Treating anxiety in early life

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Summary

Anxiety disorders in preadolescence are the most common serious disorder of childhood, affecting around 1 in 30 British children. These conditions are chronic, distressing and impairing. They are treatable, but we are currently doing a poor job of serving these children.

Treating Anxious Pre-Adolescent Children – A Neglected Group.

In an article in 2006, I wrote a systematic review, arguing that pre-adolescent children with anxiety disorders were a neglected group (Cartwright-Hatton, McNicol, & Doubleday, 2006). Scanning the epidemiological literature for prevalence of anxiety in the pre-adolescent age group, it became clear that anxiety disorders are the most common psychiatric disorder of childhood. Prevalence rates ranged from 2.6% to 41.2%, with a rate of just over 3% arising from a large, carefully conducted British study (Ford, Goodman, & Meltzer, 2003a). Of the studies that also reported prevalence rates for other psychological disorders, all seven found childhood anxiety to be more common than childhood depression, and four of six found childhood anxiety to be more common than disorders of behaviour. And, if anxiety is the most common psychiatric disorder of childhood, then might it actually be the most common serious and chronic physical health condition of childhood...? Asthma is widely thought to be the most common, serious physical health condition of childhood (in the developed world, at least), and estimates of its prevalence, according to a recent, large, multi-national study, range from 2.8% to 37.6% in 6-7 year olds (Asher et al., 2006), which is comparable to the estimates for anxiety disorders that I unearthed for the systematic review. Like anxiety disorders, asthma covers a range of severities, and, happily, is outgrown by many children. Like anxiety disorders, it is a cause of significant morbidity and mortality. Unlike childhood anxiety disorders, it is taken seriously, widely treated, and extensively researched.

Despite the fact that, even according to conservative estimates, 1 in 30 children has a diagnosable anxiety disorder, it seems likely that the majority of children never receive any kind of treatment for their condition. We don’t know much about access to treatment by anxious children, but in a two-year period of recruiting anxious children to a treatment trial in a large British city, I managed to find just six children who had made it to CAMHS. The remaining 70 were self-referred by exasperated parents, many of whom had previously tried, and failed, to get support for their child. This is supported by findings from a UK-based
survey of child and adolescent mental health service use, which showed that just 17.7% of 5-15 year olds with emotional disorders had accessed CAMHS. This figure was even lower (across disorders) for younger children, and was approximately the same proportion (again, across disorders) as had received help from ministers of religion and practitioners of alternative medicine (Ford, Goodman, & Meltzer, 2003b). I’m not going to dwell on the reasons for these difficulties. It is, I suspect, a combination of under-recognition of symptoms by some parents, under-recognition of the consequences of these by primary care staff, and under-resourcing in CAMHS.

But what is all the fuss about? Should we be bothering to treat these children? I think that the answer to this question lies in two parts, which I shall address in turn. First, what happens if we don’t treat them? Second, what happens if we do?

What happens if we don’t treat anxious children?

The good news is that a significant proportion of anxious children will grow out of their anxiety disorder. Several large-scale, longitudinal, cohort studies, such as the New York Longitudinal Study, the Dunedin Study and the Great Smokey Mountains Study have attested to this. However, each of these studies also suggests that a large proportion of anxious children will remain thus into adolescence and early adulthood, although the nature of their anxiety diagnosis may change, and this may be less likely for some anxiety disorders than others.

Moreover, we are starting to see that children with anxiety disorders are at risk of a range of other psychiatric conditions. Longitudinal studies suggest that anxious children are at particularly high risk of subsequent depression and probably also substance misuse, when they reach adolescence and discover that they can self-medicate. Regardless of whether anxious children maintain their anxiety disorder or develop other diagnoses, we know that they are at risk of a range of related difficulties, including underperformance at school, relationship problems and, less widely known, markedly increased levels of suicidality. Anxiety disorders are also costly to families, and accordingly, to society: A recent Dutch study (Bodden, Dirksen, & Bögels, 2008) showed that having a child with an anxiety disorder imposed health-related costs on families (missed work, extra childcare, etc.) that were over 20 times higher than for non-anxious children.

What happens if we do treat anxious children?

This issue of the British Journal of Psychiatry reports a trial of a cognitive behaviour therapy (CBT) based intervention for anxiety in 7-12 year olds. In this study, over 70% of those receiving the intervention were free of their primary anxiety disorder at 6-month follow up. Shockingly, the first randomized trial to attempt to treat anxious youth using a psychological intervention did not appear until 1994. This produced pretty pleasing results: using CBT with its 9-13 year old sample, two-thirds were free of their primary diagnosis at the end of treatment (P C Kendall, 1994). Since then, there have been a few dozen trials,
mostly using variants of CBT, mostly with fairly heterogeneous groups of anxious children. A recent systematic review of these (Reynolds, Wilson, Austin, & Hooper, 2012) concluded that CBT was effective for the treatment of anxiety disorders in children and adolescents. When effect sizes for studies treating adolescents and children were compared, results were more favourable for the former (a 'very large' effect size), but there was still a 'moderate' effect size for preadolescents. Unsurprisingly, results were also weaker in studies that employed an active control group, but these still showed a positive effect for CBT.

Unfortunately, we still know little about what happens to treated children in the longer term. Most recent studies have reported follow up to six or twelve months, and these usually show maintenance or slight improvement in outcomes for treated participants. Very few trials have followed up participants any longer, but those that have (e.g. Philip C Kendall, Safford, Flannery-Schroeder, & Webb, 2004 re-assessed children 7.4 years after treatment) have shown that treatment gains were maintained. Assuming that this study is representative, it seems that longer-term reductions in anxiety are possible, although, for obvious ethical reasons, no untreated control group was followed up during this period.

Similarly, there is precious little research examining the impacts of treatment on the other difficulties that anxiety is associated with. So, for example, we don’t really know whether treating childhood anxiety improves school performance, or interpersonal relationships, or whether it reduces the risk of subsequent depression or substance misuse (although the 7.4 year follow-up study described above suggests that it might). There are good theoretical reasons to think that it will, but we can’t, at present, be sure.

Conclusion

Despite the gaps in our knowledge, the case for treatment is pretty clear. Thirlwall et al (this issue) show that a fairly light touch intervention produced outcomes equivalent to those reported by the systematic review of CBT cited above. This intervention consisted of just four face-to-face sessions and four telephone calls with a therapist. Moreover, this interesting study produces some engaging evidence that therapists need not be highly skilled or experienced to achieve these results: therapists with no previous clinical experience and very little training performed as well as a group with moderate levels of experience (although it should be noted that all were well-supervised and working closely to a detailed manual.

There are a lot of anxious children out there, and while they are not being treated, they are storing up a lot of trouble for the future. We have the means to help them, and we should we be doing so.
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References


