Child mental health CoP
Session 1: Anxiety

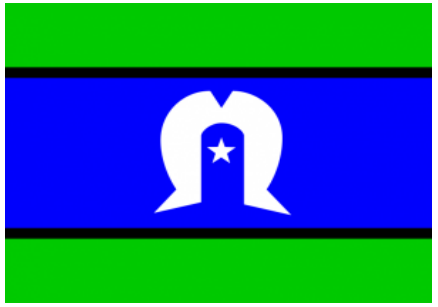
Tuesday 4 July 2023

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.

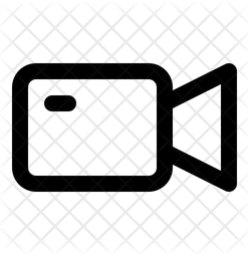


CoP guidelines
We agree to…

Stay on **mute** unless speaking

Raise your **hand** to speak

Keep conversations **confidential**



If possible, keep **camera on**

Introduce yourself and your role when speaking

Share **ideas** & promote everyone's **participation**

Acknowledge that we have **varied learning needs & interests**

Ask **questions**

No question is silly

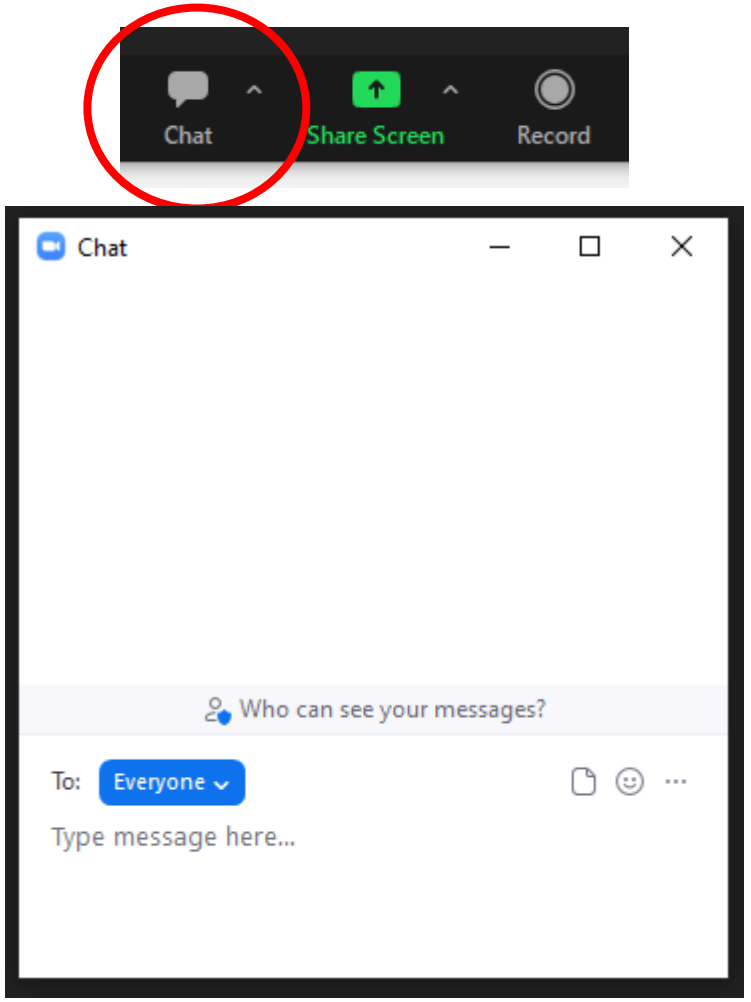
Housekeeping – Zoom Meeting

During the education component, please ask questions via the Chat box

This session is being recorded

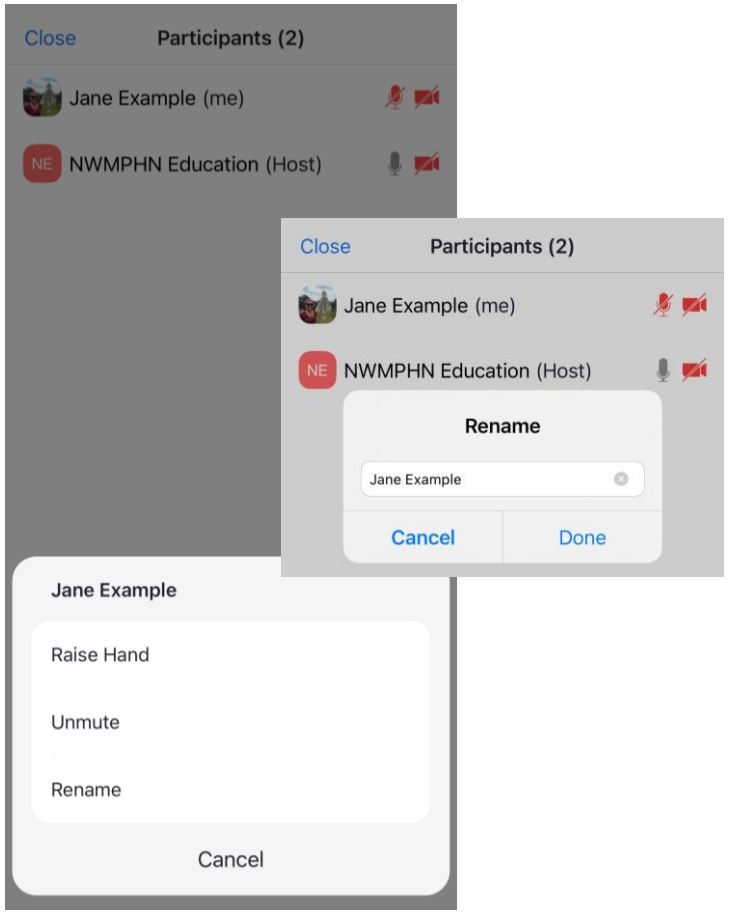
Please ensure you join the session using the name you registered with so we can mark your attendance

