When their sky is falling:
Helping youth with anxiety and depression

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Disclosure Information

• There are no relevant financial relationships related to this presentation/program

• There is no sponsorship/commercial support of this presentation/program

• The content being presented will be fair, well-balanced and evidence-based.
Objectives

Participants will:

• Recognize the risk factors and common symptoms of anxiety and depression in pediatric populations, and describe screening tools that may be used.

• Reflect on ways to initiate conversations and discuss mental health concerns with pediatric patients.

• Identify resources for youth with anxiety and/or depression and their caregivers.
Behavioral Health Diagnoses

- When does it become a formal diagnosis?
  - Distress
  - Significant impairment
- DSM-5
  - Clusters of symptoms
  - 400+ diagnoses
  - Western culture
  - potentially stigmatising

![Chart: Depression, Anxiety, Behavior Disorders, by Age](CDC.gov)
Signs of Mental Health Concerns

- Hygiene concerns
- Repeated drug or alcohol use
- Intense mood swings or feeling sad/irritable for at least 2 weeks
- Talking about or trying to harm or kill themselves
- Hiding body parts from view
- Out-of-control behavior
- Changing in eating habits
- Withdrawn/decreased social activities

- Distractible/poor attention
- Decline in academic performance
- Changes in sleeping patterns or energy levels, circles under eyes
- Worries or fears that get in the way of daily activities
- Increased physical complaints—headaches, stomach aches, racing heart
- Problems maintaining relationships
- Anything that seems uncharacteristic for the child

US Dept of Health and Human Services, 2019
Risk Factors for Depression and Anxiety

- Loss of a loved one
- Family stressors—divorce, incarceration, health issues
- Major transition—new home, new school, etc.
- Traumatic life experiences – violence, natural disasters, injuries, being bullied
- Academic difficulties
- Health issues
- Female
- Family history/modeling
Children who have a chronic illness or condition may:

- Feel "different" or be socially isolated
- Have significant lifestyle restrictions
- Experience recurrent fear and pain

- When these difficulties are not addressed, they can lead to depressive and anxiety disorders

Pinquart & Shen, 2011
• On average, children and adolescents with chronic physical illnesses have higher rates of depressive and anxiety symptoms than their healthy peers
  • Depressive symptoms are highest in those with chronic fatigue, fibromyalgia, cleft lip and palate, chronic pain, epilepsy, and adolescents with Type 1 diabetes
  • Diagnoses of asthma, chronic fatigue, headaches and neurological illnesses linked with higher rates of pediatric anxiety

• Mental health conditions are associated with poorer illness management
  • Depression in adolescents with T1D is associated with higher HbA1c, increased hospitalizations, and less frequent blood glucose monitoring
  • Poorer treatment adherence in teens with anxiety/depressive symptoms and inflammatory bowel disease
  • Difficulty managing asthma regimen for children with ADHD

Wysocki, Buckloh & Greco, 2009; Gray, Denson et al., 2012; Grey, Whittemore & Tamborlane, 2002
A note about trauma...

- Trauma or **Adverse Childhood Experiences (ACEs)** harm children’s developing brains and lead to changes in how they respond to stress as well as their immune systems.
- **More ACEs = greater risk for chronic health issues, violence, poor job performance, etc.**
- **Mental health symptoms are often driven by ACEs**
  - There is a strong dose-response relationship between Adverse Childhood Experiences (ACEs) and the probability of lifetime and recent depressive disorders.
- **Resilience** – research shows that brains and bodies can recover from ACEs through therapy, exercise, good nutrition and sleep, and healthy social interactions.

Chapman, Whitfield, & Felitti, 2004; Felitti, Anda, Nordenberg et al., 1998
Depression
Incidence & Prevalence

- Affects 2.6 million youth ages 6-17 annually
- Incidence:
  - 2.5% children (M:F 1:1)
  - 8.3% adolescents (M:F 1:2)
- Lifetime prevalence (up to age 18): 15-20%
  - 40-80% experience suicidal thoughts
  - 35% of depressed youth attempt suicide at least once
- Long-term impact of depression and suicidality
  - Impaired social, career, and economic functioning

American Psychiatric Association, 2013
## Depression vs. Dysthymia vs. Adjustment Disorder

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Symptoms and Course</th>
</tr>
</thead>
</table>
| Major Depressive Disorder (MDD)        | • Present for at least 2 weeks  
• Causes distress and/or impairment  
• Depressed mood or anhedonia plus at least 4 additional symptoms                                                                                   |
| Dysthymia                              | • Less intense but more chronic than MDD  
• Depressed mood/irritability plus at least 2 additional symptoms most days for at least 1 year  
• Not without symptoms for more than 2 months                                                                                                       |
| Adjustment Disorder with depressed mood| • Mood changes and impairment of functioning within 3 months of stressor  
• Less mood disturbance, fewer symptoms  
• Consider other diagnoses if lasting beyond 6 months                                                                                               |

