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# Anxiety and depression

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# Table of content

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# Synthesis

**How important is it?**

Mental health problems experienced in adulthood often begin in childhood and adolescence. It is estimated that 1 in 7 children suffer from mental health problems worldwide. One of the major types of mental health issues found in childhood is internalizing problems. Internalizing problems are characterized by emotional distress turned inward, which makes these problems difficult to recognize. Unlike normal fear, shyness and sadness, internalizing problems impair a young child's functioning and development.

Internalizing problems include depression and anxiety. Symptoms of depression in older children include feelings of sadness, eating/weight problems, sleep disturbance, loss of energy and low self-esteem. Although the controversy about diagnosing depression in young children is ongoing, symptoms can be experienced as early as 3 years of age. By 2030, the World Health Organization expects depression to become the second most important burden of disease after HIV/AIDS.[1]

Anxiety disorders can also cause significant distress and impairment in young children and merit special consideration. Anxiety problems exist when children's emotional reactions are disproportionate to the nature of the situation they are facing (ex.: tearful outbreaks when being separated from a parent) and when they interfere with the child's life. Anxiety disorders often precede major depression.

Although distinct from each other, depressive and anxiety symptoms often overlap and co-occur. This is especially obvious in posttraumatic stress disorder (PTSD). PTSD is a severe psychological condition that can develop following exposure to a trauma and seriously impairs a person's functioning. An early traumatic experience can lead to long-lasting effects and children who live through it are at risk for developing PTSD.

**What do we know?**

One of the reasons for the controversy in diagnosing a child with depression or an anxiety disorder is that traditional assessment tools were developed for adults and do not adequately capture impairments that are specific to different developmental stages (e.g., disturbance in family

routine). In addition, it is often difficult for young children to explain how they feel. Fortunately, new innovative methods such as puppet interviews and picture tests have been used to help children express their emotions.

The first signs of internalizing problems are often observed in the peer group, where depression and anxiety can manifest themselves as self-consciousness, fearfulness, preoccupation and nervousness. Children with internalizing problems often struggle with initiating contact or conversation, talk very little and make infrequent eye contact. These socially withdrawn behaviours make them more likely to be victimized by peers. The friendships of anxious or depressed children also tend to be less frequent, of poorer quality, and with children who also display internalizing problems, which can worsen existing problems. However, having at least one close friend can also protect a child from some of the detrimental effects of internalizing problems. Engaging in prosocial behaviours, having friends and supportive parents, and having high emotion regulation can protect bullied, victimized, and rejected youth from internalizing problems.

Both genes and environment put children at risk for developing internalizing problems. One of the most robust risk factors for anxiety is behavioural inhibition, an early temperament trait characterized by intense fear, distress and reactivity to new situations. The odds of developing anxiety disorders in later life are much higher for children who are behaviourally inhibited in early childhood. Children who are behaviourally inhibited are often socially withdrawn and, as a consequence, are at risk for peer rejection, which can exacerbate feelings of anxiety and isolation.

The link between behavioural inhibition and social withdrawal appears to be particularly strong for children who display attentional bias to threat, a cognitive distortion often related to anxiety. Skills involving executive functions such as cognitive monitoring and inhibitory control can also elevate anxiety in behaviourally inhibited children.

Environmental risk for internalizing problems includes certain parenting behaviours. The magnitude of the effect of parenting is small, but appears to be a consistent risk in the development of internalizing problems.  Moreover, parental responses may have a greater impact on anxiety in early childhood. Children of parents who are overprotective, overcritical or use harsh discipline tend to have poor emotion regulation skills and are more susceptible to emotional health difficulties. Parents who are themselves anxious can also put children at risk for anxiety disorders by modeling avoidant or anxious behaviours. The effects of these parenting behaviours

are especially strong for children with behavioural inhibition.

Poor attachment is another risk factor for the development of anxiety and depression. Caused by a history of unresponsive and insensitive caregiving environment, an insecure attachment can lead children to develop poor emotion regulation skills and a negative sense of self, both associated with internalizing problems.

**What can be done?**

An initial necessary step in understanding the development of childhood depression and anxiety is to expand assessment of these conditions in the clinical and research setting through multi-method, multi-session and multi-informant techniques. While including a screening for internalizing problems during standard check-ups might be ideal, targeting at risk children and families may represent a more cost-efficient and realistic method to prevent or reduce negative consequences associated with internalizing problems. For instance, accurate screening in locations where children are at risk for experiencing trauma (e.g., hospitals) or identifying children who are behaviourally inhibited at an early age can have a major impact on children, their families and society at large.

Parents can be reassured that several individual treatments have been found to help children who are depressed or anxious, although consistent treatment programs remain to be developed. Anti-depressant medications have been used with some success among children as young as 6 years, but their use is now limited as a last resort option because of health concerns. Cognitive behavioural therapy (CBT) is the most common and effective method to treat anxiety and depression in childhood. CBT focuses on helping children identify and confront their own distorted thinking habits and involves behavioural techniques that gradually expose children to anxiety-provoking situations. Play-based CBT has been used with children as young as 4 years of age.

Involving parents in treatment is beneficial in reducing symptoms of depression and anxiety. CBT often includes parents in the treatment agenda by coaching them on exposure techniques and teaching them management skills pertaining to anxiety. These interventions further enable parents to optimally adjust their parenting style to their child’s temperament, by becoming less overprotective and less anxious. In cases of posttraumatic stress disorder, interventions should target both the needs of the child and the parents to reduce distress of all parties and promote family functioning.

Early intervention that includes psychoeducation, parental involvement and coping skills training is also key to preventing the development of serious and enduring mental health problems. Early social interactions with peers should be supervised by parents and teachers to check for early signs of internalizing problems, and can even be an ideal target for early intervention focused on social skills training. A collaborative effort between parents, health professionals and child care workers promises to be most effective in creating a stable and coherent environment for children.

Policy makers interested in children's mental health should give priority to evidence-based programs and quality intervention studies examining treatment effectiveness for depression and anxiety in childhood. Information should be disseminated to service providers about the manifestation of anxiety and depression in early childhood as these internalizing problems often go undetected. Service providers dealing with childhood trauma should also be aware of the systemic impact of a traumatic experience on the family as a whole.

**Note:**

[1] World Health Organization. Global Health Estimates: Life expectancy and leading causes of death and disability. http://www.who.int/topics/global_burden_of_disease/en/. Accessed September 17, 2024.