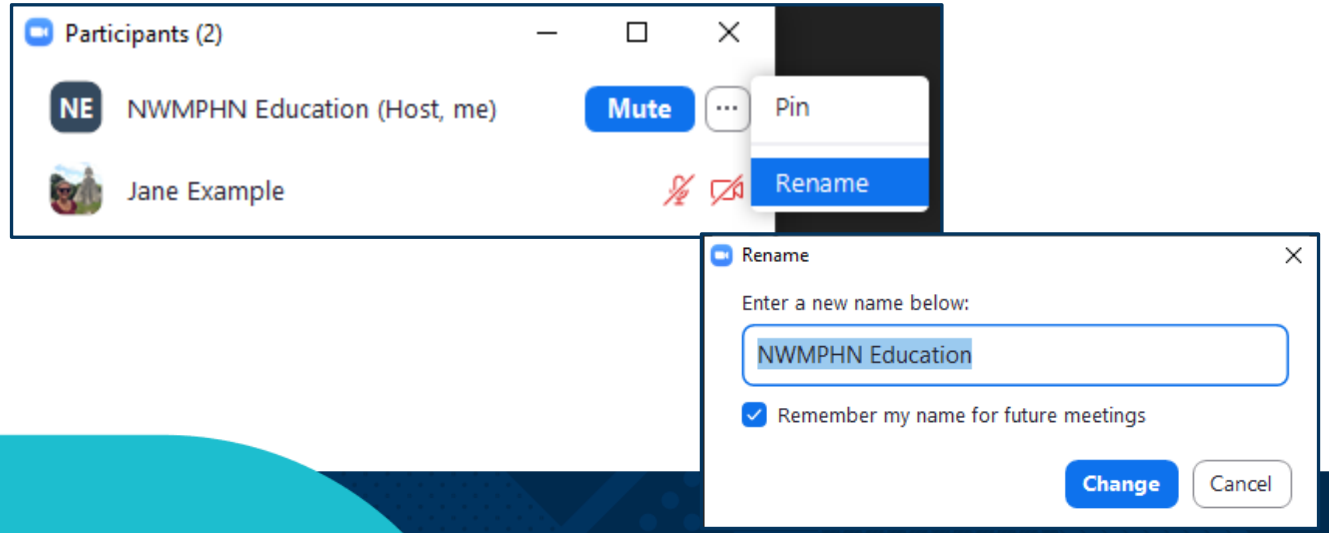
Certificates and CPD will not be issued if we cannot confirm your attendance



How to change your name in Zoom Meeting

1. Click on ***Participants***
2. **App:** click on your name
   Desktop: hover over your name and click the 3 dots
   Mac: hover over your name and click *More*
3. Click on ***Rename***
4. Enter the name you registered with and click
   Done / Change / Rename





Psychiatrist – Dr Chidambaram Prakash

- Dr Chidambaram Prakash is a senior consultant child and adolescent psychiatrist at the RCH with over 20 years' experience.
- Prakash has worked in, and managed, general and specialist clinics within child psychiatry in metropolitan and regional public mental health services.
- Prakash has worked with children and adolescents from 4 to 18 years of age assessing and managing a variety of mental health issues.

