Depression and Anxiety Disorders: Children

Bonus Recording

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Depression and Anxiety Disorders – Learning Objectives

• Recognize the prevalence of anxiety disorders and depression children.

• Review screening and evaluation processes in primary care settings.

• Understand current evidence based treatments.

• Understand how the condition care model can enhance management of these common behavioral health disorders in primary care settings.
Case Example

- 9 year old girl is struggling at school, underperforming academically, conflicts with peers, bullying and getting bullied, problems with concentration and focus.

- Teacher urges parent to get her evaluated for ADHD.

- At home she is fine – none of the symptoms seen at school including no symptoms of ADHD. Parents resistant to the evaluation and believe the problem is with the school or teacher.
Case Example

• 11 year old boy presents with suicidal statements, hopelessness, insomnia, loss of concentration.

• Trigger identified is parents separating, father moving to different city and the boy only seeing his father every other weekend.

• History reveals that the boy had significant separation anxiety since age 6 which his mother accommodated while father resisted accommodation.
Children

• Think Anxiety Disorders!
Anxiety and Depression: Children

- Anxiety disorders are the most common childhood mental health disorder with a 1 in 3 lifetime prevalence (in US).

- Specific phobias are the most common, usually start in late childhood, peak in adolescence and resolve by adulthood – not to be confused with phobic like fears which are common in young children and are brief in duration.

- More recent research studies have combined the following three conditions which share symptoms, neurobiological findings and have significant comorbidity with each other
  - Separation Anxiety Disorder
  - Social Anxiety Disorder
  - Generalized Anxiety Disorder

- Depression is much less common under age 12, and if present is likely to be in a child who already had an anxiety disorder or posttraumatic stress disorder.
Anxiety Disorders – DSM-5

- Separation Anxiety Disorder (SAD)
- Selective Mutism
- Specific Phobia
- Social Anxiety Disorder (Social Phobia)
- Panic Disorder
- Agoraphobia
- Generalized Anxiety Disorder (GAD)
- Substance/Medication Induced or Due to a Medical Condition
Recognizing Childhood Anxiety Disorders
Recognizing Childhood Anxiety Disorders

• The term ‘anxiety’ may get in the way; words used to describe the anxious child include shy, homesick, sensitive, worrier, stressed out, fearful, etc.

• All anxiety disorders have these characteristics
  ▪ Hypervigilance
  ▪ Reactivity to unexpected or novel situations
  ▪ Overvaluation of threat signals
  ▪ Coping by avoiding
  ▪ Explosive or catastrophic reactions to not being able to avoid
  ▪ Parental accommodation

• Mid-line physical symptoms (John Walkup MD)
  ▪ Tension headaches, dizziness
  ▪ Difficulty swallowing (lump in throat, worry about gagging, choking)
  ▪ Hyperventilating
  ▪ Chest pain
  ▪ Abdominal pain
  ▪ Bowel and bladder urgency
Childhood Anxiety Disorders

- Phobias
- Social Anxiety Disorder
- Separation Anxiety Disorder
- Generalized Anxiety Disorder
Course

- All of the common childhood anxiety disorders emerge from ages 6-12. Phobias are most common in younger children.
- Separation Anxiety seen first (stressed by having to attend school).
- Social Anxiety Disorder seen when peer influence increases and teacher protection decreases (middle school)
- Generalized Anxiety Disorder seen when school (then work, social and family) demands increase.
Social Anxiety Disorder

• Basic symptom is fear and avoidance of social or performance situations, either specific or generalized.
  ▪ For children, has to involve peers, not just adults.

• The person fears that they will be negatively evaluated and/or that they will give away their fear by the way they act or look and that this will be negatively evaluated.

• Overlaps with normal shyness, but among those who characterize themselves as shy, only about 10% meet criteria for social anxiety disorder.

• Level of distress may vary significantly depending on success of avoidance and adult/parental accommodation.
Separation Anxiety Disorder

- Excessive fear or anxiety concerning separation from primary attachment figure (parent usually), including worry about something bad happening to them.

- Avoidance symptoms include refusal to leave home, attend school, sleep away from home.

- Also nightmares and physical anxiety complaints when separation threatened.
Generalized Anxiety Disorder

- Excessive worry and apprehension about a number of events or activities which the person has difficulty controlling.

- Accompanied by symptoms: restlessness, feeling on edge, easily fatigued, difficulty concentrating, irritability, muscle tension, sleep disturbances.

- In its recognizable form, uncommon before adolescence but history of childhood separation anxiety, phobias and social anxiety common.
Epidemiology

- Separation Anxiety Disorder – 4% in children, 1.6% in adolescents
- Social Anxiety Disorder – 7%, in children, adolescents and young adults
- Generalized Anxiety Disorder – 1-2% in children and adolescents, 3-9% in adults
- Specific Phobia – 5% in children, 16% in adolescents
- Panic Disorder and Agoraphobia are rare in children and early adolescents, start increasing in late adolescence, 2-3% in adults.
Guidelines for Depression Screening – USPSTF

- Children: inconclusive about screening for depression for ages 11 and under
- Adolescents: screen all adolescents age 12-18 for depression
- Adults: screen all adults including pregnant and postpartum women for depression.
Screening Tools for Depression

• PHQ-2 and PHQ-9 “Patient Health Questionnaire”
  ▪ Multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression
  ▪ Incorporates DSM-5 depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool
  ▪ PHQ-9 rates the frequency of the symptoms which factors into the scoring severity index
  ▪ Screens for the presence and duration of suicide ideation

