Western Sydney & Parramatta School Counselling Service Conference
18th July 2022

Assessment of Anxiety & Depression

Dr Fran Doyle (PhD)
Clinical Psychologist
Lecturer in Clinical Psychology at Western Sydney University
f.doyle@westernsydney.edu.au
www.frandoyle.com/slides

1

Acknowledgement of Country

I pay my respects to the Traditional Owners of the lands on which I work and live on.

I pay my respects to Elders past, present, and emerging. I acknowledge all First Nations people here with us today.

It always was, and always will be, Aboriginal land.

2

Learning Outcomes

- Increase understanding of why school counsellors need to assess anxiety and depression in youth
- Increase knowledge about formulation and practice doing a case formulation
- Increase knowledge about anxiety and depressive disorders, including:
  - Key symptoms
  - Common comorbid problems
  - Differential diagnoses
- Build confidence in how to assess anxiety and depression in youth, considering:
  - Clinical interviews
  - Observations
  - Questionnaire measures
  - Psycho-metric assessments

3

Learning Outcomes

- Increase understanding of some of the:
  - Evidence-based treatments for anxiety and depression in youth
  - Typical treatment components
- Build skills and confidence in:
  - Providing psycho-education for young people experiencing anxiety problems
  - Applying some assessment and treatment skills to a video case study

4

Participation



YouTube Mentimeter

- https://www.frandoyle.com/slides

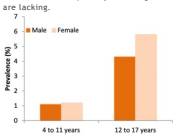
5

Why should we assess for anxiety and depression in youth?

6

Why assess for anxiety & depression in youth?

- **Highly prevalent**
  - Approximately 13.6% of Australian children aged 4-11 have a mental illness (Lawrence et al. (2015).
    - With anxiety and ADHD being the two most common illnesses in this age group
    - In other words: 1 in 8 children
    - Data from the UK suggest that the prevalence of mental illness in primary school aged children is increasing. However, Australian data are lacking.
  - 19% adolescents experience mental health disorders (Sawyer et al., 2000; ABS, 2007).
    - In other words: Almost 1 in 5 adolescents
  - 4-6% of adolescents experience depression
    - In other words: 1 in 20 adolescents



Prevalence of major depressive disorder in the past 12 months in 4 to 17 year olds

7

Why assess for anxiety & depression in youth?

- **Predictive of later problems**
  - Any childhood diagnosis increases the risk of adolescent and adult mental health problems (Kessler et al., 2005).
  - Kim-Cohen et al. (2003) found that **73.9%** of adult mental health problems had emerged at a diagnosable level by 18-years-old, with 50% emerging before 15-years-old.
    - Most adult mental health disorders should be reframed as extensions of childhood disorders.
    - Childhood disorders should be priority prevention targets for improving wellbeing in the adult population.
  - Mental health problems in youth also impact developmental trajectories and functioning throughout the lifespan.

8

Yet… only 10-56% of young people access clinical services

- According to the 2015 Report on the 2nd Australian Child and Adolescent Survey of Mental Health and Wellbeing
  - Of those aged 4-17 years, 1 in 6 (17%) had used services for emotional or behavioural problems in the past 12 months.
  - Of those aged 4-17 years with mental health disorders, 56% had used services in the past 12 months.
- The Mission Australian Youth Survey Report (2017) asked about help-seeking behaviours:
  - Most commonly cited sources of help:
    - Friends, Parents, Relatives or Family Friends, Siblings
  - One third of young people indicated their **School Counsellor** as a source of help.

9

School Counsellors have the opportunity to:

- Optimize developmental trajectories for children and adolescents by assessing and intervening early
- Observe young people in a more naturalized setting
  - In a way that caregivers and other professionals may not be privy to
    - E.g., in the classroom
    - E.g., with peers
- Collate information from various sources to more accurately inform assessments and treatments
  - Including from young people, caregivers, teachers / year coordinators, and other professionals (e.g., private/public-sector psychologists and psychiatrists)

10

School Counsellors have limited time and resources

- **The Productivity Commission** and **Royal Commission** have highlighted:
  - the incoherent policy frameworks for wellbeing in schools,
  - the barriers to accessing the right supports, and
  - **overwhelming demand on school counsellors** and psychologists.

11

So where does this leave us?

There is great need for wellbeing services for young people

Intervening early is best for young people, their families, and the communities that they are part of (including schools!)