GP Facilitator - Dr Sahar Iqbal

- Practicing as a GP at Goonawarra Medical Centre for the past 9 years

- Sahar's areas of interest are child and adolescent mental health and chronic disease management

Agenda

Introduction and housekeeping	5 minutes
Education component: Anxiety *Psychiatrist Dr. Chidambaram Prakash*	30 minutes
Health Pathways	5 minutes
Case discussion Part 1 – Breakout room **Debrief**	12 minutes 10 minutes
Case discussion Part 2 – Breakout room **Debrief**	12 minutes 14 minutes
Conclusion	2 minutes

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Education component: Anxiety Disorders and OCD

CHIDAMBARAM PRAKASH

Definitions

- **Emotion:** A Brain state that is associated with the perception of either a reward or punishment
- **Fear:** A family of brain states (emotions) resulting from a perception of danger
- **Anxiety:** Brain states associated with fear that is inappropriate to context (either in focus or extent or both)
- **Pathological anxiety:** Is an exaggerated fear state in which hyperexcitability of fear circuits that include the amygdala and extended amygdala (i.e., bed nucleus of the stria terminalis) is expressed as hypervigilance and increased behavioural responsivity to fearful stimuli.

Neurophysiology-areas of the brain mainly involved

- Cortical projections from amygdala
- Prefrontal cortex (VLPFC)
- Amygdala nuclei-Basolateral & central
- Dorsal Raphe nucleus
- Ascending tracts from thalamus
- Red nucleus of brain stem
- Bed nucleus of Stria Terminalis

Conditioned responses (Buff 2017)

- **Learned fear:** Sudden temporal cues, extinction (unlearning) is possible
- **Anxiety:** Associated with prolonged temporal cues, extinction difficult (or ? impossible)
- Cue specific (specific stimulus or trigger) associated with fear conditioning develops into anxiety
- Context (situation, people, relationships) specific fear conditioning developing into anxiety

Worry

- Verbal or linguistic in nature (rather than images) (Borkovec, Freeston)
- Mostly relates to real-life triggers, is future orientated
- Sensitisation to future problems, person remembers the worry and desperately avoids it.
- Useful for problem solving
- Planning the process of coping

Prevalence

- 3-5% children suffer from anxiety disorders (not counting OCD)
- 4-9% lifetime prevalence in children
- The risk of developing an anxiety disorder in children between the ages of 3–17 years is 3-7 times more likely if a parent has/had an anxiety disorder or if a parent had a substance abuse disorder vs parents with no psychiatric diagnosis
- Twin studies: 30–40% heritability for anxiety disorders. Multiple genes involved
- The non-genetic factors: 1. parenting style, 2. social learning and childhood adversity & maltreatment, 3. lower socioeconomic status, 4. neuroticism in temperamental trait

Comorbid conditions

- Depn in Anx: 17% (Anderson), 13% (McGee), 14% (Costello), 49 % (Lewinsohn)
- Anx in Depn: 71% (Anderson), 44 % (Costello)

Clinic

- OCD (70%), PTSD & Others (30-50%)
- Anxiety (7.2 yrs), DD (10.8 yrs), MDD(13.8 yrs)
- Anderson: 23% anxious children had ADHD & 32% had CD or ODD
- Rates of anxiety in DBD: 15-30%

