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Mental Health Professionals' Network

Webinar

Working Collaboratively to Support Students Experiencing Exam Anxiety

Wednesday, 25th May 2016

"Working together. Working better."

Supported by The Royal Australian College of General Practitioners, the Australian Psychological Society, the Australian College of Mental Health Nurses and The Royal Australian and New Zealand College of Psychiatrists

This webinar is presented by mhpn Mental Health Professionals' Network

Tonight's panel

A/Prof Craig Hassed
GP (Vic)

Prof Valsamma Eapen
Psychiatrist (NSW)

Ms Jodi Nilsson
Psychologist (Qld)

Mr Paul Jameson
School Social Worker (Vic)

Facilitator

Dr Mary Emeleus
GP and Psychotherapist (Qld)

Ground Rules

To help ensure everyone has the opportunity to gain the most from the live webinar, we ask that all participants consider the following ground rules:

- Be **respectful** of other participants and panellists. Behave as if this were a face-to-face activity.
- Post your **comments and questions** for panellists in the '**general chat**' box. For help with **technical issues**, post in the '**technical help**' chat box. Be mindful that comments posted in the chat boxes can be seen by all participants and panellists. Please keep all comments on topic.
- If you would like to **hide the chat**, click the **small down-arrow** at the top of the chat box.
- Your feedback is important. Please **complete the short exit survey** which will appear as a pop up when you exit the webinar.

Learning Outcomes

Through an exploration of anxiety in students, the webinar will provide participants with the opportunity to:

- Describe how to engage with young people to assess their anxiety
- Implement key principles of providing an integrated approach in the early identification of youth who are at risk of suicide and/or self-harm due to stress and anxiety from end of school studies
- Identify challenges, tips and strategies in providing a collaborative response to assisting youth who are experiencing stress and anxiety when completing their end of school studies.

General Practitioner Perspective

Jessica

- Stable home situation
- Conscientious student (too much so?)
- Social isolation – work helpful
- Grumpy and emotional – normal adolescence or mental health problem?
- Irregular sleeping hours (online at night?)
- Jessica reluctant to see doctor
- Really wants to be a dentist but is it her motivation or the parents'?
- GP refers Jessica to a psychologist – what can the GP offer?
- Tendency to worry / ruminate a lot

A/Prof Craig Hassed

General Practitioner Perspective

A (holistic) GP perspective

- Open and non-confrontational consulting style: curious and inquiring rather than telling
- What is her agenda?
- Would not prescribe medications – poor evidence esp. in adolescents
- Growing evidence for a range of lifestyle and self-help strategies e.g.
  - Mindfulness
  - Sleep
  - Exercise
  - Diet
  - Spirituality / meaning
  - Self-compassion
- Motivation has to be Jessica's – empowerment not imposition

A/Prof Craig Hassed

General Practitioner Perspective

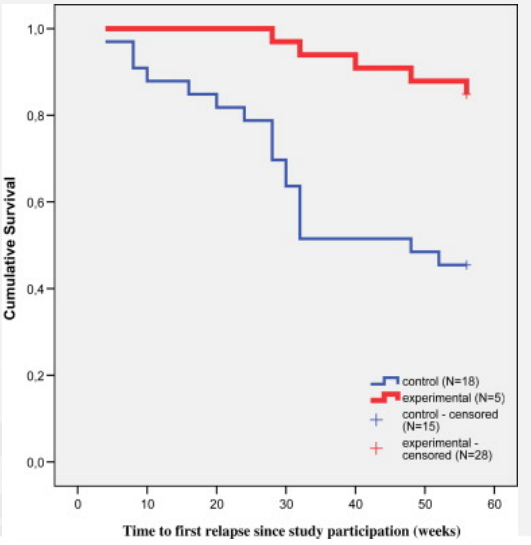
MBCT and depression

- RCT investigated the effects of Mindfulness-based cognitive therapy (MBCT) on the relapse in depression, time to first relapse and the quality of life
  - 106 recovered depressed patients with a history of at least 3 depressive episodes
  - Treatment as usual (TAU) vs MBCT plus TAU 1 year f/up
- Relapse/recurrence significantly reduced and the time until first relapse increased in the MBCT plus TAU c/w TAU
- MBCT plus TAU group also showed a significant reduction in both short and longer-term depressive mood, better mood states and quality of the life
  - Godfrin KA, van Heeringen C. The effects of mindfulness-based cognitive therapy on recurrence of depressive episodes, mental health and quality of life: A randomized controlled study. Behav Res Ther. 2010 Aug;48(8):738-46.