# Recognition and Assessment of Anxiety & Depression in Early Childhood

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## Introduction

Anxiety disorders are characterized by emotional arousal associated with fear, worry, or nervousness that is out of proportion to the situation. Significant fears in preschool-aged children have been documented since the 1920's,[1] but were not widely recognized as clinically impairing and deserving of specialized treatment until early in the 21st century. Young children's anxiety often manifests as fearfulness, defiance, or tearful outbursts in stressful situations (e.g., separating from a caregiver). Diagnosis of depression in early childhood remains rare, but symptoms seen in older children, including sadness, appetite/weight problems, sleep problems, low energy, irrational guilt, and low self-esteem can represent a distinct syndrome in young children,[2] and the clinical syndrome of preschool-onset Major Depressive Disorder has been validated.[3] Evidence suggests that anxiety and depressive symptoms in young children are correlated but distinct entities, with unique symptom trajectories.[4] To meet diagnostic criteria, symptoms must be severe enough to impair normal functioning. Most young children with depressive symptoms do not meet the criteria for a formal DSM-5 diagnosis, but experts agree that children can experience the core symptoms of depression by age 3.[2]

In psychopathology *research*, assessment is designed to capture psychological phenomena to deepen understanding of disorder presentation, course, risk factors, and treatments. Assessment in a *clinical* context refers to gathering screening and/or clinical data to inform clinical judgments regarding the diagnostic presentation of a specific child and to tailor individualized interventions to promote optimal social, academic, and family functioning. The key to valid, reliable assessment is employing a multi-method, multi-informant approach that includes repeated clinical observations, diagnostic interviews, developmental history, and standardized, comprehensive symptom checklists.[5]

## Subject

Studies that focused on the prevalence of psychiatric disorders in preschool-aged children have reported prevalence rates as high as 9% for anxiety disorders and around 2% for depression among preschool children.[3,6,7] While most childhood fears and transient sadness are normative, some children suffer from emotional problems that cause significant distress and impairment, limiting their ability to develop age-appropriate social and pre-academic skills and/or participate in age-appropriate activities and settings. Assessment is necessary to understand the phenomenology of emotional symptoms and identify young children with mental health needs, which is paramount to connecting them with ameliorative services.

## Problems

Researchers struggle to distinguish variations in *temperament*, (stable individual differences relating to reactivity and self-regulation), from symptoms of *psychopathology*. There is also inconsistency regarding studying anxiety and depressive symptoms as a single “internalizing domain” or as two clinically distinct presentations.[8,9] Similar issues with taxonomy are reflected in the lack of consensus relating to whether emotional problems should be conceptualized and studied in a categorical versus dimensional fashion.[10] Diagnostic criteria (DSM-5)[11] are often insufficient for young children and do not capture developmentally salient types of impairment (e.g., disruption in family routine), which makes it difficult to apply psychiatric research methods. One diagnostic manual, the DC: 0-5, was developed specifically to aid diagnostic decisions in young children.[12] It includes a multi-axial approach for addressing relational, developmental, medical, and other environmental contextual factors and includes some disorders that are not in the DSM-5.

Despite significant advances in the assessment, recognition, and treatment of early childhood emotional disorders,[13-15] rates of mental health service receipt and participation in prevention programs remain low, especially for ethnic minority children and those living in poverty.[16-19] Low levels of service utilization in this age group also likely reflects societal attitudes that have been slow to accept the seriousness of preschool-age mental health problems as well as ongoing stigmatization of mental health and parents of children with clinically significant mental health concerns.[20]

## Research Context

Serious emotional symptoms tend to be relatively stable throughout childhood if they are not identified and treated,[21,22] emphasizing the importance of assessment tools. Several widely-used parent-report "checklist-style" assessments (e.g., Child Behavior Checklist,[23] Infant-Toddler Social and Emotional Assessment,[24] Behavior Assessment System for Children[25]) cover a broad range of functioning, including internalizing, externalizing, and other problematic behaviors in early childhood. Other methods include semi-structured diagnostic interviews with parents, which mirror empirically-based diagnostic practices in adults. The most widely used is the Preschool Age Psychiatric Assessment.[26] Young children are often unable to describe their own emotional experiences using traditional methods. Hence, the Berkeley Puppet Interview uses child-friendly puppets to help preschool-aged children identify symptoms.[27] Another assessment method uses observation of the child's behavioral symptoms, which minimizes bias associated with parent or self-reported instruments. One such instrument, the Anxiety Dimensional Observational Scale (Anx-DOS) uses "presses" designed to evoke different dimensions related to anxiety, such as separation distress and fear of novel or potentially frightening toys.[28] The challenge with observational methods is converting the observations into quantifiable data. While many of the methods described here can be very useful from a research standpoint, they are often difficult to adapt for clinical contexts. For example, observational assessments such as the Anx-DOS are routinely rated from recordings in research settings. In contrast, most clinical observational tools are designed to be rated live, or in real-time during the assessment administration.

Advancing the study of emotional assessment in young children necessitates a conceptual distinction between temperament and internalizing symptomology. For example, behavioral inhibition (prominent shyness in novel and social situations[29]) has long been considered a normative temperamental profile that increases the risk of developing an anxiety disorder later in childhood,[30] but for some children may represent an early onset of disorder.[13,31] Unfortunately, most assessments do not capture child or family impairment, which is one way to distinguish between normative and clinical concerning variations within these constructs. Further, both early emerging symptoms of anxiety and temperamental measures have been used to successfully identify children with concurrent and later anxiety disorders.[32,33]

Whereas emotional symptoms reflect biological processes and mechanisms, there currently exists no biological "test." While psychophysiological assessments can identify anxiety-related patterns of autonomic arousal (electrodermal activity (EDA), heart rate variability (HRV), breathing rate, stress cortisol), these vary greatly from one child to the next. Hence, while they can help

researchers study emotional arousal in the laboratory, they have limited utility for making diagnostic decisions. A clinical diagnosis still requires a diagnostic interview to assess symptom onset, duration, severity, and associated impairment.

**Key Research Questions**

Key research questions include:

1. How can screening and assessment methods be improved to minimize reliance on parent report, while remaining minimally labor intensive?
2. How can assessments differentiate between normative variations in temperament and clinically significant emotional symptoms?
3. What criteria should be used to diagnose anxiety and depressive disorders in young children, or would employing a dimensional approach be advantageous?
4. How can awareness and recognition be improved to increase participation in prevention and early intervention efforts?