Assessment is one of our greatest tools to be able to effectively determine:

- Who should be referred on
- Who should receive help from their School Counsellor
  - What would be the best targets for intervention

12

Quick activity: Primary School version

- How many young people in your school? _____
- For your school, how many young people would you expect to have a mental health disorder:
  - 0.136 x _____ (number of young people in the school)
  - = _____
- How many young people in a class? _____
- In each class, how many young people would you expect to have a mental health disorder:
  - 0.136 x _____ (number of young people in the class)
  - = _____

13

Quick activity: High School version

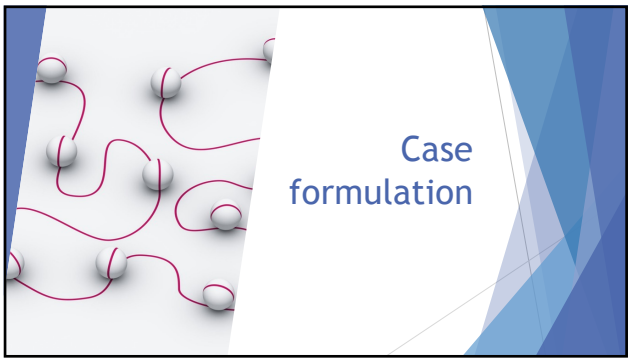
- How many young people in your school? _____
- For your school, how many young people would you expect to have a mental health disorder:
  - 0.19 x _____ (number of young people in the school)
  - = _____
- How many young people in a grade? _____
- In each grade, how many young people would you expect to have a mental health disorder:
  - 0.19 x _____ (number of young people in the class)
  - = _____

14

Discuss

- Briefly introduce yourself
- Is the estimated number of young people with mental health disorders in your school **MORE** or **LESS** than you thought?

15



16

- Caveat

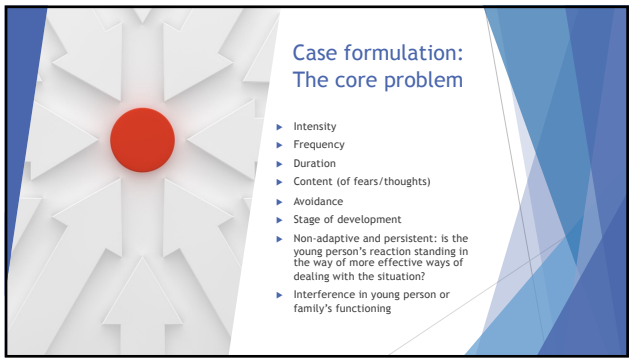
May not be diagnosing but you need to be formulating

17

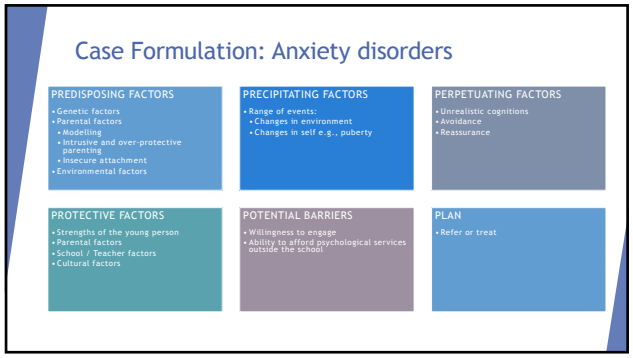
Case Formulation

- Identify the core PROBLEM
  - Intensity, frequency, duration
- What are the:
  - PREDISPOSING FACTORS or vulnerability factors?
  - PRECIPITATING FACTORS or triggers?
  - PERPETUATING FACTORS that maintain the problem?
  - PROTECTIVE FACTORS?
  - POTENTIAL BARRIERS?
  - PLAN for treatment/referral?

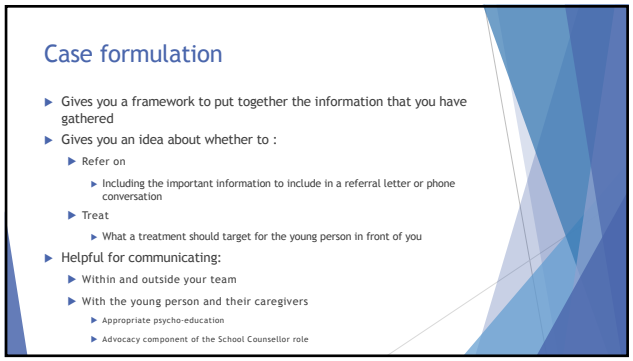
18


Case formulation:
The core problem
Intensity
Frequency
Duration
Content (of fears/thoughts)
Avoidance
Stage of development
Non-adaptive and persistent: is the young person's reaction standing in the way of more effective ways of dealing with the situation?
Interference in young person or family's functioning