A/Prof Craig Hassed

General Practitioner Perspective

Godfrin KA, van Heeringen C. Behav Res Ther. 2010 Aug;48(8):738-46.



A/Prof Craig Hassed

General Practitioner Perspective

Mindfulness, adolescents & mental health

- "Mindfulness-based stress reduction (MBSR) program for adolescents age 14 to 18 years with heterogeneous diagnoses in an outpatient psychiatric facility.
- Relative to treatment-as-usual control participants, those receiving MBSR self-reported reduced symptoms of anxiety, depression, and somatic distress, and increased self-esteem and sleep quality."
  - Biegel et al. Mindfulness-based stress reduction for the treatment of adolescent psychiatric outpatients: A randomized clinical trial. Journal of consulting and clinical psychology (2009) vol. 77 (5) pp. 855-66 http://dx.doi.org/10.1037/a0016241

A/Prof Craig Hassed

General Practitioner Perspective

Mindfulness in schools

- 2012 systematic review of evidence regarding the effects of school-based mindfulness interventions on psychological outcomes
- 24 studies identified with a total of 1348 students and 876 serving as controls, ranging from grade 1 to 12
  - Between group effect sizes for domains were: cognitive performance g = 0.80, stress g = 0.39, resilience g = 0.36, emotional problems g = 0.19 third person ratings g = 0.25
- "Mindfulness-based interventions in children and youths hold promise, particularly in relation to improving cognitive performance and resilience to stress."
  - Zenner C, Herrnleben-Kurz S, Walach H. Mindfulness-based interventions in schools-a systematic review and meta-analysis. Front Psychol. 2014 Jun 30;5:603. doi: 10.3389/fpsyg.2014.00603.

A/Prof Craig Hassed

General Practitioner Perspective

Mindfulness and adolescents

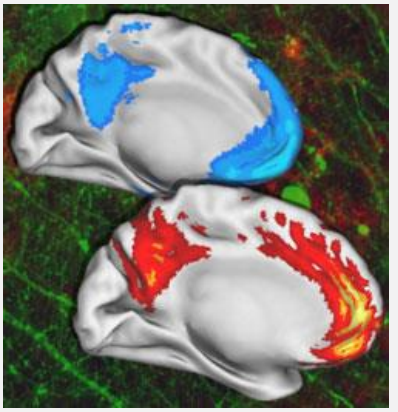
- Qualitative study on mindfulness and adolescents' emotional control
- Participants described daily lives as beset by frequent experiences of distress worsened by their unhelpful or destructive reactions
- Mindfulness practice led to greater calm, balance, and control
- Developed a clearer understanding of themselves and others
- Mindfulness described as a "mindset" associated with greater confidence and competence and a lessened risk of future distress
- "with ongoing mindfulness practice and within a relatively short time, participants were able to move beyond improved emotion regulation and gain greater confidence in their ability to manage life challenges."
  - Monshat K, Khong B, Hassed C, et al. "A conscious control over life and my emotions:" mindfulness practice and healthy young people. A qualitative study. J Adolesc Health. 2013 May;52(5):572-7. doi: 10.1016/j.jadohealth.2012.09.008

A/Prof Craig Hassed

General Practitioner Perspective

The Default Brain

- Active tasks
  - Tasks associated with paying attention
  - Brain efficient and quiet
- Default state (mode)
  - The default-mode network (DMN) is a major resting-state network that supports most of the baseline brain activity
  - Mind is inattentive, distracted, idle, recalling past, daydreaming