**Recent Research Results**

Significant advances have been made in assessment methods and age-appropriate diagnostic criteria for emotional disorders in young children.[12,34,35] Differentiation between symptoms of individual anxiety disorders (e.g., separation anxiety, generalized anxiety) has been found as early as two years of age.[8] Assessment tools for children aged 3-5, including the Preschool Anxiety Scale - Revised, captures these various dimensions of anxiety symptoms.[36] Further, requiring evidence of impairment for diagnosis can minimize over-pathologizing.[37]

The most notable research advances in assessment are in the area of studying clinically-relevant units of analysis that can be measured objectively. These include constructs that may be behavioral, cognitive, or neurobiological, which underlie clinical syndromes (diagnoses).[38] This approach represents a departure from previous research that aimed to study diagnostic syndromes themselves, which are characterized by variations in presentation and a clinical approach to assessment, frustrating research progress.

Attention bias to threat—a cognitive profile in which children show more attention to potentially threatening stimuli—has been identified as a correlate or risk factor for anxiety disorders.[39] To

study this and other cognitive phenomena, researchers have employed the use of event-related potentials (ERP), which are minute voltage changes detected by electroencephalogram, to measure brain activity in a specific region. This application of ERP has provided evidence of neural indicators related to attention bias to help uncover relationships to anxiety symptoms.[40]

Other research in young children has focused on physiological measures of arousal of the autonomic nervous system, which governs fear and emotional responses to trauma. Current research is investigating how risk and exposure to trauma can disrupt the nervous system functions, including affecting heart-rate variability as it relates to memory for traumatic events.[41] While these constructs may not aid current diagnostic procedures, they are helping researchers understand underlying constructs that may constitute risk for later emotional disorders.[42]

Regarding depression, novel findings have used functional magnetic resonance imaging (fMRI) to identify distinct patterns of brain activation, which were similar to those of adults with depression.[43] Recent fMRI research has indicated that children with preschool-onset depression showed a specific relationship between the volume of the hippocampus (which plays a role in the way fear learning and experiences of stress) and emotional responsivity in subcortical brain structures.[44] Finally, researchers have also used ERPs to measure changes in reward responses in the brain as a neural indicator of anhedonia in the context of a treatment study for preschool-onset depression.[45] These examples illustrate how modern psychological research is merging with neuroscience to clarify the relationship between clinical syndromes and brain function.

Finally, although a genetic test for anxiety and depressive disorders does not exist, the novel field of epigenetics research provides insight into how gene expression can be altered by the environment. Exposure to trauma, especially in childhood, can change gene expression and influence the risk of future generations developing similar conditions.[46]

**Research Gaps**

More research is needed to fully understand the phenomenology and diagnostic presentation of emotional disorders in young children. Also, research can improve the integration of data from observational systems, clinical interviews, child-report assessments, and measures of child and family impairment. Research that identifies meaningful ways of distinguishing between temperament and clinically significant emotional symptoms is also needed. While there have been significant advances in research on the underlying neurological functions as they relate to

emotional disorders in young children, these have yet to dramatically improve assessment in clinical contexts. Finally, research is needed on best practices for increasing awareness of clinically significant emotional disturbances in young children to better engage parents, pediatricians, and educators in early identification, prevention, and intervention efforts.

## Conclusions

Recent advances in assessment methods have made it clear that young children can suffer from serious emotional disorders. These disorders are distressing and impairing to young children and their families and present similarly to disorders in older children. Advancements have led to improved assessment methods (i.e., diagnostic interviews, observational systems, child-report assessments, psychophysiological tests) that reduce sole reliance on parent reports and increase diagnostic validity and reliability. Major advances in neuroscience and psychophysiological assessments of emotional functioning have contributed to a greater understanding of emotional disorders in young children. While these advances mark substantial progress, more research is needed. Despite availability, screening tools for identifying young children at risk are underutilized, partly due to limited awareness among pediatricians, parents, and educators. Even when identified, rates of parent participation in clinical services remain low.

## Implications for parents, services and policy

The lack of awareness regarding the importance of identifying and ameliorating young children's emotional disturbances is one of the greatest challenges facing advances in assessment and identification of early childhood emotional problems. This problem is manifested by low levels of treatment-seeking behavior by parents,[17] as well as the rarity of referrals from pediatricians and early educators. Compared with externalizing problems, such as aggression, emotional symptoms tend to be more difficult to recognize and assess, and because they are less disruptive, they are less likely to get noticed. However, it is clear that young children can struggle with distressing and impairing emotional problems that warrant sophisticated assessment and treatment approaches. Emotional disorders reflect neurological function and interfere with important aspects of development. With this in mind, researchers continue to explore and refine assessment tools and screening measures to identify young children in need of services, but dissemination and broad systems for implementation are still developing.

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# Posttraumatic Stress Disorder in Young Children

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## Introduction

Posttraumatic stress disorder (PTSD) is one of the more serious and debilitating mental disorders that can occur following trauma. Research indicates that - consistent with older children and adolescents - young children also typically manifest with the traditional three PTSD symptom clusters of re-experiencing the event (e.g., through nightmares, posttraumatic play), avoidance of reminders of the event and physiological hyperarousal (e.g., irritability, sleep disturbance, exaggerated startle).[1] However, research has shown that the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV- TR)[2] PTSD criteria does not adequately capture the symptom manifestation experienced by infants and preschool children and underestimates the number of children experiencing posttraumatic distress and impairment.[3] Therefore, the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which was released in 2013, included specific diagnostic criteria for PTSD in children under the age of 6.[4]

### *Prevalence, course, and consequences of trauma reactions*

In community samples, a prevalence rate of 0.5% has been reported in children aged 0-6 years old.[5] In trauma-exposed children, a PTSD prevalence rate of 24.8% has been reported in children under the age of 6.[6] However, the prevalence rate largely varies between studies due to multiple reasons. One of the reasons is that the type of trauma may affect the likelihood that a child develops PTSD. Repeated trauma's – as opposed to single event trauma's – along with interpersonal trauma seem to increase chances of developing PTSD by threefold. The highest rates of PTSD typically follow physical or sexual abuse, i.e., 26 and 60%.[1,3,7] Another reason that makes it challenging to determine the prevalence rate, are the different criteria being used across studies to assess PTSD. Some studies use age-specific PTSD criteria, whereas other studies have

used DSM-IV criteria which has been shown to underestimate PTSD diagnoses in children below 6 years of age.[8] Furthermore, children aged 0-6 years old undergo rapid developmental changes, and some of the behaviors during a specific phase overlap with PTSD symptomatology (e.g., tantrum during the 'terrible two's' or sleep regression at the 4th month of infancy). Most children with PTSD experience comorbid disorders, i.e., 73%-89% of the children with PTSD.[9–11] Depression, separation anxiety disorder (SAD), oppositional defiant disorder (ODD) are often diagnosed in addition to PTSD.[9,10]

Research with children of all ages has shown that untreated PTSD can follow a chronic and debilitating trajectory.[9,12,13] These findings are concerning given that young children's neurophysiological systems, including the stress modulation and emotional regulation systems, are still in the process of rapid development.[14] Additionally, trauma during childhood has been associated with permanent structural[15] and functional[16] brain impairment as well as the onset of psychiatric disorders,[17] health risk behaviours and physical health conditions in adulthood.[18] Therefore, trauma that occurs during early childhood may have even greater ramifications for developmental trajectories than traumas that occur at a later stage of development.

