicide

• A response by a caring adult can be a lifeline to a teenager in crisis

• Ask the tough questions- this will not increase the risk
  • “Are you thinking about harming or killing yourself?”
  • “You seem to be going through something (or you haven’t seemed happy), are you having any thoughts of suicide or that life isn’t worth living?”
  • “Sometimes when people are sad, they have thoughts of suicide or not wanting to live. Have you been feeling this way”.

• Be persistent, consistent, supportive
Intervening with Teens At Risk of Suicide

• Be prepared to act:
  • Do not leave the person unattended
  • Unless concerns of abuse/safety at home, contact the parents (if concerns, contact authorities)
  • If you are not comfortable helping the student, get help from other adults who are
  • Help seek out mental health support for the student
How to help...

Frontline support

Evidence Based Treatments for Depression and Anxiety
Helping a young child with depression and/or anxiety

- Identifying warning signs early (irritability, extreme emotions, problems calming, negative, low response to reward)

- Consistent, immediate, positive parenting
  - Time In and Time out
  - Positive reinforcement based behavioral plans
  - Helping avoid a negative or anxiety attention cycle
  - Not modeling emotionality or anxiety to the child - social learning theory
Disruptive behavior

Reduced positive interactions

Harsh, inconsistent or negative parental response

Negative or extreme emotions
Disruptive behavior or poor calming

Avoidance of situation

Parent attention to anxious behavior

Reduced attention to coping/calm behavior

Anxiety
Clinical treatment of depression or anxiety in preschool and early school age children

• Therapy that is a dyad (involving caregivers) and family based interventions have shown most support
  • Parent Child Interaction Therapy (PCIT- Emotion Development), being tested for use in depression

• Antidepressants are not recommended for front or second line treatment
  • There are known differences in neurotransmitter systems compared to adults and adolescents
  • Sometimes they are used for extreme cases, but monitored closely and by a pediatric psychiatrist or developmental pediatrician
Helping a teenager with depression and/or anxiety

• Speak up right away, in a supportive and non-judgmental way
• Talk about specific signs or behaviors that you have observed or noticed
• Active listening: Avoid correction- don’t “shut down” the thoughts and feelings, but instead validate and try to understand
• Teens worry about being misunderstood
  • Normalize that many teenagers go through depression and anxiety, but also discuss how what they are going through is unique and you want to understand
• Continue to offer support and an open ear. Gentle but persistent- don’t give up if they shut you out at first- be respectful of comfort level, meet them where they are at but model being a teammate and problem solver and that you will continue to listen
Clinical Treatment of Depression in Adolescents

• Antidepressant medication, selective serotonin reuptake inhibitors (SSRI) are indicated

• Cognitive-Behavioral Therapy (CBT)

• Treatment of Adolescents with Depression (TADS) study
TADS study

• Fluoxetine, Cognitive-Behavioral Therapy, and Their Combination for Adolescents with Depression
  • Randomized Controlled Trial by the TADS study group, lead by John March, MD.
  • 439 patients ages 12-17 with Major Depressive Disorder
  • 13 academic and community clinics
  • Fluoxetine alone, CBT alone, CBT with fluoxetine, Placebo
  • Combination was best and superior to either fluoxetine or CBT alone
  • Fluoxetine alone was superior to CBT alone
  • Rate of response to Combination was 71%.
Clinical Treatment of the Anxiety Disorders

• Cognitive-behavior therapy alone
  • Exposure-based CBT is a key

• Cognitive-behavior therapy plus family anxiety management also supported for younger children

• SSRIs
  • Research is more limited than CBT, but in some children very helpful
Basic Structure of Cognitive Behavioral Therapy (CBT)...

- **What I Feel**
  - EMOTIONS/PHYSICAL

- **What I Do**
  - BEHAVIOR

- **What I Think**
  - THOUGHTS
Components of CBT for Depression...