PHQ-2 is a two question tool that can lead to administering the PHQ-9 which is a nine question tool that explores depression symptoms in more depth

www.phqscreener.com
## PHQ-9

### Patient Health Questionnaire - 9

**Over the last 2 weeks, how often have you been bothered by any of the following problems?**

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

### For Office Coding

\[ 0 + 0 + 0 + 0 = \text{Total Score: } \]

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If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- **Not difficult at all**
- **Somewhat difficult**
- **Very difficult**
- **Extremely difficult**

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Guidelines for Anxiety Disorder Screening

• No general population screening recommendations, but several brief screens available.
  ▪ GAD-7 and GAD-2 for generalized anxiety disorder
  ▪ PC-PTSD-5 for posttraumatic stress disorder

• All MH and SA screens available online: www.hiv.uw.edu/page/mental-health-screening/gad-7
GAD-7

<table>
<thead>
<tr>
<th>Over the last 2 weeks, how often have you been bothered by the following problems?</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Feeling nervous, anxious or on edge</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Not being able to stop or control worrying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Worrying too much about different things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Trouble relaxing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Being so restless that it is hard to sit still</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Becoming easily annoyed or irritable</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Feeling afraid as if something awful might happen</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Total Score = Add Columns

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult
Treatment
Treatment of Childhood and Adolescent Anxiety Disorders

• Separation Anxiety Disorder, Social Anxiety Disorder (Social Phobia), and Generalized Anxiety Disorder all respond fairly well to treatment with Cognitive Behavior Therapy, adding antidepressant medication for more severe conditions.
  ▪ Guidelines recommend first line treatment as CBT or CBT plus SSRI medications.

• Children tend to have better results than treatment of the same conditions in adolescents and adults. Treatment benefits are greater for younger children or those with shorter duration of illness.
Cognitive Behavior Therapy (CBT)

- Practice Guidelines: first line treatment for mild and moderate anxiety disorders, combined with SSRI antidepressants for severe anxiety disorders.

- CBT for adolescents and children is adapted from the method developed for adults.

- Most of the evidence base for children and adolescents is brief CBT: 10-16 weekly 50 minute individual sessions that involves the following elements:
  - Homework, between session practice.
  - Psychoeducation for the child and parents
  - Exposure
  - Cognitive restructuring
  - Relaxation training
CBT

• For younger children, 8 and younger, CBT for parents alone or parents with the child are effective.

• Parents are trained to either deliver the CBT to their child (parents as therapist) or coach the child with the CBT skills delivered by the therapist (parents as coach).

• Internet and computer delivered CBT has evidence for benefit and different models are available.
Medication –
Child and Adolescent Anxiety Disorders

• Despite the evidence from studies, the only medication with FDA approval for pediatric (ages 7 – 17) use is duloxetine (Cymbalta) and that is for GAD only.

• Since all the anxiety disorders other than GAD use of medications are off-label for children or adolescents, it would be safest to use one that is approved for another condition such as fluoxetine and escitalopram (approved for depression), sertraline or fluvoxamine (approved for OCD).
Case Example

• 9 year old girl is struggling at school, underperforming academically, conflicts with peers, bullying and getting bullied, problems with concentration and focus.

• Teacher urges parent to get her evaluated for ADHD.

• At home she is fine – none of the symptoms seen at school including no symptoms of ADHD. Parents resistant to the evaluation and believe the problem is with the school or teacher.

• Knowing that ADHD is pervasive, the symptoms are better explained by anxiety. A screen result is consistent and further evaluation shows both separation and social anxiety disorders. Treatment: cognitive behavior therapy.
Case Example

• 11 year old boy presents with suicidal statements, hopelessness, insomnia, loss of concentration.

• Trigger identified is parents separating, father moving to different city and the boy only seeing his father every other weekend.

• History reveals that the boy had significant separation anxiety since age 6 which his mother accommodated while father resisted accommodation.

• Childhood anxiety disorder confirmed, anxiety disorder also diagnosed in mother; depression assessed and found in the boy; both parent and child treated with CBT.
Why Integrate Care?

• Separate medical and behavioral health is a legacy from a past marked by a behavioral health specialty found mainly in state hospitals, community mental health centers or psychoanalytic office practices, a limited insurance benefit, federal and state financing, mind-body separation bias and stigma.

• The patients don’t make this distinction.
  ▪ Those with a mental health disorder are likely to have a major medical condition (70%) and those with a medical disorder are more likely to have a major mental health disorder (30%).
  ▪ An estimated 80% of those first seeking BH care present to either primary care or emergency departments/urgent care.

• Integrated care is cost effective and also compatible with value based payment.
What is Integrated Care?

• The full range of healthcare services, which includes addressing health behaviors, behavioral health and substance use treatment, provided under one roof. Also: patient/family centered, team based, systematic and holistic.

• Currently, when behavioral healthcare is considered in the context of primary care, there are three general models that reflect levels from least to most integrated: coordinated, co-located and fully integrated.
  ▪ This might also be viewed as a step process in the development of integrated BH-PC.
Child Psychiatry Access Projects

• Over 20 various types of collaborative care projects for children with the purpose of improving primary care providers’ care for children’s mental health needs.

• These have been set up with State financing, involving academic centers and/or professional organizations.

• Most involve training or consultation with child psychiatrists and therapists who are available by phone anytime on very short notice.
Summary – Promoting Integrated Care

- Leadership buy-in and support.
- Team based primary care with a non-physician clinician designated for BH care.
- Patient/family centered care.
- Screening of all patients using standardized screens with algorithm based processes for positive screens.
- Use of evidence based treatments following practice guidelines.
- Tracking and measuring adherence and outcomes using patient tracking tools and standardized measures.
- Connection with community resources and supports.