A/Prof Craig Hassed

General Practitioner Perspective

Default mode network

- Default mental activity flourishes in various forms of psychopathology including depression, anxiety, schizophrenia and autism
- Default activity decreased or deactivated when paying attention (e.g. experienced meditators)
- In experienced meditators but not novices, even when the default mode network is active, brain regions associated with self-monitoring and cognitive control are co-activated
  - Reduces vulnerability to default thinking
    - Brewer JA, Worhunsky PD, Gray JR, et al. Meditation experience is associated with differences in default mode network activity and connectivity. Proc Natl Acad Sci U S A. 2011 Dec 13;108(50):20254-9.

A/Prof Craig Hassed

General Practitioner Perspective

Sleep and health: depression

- Detailed histories from depressed patients reveal that it is common for sleep disturbance to precede lowered mood
  - i.e. chronically poor sleep is a major risk factor for mood disorders
- Chronic insomnia trebles the chance of depression
  - Increased risk four times greater for women and twice as great for men
- Insomnia second to bereavement as a risk factor for depression: more significant than a previous episode of depression
  - Holsboer-Trachsler E, Seifritz E. World J Biol Psychiatry. 2000;1(4):180-6.
  - Buysse DJ. Geriatrics 2004;59(2):47-51.
  - Riemann D, Voderholzer U. Journal of Affective Disorders 2003;76(1-3):255-9.
  - Cole MG. Dendukuri N. American Journal of Psychiatry. 2003;160(6):1147-56.
  - Mallon L, Broman J, Hetta J. Int Psychogeriatr. 2000;12(3):295-306.

A/Prof Craig Hassed

General Practitioner Perspective

Exercise and mental health

- Evidence supports inclusion of Physical Activity programs as an adjunct to treatment for various conditions including:
  - Depression
  - Schizophrenia
  - Anxiety disorders
  - Post-traumatic stress disorder
  - Substance abuse
- Need for inclusion of clinical PA programs within mental health treatment, facilitated by dedicated clinicians (e.g. exercise physiologists / physiotherapists)
- "PA is a feasible, effective and acceptable adjunct to usual care for a variety of mental disorders. There is a clear need for greater investment in initiatives aiming to increase PA among people experiencing mental illness, given the benefits to both mental and physical health outcomes."
  - Rosenbaum S, Tiedemann A, Stanton R, Parker A, Waterreus A, Curtis J, Ward PB. Implementing evidence-based physical activity interventions for people with mental illness: an Australian perspective. Australas Psychiatry. 2015 Jul 2. pii: 1039856215590252.

A/Prof Craig Hassed

General Practitioner Perspective

Nutrition and mental health

- Healthy and unhealthy diet quality scores correlated with incidence of depression
  - Adjusted for age, gender, socioeconomic status, parental education, parental work status, family conflict, poor family management, dieting behaviours, body mass index, physical activity, and smoking
- Compared to the lowest quintile, the adjusted odds ratios for symptomatic depression across increasing quintiles of the unhealthy diet score were:
  - Q1 = 1.00 (healthy whole-food diet)
  - Q2 = 1.03
  - Q3 = 1.22
  - Q4 = 1.29
  - Q5 = 1.79 (poor diet – fast and processed foods, empty calories)
  - Jacka FN, Kremer PJ, Leslie ER, et al. Associations between diet quality and depressed mood in adolescents: results from the Australian Healthy Neighbourhoods Study. Aust N Z J Psychiatry. 2010 May;44(5):435-42.

