Anxiety management in CAMHS: Developmental perspectives, treatment options and medication dilemmas
Dr Philip Shoebridge philip.shoebridge@nbt.nhs.uk
Dr Helen Stephens helen.stephens@nbt.nhs.uk
Consultant Psychiatrists - NW Bristol CAMHS

Workshop Structure

- Introductions
- Overview
- Aetiology and Risk factors
- Developmental aspects
- Management Options
  - Psychotherapeutic
  - Pharmacological
- Case discussions

Introductions – who you are?

- Your name
- Job title now (ST / basic / 4-6 / Staff grade / Consultant)
- Your experience in treating Children and Adolescents with anxiety difficulties to date.
Anxiety management in CAMHS: Developmental perspectives, treatment options and medication dilemmas

What were you hoping to get out of this workshop?

Groups of 3
5 minutes
Feedback – 5 points

Anxiety management in CAMHS: Developmental perspectives, treatment options and medication dilemmas

Personal perspectives

- The most difficult cases almost always involve very anxious parents too
- Fluoxetine can be helpful in stuck cases, but need to be patient and set goals
- Use of benzo’s as a psycho-educational tool
- When to consider medication?
- How to manage anxiety in young people who are too anxious to attend CAMHS?

Overview

- Most common psychiatric disorder in childhood
- Affect 5 – 18% of children
- Strikingly common, strikingly disabling
- Can cause serious disruption to children’s lives
- Often persistent over time
- Increase risk of anxiety disorders, major depression, substance misuse and educational underachievement in later life
Anxiety Disorders of Childhood and Adolescence

- Separation Anxiety Disorder
- Specific phobias
- School phobia
- Social phobia
- GAD
- PTSD
- OCD

Theoretical constructs for the development of anxiety in children and adolescents

- Affective and Cognitive processes
- Behavioural Inhibition
  - Temperament
- Psychosocial development
- Psychodynamic theory
- Neuropsychiatry
- Family and Genetic influences
- Parent-child interaction
  - Attachment
  - Parenting styles

Aetiology and Risk Factors

- Genetics
- Temperament
- Behavioural Inhibition System
- Cognitive style
- Exposure to threat
  - Abuse
  - Violence
  - Trauma
- Cultural influences

Parenting style
- over-reactive

Mental illness
Family and genetic influences

- Anxiety disorders run in families
- Children of anxious parents are prone to develop anxiety problems of their own
- Parents of anxious children show more anxiety problems than parents of non-anxious children
- Modest but significant genetic role
- Nature vs nurture?

Environmental role

Families that harbour threat and/or insufficient protection from it
- Eg abuse, neglect, parental discord, conflictual home environment
- Disorganised attachment

Families that promote threat sensitivity and/or impede the development of coping skills
- Vicarious learning
- Social referencing

Impact of maternal anxiety on parenting style

- Mothers with Anxiety Disorders
  - Higher levels of criticism
  - Less positive, less warm
  - More catastrophising
  - Less involved in play
  - Over-reactive discipline
- Over-protective parenting: child appraises situations as unsafe

Clinical implications
- Need for anxiety management for parents
- Parental beliefs need to be addressed
Behavioural Inhibition
and the development of childhood anxiety disorders

• Behaviourally inhibited temperament
  – 10% toddlers
  – React to novelty and unfamiliarity with initial restraint and avoidance
  – Genetic influence
  – Fairly stable through childhood
  – Increased reactivity in sympathetic NS
  – *Affords high risk of developing anxiety disorder in children whose parents have an anxiety disorder*

Attachment

• Rates of insecure attachment in the children of concurrently anxious mothers may be as high as 80% (Manassis et al, 1994).

How do we conceptually understand how this develops?
Attachment - Dynamic maturational model

- Forged in the crucible of the parent-child relationship
- What behavior repertoire works best to keep the carer close by and available?
- How does this get internalised by the child?
- Attunement to risk
- Child signals fear – what does the carer do?
- Safety behaviours work

Separation Anxiety Disorder

- Essentially a chronic inappropriate activation of the attachment system in the child.
- The child presents with:
  - Inappropriate clinging,
  - Sleep disturbance (including insisting on sleeping in the parent's bed)
  - Anxiety about parental health or accidents.
- It may be associated with:
  - Either over close or excessively distant parental relationships
  - Parental separations (from each other and the child)
  - Maltreatment
  - Maternal mental illness is an important maintaining factor.