• Behavioral activation - scheduling activity for pleasure and mastery
  • Get them functioning and going again
  • Some components of systematic desensitization

• Mood monitoring and emotional intelligence

• Cognitive restructuring, identifying thinking mistakes and correcting

• Active problem-solving

• Assertive communication - interpersonal skill building
Behavior Activation

• Often the goals set by therapists are small, gradual, aim to build back activity, self-confidence, and mastery

• Allow successes and upward spiral behaviors to occur

• Sometimes the behavior goals start with fairly minimal functioning–child/teen may need significant support

• Family or support system will need to be involved, understanding, and patient
**Behavioral Activation**

**Improving Your Mood: Tracking Pleasure and Mastery**

Track what you do throughout the day, and rate each activity on a scale from 1-5 for both Mastery and Pleasure. **Mastery** indicates a sense of satisfaction you get from doing something well. **Pleasure** is used to rate how much an activity “feels good.” On the scale, a “1” indicates “not at all” while a “5” indicates “very much.” You can improve your mood by engaging in a variety of activities that bring both mastery and pleasure on a regular basis.

<table>
<thead>
<tr>
<th>Activity/Behavior</th>
<th>Mastery (1-5)</th>
<th>Pleasure (1-5)</th>
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Emotional Awareness/Mood Monitoring

• Teens are taught about different emotional states and what comes with them
• Asked to rate mood multiple times per day and evaluate changes/situations
• Smartphone apps (T2 Mood Monitor)
• Young children use emotions thermometers and visuals
Tools to help Improve Emotional Awareness

The Way I Feel

- Happy or Excited
- Calm
- Worried or Nervous
- Irritated or Frustrated
- Angry or Mad
- Sad

Feelings Thermometer

- Stop angry very upset
- Be Careful confused not listening need to think
- Go good happy working well
Working on thinking...Cognitive Restructuring

• Teens and children are taught about the power of their thinking in determining how they feel and behave

• First taught to identify “knee jerk reactions” or “automatic thoughts”

• Scientific team OR Thought Detectives to learn and then evaluate unhelpful versus helpful or negative versus positive thinking
Helping implement Thinking Tools

• Cognitive restructuring in both depression and anxiety includes...

1. Identify an increase in stress or change in emotion-What I am feeling?
2. What I am thinking? Unhelpful thoughts
3. What are other more helpful thoughts?
4. Plan and problem solve
<table>
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<tr>
<th>SITUATION</th>
<th>Emotions/Feelings</th>
<th>Automatic Unhelpful Thoughts</th>
<th>Problem solving/Alternative Thoughts</th>
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**Thought Change Practice**

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<th>Situation:</th>
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<td>Thoughts:</td>
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<tr>
<td>Feelings (0-100):</td>
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<td>Questions/Evidence:</td>
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<tr>
<td>More Helpful Thoughts:</td>
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<tr>
<td>Feelings (0-100):</td>
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COGNITIVE ERRORS

1. Black and White Thinking
You see things as perfect or terrible, or you see people as all good or all bad. You have "grey color blindness." Either you do it perfectly or you fail.

2. Catastrophizing
You react to a disappointment or momentary failure as though it means the end of the world.

3. Jumping to Conclusions
You assume the worst without checking the evidence. You decide that someone dislikes you, but you don’t check it out, or you decide that terrible things will happen when there is no evidence for this.

4. Missing the Positive
You don’t pay attention to positive experiences, or you reject them or say they somehow “don’t count.”

5. My Fault
You take responsibility for things that are not your job, or are not in your power to control.

6. Should’s
You get all over yourself or criticize other people with ideas about what absolutely should or must be done by you or them.

7. Overgeneralization
Jumping to a conclusion based on a single incident or piece of evidence; expecting something bad to happen over and over again if it occurred once in the past.
Problem solving and interpersonal skills

• Children and teenagers are taught how to approach or “attack” a problem rather than withdraw or avoid
• Step by step problem solving strategies

• Assertive communication training
  • “I” statements, I feel..., I need ...
  • Being assertive but not aggressive
  • Interpreting the actions of others
Components of CBT for Anxiety

- Different anxiety conditions, but they all have the same CBT foundation
  - Psychoeducation
  - Recognize emotions, somatic or physical signs
  - Relaxation and somatic control
  - Thinking identification and cognitive restructuring
  - Systematic desensitization
  - Exposure through imaginal and in vivo experiences
  - Social anxiety have skill building and role playing
Specific CBT for Anxiety (Coping Cat)...