*The role of parents*

When working with traumatised children it is also important to be aware that the child's trauma and the child's response to the trauma can also be traumatic for parents and can be a source of chronic stress. Results of two recent meta-analyses showed that parental PTSD rates following a child's trauma largely vary, depending on the type of trauma. The first meta-analysis reported an estimated prevalence of 17% and only included children with single-event traumas, such as a traffic accident or burn.[19] The second meta-analysis investigated parental PTSD following a child's medical trauma, and reported a prevalence rate of 30%.[20] Parental PTSD rates seemed to be lowest following a child's injury (12.6%), but increased when the child had to be admitted to the pediatric or neonatal intensive care unit (around 20%). The highest rates for parental PTSD were reported for children that had a transplantation (30%) or a cancer diagnosis (40.7%). In addition to PTSD, parents can experience clinically elevated levels of acute stress, anxiety, depression and stress within the first 6 months of their child's trauma.[21–23] While the majority of parents are likely to be resilient or improve to below clinical levels over time, parental distress during the acute phase has been shown to contribute to the development and maintenance of trauma symptomatology in injured children.[21,23,24] There is evidence that parents with PTSD may have more difficulties in showing sensitive behaviors towards their children's needs, which in turn results in

higher levels of PTSS in children.[25,26] Furthermore, parents with PTSD seem to be less receptive to their child's traumatic symptoms, which may hinder them in providing adequate care.[27] Therefore, it is important to also treat parental PTSD following a child's traumatic event.[28]

It is widely recognised that the quality of the parent-child attachment, parental mental health and parenting behaviours are crucial factors that influence a child's adjustment following trauma.[14,28–30] For young children, the parent-child relationship is particularly important as they lack the coping capacities to regulate strong emotion and are therefore dependent on a sensitive and emotionally available caregiver to assist with affect regulation during times of distress.[14,29] Additionally, young children are particularly reliant on their parents' reactions to determine how to interpret or respond to an event and may therefore model their parents' fear responses and maladaptive coping responses.[31,32] Parents may also directly influence their child's exposure to traumatic reminders (e.g., allowing avoidance of conversations), and thereby impede their child's habituation to the event.[31]

Adverse psychological responses in the parent are likely to impact the development of children's trauma symptoms as well as the quality of the parent-child relationship. It is therefore important to also attend to the needs of parents to reduce their own distress and to support their ability to assist their children. Interventions that target child distress, parent distress and the parent-child relationship are likely to be beneficial in reducing the subsequent development of parent and child posttraumatic stress reactions. Research has shown that parental behaviors characterized by coping assistance, emotional processing assistance, modeling and encouraging seeking social support have been associated with higher resilience in the child after a traumatic event.[28]

*Prevention and early intervention*

It is clear that early identification and intervention to prevent the development of acute and persistent PTSS after early childhood trauma are of considerable public health significance. There is considerable potential for intervention in settings such as hospitals and early childcare settings to reduce the risk or prevent the onset of traumatic stress reactions through screening and indicated prevention or early intervention programs.[33] Early identification and intervention when symptoms first present, can prevent problems from becoming entrenched or at least minimise the impact of these problems on the child, family, and society. However, the challenge is to be able to differentiate between children who experience acute transient distress and those that are at risk of developing chronic PTSD[13] and other psychopathology so as not to over-burden scarce mental

health resources. It is also important to know whom will benefit from intervention, as some research has shown that early intervention for some children could have detrimental effects as it may intervene with their natural recovery.[34] This may be the case for ongoing traumatic event, such as wars.[34]

In the pediatric trauma literature, a stepped-care model has been introduced in which 1) *universal interventions* are aimed at all children following exposure to a potentially traumatic event, 2) *selective interventions* are targeted towards children experiencing elevated PTSS and/or have identifiable risk factors present and 3) *indicated interventions* are for children presenting with PTSD and additional risk factors for poor long-term outcomes. At the universal level, there are now several excellent evidence-based information provision resources available to support young children, caregivers, early childhood educators, teachers, disaster response teams, mental health clinicians, and other community providers (e.g., The National Child Traumatic Stress Network: http://www.nctsn.org/trauma-types; Healthcare Toolbox: https://www.healthcaretoolbox.org/; Community Trauma Toolkit: https://emergingminds.com.au/resources/toolkits/community-trauma-toolkit/; Birdie's Tree: https://www.childrens.health.qld.gov.au/our-work/birdies-tree-natural-disaster-recovery). There are also a growing number of evidence-based storybooks that have been written to support young children and families who have experienced a range of different potentially traumatic experiences, including natural disasters, pandemics, and medical trauma (e.g., https://www.childrens.health.qld.gov.au/our-work/birdies-tree-natural-disaster-recovery; https://piploproductions.com/).

In the first phase of the stepped-care model, i.e., the *universal level*, screening is recommended as a simple and cost-effective method for identifying children and parents who should continue to be monitored for risk or referred for more comprehensive targeted assessment or treatment. Screening and assessment tools for identifying children at risk for PTSD have been developed and have been used in children under the age of 6 (see for an overview[8,35]). These tools have shown acceptable reliability and validity for preschool aged children. However, for infants (<12 months), no validated screening methods are available which is a significant gap in the field.

