Depression, anxiety and self-harm in adolescence.
Who are we?

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Today’s workshop

• Case study
• Diagnostic criteria
• How young people present
• Management in the GP surgery
• Pathways into and within CAMHS
• Treatment of Emotional Disorders
• Signposting
Case Study

• Ann, 14, year 10
• Lives with mum, dad, sisters 11 and 8.
• Attends GP with mum, low mood, anxiety, self harm by cutting.
• Mum and Ann concerned about her mental health.
• Impacting on school – unhappy there, attends, poor concentration, studies hard.
What to ask next?

• In GP surgery very limited time.
• Primary goal:
  • Some exploration of history/MSE
  • Risk assessment – self and others
    - Risk factors
    - Protective factors
Further history –

ICD 10 DEPRESSIVE SYMPTOMS *

- 2 yrs low mood *
- Tearful daily
- Anergia, self neglect*
- Lacks motivation/interest *
- Poor concentration *
- Sleep initial insomnia, EMW *
- Appetite reduced *
- Guilt about burdening family *
- Suicidal thoughts daily and plans, no means *
- Hopelessness *
- Chronic bullying
- Never goes out
- IRRITABLE
- Self harm cutting
Further History

Family history
• Mum – recurrent depression since being a teenager
• Maternal grandfather – in mental health hospital
• Baby brother passed away meningitis age 5 months
• Extended family well

Other hx
• Forensic – nil
• Drugs/alcohol – nil
• PMP – always quiet
• Devel Hx – NAD
• School – bullying from year 6, transition to high school tricky.
Mental state examination

- **Appearance:**
  - Very petite, unreactive
  - Psychomotor retardation
- **Speech:** low volume paucity of content
- **Mood:** severely depressed

- **Thought:**
  - Negative content, intrusive imagery and urges to harm others egodystonic.
  - Suicidal ideation, not delusional
  - **Perception** – did hear a voice, not now
Risk assessment:

Risk factors static
- Baby brother died 11 years ago
- FHx of depression in adolescence
- Past history of bullying
- Previous overdose
- Chronic bullying

Risk factors fluid
- Mum had recurrent depression, currently improving although in room unreactive to daughter.
- Unhappy at school
- DSH
- Suicidal plans
- Thoughts about stabbing others although no plans.
Risk assessment (Ann)

- Significant risk of harm, accidental or deliberate to self
- Lower risk of harm to others

- Protective factors
  - Supportive family
  - Confides in mum
  - Mum has secured tablets and knives
  - Some plans for the future.
  - Some optimism that she can get better
### Box 1 Warning and protective signs for suicide

**Warning signs**
- Expressing suicidal feelings
- Planning suicide
- Marked hopelessness
- Giving away valuable possessions
- Making out a will
- Signs of depression
- Psychiatric disorder
- Past suicide attempt or self-harm
- Life events

**Protective signs**
- Increased alcohol/drug use
- Social isolation
- Expressing hope that things may get better in future
- Not wanting to cause pain and distress for family and friends
- Religious beliefs
- Having a supportive network
ICD10 Diagnostic criteria depression— as for adults

- Sad mood or bleak future
- Withdrawn, uncharacteristically lacks energy and initiative
- Neglected appearance
- Slow movements and monotonous voice
- Heightened sensitivity to rejection by others
- Low self esteem
- Poor concentration, deterioration in school grades
- Loss of interest in extracurricular activities
- Sleeping throughout the day or early in the evening
- Use drugs or alcohol, in some cases as self-medication
Teenage Depressive Disorders

• Similar presentation to adults, same diagnostic criteria however:
  • Increased irritability and risk taking
  • Ann meets criteria for a severe depressive episode with suicidal ideation, marked anxiety, not delusional
Aetiology of depression

• Multiple pathways to onset of depression
• Majority 95% long standing psychosocial stressors

• Family disharmony
• Divorce/separation
• Domestic violence
• Phy/sexual abuse
• School bullying
Epidemiology

Prevalence

• Prepubertal children 1-2%
• Adolescents 3-8%, up to 20% by 18, comparable to adults.
• Adolescent onset is associated with a strong risk for reoccurrence in adulthood
• The gender difference appears in adolescence
• Increase risk of suicide (50% were depressed)
Epidemiology

Gender

Increases in depressive symptomatology in girls begin to be detected at age 12 (Angold et al, 2006).