Affective/cognitive theory

- Dysfunctional schemas formed in early childhood
  - Influenced by parent-child interactions
  - "Anxious-cognitive style" overestimates threat or danger
- Patterns of cognition in anxious children
  - Higher proportion of negative self-evaluative cognitions, and higher rates of cognitive errors (catastrophising, overgeneralising, personalising and selective abstraction)
Developmental aspects of Anxiety Disorders

- Types of stimuli which elicit fear change throughout childhood and adolescence
- Changes parallel developments in cognitive and social competencies and concerns
- Psycho-social development theory

<table>
<thead>
<tr>
<th>Age</th>
<th>Psychological &amp; social competencies</th>
<th>Principal source of fear</th>
<th>Principal anxiety disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-4 years Pre-school</td>
<td>Pre-operational thinking • Capacity to imagine but inability to distinguish fantasy from reality</td>
<td>Imaginary creatures • Potential burglars • The dark</td>
<td>Separation anxiety</td>
</tr>
<tr>
<td>5-7 years Early childhood</td>
<td>Concrete operational thinking • Capacity to think in concrete logical terms</td>
<td>Natural disasters • Injury • Animals • Media-based fears</td>
<td>Animal phobia • Blood phobia • Separation anxiety</td>
</tr>
<tr>
<td>8-11 years Middle childhood</td>
<td>Self-esteem centres on academic and athletic performance</td>
<td>Inadequate academic and athletic performance</td>
<td>School phobia • ODD</td>
</tr>
<tr>
<td>12-18 years Adolescence</td>
<td>Formal operational thought • Capacity to anticipate future dangers • Self-esteem derived from peer relationships</td>
<td>Peer rejection</td>
<td>Social phobia • Later adolescence</td>
</tr>
</tbody>
</table>

Developmental Continuities

Separation anxiety
School phobia
Agoraphobia
Panic disorder
Social phobia
Management options

- Prevention – IMH / SEAL
- CAMHS treatment - Psychological Vs Pharmacological
- Psychological – CBT. FT. Family based CBT. Gp. (PTies)
- Medication options

EBM - CBT

Major reviews
Wolpert et al 2006 (What works for Whom Fonagy et al)
Cartwright-Hatton et al 2004
Carr 2000
Ishikawa et al 2007


Drawing on the Evidence
Advice for mental health professionals working with children and adolescents
SECOND EDITION 2006
Categories of Evidence:
1a Evidence from meta-analysis of randomised controlled trials;
1b Evidence from at least one randomised controlled trial;
2a Evidence from at least one controlled study without randomisation;
2b Evidence from at least one other type of quasi-experimental study;
3 Evidence from descriptive studies such as comparative studies, correlation studies and case-control studies;
4 Evidence from expert committee reports or opinions, or from clinical experience of a respected authority, or both.

Strength of Practice Implications:
A Directly based on category 1 evidence;
B Directly based on category 2 evidence or extrapolated from category 1 evidence;
C Directly based on category 3 evidence or extrapolated from category 2 evidence;
D Directly based on category 4 evidence or extrapolated from category 3 evidence.

It is important to recognise that the evidence base has limitations and should always be responded to within the context of professional judgement.

Implications for Practice (Drawing on the Evidence)
- BT and CBT (whether gp or indiv) should be considered the first-line treatment for ch with sp phobias and ch with GAD. (A)
- BT and CBT should be considered or ch with OCD. (A)
- Parents should be included in CBT where the child is under 11 or where there is high parental anxiety. (B)
- Educational support should be considered in the management of children with anxiety problems. (B)
- Clomipramine and SSRIs should be considered in the treatment of OCD when CBT alone has proved ineffective. (A)
- SSRIs should be considered in the treatment of social anxieties when CBT alone has proved ineffective. (A)

Ishikawa et al 2007
- 20 RCTs
- Gp ; child CBT ; Family/parent CBT
- 6-20 sessions
- ES pre-post d=0.94 for active Rx
- ES pre-post d=0.61 active cf control
- Parent reports give larger ESs than self report (0.6-0.8 Vs 0.85-1.08)
- ESs maintained in longer FU intervals
**Components of CBT for anxiety disorders in C&A**