19


Case Formulation: Anxiety disorders
PREDISPOSING FACTORS
Genetic factors
Parental factors
Modelling
Intrusive and over-protective parenting
Insecure attachment
Environmental factors
PRECIPITATING FACTORS
Range of events:
Changes in environment
Changes in self e.g., puberty
PERPETUATING FACTORS
Unrealistic cognitions
Avoidance
Reassurance
PROTECTIVE FACTORS
Strengths of the young person
Parental factors
School / Teacher factors
Cultural factors
POTENTIAL BARRIERS
Willingness to engage
Ability to afford psychological services outside the school
PLAN
Refer or treat

20


Case formulation
Gives you a framework to put together the information that you have gathered
Gives you an idea about whether to :
Refer on
Including the important information to include in a referral letter or phone conversation
Treat
What a treatment should target for the young person in front of you
Helpful for communicating:
Within and outside your team
With the young person and their caregivers
Appropriate psycho-education
Advocacy component of the School Counsellor role

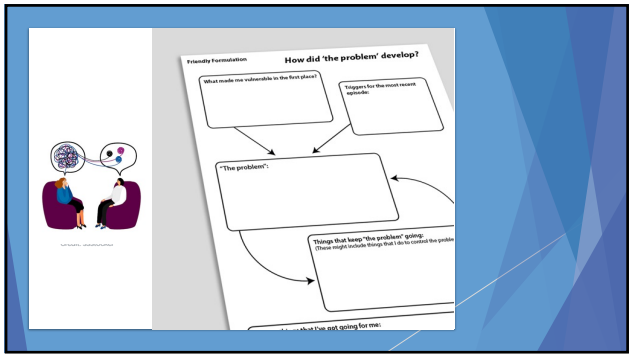
21

Case Example

- Identify the core PROBLEM(S)
  - Intensity, frequency, duration
- What are the:
  - PREDISPOSING FACTORS or vulnerability factors?
  - PRECIPITATING FACTORS or triggers?
  - PERPETUATING FACTORS that maintain the problem?
  - PROTECTIVE FACTORS?
  - POTENTIAL BARRIERS?
  - PLAN for treatment/referral?

- Sam is 11-years-old. Sam was referred to you from the classroom teacher due to social and behavioural difficulties at school.
- A previous cognitive assessment using the WISC-5 found below average abilities. Achievement on the WIAT-III was also below average. Sam's mother completed the Child Behaviour Checklist (CBCL) and all the scales were elevated.
- Sam is an only child. Sam's parents separated 3 years ago. Sam's dad sees Sam every second weekend.
- For the past 2 years, Sam frequently complained of stomach aches and headaches. Sam has had multiple medical investigations (including 2 colonoscopies) after reportedly experiencing diahorrea and constipation. There have been no unusual findings to report.
- Sam often seeks days off (usually Mondays) due to stomach and headaches.
- Sam brings a mobile phone to school each day and routinely contacts Sam's mother during recess and lunch. Sam's mother is also often at the school in various other volunteer roles.

22



23

Anxiety and Depressive Disorders

24

Developmentally-Typical Worries

- 6-12 months: Separation, strangers
- 2-4 years: Imaginary creatures, burglars, the dark
- 5-7 years: Natural disasters, injury, animals, media-based
- 8-11 years: Poor academic / sport performance
- 12-18 years: Peer rejection

25

Selective Mutism

Key symptoms

Consistent failure to speak in social situations; although the child can speak in other situations

Avoidance: Child may stand motionless and expressionless; avoid eye-contact; withdraw to avoid talking

Interferes with educational achievement and/or peer interactions

Common comorbid diagnoses

Other anxiety disorders

Differential diagnoses

Failure to speak is not attributable to a lack of knowledge, or comfort with, English (or the spoken language in the situation)

Communication disorder

Other

- Prevalence 0.03-1%
- Equally present in boys and girls
- Onset usually before age 5
- Cannot be diagnosed in the first month of school