Recently, a *selective intervention* was developed and evaluated for young children specifically (1-6 years old) who had been involved in an accidental traumatic injury.[36] The *CARE Trauma Resilience Program* is a brief targeted early intervention (2-4 sessions) for families where a young child (1-5 years) has experienced a traumatic event and experiencing mild to moderate levels of PTSS and/or anxiety. A multi-site randomised control trial has provided promising preliminary

evidence for the efficacy of the CARE intervention was found to be effective in reducing PTSS, functional impairment and behavioral problems, compared to children who received treatment as usual.[36]

Clinically *indicated interventions* that are recommended for treating PTSD in children are Eye Movement Desensitization and Reprocessing (EMDR) and Trauma-focused Cognitive Behavioural Therapy (TF-CBT). Protocols of these treatments have been adjusted for younger children, but the effectiveness of these treatments is mostly studied in older children with just a few studies including children <6 years of age. In younger children (4-10 years of age), two case studies have reported on the effectiveness of EMDR and showed that PTSS reduced in 85% to 100% of the children.[37,38] However, another study, in which one to three EMDR sessions were provided, did not show any improvement in PTSS for children of preschool age.[39] TF-CBT has been studied in preschool aged children (3-6 years of age), and according to a systematic literature review incorporating 11 studies, TF-CBT was effective in reducing PTSS.[40] In addition, Scheeringa and colleagues (2011) have shown that a 12-session TF-CBT with 3-6 year old children exposed to a variety of traumatic events was feasible and effective in reducing established posttraumatic stress symptoms.[41]

Few studies have included an intervention component that also targets parent distress following a child's trauma. Kenardy and colleagues found that psychoeducation provided to parents within 72 hours of their child's accident was effective at reducing parental posttraumatic symptoms at the 6-month follow-up.[42] Melnyk et al have examined the effectiveness of an early intervention program for parents of children (2-7 years) who were admitted to a paediatric intensive care unit.[43] They found that parents in the intervention group had significantly lower stress, depression and PTSD symptoms and their children exhibited fewer internalising and externalising difficulties post discharge.

**Implications for Parents, Services and Policy**

Recognition and understanding of the impact of trauma during early childhood has grown over the past 15 years. However, a lack of empirical research and significant knowledge gaps of how to assess, diagnose, and treat traumatic stress responses during early childhood remain. Further research is needed to (a) determine the nature, frequency, and trajectories of PTSS and other psychological consequences across different stages (infants, toddlers, and preschoolers), trauma types and from underrepresented communities, (b) identify risk and protective factors and identify

interactions that moderate or mediate PTSS over time, and (c) develop and validate age-appropriate and culturally sensitive psychological screening and assessment tools and interventions across stepped-care models.

Despite the knowledge gaps, implications for clinical practice and policy can be drawn from the current evidence base. Parents, health services, early childhood education settings and policy makers need to be aware that some (young) children are exposed to traumatic events, potentially on a regular basis. This can result in serious psychological, physical, and social consequences and can have short- and long-term implications and costs across the lifespan. Hospitals and early childcare centres are ideal settings to support child recovery following trauma. Investments are needed to support service and workforce development in early childhood mental health across the continuum of care - from universal mental health promotion, including screening and prevention, to intensive and specialized mental health care. However, any screening and intervention programme needs to be linked into a clinical service with the capacity to deliver appropriate, and developmentally sensitive care, when needed. Furthermore, it is crucial to focus on the parents' mental health, as children's recovery from stressful events occurs best in the context of healing relationships. Young children regulate affect within relationships through co-regulation and learn how to interpret and cope with events by watching how their caregiver reacts. It is therefore essential that evidence-based resources and services are available to support parental wellbeing following a child's trauma, alongside services targeting children's wellbeing.

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# Parent-Child Relationships in Early Childhood and Development of Anxiety & Depression

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## Introduction

Parents play a role in shaping children's emotional wellbeing, particularly in early childhood. Parental reactions to children's emotions, their modelling of affect and expression of emotions are important for children's emotion socialisation, and influence the development of children's emotional regulation capacity and emotional understanding.[1] There is also evidence that parent-child relationships play a specific role in the development of anxiety and depression in young children. This research has focused on parent-child relationship factors that may increase the child's sense of threat and limit opportunities for the child develop a sense of mastery over their environment. Broadly, these are categorised into: (1) parenting behaviours (control, rejection/low warmth); (2) modelling and/or information transfer and (3) insecure attachment.

## Subject

The key feature of anxiety disorders is avoidance of feared stimuli. Parenting behaviours that reinforce a children's avoidant behaviours, discourage independence or limit confidence in coping are likely to impact on the maintenance and development of anxiety disorders. For example, parental control (excessive regulation, overprotection, intrusiveness and low autonomy granting) may undermine children's sense of autonomy and safety and reinforce avoidant behaviours, increasing the risk of anxiety.[2-6] Parental rejection (punitiveness, excessive criticism or dismissal) and low warmth (coldness or low support) may also lead children to believe their environment is hostile or threatening, and children are less likely to develop a sense of competence.[6,7] Parental rejection and low warmth also undermines children's self-esteem and can lead to hopelessness and a negative sense of self, which may increase the risk of depression.[6,7]

Parents who model anxious behaviour and/or verbally communicate threat-relevant information to their child may also increase a child's fears and risk of developing anxiety disorders.[2,4] Parents who are anxious or depressed themselves are more likely to exhibit these kinds of behaviours.

Although most research has focused on a top-down parent-effect (i.e., parents transferring risk to their child), it is well-recognised that children's internalising symptoms might also affect parents (i.e., child eliciting parent behaviours).[2,4] Further, the effect of modelling/information transfer and overcontrol may be exacerbated when the child has an inhibited or anxious temperament.[4]

An insecure attachment has also been identified as a risk factor for the development of anxiety and depression.[8] Attachment is defined as the intimate emotional bond that forms between a child and caregiver.[9] An insecure attachment is one in which the child experiences the caregiver as unpredictable or unresponsive or does not experience comfort from the relationship. This can lead children to develop poor emotion regulation skills or a negative sense of self, which are both associated with anxiety and depression.[10-12]

**Problems**

A significant problem in this area of study is the accurate measurement of parent-child relationships. Early research examining overcontrol and parental rejection/low warmth focused on retrospective reports from adults with anxiety and depression, leading to potentially biased reports.[6] Prospective or contemporaneous questionnaire measures are also subject to response bias.[3,7] To overcome these difficulties, some researchers have used observational methods to assess these behaviours.[12-14] Observational methods, however, are not without problems, as parents may behave differently or more positively when being observed in a research laboratory or at home.

**Research Context**

Parenting is a valuable research target as it is a potentially modifiable risk factor for the development of anxiety and depression.  Despite this, meta-analyses indicate that overall parenting accounts for only 4% of child anxiety[3] and 8% of child depression,[4] which is smaller compared to other risk factors, such as genetic influences.[15] However, there is a large amount of variation in the research literature, and the relationship between parenting and child anxiety and depression varies according to how parental control is operationalised and measured. For example, there are stronger effects between parenting and child anxiety/depression in studies that use observational measures compared to questionnaire measures.[3,4] Further, the majority of studies examining the relation between parenting behaviour and anxiety and depression are cross-sectional in design which limits their ability to test causality. A few longitudinal studies, and

a small number of experimental studies, have been conducted allowing an improved estimate of the causal impact of parenting behaviour on anxiety and depression. Most research focuses on school-aged children but there are a few studies investigating parent-child relationships in younger children.