- Psychoed – the model / recognising anxiety / how it takes over
- Skills training – realistic, coping-focused thinking
- Exposure methods – systemic desensitization, hierarchies...
- Goals, reinforcement, alliance, child in control
- PARENTS

---

**Cognitive Model For Anxiety**

- **Trigger:** E.g. Return to school after illness
- **Cognitions:**
  - **Thoughts:** “It'll be a disaster”, “I can’t do it”
  - **Images:** looking odd, blushing, sweating
  - Isolated in class, the target of laughter
- **Behavioural avoidance:**
  - Staying away from school
  - Not contacting friends
- **Feelings of anxiety:**
  - Sweating, stomach cramps, tense muscles, mind goes blank

---

**Anxiety management in CAMHS: Developmental perspectives, treatment options and medication dilemmas**

- Selling the CBT model of anxiety - Safety behaviours make such intuitive short term sense but they have stopped working
- Treatment metaphor – retiring to a not quite safe distance
- Ladder metaphor
- Behavioural motivators are really helpful;
- Use of benzo’s as a psychoeducational tool
Anxiety management in CAMHS: Developmental perspectives, treatment options and medication dilemmas

Personal perspectives re CBT cont

- Power of psycho-education
- Supporting exposure – role of PMHS
- Role of parenting groups for parents of anxious children?
- Maintaining gains from CBT?

Role of Family Therapy

- Narrative approach
  - Externalising the anxiety
  - Whole family enlisted to fight the anxiety
  - Helpful for ritualised behaviours
  - Similarities to CBT
- Wider family network involved
  - Hearing from family members who have overcome anxiety problems
- FT useful alongside individual work
- Words and pictures approach to helping children understand parental mental illness

Role of other CAMHS therapists?

- Individual therapies??
Medication

- Success rates for CBT – 70-80%
- Not all children and adolescents with anxiety disorders are able to engage in CBT
- Significant evidence for efficacy of certain medications in adults
- Less evidence in C & YP

Medication options

- SSRIs
- TCAs
- Buspirone
- Benzodiazepines
- Beta-blockers
- pregabalin

SSRIs

- RUPP (Research Unit on Paediatric Pharmacology) 2001
  - RCT – fluvoxamine vs placebo
  - 128 children and adolescents with social phobia, separation anxiety disorder or GAD who had failed to respond to 3 weeks of psychological therapy
  - Fluvoxamine group – greater reduction on Paediatric Anxiety Scale and Clinical Global Impression of Improvement Scale
- Rynn et al (2001)
  - Small RCT (22 C&A): sertraline vs placebo
  - Significant global improvement and reduction in anxiety beginning at 4 weeks of treatment
- Both short-term trials (8-9 weeks) – no clear evidence to support long-term use of SSRIs in C&A
OCD

The Paediatric OCD Treatment Study

- National Institute for Mental Health
- March et al (2004 JAMA)
- RCT, 112 C&A (7-17 years), 12 week trial
- CBT plus SSRI superior to either treatment alone
  - 53.6 percent of the participants in the combination group (CBT plus sertraline) showed no signs of the disorder by the end of their treatment.
  - For the CBT-only group, 39.3 percent of participants became nearly asymptomatic for OCD
  - sertraline alone, 21.4 percent of the group became asymptomatic
  - placebo, only 3.6 percent responded with greatly reduced symptoms of OCD

Buspirone

- Non-benzodiazepine anxiolytic reported in adults to be comparable in efficacy to benzodiazepines
- Several open-labelled studies in childhood anxiety disorders
- No controlled data for safety or efficacy
- SE usually mild – nausea, dizziness, headache, insomnia
- May lead to increased aggression and development of manic symptoms

Audiences experience with medication?
Further discussion points

• How to address maternal anxiety when it is perpetuating the anxiety in the child?
• When to consider medication?
• How to manage anxiety in young people who are too anxious to attend CAMHS?
• How to reduce anxiety in a child of a parent with significant mental health problems?
• Transition to adult services
• When does one bail out of trying to get a school phobic into school?

Cases

• When social anxiety presents as paranoia?
• Too anxious to get to CAMHS
• Anxiety Disorder presenting as FAED
• Anxiety presenting as autistic behaviour