26

Separation Anxiety Disorder

Key symptoms

- Fears separating from home or major attachment figures
- Worry about potential harm to attachment figures
- Avoidance: Reluctance or refusal to go out away from home
- Fear of being alone
- Repeated nightmares
- Physical distress symptoms (eg headaches, stomach-aches, nausea)

Common comorbid diagnoses

Other anxiety disorders, particularly Generalised Anxiety Disorder and Specific Phobias

Differential diagnoses

Panic disorder

PTSD

Bereavement

Oppositional defiance disorder

Other

Symptoms must last at least 4 weeks in youth

- Prevalence: Children: 4%

Adolescents: 1.6%

- Most common anxiety disorder in children under 12 years of age

- Onset peaks at several points of development including with entry into Kindergarten, between ages 7-9, and again with entry into High School.

27

Social Anxiety Disorder

Key symptoms

Excessive fear or anxiety about social situations in which the individual is exposed to possible scrutiny by others

Fear of Negative Evaluation: Belief situation will be humiliating or embarrassing, lead to rejection, or that individual will offend others

Avoidance

Common comorbid diagnoses

Other anxiety disorders

In adolescence: alcohol and substance use

Differential diagnoses

Prodromal psychosis / psychosis

Other

- Often take years to get help
- May need more targeted interventions as do not respond as well to treatment

-Prevalence: Estimated at 7%
The prevalence in children & adolescents is comparable to adults

- 75% of individuals have age of onset between 8 and 15 years

28

Specific Phobias

Key symptoms

Paralyzing fear of a specific event, situation or object

Avoidance and distress caused when confronted by phobic stimuli

* **Animals** (e.g., spiders, insects, dogs)
* **Natural environment** (e.g., heights, storms, water)
* **Situational** (e.g., airplanes, elevators, enclosed places)
* **Blood-injection-injury** (e.g., needles, medical procedures, fear of blood, fear of injury)
* **Other** (e.g., clowns, vomit)

Common comorbid diagnoses

Other anxiety disorders

Other phobias (75% people fear more than one)

Differential diagnoses

Generalised anxiety disorder

OCD

Other

Typically lasting 6 months or more

Prevalence - Children: 5%
Adolescents: 16%
Greater prevalence in girls

Onset is usually between 7 and 11 years

29

Generalised Anxiety Disorder

Key symptoms

Excessive worry about everyday life

Seek out reassurance constantly
Uncanny ability to identify negatives in a situation

Worry accompanied by stomach or head aches, irritability, poor concentration or fatigue

Common comorbid diagnoses

Other anxiety disorders

Depression
Sleep disturbance

Differential diagnoses

Mood disorders

Other

Prevalence: Children 1%, Adolescents 3%

30

Panic Disorder

Key symptoms

Regular panic attacks for no apparent reason

Worry that an attack will happen again

Avoidance of places or activities for fear of having a panic attack

Heightened awareness and/or concern about feelings in their body

Common comorbid diagnoses

Other anxiety disorders

Depression

Bipolar

Adolescence: Alcohol and substance use

Differential diagnoses

Other anxiety disorders

PTSD

Anxiety disorder due to another medical condition

Other

Prevalence: Children: <0.4% before 14 years.
Adolescents: 2-3%

More prevalent in females than males from adolescence.

31

Obsessive Compulsive Disorder

Key symptoms

Recurrent, persistent and intrusive thoughts

Repetitive behaviours aimed at reducing or preventing a dreaded event
e.g., washing hands, counting to a certain number, symmetry

Common comorbid diagnoses

Other anxiety disorders

Body focused repetitive behaviours

Depressive or bipolar disorder

Tics

Differential diagnoses

Depression

Body dysmorphic disorder

Body focused repetitive behaviours

Anorexia

Tics

Psychosis

Other

1.2% prevalence

Males are more commonly affected in childhood than females.

25% of cases start by 14-years-old

32

Body Focused Repetitive Behaviours

Key symptoms

BFRBs include: hair-pulling (trichotillomania), skin picking, nail biting, lip chewing, thumb sucking.