Gender differences are possibly due to biological, psychosocial and cognitive factors

Significant increase in prevalence of teenage depression in girls 2014-17
Neurobiological factors

- lower whole-blood serotonin
- Neuroendocrine system – changes in cortisol, DST, CRH, GH, TSH
- **Sleep** - shorter REM latency, REM density differences and less sleep efficacy was found in adolescents
- **Neuroimaging** - smaller PFC and amygdala, and larger third and fourth ventricles of depressed young adults and adolescents
Co morbidity

- **Poor physical** increased risk of future depression and a diagnosis of major depression predicted an increased risk of future poor physical health (Cohen et al, 1998; Lewinsohn et al, 1996). Depressive symptoms can accompany cancer, hyperthyroidism, hypothyroidism, lupus erythematosus, acquired immune deficiency syndrome, anemia, diabetes, epilepsy.
- **5%–23% of ill children and adolescents** met criteria for major depression.
- Children suffering from conditions directly involving the central nervous system showed higher rates of psychiatric disorders (Melzer et al, 2000).
- **Chronic illness** such as severe asthma, inflammatory bowel disease and diabetes sickle cell disease were found to have higher rates of depression (Burke & Elliot, 1998; Bennet, 1994).
Co morbidity

- **ADHD**: 0%-57.1% of children and with depression also met criteria for ADHD (Comorbidity of ADHD was found among 30% of children and 15% of depressed adolescents (Masi et al, 1998).

- **Conduct Disorder**

- **OCD:**
  68 yp (Goodyer et al) with a first episode of major depressive disorder, 24% of yp had comorbid OCD at presentation. Comorbid OCD at presentation risk factor for persistent depression at 72 weeks f/u
GP management options

No referral
- Watchful waiting – for mild depressive episode
- Brief advice – self help
- Signposting for support and reading

Refer to SPA or CAMHS CRISIS
- Call or write to SPA
- Or call camhs crisis team
- They will triage by phone
- Either ICA or appointment
Management plan for Ann

1. GP refer to SPA
2. SPA – 30 min call
3. ICA – initial assessment, formulation, risk assess, care plan:
4. Initial CBT (NICE: CBT group/individual/IPT/FT/psychotherapy
5. 6 sessions review no improvement
6. Psychiatric review:
   • Noted systemic issues alongside severe depression and suicidal ideation:
7. START SSRI TO AUGMENT TALKING WORK.
Medication for adolescent depression

- Only **Fluoxetine** benefits outweigh side effects, licenced for use in depression, initiated by specialist psychiatrist, monitored by CAMHS.

- **Sertraline and Citalopram 2nd line**, off license

- Close monitoring of adolescents such as irritability, hostility, self-harm, self-destructive actions, mania, akathisia.
Signposting for Depression:

**ChildLine** - Provides a free and confidential telephone service for children. Helpline: 0800 1111.

- **Epic friends** - Mental health problems are common

**YoungMinds** - Provides information, advice on child mental health issues

- **HeadMeds**  info on medication

- **Rethink Mental Illness** -

- **Changing Minds: Mental Health: What it is, What to do, Where to go?:** This CD-ROM is designed for 13-17 years. It includes a wide range of resources - audio, visual, video and written materials - and a wealth of reference for further information and help, including a section on depression.
What is Self-Harm?

- Self-harm is a *behaviour*, not a mental illness
- A way of managing distress
- Intentional Self-Harm’ is an ICD 10 diagnosis, multiple different methods described
Anatomy of a Teenager's Brain

- Embarrassed by parents section
- Sensorimotor area
- Ability to remember the lyrics to offensive hip hop song...
- Prefrontal
- Have no idea...
- Girls are suddenly fascinating section
- Ability to listen to extremely loud bass tracks
- School Work (smallest section of the brain)

- Sleep
- Chillax
- Rotf!
- Self-control
- Gta
- PLanking
- More sleep
- Fours Loko
- First love
- Whatever
Definitions

- **Self Harm** is (non-accidental) self-poisoning or self-injury, irrespective of the apparent purpose of the act. (NICE)

- **Self-injury** – referred to as self-mutilation, self-injurious behaviour, non suicidal self-injury

- **Self-poisoning** – includes the ingestion of a substance in excess of the prescribed or generally therapeutic dose or of a recreational or illicit drug in a way that is intended to be harmful. (WHO)
Question – at what age is self harm most common?

- 15-20
- 30-44
- 55-64
- 75-84
- 21-29
- 45-54
- 65-74
- 85+
Of those who self harm, what % are female?