American Psychiatric Association, 2013
Co-morbidities with Depression

• 40-90% co-morbid conditions
  • Anxiety (30-80%)
  • Disruptive disorders (10-80%)
  • Substance use (20-30%)

American Psychiatric Association, 2013
Treatment of Depression

- Treatment of Adolescents with Depression (TADS)
  - 439 adolescents with moderate to severe depression
    - Medication (Fluoxetine) + CBT response: 71% responders
    - Medication alone: 61% responders
    - CBT alone: 43% responders
    - Placebo: 35% responders

March, Silva, Petrycki et al., 2004
Suicide

- Mortality
  - 2\textsuperscript{nd} leading cause of death in US and WI for ages 15-19
  - 3\textsuperscript{rd} leading cause of death in US and WI for ages 5-14
  - 77\% of people who die by suicide have received medical care in the past year
    - 45\% have visited within the last month
  - Suicide risk is most common in individuals with Major Depressive Disorder

NCHS, 2010; CDC.gov
# Youth Risk Behavior Survey

<table>
<thead>
<tr>
<th>Percentage Youth Reporting</th>
<th>National 2013</th>
<th>National 2017</th>
<th>Wisconsin 2013</th>
<th>Wisconsin 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anxious</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>39.9</td>
</tr>
<tr>
<td><strong>Sad/Hopeless</strong></td>
<td>29.9</td>
<td>31.5</td>
<td>24.6</td>
<td>27</td>
</tr>
<tr>
<td><strong>Thoughts of Suicide</strong></td>
<td>17.0</td>
<td>17.2</td>
<td>13.2</td>
<td>16.4</td>
</tr>
<tr>
<td><strong>Suicide Plan</strong></td>
<td>13.6</td>
<td>13.6</td>
<td>12.1</td>
<td>15</td>
</tr>
<tr>
<td><strong>Suicide Attempt</strong></td>
<td>8.0</td>
<td>7.4</td>
<td>6.0</td>
<td>7.8</td>
</tr>
<tr>
<td><strong>Medical Treatment</strong></td>
<td>2.7</td>
<td>2.4</td>
<td>2.5</td>
<td>2.5</td>
</tr>
</tbody>
</table>
Risk Factors for Suicide

- Male
- Racial/Ethnic Minorities
- Psychiatric Illness, especially MDD
- Family history of depression or suicide
- Access to lethal means
- Substance abuse
- Impulsivity/aggression

- Chronic illness
- History of abuse
- Family discord or loss
- Socially isolated or bullied
- LGBTQ youth
- Previous ideation and/or attempt(s)
Non-Suicidal Self-Injury

- Self injurious behaviors that do not have life-ending intent as their purpose
  - Examples: Cutting, scratching, burning
- These behaviors are a coping mechanism
  - Soothing
  - Make emotional pain into physical pain
  - Sometimes can be attention seeking
Anxiety

ANXIETY GIRL!
Able to jump to the worst conclusion in a single bound!
Anxiety Disorders

- Lifetime prevalence (up to age 18): 25%
  - Separation anxiety: 3-5%
  - Generalized anxiety disorder (GAD): 2-5%
  - Social anxiety/phobia: 3-18%
  - Selective mutism: <1%
  - Specific phobias: 3-20%
  - Panic disorder: 1%
  - Post-traumatic stress disorder (PTSD): 6%
  - Obsessive compulsive disorder (OCD): 1-4%
- Sometimes “trade” one anxiety disorder for another

American Psychiatric Association, 2013
Anxiety vs. “Normal” Fear

- **Object:** Is this something a child of this age should be worrying about?
- **Intensity:** Is the degree of distress unrealistic given the child’s developmental stage and the stressor?
- **Impairment:** Does the distress interfere with the child’s daily life?
  - Social functioning: unable to make friends
  - Academic functioning: failing classes
  - Family functioning: creating conflicts, limiting family choices
- **Ability to recover/coping skills:** Is the child able to recover from distress when stressor is not present?
  - Is s/he worried about future occurrences of stressor?
  - Does distress occurs across multiple settings?