Can be to reduce anxiety; can also have become habitual

Common comorbid diagnoses

Other anxiety disorders, particularly GAD

- Other BFRBs
- ADHD
- Pervasive Developmental Delay
- Depression in adolescents

Differential diagnoses

Trichotillomania Differential

- OCD (Symmetry rituals)
- Normative hair removal (i.e. cosmetic reasons to improve appearance)
- Body dysmorphic disorder

Other

Need to assess range of antecedents for engaging in BFRBs

33

Major Depressive Disorder

Key symptoms

- Low mood (or irritability, such as low frustration tolerance)
- Loss of interest and pleasure in usual activities
- Sleep disturbances
- Guilt
- Low Energy/fatigue
- Concentration/attention
- Appetite
- Psychomotor agitation or retardation
- Suicidal Thoughts/Self-harm

Common comorbid diagnoses

Anxiety disorders

?Trauma

Oppositional defiance disorder

Substance use

Disordered eating

Engaging in risky behaviour

Differential diagnoses

Persistent Depressive Disorder

Other

- Some young people feel **irritable**, while others feel **sad** and really **stressed** most of the time
- Symptoms interfere with all areas of a person's life, including school and social relationships
- Symptoms are experienced most days and last for at least two weeks

34

MDD symptom presentation in children aged 5–12 years

MDD symptoms	How symptoms may present in a child
Depressed mood	Irritable, temper outburst, cranky, unhappy, miserable
Anhedonia/lack of interest	Loss of interest in pleasurable activities (eg does not want to see friends, do usual activities)
Somatic symptoms	Stomach ache, headache, musculoskeletal pain, fatigue
Sleep disturbance	Change in sleep
Appetite disturbance	Failure to meet expected weight gain, not getting hungry, eating too much
Concentration	Concentration difficulty
Motor	Moving and walking slowly, restlessness
Cognitions	Guilt, fear of bad things going to happen, being bad person, hating themselves, thinking no one loves them, negative comments about themselves
Suicidal ideation	Thoughts of death/talk about death/wanting to kill themselves
Behaviour	Anger, aggression, poor impulse control, separation anxiety
Function	Social withdrawal, impairment in relationships with family/friends, reduced activities, decline in academic performance

(Charles & Fazeli, 2017)

35

Persistent Depressive Disorder (formerly, dysthymia)

Key symptoms

Presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect child's capacity to function

Different in duration and timing than Major Depression (MDD).

Symptoms **last longer** than in depression - for children and adolescents this is 1 year AND must not be without symptoms for more than 2 months at a time during that period

Common comorbid diagnoses

Other anxiety disorders

? Trauma

Differential diagnoses

Major Depression

Other

- Occurs in 0.6 - 4.6% of children and 1.6 - 8.0% of adolescents
- Symptoms still interfere with all areas of life, including school and, social relationships, though level of impairment may be less than seen in MDD
- Has long-term disabling consequences on social skill learning, psychosocial functioning and consequent professional life
- Higher risk of relapse or development of MDD

36

School Refusal

- School refusal may be associated with many of these disorders
- Discuss: Why might a young person with _____ refuse to go to school?
  - Selective mutism
  - Separation anxiety
  - Specific phobias
  - Social anxiety
  - Generalised anxiety disorder
  - Obsessive compulsive disorder
  - Body focused repetitive behaviours
  - Panic disorder
  - Depression
  - Persistent Depressive Disorder

37

38

Four pillars of assessment

- Clinical Interview
- Observations
- Questionnaires
- Psycho-metric Testing

39

Why don't we do a thorough assessment?

- https://www.menti.com/xbokf4e247

Mentimeter

40

Why should we do a thorough assessment?

- https://www.menti.com/xbokf4e247

Mentimeter

41

What is useful for assessment? What is not useful?

- You need to be able to determine your formulation: what is happening for the student and why?
- You need enough information to inform your differential diagnosis
  - Example: School refusal – many ways to have got there
    - They might ALL be under the 'Internalising Problems' heading
- In turn, this will inform treatment

42

How do I do a thorough assessment? Interview

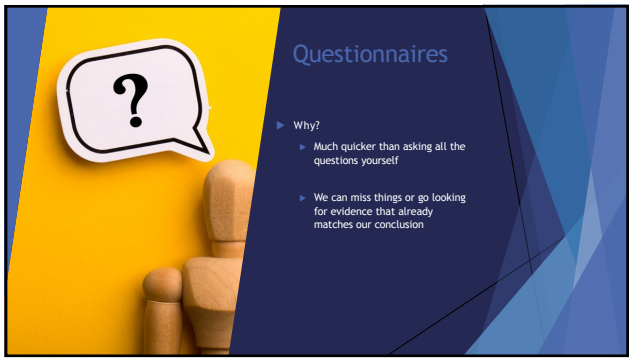
- Ask questions
  - For example, screener questions you may want to look at the ADIS
  - Mood - also assess for suicidality and self-harm
- Functional analysis of recent or typical episodes of the problem
  - ABC: Antecedent - Behaviour - Consequence
  - Chain analysis
- Multi-informant (when possible)
  - Conversations with:
    - Teacher / Year Co-Ordinator
    - Caregivers
    - Inter-disciplinary team: GP, Psychologist (when relevant)