**Key Research Questions**

1. What parenting behaviours are associated with anxiety and depression in early childhood?
2. Is there a causal relationship between parenting behaviours and anxiety and depression in early childhood? Is there a bidirectional relationship?
3. Is the impact of parenting behaviours greater for some children over others? In other words, do these parenting behaviours increase the risk of anxiety and depression in all children or only in children already at risk for anxiety (e.g., inhibited children)?

**Recent Research Results**

A number of studies have shown that parental control is associated with child anxiety disorders. The majority of these studies are cross-sectional, however a few longitudinal studies have emerged showing that parental control (particularly overprotection) in early childhood is associated with later anxiety disorders.[16-18,20] For example, Hudson and Dodd[16] followed a group of inhibited and uninhibited children from the age of 4 years. In this study, children's anxiety at age 9 was predicted by the child's anxiety and inhibition at age 4 but also by maternal anxiety and maternal control. Thus, greater maternal anxiety and maternal over-involvement predicted greater child anxiety. This suggests that the relationship between risk factors for child anxiety is additive (that is, the presence of one risk factor in the face of another risk factor does not affect either's impact). When longer term outcomes were considered, Hudson et al.[17] found evidence for interaction of risks (that is, the presence of one risk factor in the face of another alters its impact). Specifically, inhibited children at age 4 years predicted anxiety symptoms at age 12 years, but *only* for children whose mothers were controlling at 4 years. In these studies, the security of a child's attachment and maternal negativity did not predict later anxiety.

Other longitudinal studies indicate that observed maternal controlling behaviour and negativity predicts preschoolers' anxious symptoms one year later.[18] In contrast, no such prediction is shown when the child is in early adolescence,[19] which suggests that parental responses may have a greater impact on anxiety in early childhood.

Experimental studies have also provided support for a causal effect of parental control on child anxiety. In a study of non-clinical mother-child dyads (child at age 4-5 years), mothers were trained to behave in controlling ways while helping their child prepare to give a presentation. Children showed more anxiety when their mothers behaved with more control, although this relationship was only evident in children with higher trait anxiety.[20]

There is also increasing evidence of a bidirectional relationship between child anxiety and parental control. For example, one study demonstrated reciprocal effects between maternal control and child anxiety based on maternal report across a one-year period in preschoolers. In contrast, paternal reports showed that control behaviours predicted later child anxiety.[18]

There have been a few studies demonstrating that parent anxiety can be transmitted through modelling and verbal transmission of threat and avoidant information.[21,22] In one experimental study, young infants showed increased fearfulness and avoidance of a stranger following exposure to a socially-anxious mother-stranger interaction, and the effect was stronger for children with an inhibited temperament.[21] Naturalistic longitudinal studies have demonstrated similar findings, with higher maternal and paternal expressed social anxiety being associated with later infant avoidance of a stranger.[23,24] Research has also shown that early parental anxious modelling (at child age 12 months) predicted anxious responding in children at 30 months, although parent behaviour measured concurrently did not.[23] Again, this suggests that there may be sensitive periods for the impact of parent modelling.

Empirical evidence has demonstrated a relationship between insecure attachment to caregivers and higher anxiety and depressive symptoms in children, but results are mixed and inconsistent.[12,25,26] This is partly due to methodological variability across studies. One meta-analysis measured attachment in infancy through observational studies only and found that a child with an insecure attachment is twice as likely to have internalising problems as a child with secure attachment,[12] although the causal relationship is unknown. There is some evidence that there are differences between maternal and paternal influence on child outcomes;[26,27] with father-child attachment predicting clinical levels of anxiety whereas mother-child attachment did not.[26]

**Research Gaps**

The majority of research remains questionnaire-based and cross-sectional. Although there are studies that have used longitudinal or experimental designs, more research is needed to assess

the causal role of parental behaviours in the development of anxiety and depression. At the same time, far more sophisticated work is needed to understand the complex interplay between parent behaviours and the age of the child, informant source and parent gender. Indeed, research to date has focused mostly on mothers, although recent research investigating the unique role of fathers in the development of anxiety and depression in early childhood has emerged.[26,27] Most of the research has also been conducted in predominantly Western populations, and research on the relationship between parenting and emotional health across diverse cultures is needed. Another difficulty of research examining the role of parents in child anxiety and depression is to examine the impact of parental behaviours independent of the influence of shared genes.

**Conclusions**

Together, evidence shows that parent-child relationships have a small but significant impact on the development of anxiety and depression in young children. The most consistent evidence for this relationship has come from research examining maternal control and child anxiety. While higher parental control may be a normative response to a child's anxious or inhibited behaviour, these behaviours may lead to an increased risk of a child developing anxiety and depression in some circumstances. Further research is needed to better understand the intricacies of this relationship and, particularly, its reciprocal nature, as well as the interplay with other factors.

Evidence also supports the idea that parents can have an impact on their child through modelling anxiety and verbal transmission of threat information. Research which shows the impact of this modelling on anxiety development, over and above shared genes and across developmental stages, is needed.

The security of a child's attachment with their parent has been linked to later psychopathology. Given the overlap with other constructs (such as the child's temperament, other parenting behaviours) and wide variation in methods across studies, the degree to which attachment independently predicts child outcomes is uncertain.

**Implications for Parents, Services and Policy**

Understanding which parenting behaviours increase a child's risk for later anxiety and depression has direct implications for early intervention. The findings to date suggest that reducing the degree of parental control and reducing anxious modelling/verbal transmission of threat and avoidance may be important for preventing later internalising problems. Parenting strategies that

encourage children’s non-avoidant behaviours and increase opportunities to develop confidence in coping may particularly beneficial. Evidence indicates that these parenting strategies should be targeted at parents of at-risk children, namely children who are behaviourally inhibited. For a child who is uninhibited or displays low levels of anxious behaviours, the increased risk conferred by parenting behaviours may be inconsequential.