A/Prof Craig Hassed

General Practitioner Perspective

Spirituality and depression

- Meta-analysis on association between religiousness and depressive symptoms (147 independent investigations (N=98,975))
- Overall, correlation b/w religiousness and depressive symptoms –.096 i.e. greater religiousness is mildly associated with fewer symptoms
- Religious orientation: Intrinsic -.175, Extrinsic +.155
- Religious coping: Positive -.167, Negative +.136
- Religiousness–depression association stronger in studies involving people who were undergoing stress due to recent life events
- Extrinsic religious orientation and negative religious coping (e.g., avoiding difficulties through religious activities, blaming God for difficulties) associated with higher levels of depressive symptoms
  - Smith TB, McCullough ME, Poll J. Religiousness and Depression: Evidence for a Main Effect and the Moderating Influence of Stressful Life Events. Psychological Bulletin 2003;129(4):614–636.

A/Prof Craig Hassed

General Practitioner Perspective

Self-compassion

- Can treating oneself with compassion after making a mistake increase self-improvement motivation?
- Self-compassion intervention compared to a self-esteem control group, no intervention or a positive distraction control group
- Self-compassion associated with:
  - Greater belief that a personal weakness can be changed for the better
  - Greater motivation to make amends and avoid repeating a moral transgression
  - More time studying for a difficult test following an initial failure
  - A preference for upward social comparison after reflecting on a personal weakness
  - Greater motivation to change the weakness
  - Breines JG, Chen S. Self-Compassion Increases Self-Improvement Motivation. Pers Soc Psychol Bull published online 29 May 2012 DOI: 10.1177/0146167212445599

A/Prof Craig Hassed

School Social Worker Perspective

School support options

- Alternative options for completing year 12
- School engagement – are there concerns around disengagement, non-attendance or school refusal?
- Interventions aimed at improving level of school engagement
- Speaking with year level coordinators and teachers at school
- In school referrals for support - student wellbeing, school counsellor, adolescent health nurse and school chaplain
- Safety planning at school if there are concerns about safety

Mr Paul Jameson

School Social Worker Perspective

Careers/Course counselling

- Careers counsellors' area available through many secondary schools
- Careers expos are available for young people and parents to explore different career and study options
- Online careers and course help is available
- Job outlook careers quiz: http://joboutlook.gov.au/careerquiz.aspx
- Careers help: http://myfuture.edu.au

Mr Paul Jameson

School Social Worker Perspective

Risk assessment and safety planning

- What are the risk factors for Jessica?
- Suicidality - is there a history of suicidal thoughts, current or previous plans, previous attempts?
- Self-harming behaviour - is Jessica engaging in self harming behaviours?
- What is her current level of self-care?
- Online behaviour and engagement with social media
- Substance misuse issues?
- Other at risk behaviours?

Mr Paul Jameson

Psychologist Perspective

Standard approach anxiety/depression and stress

- HEADSS and further mental health assessment
- Treatment and advocacy
  1. **Address physical distress**
     - Lifestyle factors (regulate and balance)
  2. **Problem solve**
     - Involve school
     - Change routine
     - Pathway planning
  3. **If you can't change the world, change your mind**
     - Treat cognitive symptoms

Ms Jodi Nilsson

Psychologist Perspective

Psychological treatment

- Note internal versus external pressures
  - Psycho-education (family and individual)
  - Interpersonal therapy
  - Existential therapy
  - CBT
  - ACT
  - Schema (limited time frame makes this more difficult)

Ms Jodi Nilsson

Psychologist Perspective

Specifics to this case

- Urgency and alarm (catastrophic thinking can dominate)
- Relationship with mother, change in family home
- Explore beliefs of different family members and find resolution
- Educate parents on pathways and school advocacy
- Crisis of Individuation/developmental stage

Ms Jodi Nilsson

Psychologist Perspective

Specifics to this case

- Where are you most comfortable/most uncomfortable?
- What would you like your parents to say to you?
- If you could do anything you want right now, what would it be?
- Tell me about your day yesterday?
- Why dentistry?
- What would happen if you decided not to do dentistry?