43

Observation

- How do they present to you / in class / with peers?
- Monitoring forms
  - Young person
  - Teacher / Year Coordinator
  - Caregivers

44



Questionnaires

- Why?
  - Much quicker than asking all the questions yourself
  - We can miss things or go looking for evidence that already matches our conclusion

45

Questionnaires

Strengths and Difficulties Questionnaire: https://www.sdqinfo.org/a0.html

- Free
- 3-16 year olds
- Internalising and Externalising Symptoms

Spence Children's Anxiety Scales: https://www.scaswebsite.com/

- Free
- Have Australian norms
- Child-version and parent-version (also preschool-version)
- Translations
- Helps with teasing apart which anxiety problems may be occurring (or co-occurring)

46

Questionnaires

https://www.mq.edu.au/research/research-centres-groups-and-facilities/faculties-people/centres/centre-for-emotional-health-chh/resources

- Range of scales
- Free
- Children & Adolescents
- Child & Youth RADAR: School Connectedness, Family Relations, Academic Success, Peer Acceptance, Sporting Interest, Acceptance of Appearance.

Children's Depression Inventory (CDI)

- $$
- Children and adolescents ages 7-17
- Self-, teacher- and parent-report
- Reports on a variety of symptoms including negative mood, interpersonal problems, ineffectiveness, depressed facial affect, and negative self-esteem.

47

Questionnaires

Beck Depression Inventory for Youth (BDI-Y)

- $$
- Ages 7-13
- Self-report
- It includes items related to sleep disturbance; negative thoughts about self, life, and the future; and feelings of sadness and guilt.
- 20 items

Beck Depression Inventory-II

- $$
- Ages 14+
- Self-report

48

Questionnaires

DASS-21

https://www.yumpu.com/en/document/view/12108600/dass-21-with-scoring-sheet-black-dog-institute

- Free
- Has also been used as a measure of **negative affect** in adolescent populations
- The original three-factor structure has consistently yielded reasonable fit indices in adolescent samples
- Validity of the stress sub-subscalewith adolescents has been questioned in some studies

49

Psycho-metric Assessment

- Differential diagnosis tool
  - E.g., Is there a Learning Disorder sitting under some of this anxiety/mood problems?
- Not required for the majority of youth with anxiety and depression, but a very useful tool for some

50

51

Evidence-based prevention and intervention

Evidence-based parenting programs

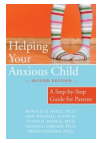
Cognitive behavioural therapy

52

Examples

- Preschool and Early Primary School
  - **Evidence-based parenting programs can have a range of positive outcomes including preventing emotional health problems**
    - E.g., Triple P, Tuning into Kids
    - Group or Individual
    - Online or in person
    - Parent-only
  - **Cognitive Behavioural Therapy - Cool Little Kids program**
    - https://coollittlekids.org.au/
    - Group or Individual
    - Online or in person
    - Parent-only
    - Targeted prevention or early intervention
  - **Turtle program: anxiety and social skills components**
    - Group, in person
    - Parent and child participate
    - Targeted prevention or early intervention

53



Examples

- Age 7 - 12 years
  - **Cognitive Behavioural Therapy - Cool Kids program**
    - Group or Individual
    - Online or in person
    - Online: https://coolkids.org.au/ (Cost)
    - Training and worksheets: https://www.mq.edu.au/research/research-centres-groups-and-facilities/healthy-people/centres/centre-for-emotional-health-cei/cei-programs/cool-kids-anxiety-program-for-professionals
  - **Cognitive Behavioural Therapy - Coping Cat**

54

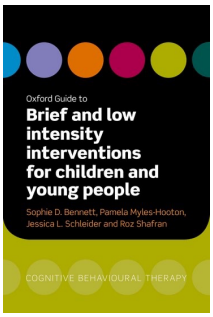
Examples

- Adolescence
  - **Cognitive Behavioural Therapy - Chilled program**
    - Training and worksheets: https://www.mq.edu.au/research/research-centres-groups-and-facilities/healthy-people/centres/centre-for-emotional-health-ceh/our-programs/cool-kids-anxiety-program-for-professionals
  - **Cognitive Behavioural Therapy - Centre for Clinical Interventions**
    - https://www.cci-health.wa.gov.au/Resources/For-Clinicians
  - Moderate to Severe Depression: Refer for medication management
    - NICE Guidelines

55

But... All these evidence-based programs are too long!