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# Temperament in Early Childhood and the Development of Anxiety and Depression

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## Introduction

Anxiety disorders, in general, and Social Anxiety Disorder (SAD) in particular, produce considerable acute suffering and increase the risk for long-term adverse outcomes. Most adult anxiety disorders begin in childhood or adolescence,[1] with exceedingly common rates between 5% and 10%; and rates of SAD varying from 1.6% to 8.5%.[2-4] In prospective research, the temperamental trait of behavioural inhibition emerges as the best known predictor of risk for later anxiety.[5,6]

The topic of this chapter is to briefly examine relations between this temperament and the emergence of anxiety disorders. We will examine the research on two cognitive processes, attention and executive processes, which contribute to the onset of anxiety disorders amongst behaviourally inhibited children. Finally, in line with recent evidence suggesting that behavioural inhibition may not only represent a specific predisposition to anxiety but rather a more general risk factor for internalizing disorders,[7] we will review the existing (yet limited) literature linking early temperament and later development of depression.

## Subject

Behavioural inhibition is a temperament that can be identified in infancy and early childhood. Infants with this temperament display heightened distress and motor reactivity to novel stimuli. As toddlers and young children they avoid social encounters and tend to withdraw from unfamiliar social situations making them less assertive[5,6] and prone to peer rejection,[8,9] with its associated negative self-perceptions.[10] As such, inhibited children have fewer friends,[11] and report greater anxiety and loneliness.[12]

Research on risk for anxiety focuses on early temperament, particularly behavioural inhibition.[10,13,14] For example, Schwartz et al.[6] found that 61% of 13 year olds, identified as behaviourally

inhibited at age two, demonstrated clear signs of anxiety during social interactions, compared to only 27% of those who were not inhibited. Similarly, Chronis-Tuscano et al.[15] reported four-fold increased odds of a lifetime diagnosis of social anxiety disorder among adolescents with consistently high levels of behavioural inhibition from ages 1 to 7. Data from both studies suggest that early temperament constrains, but does not rigidly determine, outcome. Only about half of inhibited children manifest risk, and anxiety tends to wax and wane over time.[16]

We contend that childhood temperament shapes the manner in which individuals perceive their surroundings, which influences their social interactions in a reciprocal manner and eventual social and mental health outcomes.[17] This dynamic is particularly evident in early adolescence during which the emergence of the peer group as a more salient influence on development coincides with sharp increases in psychopathology,[16] particularly SAD.[6,15,18] Temperament also shapes vital cognitive processes, such as attention and certain executive processes which provide the foundation from which children perceive and respond to social cues in the environment.

**Problems**

Questions remain concerning the functional and structural relations between temperament and anxiety.[19] Several reviews[10,17,20,21] have noted a variety of behavioural and physiological similarities as well as distinctions between inhibited temperament groups and anxious individuals. Conceptualized as separate constructs, temperament can either place a child at risk for developing anxiety or influence the stability or severity of anxiety disorders once they have emerged.[10] Alternately, these terms may simply refer to different aspects of the same underlying construct with distinctions between them simply imposed from the field.[21]

**Research Context**

Literature suggests that perturbations in *both* "*bottom up*" attention mechanisms and "*top down*" executive control processes may play a central role in the etiology and maintenance of anxiety.[22] These perturbations extend to both emotionally charged and affectively neutral stimuli, reflecting both preferential treatment of specific categories of stimuli (i.e., bias to threat cues) and heightened vigilance of one's own performance and behaviour (i.e., cognitive monitoring).

Anxious children[23-25] and adults[26,27] show attention biases to threat stimuli. Prior work has found[28,29] that clinically anxious adolescents display perturbations in the *amygdala* and ventrolateral *prefrontal cortex* (vlPFC) responses to threat while completing an attention bias task. As such,

biases to threat represent early, automatic "bottom up" attention mechanisms that shape cognition and behaviour. Research also implicates a distributed network within the prefrontal cortex through which attention is deployed to closely monitor performance, incorporating feedback, as individuals then call on more specialized cognitive control mechanisms to modify subsequent behaviour.[30-32] Anxiety related perturbations in this pattern are evident in both children [33] and adults.[34] Imaging studies have implicated the *anterior cingulate cortex (ACC)* in this process, as it appears to be hyperactive in anxious individuals during tasks requiring cognitive or "top down" control.[35]

**Key Research Questions**

Amongst typically developing, Caucasian children in the United States, around 15-20% manifest the temperament of behavioural inhibition in early childhood. Longitudinal studies have found that around half of these behaviourally inhibited children go on to develop anxiety disorders as adolescents or young adults. A key research question from a perspective of early intervention is to identify what factors contribute to these different trajectories over time. That is, what factors (either within the caregiving environment or within the child) either protect or enhance risk for anxiety.

**Recent Research Results**

*Attention bias to threat*

Results from recent studies suggest that behavioural inhibition is marked by perturbations in attention control.[36,37] Two recent longitudinal studies[18,38] have examined the link between childhood behavioural inhibition, attention bias to threat and later emergence of social withdrawal. Pérez-Edgar et al.[18] found that adolescents who were behaviourally inhibited as young children showed heightened attention bias to threat. In addition, attention bias to threat moderated the relation between childhood behavioural inhibition and adolescent social withdrawal. In a separate study, Pérez-Edgar et al.[38] found that behavioural inhibition in toddlerhood predicted high levels of social withdrawal in early childhood. Again, this relation was moderated by attention bias, such that this behavioural inhibition-social withdrawal association was only evident for children who displayed an attention bias toward threat. These data provide support for viewing attention bias to threat as a significant moderator of behavioural inhibition and the later emergence of clinical anxiety.

*Executive processes: Inhibitory control and cognitive monitoring*

Inhibitory control describes the ability to inhibit and override dominant responses and behaviours in favor of more appropriate or subdominant responses and behaviours.[39] Cognitive monitoring reflects the ability to attend to one's own performance, notice errors and correct behaviour as a result of feedback. These executive processes are thought to play a role in the regulation of negative emotions and temperamental reactivity.[40-42]

A number of studies have found that inhibitory control moderated the temperament of behavioural inhibition to predict heightened anxious behaviours. Behaviourally inhibited children with high levels of inhibitory control were found to be more socially anxious,[43] less socially competent, and more socially withdrawn[44] than behaviourally inhibited children with low levels of inhibitory control. Similarly, White et al.[45] found that high levels of inhibitory control increased the risk for anxiety disorders amongst high behaviourally inhibited children.

Parallel work has found enhanced cognitive monitoring to be associated with heightened anxiety both in adults[46,47] and children.[48] McDermott et al.,[49] found that cognitive monitoring was higher in adolescents with high childhood behavioural inhibition as compared to adolescents low on childhood behavioural inhibition. Moreover, heightened monitoring moderated relations between early behavioural inhibition and later anxiety disorders.[49] Thus, like attention bias to threat, executive processes of inhibitory control and cognitive monitoring moderate child temperament towards heightened risk for anxiety.

