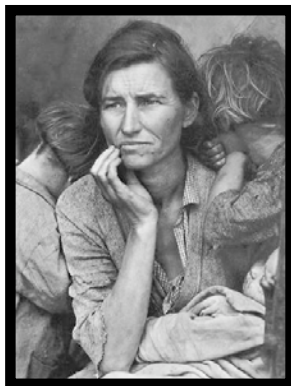


INTERNALIZING DISORDERS

EDSP 306
December 1, 2007



1

Today's Agenda

Class Business	8:00 to 8:15
Virtual Class # 2	8:15 to 8:30
Case Study Review	8:30 to 9:30
Break	9:30 to 9:45
Mood Disorders	9:45 to 11:30
Lunch	11:30 to 12:00
Mood Disorders / Anxiety Disorders	12:00 to 1:30
Break	1:30 to 1:45
Anxiety Disorders	1:45 to 3:30
Next Steps	3:30 to 4:00

2

What school data are you interested in reviewing for the last class?

- Service Delivery?
 - Total enrollment
 - % of students on IEPs, 504s, ESTs
 - FTE of special educators
- Behavioral Data?
 - Incident reports
 - Suspension / expulsion

3

Virtual Class

- Need for interpreters
- Conflict b/w FAPE, LRE and family culture
- Separation of church and state

4

Unanswered questions

- How does No Child Left Behind assist schools in addressing the issue of providing multicultural assessment when testing is standardized to accommodate an American curriculum? What about the ESL student?

5

Unanswered questions

- What kinds of training is available for practitioners to become more effective with multicultural families in the state of Vermont?

6

Unanswered questions

- According the article, when practitioners and parents accept each other's traditional beliefs, intervention approaches can occur with a combination of belief systems. What examples can you provide of when a child's cultural beliefs conflicted with classroom management and how was this handled with respect to the families belief system?

7

Unanswered questions

- The article discussed how “parent beliefs about the nature of disability are related to parent beliefs about and participation in treatment and intervention”. Have you ever experienced this in a way that you felt limited or benefited the child? Please give examples.

8

Unanswered questions

- The article urged special educators to be “guides who respectfully offer services that families may or may not choose to embrace”. Have you experienced times when families chose not to accept special education services? How have you handled this as a professional?

9

What about Maria?

- What are her strengths?
- What are your concerns for her?
- What potential disorders?
- Hypotheses on functions?
- Meet criteria for special education?
- What else did you want to ask or know more about?

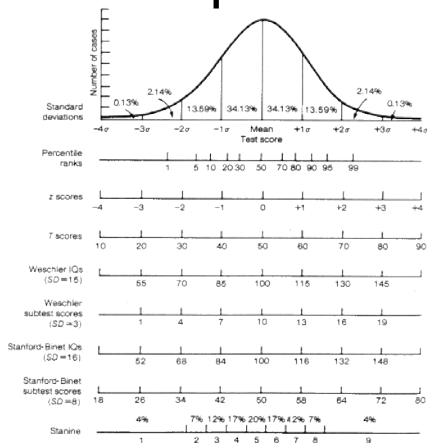
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Maria's EBD Assessment

- Interviews
- Observations
- Social Skills Rating System (SSRS)
- Children's Depression Inventory (CDI)
- Relevant Syndrome Scales of Achenbach System

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Bell Shaped Curve



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Maria's Achenbach's

	<i>Anxious / Depressed</i>	<i>Withdrawn / Depressed</i>	<i>Somatic Complaints</i>	<i>Social Problems</i>	<i>Thought Problems</i>	<i>Attention Problems</i>	<i>Rule-Breaking Behaviors</i>	<i>Aggressive Behavior</i>
Ms. Cortez	Borderline	Clinical	Normal	Clinical	Normal	Clinical	Normal	Clinical
Mrs. Pleasant	Borderline	Borderline	Borderline	Clinical	Normal	Clinical	Normal	Clinical
Ms. Gabby	Clinical	Clinical	Clinical	Clinical	Normal	Clinical	Normal	Borderline
Maria	Clinical	Clinical	Borderline	Clinical	Normal	Borderline	Normal	Borderline