• 49 %

• 75 %

• 89 %

• 63 %
Of those young people who self harm, which % of them stop self harming through natural support?

50%
30%
70%
80%
Self-harm in teenagers—UK highest rates in Europe

Manchester study 2017:
- Self harm rates increased by 68% in 13-16 year old girls between 2014-2017
- Gender disparity increasing
- Female 3: male 1 (age 10-19)
- Self harm: 50 x more likely to attempt suicide
- 11.2% female and 5.1% male lifetime prevalence.
Self harm

Risk increases:
• Deprived area
• Less likely to be referred to camhs in deprived area
• Increased incidence of mental health disorder increasing in YP
• Internet
• Increase in calls to childline

Risks from self-harm
• 9 x increase in mortality rate from unnatural causes
• 17 x increased risk of suicide
• 34 x increased risk of death from alcohol/drug O/D
Reasons why young people self harm

Life experiences:

- Sexual/physical/emotional abuse
- Bullying
- Bereaved
- Socioeconomic status – still debated
- LAC
- LGBT
- Involvement in the criminal Justice system
- Parental neglect
- Being witness to Domestic Violence
- Transition between childhood and adulthood
- Relationships; peers/parents/developing sexual identity
- Having someone in their circle who self harms
- ExRejection/loss
- Confinement in residential establishments
- Exam pressure
- Has a parent who experiences D&A and/or MH
Why is self-harm so common in young people?

- Risk Taking increases
- Reduction in dopamine
- Future or forward thinking brain not fully developed – right hemisphere stores infantile memories, adolescent brain can’t access these.
- Reduced serotonin
- Skin sensitive in nerve endings
Young People Tell us that they self-harm to:

- Relieve suffering and pain
- Transport pain from my heart to my arm
- Feel in control
- Feel alive
- Feel something
- I should be punished
- A dislike of my body
Advice for GPs seeing YP with self-harm

• Risk assessment as for any mental disorder eg depression.
• Exclude serious mental illness, if concerned about this call CAMHS CRISIS team asap.
• Any yp with self-harm should be seen urgently by CAMHS.

• My Self Help Book
• Signpost to websites
• Give useful numbers
• Some ideas to follow:
Alternative coping strategies:

- **Anger, frustrated, restless** Something physical, rip up old newspapers, break sticks, make noise (playing an instrument or loud music), clean bedroom, use a pillow, squash cans – anything that does not involve another person.

- **Sad, low mood, depressed, unhappy** Something soothing, hot bath/shower, having an early night, hot drink, read a book, listen to soothing music, anything that makes the person feel taken care of, keep a diary of all the things you are good at/having others write on post it notes what they believe is good about you, write a poem.

- **Feeling blunt and feeling unreal** Using any of the senses to reconnect, squeezing ice, chewing something hard, brush skin with a toothbrush, stomp feet, take a cold bath, snap wrist with a rubber band.
Wanting to see blood

Draw on skin with red pen, use food colouring, freeze food colouring into cubes so when squeeze see red, use red plasticine, smear it on to the skin, use make up to create fake injuries

Wanting to see/pick scabs

Painting on nail varnish and picking it off, cool candle wax and peel off

Expressing feelings differently

Draw or paint feelings, keeping a diary – can help identify triggers and potential ways to manage them, know when things are feeling out of control and start keeping a note of who or what you can turn to for support.
Management of self harm by CAMHS

- Assessment
- Formulation
- Risk management plan
- If serious mental disorder treat this as per NICE/TEWV pathway.
- Multi agency working
- If emotional dysregulation offer treatment for this:
  - DBT informed work useful
  - Group work
  - Medication not indicated in absence of mental illness.
Signposting for GPs

Young minds:  www.youngminds.org.uk
RCPsych:  www.rcpsych.ac.uk
Self harm network:  www.nshn.co.uk
Youthscape self harm project :  www.selfharm.co.uk
Samaritans : 08457 909090
Childline : 0800 1111
What is anxiety?

Anxiety disorders
Clinical presentation of Childhood Anxiety Disorders

• Diagnosis:
  Categorical/continuous?
  Childhood anxiety can be adaptive.