Evidence-Based Treatments for Anxiety Leveling on Symptoms

Treatment Family	Wins/Ties[a]	Year[b]	Effect Size[c,d]	% With Follow-Up Measure	Minimum Length Successful Follow-Up
Level 1: Best Support/Well-Established Treatments					
CBT	46	2011	1.19 (0.94)	49%	1 year
Exposure	32	2009	1.05 (1.05)	26%	1 year
Modelling	9	2001	1.42 (0.78)	31%	1 month
CBT With Parents	7	2010	1.25 (0.92)	60%	1 year
Education	3	2009	1.26 (1.13)	50%	2 months
CBT Plus Medication	1	2008	2.37	0%	—
Level 2: Good Support/Probably Efficacious Treatments					
Family Psychoeducation	2	2009	0.40	100%	1 year
Relaxation	2	1970	—	0%	—
Assertiveness Training	1	1987	—	0%	—
Attention Control	1	2010	0.72	50%	1 year
CBT for Child and Parent	1	2003	—	100%	1 year
Cultural Storytelling	1	1994	—	0%	—
Hypnosis	1	1994	2.29	100%	6 months
Stress Inoculation	1	1994	1.10	100%	1 month
Level 3: Moderate Support/Possibly Efficacious Treatments					
Contingency Management	1	1970	—	0%	—
Group Therapy	1	1970	—	0%	—
Level 4: Minimal Support/Experimental Treatments					
Biofeedback	1	1996	—	0%	—
CBT with Parents Only	1	2011	0.68 (0.98)	33%	1 year
Play Therapy	1	1982	—	0%	—
Psychodynamic	1	1972	1.53	100%	2 months
Rational Emotive Therapy	1	1984	1.38	67%	1 month

Treatment

- CBT requires verbal linguistic skills, motivation and application so it is not for all.
- In younger children parent work/dyadic parent-child work must be combined with 1:1 child therapy otherwise it will not work.

Prescribe when:

- 1. There is lack of response to CBT after min 12 sessions (ensure first that it is CBT that they are receiving, as it is a skills training therapy they should be able to describe what they are doing in therapy)
- 2. Severe symptoms needing conjoint treatment from the start
- SSRIs are the first choice: safety, effectiveness in paed age group
- All have black box warnings
- Dosing depends on diagnosis: using Fluoxetine and Sertraline as examples
- 1. For gen anxiety/social anxiety: Flx 5 mgs Sert 12.5 mgs 2. For depression Flx 10 mgs Sert 25 mgs for OCD Flx upto 80 or even 100 mgs if tolerated Sert 250 mgs

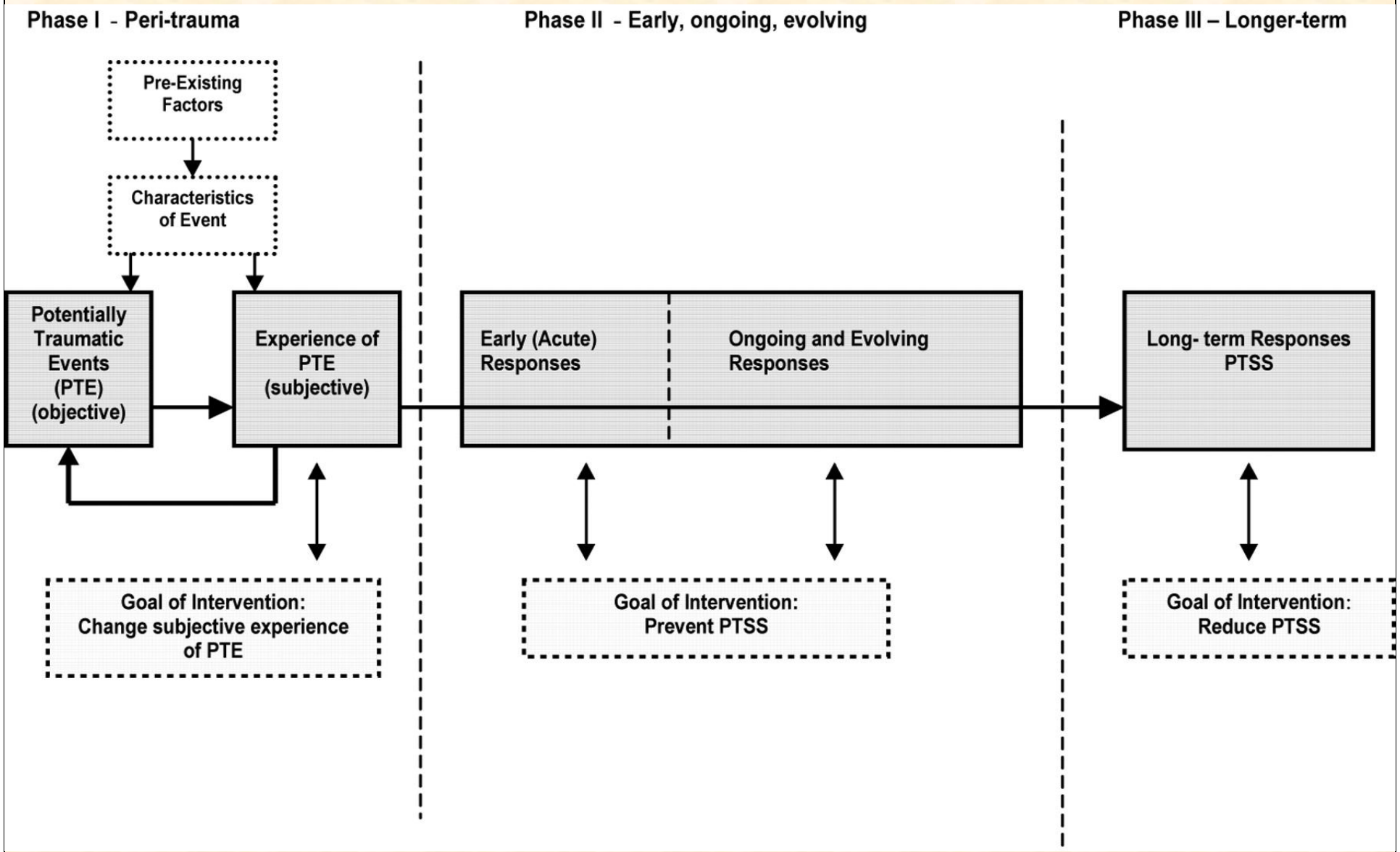
More on the SSRIs: adverse effects specifics