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Maria's Conners' Scales

	<i>Oppositional</i>	<i>Cognitive Problems</i>	<i>Hyperactivity</i>	<i>ADHD Index</i>
Ms. Cortez	Clinical	Clinical	Borderline	Borderline
Mrs. Pleasant	Clinical	Clinical	Borderline	Clinical
Ms. Gabby	Clinical	Clinical	Clinical	Clinical

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Social Skills Rating System

- *Social skills*: cooperation, assertion, responsibility, empathy, self-control
- *Problem Behaviors*: externalizing, internalizing

- What did you think of the SSRS?
- What did it tell you about Maria?
- How could this be helpful in your work?

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The unfinished scale

- Maria's evaluator chose to discontinue administration of the *Piers-Harris 2 Children's Self-Concept Scale*
- A well-established measure of children's perceptions about themselves
- Standardized for children 7-18 years
- Brief self-report measure with yes / no responses



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Piers-Harris 2

- Provides a measure of child's self-concept with a total score (*most reliable*) and six domain scales:
 - *Physical Appearance and Attributes*
 - *Intellectual and School Status*
 - *Happiness and Satisfaction*
 - *Freedom From Anxiety*
 - *Behavioral Adjustment*
 - *Popularity*

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Mood Disorders

"I find nothing more depressing than optimism."
- Paul Fussell

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Depression Concepts

- *Depressed Mood* - focus on symptom or emotional state (*normative approach*)
- *Depression as Syndrome* - empirically derived cluster of behaviors & emotions (*Achenbach approach*)
- *Depression as Disorder* - Combination of conceptually related symptoms show presence of a disorder (*DSM-IV approach*)

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History of Depression

- It was believed that depression did not exist in children in a form comparable to that in adults
- Now believed that children do experience depression, and that depression in children is not masked, but rather may be overlooked because it frequently co-occurs with other more visible disorders

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Mood Disorders

- A mood disorder (also called *affective disorder*) describes a disturbance in mood
- children with mood disorders suffer from extreme, persistent, or poorly regulated emotional states

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Depression in Young People

- Depression is one of the most disabling childhood disorders
- Prevalence in young people is increasing and age of onset is decreasing
- The way in which depression is experienced and expressed changes with age
- Depression in children under age 7 tends to be diffuse and less easily identified

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Major Depressive Disorder

- *DSM-IV clinical diagnosis requires presence of a major depressive episode, which is suggested by:*
 - depressed mood/sadness most of the day, most days (*in children and adolescents, may be irritable mood*)
 - diminished interest or pleasure in activities
 - changes in appetite or weight
 - sleep disturbances
 - psychomotor retardation or agitation
 - fatigue or loss of energy
 - feelings of worthlessness or inappropriate guilt
 - difficulty thinking or concentrating
 - thoughts of death or suicidal ideation

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MDD Prevalence/Comorbidity

- Prevalence:
 - point prevalence 2-8% of children ages 4-18
 - lifetime 0% to 31%
 - more rare among preschool and school-age children, increases into adolescence and adulthood
- Most common comorbid disorders are:
 - anxiety disorders
 - dysthymia
 - conduct problems
 - ADHD
 - substance use disorder

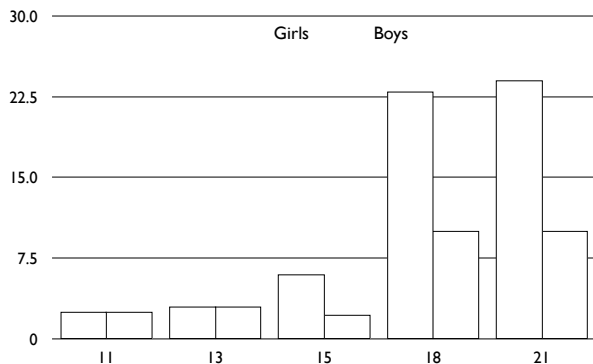
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MDD Developmental Course