- Ch 9: Form and Function when Treating Anxiety in Youth: Maintaining Flexibility within Fidelity in Low Intensity Interventions
- Ch 10: Low intensity interventions for anxiety disorders in children and adolescents
- Ch 11: Brief Behavioural Activation for Treating Depressive Symptoms in Children and Adolescents
- Ch 14: Low intensity interventions for OCD in children and adolescents
- Ch 21: Stepped care
- Ch 24: Playing anxiety and depression away: Serious games for mental health problems in children and adolescents



56

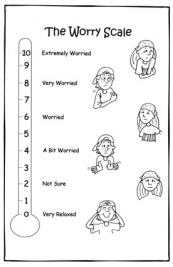
Evidence for school-based prevention programs

- Modest but positive effect of well-designed and implemented prevention programs for depression and anxiety (Merry et al., 2011; Erskine et al., 2016; van Zoonen et al., 2014).
  - Although effects may be conventionally small at a clinical level, even modest reductions can have tremendous implications at a population level.
  - The largest effects of prevention programs are seen with programs based on CBT, and for targeted rather than universal prevention programs.
  - Two important caveats to the support for targeted prevention programs are that
    - (i) they can potentially fail to identify those who aren't yet symptomatic, and
    - (ii) can result in stigmatisation due to students being taken out of class to do the program (though this can be offset by increased levels of participant satisfaction for targeted programs).

57

Typical treatment components of CBT-based interventions

- **Psycho-education**
- Emotion regulation strategies
- **Cognitive Restructuring**
- Exposure
- Problem Solving
- Parent/Teacher Management
- Skills Training e.g., Assertiveness, Coping with Stress
- Behavioural activation for depression



58

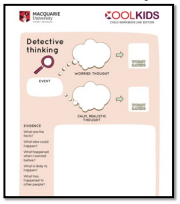
Psycho-education for anxiety

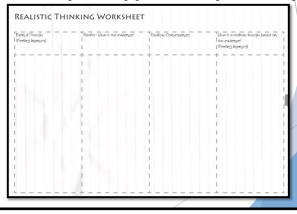
- https://youtu.be/FfSbWc3Q_5M (Child - 2 minutes)
- https://www.youtube.com/watch?v=rpolpKTWrp4 (Teen - 2.5 minutes)

59

Case study: Let's meet Rob

- Write yourself some notes as if you would during a session
- Video: https://youtu.be/LFM8M33k2UI (1 minute)
- Discuss:
  - What are some negative thoughts that Rob is having?
  - Pick one that would be a good candidate for some cognitive challenging / Detective Thinking / Realistic Thinking

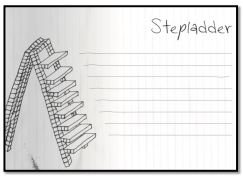




60

Case study: Exposure Hierarchy

- Using the cognition that you chose earlier:
  - Set a related goal for Rob
  - Come up with a stepladder plan for Rob
- Video: https://youtu.be/clSDRVw_4PE (2 minutes)



61

Summing up

62

Summing up

- Why school counsellors need to assess anxiety and depression in youth
- Discussed formulation and practiced doing a case formulation
- Outlined a range of anxiety and depressive disorders
- Considered how to assess anxiety and depression in youth, using:
  - Clinical interviews
  - Observations
  - Questionnaire measures
  - (Psycho-metric assessments)
- Mentioned some of the:
  - Evidence-based treatments for anxiety and depression in youth
  - Typical treatment components
- Briefly built skills and confidence in:
  - Providing psycho-education for young people experiencing anxiety problems
  - Applying some assessment and treatment skills to a video case study

63

64

Western Sydney & Parramatta School Counselling Service Conference
18th July 2022
Dr Fran Doyle

Assessment of Anxiety & Depression

Keep in touch

LinkedIn: https://www.linkedin.com/in/frandoyle
Twitter: @DrFranDoyle
www.frandoyle.com

65