Koocher & La Greca, 2011
# Common Fears

<table>
<thead>
<tr>
<th>Age/Development</th>
<th>Type of Fear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td>Noises, strangers</td>
</tr>
<tr>
<td>Toddlers</td>
<td>Imaginary creatures, darkness, separation</td>
</tr>
<tr>
<td>School-age</td>
<td>Injury, natural events, separation</td>
</tr>
<tr>
<td>Adolescents</td>
<td>School, social, health</td>
</tr>
</tbody>
</table>
## The many faces of anxiety…

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Separation Anxiety Disorder</strong></td>
<td>• Excessive fear when away from home or caregiver</td>
</tr>
<tr>
<td></td>
<td>• May manifest as difficulty sleeping alone or refusing to attend school</td>
</tr>
<tr>
<td></td>
<td>• Typically earliest age of onset for anxiety disorders</td>
</tr>
<tr>
<td><strong>Generalized Anxiety Disorder (GAD)</strong></td>
<td>• Chronic and obsessive worry in a number of areas</td>
</tr>
<tr>
<td></td>
<td>• At least 1 associated somatic complaint</td>
</tr>
<tr>
<td></td>
<td>• May also be associated with sleep problems and/or trouble focusing</td>
</tr>
<tr>
<td><strong>Obsessive – Compulsive Disorder (OCD)</strong></td>
<td>• Obsessions – recurrent, persistent thoughts/images that are intrusive and unwanted</td>
</tr>
<tr>
<td></td>
<td>• Compulsions – attempts to ignore or suppress obsessions</td>
</tr>
<tr>
<td><strong>Selective Mutism</strong></td>
<td>• Child may only speak to those they are closest to</td>
</tr>
<tr>
<td></td>
<td>• May only speak in whispers</td>
</tr>
<tr>
<td></td>
<td>• Some kids outgrow, others progress to social phobia</td>
</tr>
</tbody>
</table>

American Psychiatric Association, 2013
<table>
<thead>
<tr>
<th>Diagnosis</th>
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</table>
| Panic attacks (not a disorder)  | • Period of intense fear with physiologic symptoms that develop and peak within 10 minutes  
                                | • Sweating, racing heart, shaking, chest pain, SOB/choking feeling, dizzyiness  
                                | • May occur without explanation                                                                                                                |
| Panic Disorder                  | • Recurrent panic attacks  
                                | • Common among adolescents (onset 15-19 yrs)  
                                | • Often associated with fear of impending doom and a desire to stay home                                                                      |
| Social Anxiety/Social Phobia    | • Fear of scrutiny and doing something embarrassing in social settings  
                                | • Anxiety dissipates when not in social situations  
<pre><code>                            | • More prevalent in teens                                                                                                                   |
</code></pre>
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific Phobias</td>
<td>• Fear of particular object or situation lasting greater than 6 months</td>
</tr>
<tr>
<td></td>
<td>• Fear is out of proportion to actual danger</td>
</tr>
<tr>
<td></td>
<td>• Onset - typically early in life</td>
</tr>
<tr>
<td>Post Traumatic Stress Disorder</td>
<td>• Symptoms start after physical or emotional trauma</td>
</tr>
<tr>
<td></td>
<td>• May include nightmares, “flashbacks,” jumpiness, dissociation, and/or behavior changes</td>
</tr>
<tr>
<td></td>
<td>• Less common in young children</td>
</tr>
<tr>
<td>Adjustment Disorder with Anxious Mood</td>
<td>• Worry in response to identifiable stressor within 3 months of stressor onset</td>
</tr>
<tr>
<td></td>
<td>• Consider other diagnoses if lasting beyond 6 months (assuming stressor has terminated)</td>
</tr>
</tbody>
</table>

American Psychiatric Association, 2013
Treatment of Anxiety: Child and Adolescent Anxiety Multimodal Study (CAMS)

• Compared cognitive behavioral therapy (CBT), medications, and combined treatment of anxiety disorders

• 488 children and adolescents (separation anxiety, social phobia, generalized anxiety) 7 to 17yo
  • CBT, Sertraline, CBT + Sertraline, Placebo

• **Over 80% who received combined treatment improved**, as opposed to 60% receiving CBT only and 55% receiving medication only (placebo 28%)

Walkup, Albano, Piacentini, 2008
Screening and Prevention
Best Practice

- US Preventative Services Task Force recommends youth be screened for depression and suicide as part of routine care
- Screening also recommended by:
  - American Academy of Pediatrics
  - American Medical Association
  - Society for Adolescent Health and Medicine
- ED, primary care, inpatient units and multiple specialty clinics at CHW have also initiated routine screenings
- Helps to reduce stigma related to mental health
Myth: Screening increases risk.

A randomized controlled trial of high school students found that students at high risk of suicide who were screened displayed lower levels of distress and suicidal ideation than students in the control group.