- Age of onset usually between 13-15 years
- Average episode lasts 8 months, with almost all children eventually recovering; however a majority of children experience recurrences
- Even after recovery, children often continue to experience adjustment and health problems and chronic stress
- No gender differences until puberty; after puberty, the ratio of girls to boys is about 2:1 to 3:1

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MDD Developmental Course



(p. 228, Mash & Wolfe, 2005)

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Dysthymic Disorder

- less severe but more chronic (depressed mood most of the day, most days, for at least 1 year) than MDD
- in comparison to MDD, DD is associated with less anhedonia, social withdrawal, impaired concentration, death thoughts, and physical complaints, but more constant sadness, self-depreciation, low self-esteem, anxiety, irritability, anger, and temper tantrums
- children with both MDD and DD have “double depression”

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DD Prevalence/Comorbidity

- Rates of DD are lower than MDD, with approximately 1% of children and 5% of adolescents affected
- Most common comorbid disorder is MDD

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DD Developmental Course

- Most common age of onset 11-12 years (earlier than for MDD)
- May be a precursor to MDD for some children
- Average episode length 2-5 years
- Most recover, but are at high risk for developing other disorders, especially MDD, anxiety disorders, and conduct disorder

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Associated Characteristics

- Interference with academic performance
- Cognitive disturbances
- Low or unstable self-esteem
- Social difficulties
- Poor relations with parents and siblings

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Bipolar Disorder (BD)

“Manic-depression distorts moods and thoughts, incites dreadful behaviors, destroys the basis of rational thought, and too often erodes the desire and will to live. It is an illness that is biological in its origins, yet one that feels psychological in the experience of it; an illness that is unique in conferring advantage and pleasure, yet one that brings in its wake almost unendurable suffering and, not infrequently, suicide.”

- Kay Redfield Jamison, Ph.D., *An Unquiet Mind*, 1995, p. 6.

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Bipolar Disorder Features

- periods of abnormally and persistently elevated, expansive, or irritable mood, alternating with one or more major depressive episodes
- several DSM subtypes, based on whether youngster displays a *manic, mixed, or hypomanic episode*

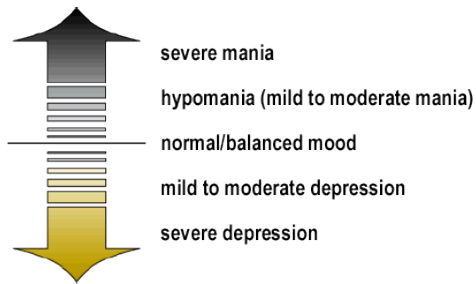
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Symptoms of Mania (*manic episode*)

- Increased energy, activity, and restlessness
- Excessively “high,” overly good, euphoric mood
- Extreme irritability
- Racing thoughts and talking very fast, jumping from one idea to another
- Distractibility, can’t concentrate well
- Little sleep needed
- Unrealistic beliefs in one’s abilities and powers
- Poor judgment
- Spending sprees
- A lasting period of behavior that is different from usual
- Increased sexual drive
- Abuse of drugs, particularly cocaine, alcohol, and sleeping medications
- Provocative, intrusive, or aggressive behavior
- Denial that anything is wrong

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Spectrum of Mood



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Forms of Bipolar Disorder

Form	Description
Bipolar I	recurrent episodes of mania and depression
Bipolar II	milder episodes of hypomania that alternate with depression
rapid-cycling	four or more episodes of illness occur within a 12-month period

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Bipolar Disorder in Children