• Anxiety is normal.
• Anxiety is not dangerous.
• Anxiety is adaptive—it triggers our "fight-flight-freeze" response,
• If it limits developmentally appropriate behaviour and thus causes limitation or distress may be considered pathological.
Anxiety Disorders

- Phobic Disorders
- Separation Anxiety Disorder
- Social Anxiety Disorder
- Generalised Anxiety Disorder
- Panic Disorder
Phobic Disorder

Presentation
- Marked unreasonable fear of specific object which is not intrinsically dangerous eg animal, elicits fear, distress, avoidance, impairs normal activities,
- Normal childhood fears, age 2-4, animals, fear of dark, imaginary animals age 4-6, death/war in adolescence.

Demographics
- Often onset in childhood
- Epidemiology: 2-4% (Isle of Wight), more common in girls
- Course: frequently follow onto adulthood
Panic Disorder
Panic Disorder

**Presentation**

- Repeated unprovoked panic attacks
- May lead to agoraphobia and limited independent travel.

**Demographics**

- Onset peak age 15-19
- If younger usually family history
Generalised Anxiety Disorder

• Multiple worries about school, friends, work, appearance
• Requires reassurance
• Needs to be functionally impairing
• Unable to relax
• Distress

• Females more than males
• 3% young people
• Co morbidities very high
• Age of onset poorly understood
Separation Anxiety Disorders

**Presentation**
- Presents in childhood, commonly pre-adolescence then improves.
- Anxiety at separation from home/caregivers, developmentally inappropriate, leads to substantial social incapacity.
- Normal separation anxiety in young child.

**Demographics**
- 2-4% children, commonest anxiety disorder in prepubertal children.
- Girls, lower socioeconomic groups more common. Course: fluctuating, increasing during transitions, may progress to GAD in adulthood or adult panic disorder.
Social phobia/Social Anxiety Disorder ICD 10

- Can be difficult to differentiate mild PDD and severe anxiety disorder. The latter usually craves social contact.
- Exaggeration of and undue persistence of normal phase of stranger danger (normally up to 30 months). Extremely shy personalities.
Aetiology and co morbidity

• NATURE - inhibited temperament, childhood separation.
• Modest influence of genetic transmission
• Few antecedants identified

• Co morbidity high
• GAD 90% particularly depressive disorders
• Increase in conduct disorder and substance misuse.
• Common in ASD.
STRESS RESPONSE SYSTEM

CRH - Corticotropin-releasing hormone
ACTH - Adrenocorticotropic hormone

DrLam
Body Mind Services.
Longitudinal outcomes

• Most adults with anxiety or mood disorders are likely to have childhood history of anxiety.
• Most children with anxiety disorders show stability, however most do not go onto adult anxiety or depressive disorder.
ANXIETY PATHWAY

PRESENT TO GP

• Young person is functionally impaired?
• Ie:
• Poor school attendance, avoidant
• Social withdrawal
• Low mood, physical symptoms
• Appetite and sleep affected

REFER TO CAMHS SPA

• Initial 30 min phone triage
• ICA (Initial comprehensive assessment with signposting and advice)
• Treatment on emotional pathway.
Management of anxiety

• Tewv pathway plus NICE guidance
• Initial self help
• Then CBT/other psychological work
• Usually group CBT, if severe individual, if no improvement within a few sessions consider
• MEDICATION
Generalised anxiety disorder

- RX: Relaxation, CBT
- 2 systematic studies (Kendal et al), CBT superior, sustained reductions over several years. Parental involvement/group based CBT both increase response.
MEDICATION FOR ANXIETY

• None licensed for any anxiety disorder in young people.

• Little evidence for use however when functional impairment high consider use of

• SSRI – *Sertraline or Fluoxetine*

• NOT BENZODIAZEPINE

• BETA BLOCKERS often prescribed by GPS, little evidence.
Signposting for anxiety:

- **Anxiety UK** - A charity providing information and support for people suffering with anxiety problems.
- **Epic friends** - This website is all about helping you to help your friends who might be struggling emotionally.
- **YouthNet UK** - Online charity which guides and supports young people, enabling them to make informed choices, participate in society and achieve their ambitions.
- **YoungMinds** have also developed **HeadMeds** gives young people in England general information about medication. HeadMeds does not give you medical advice. **Useful CD: Rays of Calm**, Christiane Kerr, Audio CD/Audiobook: CD from the "Calm for Kids" range created for teenagers. It talks through various relaxation techniques and visualisations designed to promote a sense of calm and wellbeing and to help teenagers deal with stress.
Bibliography: please contact presenters for further list.


• NICE (2011) *Longer- term management of Self Harm*  *Clinical Guideline 133*. London: NICE.
The End

• Thank you!