- Fluoxetine may activate the already heightened child/teen so start very low (5 mgs) and titrate very slowly (every 6-8 weeks)
- Paroxetine, fluvoxamine, and sertraline: discontinuation syndrome
- Fluvoxamine may have greater potential for drug-drug interactions.
- Citalopram may cause QT prolongation associated with Torsade de Pointes, ventricular tachycardia, and sudden death at daily doses exceeding 40 mg/d and should be avoided in patients with long QT syndrome.
- Paroxetine has been associated with increased risk of suicidal thinking or behavior compared to other SSRIs.

SNRIs and Buspirone

- Duloxetine is the only SNRI to have an FDA indication for the treatment of any anxiety disorder (specifically, generalized anxiety disorder in children and adolescents 7-17 years old). Be aware that it can affect liver functions so do a baseline and repeat after 4 weeks into the drug.
- Limited data are available on drug pharmacokinetics and pharmacodynamics of SNRIs for young people. Venlafaxine extended release, desvenlafaxine, and duloxetine have sufficiently long elimination half-lives to permit single daily dosing.
- Because of its short elimination half-life, venlafaxine immediate release may require twice- or thrice-daily dosing.
- Buspirone is well tolerated in pediatric patients with GAD, although two randomized controlled trials were underpowered to detect small effect sizes
- 10–40 mg/day, mean dose 25 mg/day) over an average follow-up of 2.5 months

A model of pediatric medical traumatic stress (PMTS) for pediatric patients and their families



Kazak, A. E. et al. J. Pediatr. Psychol. 2006 31:343-355; doi:10.1093/jpepsy/jsj054

Journal of PEDIATRIC PSYCHOLOGY

Prevalence-OCD

Community

- 3 month prevalence 0.17% (Costello)
- Point prevalence 0.06% (Lewinsohn)
- Life time prevalence 2-4% (Douglas, Valleni-Basile et al)
- Co-morbid: SAD, SOP, AGOR, GAD
- Males > Females

Clinic

- 7% Incidence

Co-morbid: SP (Lenard) GAD, SAD, SOP (Biederman)

OCD course and comorbidity with ADHD

- 23-70% chronic course
- 12-50% remit in 1-7 years
- Poor prognosis-Earlier or much later age of onset, increased duration of sx, more severe sx, hoarding compulsions, absence of tics, presence of co morbid ODD, female gender
- Maintenance: after 3-4 mild relapses or 2-3 severe relapses
- Gradually taper over 1-2 years-reduce by 25% wait for 2 months before next decrease. Continue monthly CBT
- Prevalence estimate of 25.5% for co-morbid ADHD
- Co-morbid OCD–ADHD from a young age was associated with greater OCD severity