- often experience very fast mood swings between depression and mania many times within a day
- more likely to be irritable and prone to destructive tantrums than to be overly happy and elated
- Mixed symptoms also are common in youths with bipolar disorder
- Older adolescents who develop the illness may have more classic, adult-type episodes and symptoms
- Can be very difficult to differentiate from ADHD, conduct problems, MD, substance use

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Prevalence/Comorbidity of Bipolar Disorder

- Lifetime estimates of 0.4%-1.2%
- In youngsters, milder bipolar II and cyclothymic disorder are more likely than bipolar I; “rapid cycling” also more common
- Extremely rare in young children, but increases after puberty (when rates are as high as for adults)
- Affects males and females equally
- Most commonly comorbid with anxiety disorders, ADHD, conduct disorders, and substance abuse

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Developmental Course of Bipolar Disorder

- Peak age of onset between 15 and 19 years of age
- Depression usually appears first
- Chronic and resistant to treatment, with poor long-term prognosis

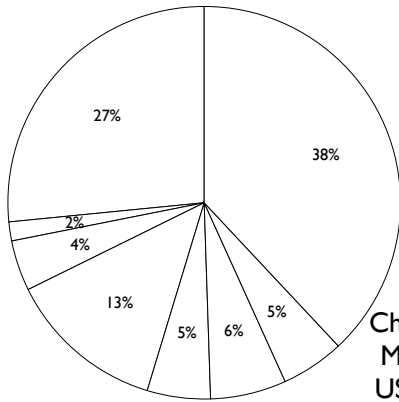
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Suicide

- 276,000 teenagers will attempt; about 5,000 will succeed
- rates declining since peak in 1992
- third highest cause of death for youths (15 to 24 years)
- suicides outnumber homicides 3:2

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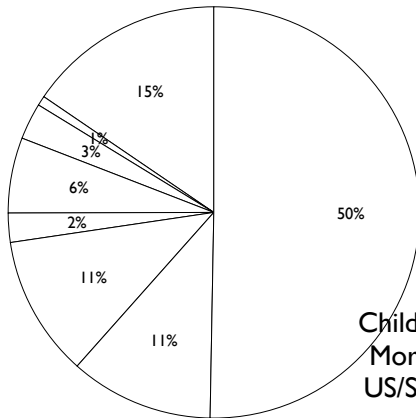
Causes of Death 10-14



Child and Adolescent
Mortality by Cause:
US/State, 2000-2003
CDC, 2006

46

Causes of Death 15-17



Child and Adolescent
Mortality by Cause:
US/State, 2000-2003
CDC, 2006

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Suicide Assessment

- *Suicidal Ideation*: What thoughts is the student having regarding suicide?
- *Suicidal Intent*: How strong is the desire to commit suicide?
- *Suicidal Plan*: Specifics of Plan/Means/Preparations

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Suicide Assessment

- Check specific items on existing checklists & self-reports
 - *Achenbach* "deliberately harms self or attempts suicide"
 - *CDI*:
 - (0) "I do not think about killing myself,"
 - (1) "I think about killing myself but would not do it," or
 - (2) "I want to kill myself."

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*How does your school assess for suicidal ideation?
How does your school handle a situation when a student is suicidal?*

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A few recommendations

- Always take warning signs serious, especially if youth says they want to or are planning on killing themselves
- No evidence that asking about feeling sad or suicidal thoughts increases risk
- Make sure there is a clear safety plan and it is with the youth across all environments

http://www.aacap.org/cs/root/facts_for_families/teen_suicide

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Anxiety Disorders

*"We have nothing to fear but fear itself."
-Winston Churchill*

*"Anxiety is the dizziness of freedom."
- Soren Kierkegaard*

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Experiencing Anxiety

- Anxiety: characterized by strong negative emotion and tension in anticipation of future danger or threat
- Moderate amounts of anxiety is adaptive; helps us cope with potentially dangerous situations
- Anxiety experienced by children with anxiety disorders is excessive and debilitating