Sessions 1-2  Educate about anxiety and treatment goals
              Introduce fear thermometer or emotions ratings
              Hierarchy of anxiety situations
              Parent education-reward systems for younger kids

Sessions 3-6  Identify somatic symptoms
              Introduce relaxation skills
              Identify anxious versus coping self-talk
| Sessions 7-11 | Problem-solving training (active coping)  
|              | Systematic Desensitization  
|              | Exposure-low anxiety scenarios (imaginal and in vivo).  
|              | Parent education regarding exposure  
| Sessions 12-15 | Exposure to moderate anxiety  
|               | Exposure to moderate to high  
| Session 16 | Review and celebrate success  
|             | Educate on potential future difficulties |
Stress management and relaxation tools

• Relaxation techniques return body to homeostasis (physical and mental)
  • Techniques to slow the stress response (sympathetic) and help the body return to a state of calm (parasympathetic)

• Breathing- bubbles, belly breathes, pinwheel, candles
• Progressive Muscle Relaxation- basic to advanced
• Guided Imagery and meditation- “change the channel” to more complex

KEY points-
• Helping practice and rehearse DAILY
• Prompting for both imaginal and “real life” exposures or approach towards stressful situations
Working on thinking...Cognitive Restructuring

Controlling My Anxiety-Thought Bubble Exercise

What are my Anxiety Thoughts?

Change Thoughts to cool down and take control
Step 1: Circle what feeling you had- what number were you?

Step 2: Why did you get upset?

Step 3: List calm down tools you could have used.

Step 4: Write 1 thought that would have helped you relax.
What is Systematic Desensitization

• **Systematic Desensitization** - gradual, controlled exposures that includes competing responses (coping skills or other actions) during exposure to a situation
  
  • Desensitization can be to...
  
  • A child or teenagers thoughts or images
  
  • A situation in their environment
When we avoid situations because we get too anxious or distressed, if we think about or find ourselves in those situations, our anxiety rises sharply, stays on a level for a while, then slowly starts to decrease gradually....

If we didn’t avoid the situation, just do it anyway and stick with it, then the first time will be the worst. Each time after that, we’ll find that we won’t be quite so anxious as the time before, and the anxiety will start to pass a little quicker than the previous time, so the diagram might look something like:
Imaginal and Real Exposures

• Children and teens are taught skills on reducing or tolerating distress
• They learn to “face their fears” in a hierarchy
• First with therapist support, then parent or other support, then on their own
  • Imaginal Exposure- therapist helps prompt thinking, images, or memories of anxiety situation
  • In vivo, real exposures- actually approaching the anxiety situation
In Young Children - Provider and parent(s) may design hierarchy and use strong reinforcers or rewards for gradual steps

In Adolescents - Teen helps design hierarchy with provider

SUDS Ratings
Simple acronym for CBT basics

STOP

- Are you feeling SCARED?
- What are you THINKING?
- OTHER helpful thoughts?
- PRAISE yourself and PLAN.
The FEAR plan: mastering anxiety arousal

- Feeling Frightened (anxious)- If you feel the internal or physical signs of anxiety, ask yourself why?

- Expecting something bad/negative?- Ask yourself about the potential “catastrophes” that you are thinking about. These are just thoughts. Identify anxiety related thinking.

- Actions and Attitudes that help- What can you do? Adjust your thinking, have a daily stress management or relaxation plan. Approach and solve.

- Rate and Reward- Pay attention to how your distress and anxiety go down when you use your skills. Reward yourself for progress and THINK about your success.
Resources

- www.helpguide.org
- www.worrywisekids.org
- How to help your anxious child. Rapee, Wingnall, Spence, et all
- Freeing your child from anxiety. Chansky
- You and your anxious child. Albano
- Helping your depressed child. Barnard
- Understanding teenage depression. Empfield & Bakalar
References


• National Institutes of Mental Health


• The TADS study team (John March, MD). Fluoxetine, cognitive behavioral therapy, and their combination for adolescents with depression. JAMA.