ASD and OCD

Age Distribution of Specific Diagnoses of Autism Spectrum Disorders in Relation to a Prior Diagnosis of Obsessive-compulsive Disorder (OCD; 1994-2012)

		Autism cases in general			Autism cases with prior OCD	
Diagnosis		Mean	Standard Deviation		Mean	Standard Deviation
Childhood Autism		9.42	7.13		13.94	8.90
Atypical Autism		12.37	7.01		15.23	5.32
Asperger's Syndrome		14.90	8.56		19.08	9.02
Other Pervasive Developmental Disorder		11.09	5.50		14.75	5.88
Unspecified Pervasive Developmental Disorder		11.56	6.81		18.01	9.11

Treatment-OCD

- Prepubescent children-CBT first. Adolescents-CBT for milder OCD, CBT+ SRI for severe OCD
- Contamination, symmetry, counting, hoarding, aggressive: Ex/RP (March, Mulle, Rey, Franklin)
- Scrupulosity, moral guilt, pathological doubt: CT
- If inadequate response to CBT or SSRI alone then combine
- SRI: Inadequate response to ave dose-push to max in 4-9 wks of starting, then after 4-6 wks if inadequate response switch to another SRI
- After 2-3 trials of SSRI +CBT then Clomipramine
- If still no response then augment with another medication (depending on symptom)
- Maintenance treatment: after 3-4 mild relapses or 2-3 severe relapses
- Stopping treatment on remission: Gradually taper over 1-2 years-reduce by 25% wait for 2 months before next decrease. Continue monthly CBT
- Where medical contraindications present then use CBT only or mainly with low dose SSRI

Evidence Base Update of Psychosocial Treatments for Paediatric Obsessive-Compulsive Disorder: Evaluating, Improving, and Transporting What Works. ***Freeman J et al (2018)***

- Findings again converge in support of cognitive-behavioral therapy (CBT) as an effective and appropriate first-line treatment for youth with obsessive-compulsive disorder.
- Family-focused CBT is now well-established.
- A number of other treatments including CBT+ D-Cycloserine, CBT+ Sertraline, CBT+ positive family interaction therapy, and technology-based CBT are now probably efficacious.
- Demographic, clinical, and family factors are consistent predictors of CBT outcome with conflicting findings for neurocognitive predictors.

Useful free online resources

Clinician resource for OCD:

https://www.psychologytools.com/professional/problems/obsessive-compulsive-disorder-ocd/

Parent resources for OCD:

https://adaa.org/sites/default/files/How-to-Help-Your-Child-A-Parents-Guide-to-OCD.pdf

https://childmind.org/guide/parents-guide-to-ocd/

Clinician resources for anxiety disorders:

https://depts.washington.edu/uwhatc/PDF/TF-%20CBT/pages/cbt_anxiety.html

Useful free online resources

CBT resource for kids and teens:

https://www.hpft.nhs.uk/media/1655/wellbeing-team-cbt-workshop-booklet-2016.pdf

Trauma Focused CBT resource for adolescents:

https://tfcbt.org/wp-content/uploads/2019/02/Revised-Dealing-with-Trauma-TF-CBTWorkbook-for-Teens-.pdf

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Case studies

Breakout 1 – Case study

Tina comes to see you with her mother. She is 12 years old and has just started high school this year. She presents with **recurrent headaches and tummy pains**. She has had a **vision check which is normal**. In the past, the school has said **she is quiet but has a good circle of friends**. She is an average student but struggles with maths and can feel bad about this.

So far this year she has missed 2 weeks of school due to her tummy pains and her mother has had to take time off work to look after Tina at home. She also **presented to her local ED** and they could find **no organic cause for her tummy pain or headaches**.

What else do you want to know? ***What would you do next? What assessment and what treatment options should you explore…?***

Breakout 2 – Case study

You diagnose Tina with **generalised anxiety and refer her to a psychologist for CBT**. Miraculously she gets in to see someone quickly but after 6 sessions, **her symptoms have not shifted a lot and she has had a couple of panic attacks.**

What would you do next? What treatment options would you explore now…?

Session Conclusion

Next session – Tuesday 1st August (same time)

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

RACGP CPD hours will be uploaded within 30 days.

To attend further education sessions, visit,

https://nwmphn.org.au/resources-events/events/

This session was recorded, and you will be able to view the recording at this link within the next week.

https://nwmphn.org.au/resources-events/resources/

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