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Experiencing Anxiety

- Three interrelated anxiety response systems:
 - physical system - fight/flight response, mediated by the sympathetic nervous system
 - cognitive system - attentional shift and hypervigilance, nervousness, difficulty concentrating
 - behavioral system - aggression and/or avoidance

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Table 7.1
The Many Symptoms of Anxiety

PHYSICAL		
Increased heart rate	Dizziness	Blushing
Fatigue	Blurred vision	Vomiting
Increased respiration	Dry mouth	Numbness
Nausea	Muscle tension	Sweating
Stomach upset	Heart palpitation	
COGNITIVE		
Thoughts of being scared or hurt	Thoughts of incompetence or inadequacy	Thoughts of bodily injury
Thoughts or images of monsters or wild animals	Difficulty concentrating	Images of harm to loved ones
Self-deprecatory or self-critical thoughts	Blanking out or forgetfulness	Thoughts of going crazy
	Thoughts of appearing foolish	Thoughts of contamination
BEHAVIORAL		
Avoidance	Trembling lip	Avoidance of eye contact
Crying or screaming	Swallowing	Physical proximity
Nail biting	Immobility	Clenched jaw
Trembling voice	Twitching	Fidgeting
Stuttering	Thumb sucking	

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Anxiety vs Fear and Panic

- **Anxiety:** future-oriented mood state, which may occur in absence of realistic danger
- **Fear:** present-oriented emotional reaction to current danger, characterized by alarm and strong escape tendencies
- **Panic:** sudden and unexpected fight/flight response in absence of obvious danger or threat



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Normal Fears, Anxieties, Worries & Rituals

- Many fears are developmentally appropriate and most decline with age
- Anxieties common, but *anxious symptoms* do not show the same age-related decline as fears
- Children of all ages worry, but children with anxiety disorders worry more intensely
- Ritualistic and repetitive activity common in young children and helps them to gain control and mastery of their environment

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Generalized Anxiety Disorder

- Excessive, uncontrollable anxiety and worry about numerous events and activities, occurring more days than not
- Worry excessively about minor everyday occurrences
- Often accompanied by physical symptoms (e.g., headaches, stomachaches, muscle tension, trembling)
- 3% to 6% of children (*equal rates in boys and girls*)
- Onset in late childhood or early adolescence
- High co-morbidity with other anxiety disorders and depression

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Social Phobia

- Marked, persistent fear of being the focus of attention or doing something humiliating
- Children with social phobias are more likely to be highly emotional, socially fearful and inhibited, sad, and lonely
- 1-3% of children; slightly more common in girls
- Age of onset often early to mid-adolescence
- Selective mutism may be a form of social phobia

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Specific Phobia

- Extreme, disabling fear of specific objects or situations that pose little or no danger
- Often leads to avoidance or disrupted routines
- Children may not realize the fear is extreme and unreasonable
- 5 DSM-IV subtypes: animal, natural environment, blood-injection-injury, situational, "other"
- 2-4% of children; *more common in boys*
- Peak onset between ages 10 and 13

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Phobias?

Name	Fear of...
Aibohphobia	palindromes
Anachrophobia	temporal displacement
Anatidaephobia	somewhere, somehow, a duck is watching you
<u>Arachibutyrophobia</u>	peanut butter sticking to the roof of the mouth
Hippopotomonstrosesquipedalio phobia	long words
Phobophobia	fear itself

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Obsessive-Compulsive Disorder

- Repeated, intrusive, irrational, and anxiety causing thoughts (obsessions), accompanied by ritualized behaviors (compulsions) to relieve the anxiety
- Extremely resistant to reason
- Often leads to severe disruptions in health, social and family relations, and school functioning
- 2-3% of children; twice as likely in boys
- Age of onset 9-12 years
- High co-morbidity with other anxiety disorders, depression, disruptive behavior problems