Gould, Marrocco, Kleinman, et al., 2005
Screening tools

- **Depression - Patient Health Questionnaire Modified for Teens (PHQ-9)**
  - Free
  - Can be used by medical professionals (not just mental health professionals)
  - 9 items plus a couple of questions related to suicide

- **Suicide - Ask Suicide Screening Questions (ASQ)**
  - Free
  - For medical setting use by nurses, MDs, social workers, etc.
  - 4 questions, takes 20 seconds to administer
  - NIMH study showed that ASQ successfully identified 97% of youth (ages 10-21)

Kroenke, Spitzer, & Williams, 2001; Horowitz, Bridge, Teach, et al., 2012
Screening tools

• Anxiety - Generalized Anxiety Disorder 7-item scale (GAD-7)
  • Free
  • Quick to administer, can be done by medical professional
  • Though designed for GAD screening, also performs as a screening tool for Panic Disorder, Social Anxiety Disorder, and Posttraumatic Stress Disorder

• Trauma
  • Currently, most validated child trauma screening measures are lengthy and impractical
  • Recommend a basic question such as “In your life, has anything really scary or upsetting happened to you or your family?”

Prevention

• Routine screening
• Support healthy lifestyle (diet and physical activity)
• Be mindful of stressors, whether that be school work, social relationships, etc.
• Set healthy limits on technology/social media
• Try not to reinforce avoidance of anxiety provoking situations, offer support and encouragement
• Model and encourage health coping skills:
  • Deep breathing, practicing mindfulness, talking through difficult situations and emotions

Koocher & La Greca, 2011
Communication
Talking to youth about mental health

- Communicate in a straightforward manner
- Speak at a level that is appropriate to a child or adolescent's age and development level
- When possible, discuss the topic when the child is feeling safe and comfortable
- Watch for reactions during the discussion and slow down or back up if the child becomes confused or looks upset
- Listen openly and let the child tell you about their feelings and worries

US Department of Health and Human Services, 2019
How do I start talking about mental health?

Can you tell me more about what is happening and how you are feeling?

Sometimes it helps to talk to someone about your feelings. I'm here to listen.

Do you feel like you want to talk to someone else about your problem?

I'm worried about how you’re doing. Can you tell me if you have thoughts about harming yourself or others?
Communication Strategies

OARS

- Open-Ended questions
- Affirmations
- Reflective listening
- Summary

Miller & Rollnick, 2002
Open-Ended Questions

- The key to helping the patient do most of the talking
- Allows you to gather more information – can’t answer “yes” or “no”
- Use “How” and “what” – avoid “why”
- **Examples:**
  - How are you feeling today?
  - What is bothering you today?
  - Tell me more about…
Affirmations

- Sends the message - “I see and hear you”
- May be compliment or statement of appreciation/understanding
- Can be non-verbal gestures
- Examples:
  - I care about what happens to you.
  - It takes courage to share how you’re doing.
  - Sustained eye contact, smiling

“It’s the repetition of affirmations that leads to belief. And once that belief becomes a deep conviction, things begin to happen.”

Muhammad Ali
Reflective Listening

- Helps ensure understanding of what was said or observed
- Makes patients feel “heard”
- Avoids falling into the Q&A trap
- Examples:
  - It seems like…
  - What I’m hearing you say…
Summary

• A specific type of reflective listening
• Summarizes what was heard and end with question to solicit feedback from patient
• Helps when transition topics or reviewing what’s been discussed
• Examples:
  • I heard you say… What did I miss?
  • You’re really struggling with… Am I understanding what you’re saying?
Psychoeducation and Support

• **Education**
  • Depression and anxiety are treatable!
  • Getting help (through therapy or medication) demonstrates strength

• **Support**
  • Identify stressors and problem solve (but don’t avoid)
  • Improve sleep hygiene
  • Increase physical activity
  • Schedule pleasurable activities

Koocher & La Greca, 2011
What to Avoid

• Trying to cheer a child up or telling them everything will be ok
• Assuming the situation will take care of itself
• Being sworn to secrecy
Resources - Milwaukee

NAMI Greater Milwaukee
https://www.namigrm.org/clinics
https://www.namigrm.org/teen-young-adults

CHW Department of Psychiatry and Behavioral Medicine
Intake (414) 266-3339

Milwaukee County Crisis
(414) 257-7621 – Children's Mobile Crisis (CMC) (children and adolescents)

Hours: 9 a.m. to 10 p.m. M-F, 1:30 p.m. to 10 p.m. Sat/Sun/holidays. Responds on site to children, adolescents and their families experiencing a mental health emergency. Crisis stabilization, assessment and links to appropriate follow-up care provided.

24-hour on call telephone support.
Resources – outside Milwaukee


• National Hopeline Network
  • 1(800) SUICIDE (784-2433)
  • Counselors are available 24-hours-a-day, seven-days-a-week. Open to all ages. English and Spanish speaking counselors available.

• National Suicide Prevention Lifeline
  • 1(800) 273-TALK (8255)
  • English and Spanish speaking counselors are available.
References


Screening for Depression in Children and Adolescents: US Preventive Services Task Force Recommendation Statement Albert L. Siu, on behalf of the US Preventive Services Task Force *Pediatrics* Mar 2016, 137 (3) c20154467