Ms Jodi Nilsson

Psychiatrist Perspective

Assessment: Points to consider

- **Symptom pattern:** first time or any past history? Severity, duration, urgency for Rx?
- **Clinical features:** mixed anxiety (e.g. panic attacks, other anxiety symptoms (e.g. social, generalised etc.); & depressive symptoms (e.g. melancholic or vegetative symptoms such as sleep and appetite disturbance; psychotic symptoms, atypical or somatic symptoms etc.)
- **Predisposing** (e.g. genetic – family history; environmental - school or home related (e.g. relationship issues - family or friendship issues), **precipitating** (e.g. HSC; interpersonal conflicts,) or **perpetuating** factors (e.g. poor self esteem, bullying, pressure to perform, high expectations - self (e.g. high self imposed expectations; perfectionistic) or others (family exerting pressure to perform) etc.
- **Risk Assessment** (e.g. deliberate self harm, suicidality)

Prof Valsamma Eapen

Psychiatrist Perspective

Other diagnostic considerations

- Bipolar (history of any manic or hypomanic features: elated, excited or irritable mood etc.)
- Disruptive Mood Dysregulation disorder (new DMS-5 category for young people presenting with persistent irritability, anger outbursts etc.)
- Premenstrual Dysphoric Disorder (low mood that commences following ovulation and lasts till beginning of new menstrual cycle)
- Secondary (e.g. substance or medication induced; due to medical condition e.g. Hypothyroidism)

Prof Valsamma Eapen

Psychiatrist Perspective

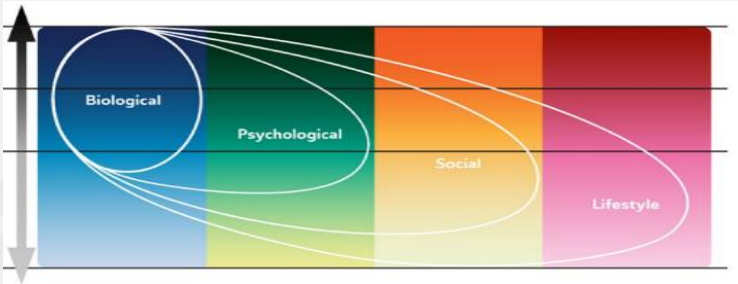
Goals of Treatment

- Relieve symptoms, reduce functional impairment (cope & adapt); improve quality of life
- Patient-centric perspective: collaborative treatment plan with shared decision making
- Expectation, attitudes and perception of the therapeutic alliance is a strong predictor of engagement, adherence to Rx and outcomes
- Failing to engage in psychological therapy: ? Internet based interventions; school/family support is critical
- Medication: SSRIs for moderate to severe anxiety /depression esp. with sleep/appetite issues; severe panic, psychomotor retardation, hopelessness, guilt, suicidality, severe obsessive/compulsive features etc.
- Co-morbidity: Substance use; personality (e.g. borderline)

Prof Valsamma Eapen

Psychiatrist Perspective

Biopsychosocial lifestyle model (Malhi et al 2015)



Biological Treatments	Psychological Treatments	Social Treatments	Lifestyle Treatments
· Antidepressants · Antipsychotics · Mood stabilisers · Electroconvulsive therapy · Transcranial magnetic stimulation	· Brief cognitive behavioural therapy · Formal cognitive behavioural therapy · Interpersonal therapy · Mindfulness · Acceptance and commitment therapy · Schema therapy	· Family psychoeducation · Family / friends · Formal support groups · Community groups · Caregivers · Employment · Housing	· Exercise · Diet · Smoking cessation · Alcohol cessation · Ceasing drugs · Managing substance misuse · Sleep

Prof Valsamma Eapen

Q&A session

Thank you for your participation

- Please ensure you complete the *exit survey* before you log out (it will appear on your screen after the session closes). Certificates of attendance for this webinar will be issued within two weeks.
- Each participant will be sent a link to online resources associated with this webinar within one week.
- Our next webinar:

Working together to support people who deliberately self-harm
Monday, 20th June 2016

Are you interested in joining an MHPN youth network in your local area? View a list of MHPN's youth networks here. Join one today!

For more information about MHPN networks and online activities, visit www.mhpn.org.au

Thank you for your contribution and participation