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Panic Disorder

- *Panic attack*: a sudden and overwhelming period of intense fear or discomfort accompanied by characteristics of the flight/fight response
- *Panic disorder*: recurrent unexpected panic attacks, as well as persistent concern about the possible implications and consequences of having another attack
- High anticipatory anxiety and situation avoidance may lead to agoraphobia
- Panic attacks common, panic disorder much less common
- Age of onset 15-19 years
- *Worst prognosis of all anxiety disorders!*

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Adjustment Disorders

- Maladaptive behavioral or emotional reaction to identified stressful event
- Occurs within 3 months of stressor
- Depressed mood, anxiety, both
- Disturbance of conduct
- Mixed disturbance of emotions and conduct

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PTSD & Acute Stress Disorders

- PTSD: characterized by persistent anxiety following an extremely traumatic experience; 3 core features:
 - 1) persistent re-experiencing of the event,
 - 2) avoidance of associated stimuli and numbing of general responsiveness, and
 - 3) symptoms of extreme arousal
- Acute stress disorder: development of dissociative symptoms within one month after a traumatic experience, lasting at least two days but not longer than a month (short-lived)

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Complex PTSD

- Prolonged period of *total control* by another (e.g., child abuse)
- Can lead to severe alterations in:
 - emotion regulation
 - consciousness
 - self-perception
 - perception of perpetrator
 - relationships
 - system of meaning

For more info see:
*National Child Traumatic
Stress Network*
<http://www.nctsnet.org>

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Associated Characteristics of Anxiety Disorders

- Cognitive deficits in areas such as memory, attention, speech, or language
- Interference with academic performance
- Hypervigilance to and avoidance of threatening stimuli
- Misattribution of threat
- Somatic complaints
- Social withdrawal, loneliness, low self-esteem, difficulty initiating and maintaining friendships
- Strong relationship between depression and anxiety

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Gender, Ethnicity, and Culture

- Higher incidence in girls
- Children's ethnicity and culture may affect the expression and developmental course of fear and anxiety
- Cultures that favor inhibition and compliance may have increased levels of fears in children
- Child psychopathology reflects a mix of actual child behavior and the lens through which others view it in a child's culture (Behavior + Lens Principle)

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Comorbidity Anxiety/Depression

- More likely for children with depression to have an anxiety disorder than children with anxiety disorders to also be depressed (i.e., anxiety precedes depression)
- Why such high comorbidity?
 - high rate of symptom overlap
 - one underlying construct is split into two separate disorders
 - disorders share common risk or etiological factors
 - one disorder causes or increases the risk of developing the second disorder

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Tripartite Model

	Negative Affect	Positive Affect	Physiological Arousal
anxiety	high	normal	high
depression	high	low	normal

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Treatment

- Behavior therapy - exposure to feared stimulus, while providing ways of coping other than escape and avoidance
- Cognitive-behavioral therapy - teaches modification of maladaptive thoughts to decrease symptoms (most effective for most anxiety disorders)
- Medications can reduce symptoms, especially for OCD
- Family interventions may result in more dramatic and long-lasting effects

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The power of relaxation



75

Coping Cat & C.A.T. Programs

(Kendall, 2003)

- For: SAD, GAD, & SoP
- Education
- Relaxation training
- Cognitive restructuring (FEAR plan)
- Problem solving
- Exposure



The Coping Cat

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Coping Cat - FEAR Plan

- F - Feeling frightened? (*physical symptoms*)
- E - Expecting bad things to happen? (*cognitions*)
- A - Actions & Attitudes (*self-talk & behaviors*)
- R - Rewards (*evaluating and rewarding effort*)

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Exposure & Practice

- develop a list of easy, moderate, and hard situations
- experience situations first in imagination; next in reality
- “practice in private; perform in public” (Kendall, 2003)

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Now to address your anxiety...

- Changes to readings for last class
 - Chapters 11 & 15 + Updated readings on strength-based assessment (I'll send to you by email)
- Resource chapter-guide - *Next class*
- Functional behavioral assessment - *Next class*
- *Case study feedback by the end of the day on Monday*
- School-level data