**Research Gaps**

Developmental change occurs as a result of reciprocal interactions between the intrinsic characteristics of a child and his environmental context, making the child both the producer and product of the environment.[50] Behavioural inhibition may initiate a child in one of a number of directions, and the targeted outcome can result from a host of predisposing pathways.[10] Research must therefore account for a number of potential moderating factors that can come into play at various points throughout development. There is limited research examining the discontinuous nature of behavioural inhibition and possible intervening protective factors that may contribute to discontinuity in behavioural inhibition trajectories and subsequent prevention of psychopathology. Discontinuity of these patterns provides an important opportunity for the identification of factors which may potentially be applied in preventive interventions.

Additionally, the link between behavioural inhibition and depression has received less empirical attention. In considering the relations between behavioural inhibition and depression, it is important to note that individuals suffering from anxiety disorders are at an increased risk for

developing depression in comparison to non-anxious individuals,[51] and evidence suggests that in many instances the presence of an anxiety disorder precedes the development of major depression.[52] Given such temporal relations between anxiety and depression, it is important to consider that associations between behavioural inhibition and depression may be largely contingent upon the presence of anxiety. In fact, one study found that social anxiety fully mediated the relation between behavioural inhibition and depression.[53] Similarly, other studies,[54] revealing associations between behavioural inhibition and anxiety and depression employed structural equations modeling which found that a pathway in which behavioural inhibition results in anxiety, which in turn leads to depression, provided the best fit for the data.

Additional studies investigated the specificity of the social versus nonsocial components of self-reported behavioural inhibition during childhood and their relation with young adults' current symptoms of anhedonic depression, social anxiety and anxious arousal. Findings were mixed with some studies revealing that nonsocial behavioural inhibition (''fearfulness''), but not social behavioural inhibition, increased risk for future depression[55] and other studies revealing that symptoms of depression were more strongly related to social rather than nonsocial behavioural inhibition in childhood.[56]

Interestingly, Sportel[57] investigated the additive and interacting effects of behavioural inhibition and attentional control on internalizing dimensions in a sample of non-clinical adolescents. Findings revealed stronger associations of behavioural inhibition than of attentional control with anxiety symptoms and stronger associations of attentional control than of behavioural inhibition with depressive symptoms. Furthermore, while behavioural inhibition was associated with both anxiety and depression, attentional control moderated this association thus reducing the impact of high behavioural inhibition on the generation of both internalizing dimensions.

Finally, in considering temperament as a vulnerability factor for depression, it is important to note that in addition to behavioural inhibition several theorists have developed temperament models that link additional temperamental styles, particularly Positive Emotion (PE) and Negative Emotion (NE) to depression.[58] Many cross-sectional studies have reported that youth and adults with depressive symptoms exhibit diminished levels of PE and elevated levels of NE[59,60,61] and the combination of these have been associated with concurrent depressive symptoms in clinical[62,63] and community samples.[61,64,65] Furthermore, longitudinal studies have found that lower levels of PE [60,66,67] and higher level of NE in childhood[68-70] predict the development of depressive symptoms and disorders. For instance, low PE in preschool-aged children predicted higher levels of depressotypic cognitive styles at age 7 and depressive symptoms at age 10.[71,72]

## Conclusions

Behavioural inhibition is a risk factor for the development of internalizing disorders, though research suggests that not all children with this temperament develop a disorder. Current research is focused on describing the complex interplay between temperament and potential moderating factors which may alter temperamental trajectories. Research on endogenous factors suggest that both attention and executive processes are important moderators of behavioural inhibition toward anxiety or resilience from these disorders. While not covered in this review, there is a good deal of work on the role of exogenous factors in moderating the temperament of behavioural inhibition.[16,73]

## Implications for Parents, Services and Policy

Identification of young children who are at risk for anxiety disorders and the implementation of prevention efforts to reduce risk are important outcomes of research on behavioural inhibition. Due to the compliant and nondisruptive nature of behaviourally inhibited children, teachers and parents do not necessarily identify these children early in childhood and elementary school. Because only some children with behavioural inhibition go on to develop anxiety disorders it is important to identify both the endogenous and exogenous factors that moderate temperament psychopathology relations. Preliminary research suggests an optimistic picture for preventative strategies and easily accessible education programs for the parents and caregivers of inhibited preschool children.[74] Such programs are aimed at educating the caregivers regarding the nature of temperament and withdrawal and providing techniques through which they may help behavioural inhibition children develop the ability to regulate reactivity to novelty thus promoting the development of social skills and decreasing inhibited and anxious behaviour over time. Finally, innovative approaches including attention and executive process training may effectively reduce anxious withdrawal in this temperamentally at risk population.

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# Young Children's Peer Relations: Links with Early Developing Anxiety and Depression

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## Introduction

The peer group represents an important and unique context for the development of a wide range of skills and competencies in early childhood.[1] Simply stated, ‘playing with friends’ helps young children acquire and practice social (e.g., resolving conflicts), cognitive (e.g., perspective-taking), emotional (self-regulation) and communicative skills that provide foundations for their subsequent development. However, for many young children, the peer group also represents the first setting where the earliest signs of internalizing problems (such as anxiety and depression) are manifested. In the peer group, anxious children may experience feelings of fear, worry, uneasiness, and self-consciousness. Symptoms of depression in the early childhood peer group may include anhedonia (inability to experience pleasure), excessive guilt, and changes in appetite and activity levels.[2,3,4] Of note, symptoms of anxiety and depression can often co-occur.[5,6]

## Problems

Research exploring links between internalizing problems and peer relations in early childhood typically rely on parent and teacher reports, and less frequently on naturalistic observations. Parents and teachers have the advantage of being able to observe children’s behaviours across a wide range of time and contexts but may also bring biases to their responses.[7] Observations provide a potentially more objective perspective but are typically more limited in their context and are comparatively costly and time consuming.[8] A particular challenge for assessing internalizing problems is their ‘covert’ nature. That is, many of the emotional and cognitive symptoms of anxiety and depression may not be externally evident and young children may have difficulties expressing their inner states.

## Research Context

Children's peer relations can be studied at multiple levels.[1] For example, at the level of *peer interactions*, the focus is on children's prosocial (e.g., cooperation, sharing, empathy), antisocial (e.g., aggressive) and asocial (e.g., socially withdrawn) behaviours with peers. *Peer relationships* typically refer to aspects of mutual friendships (e.g., intimacy, conflict), whereas *peer groups* pertain to children's experiences within a wider social circle (e.g., exclusion, victimization).

**Key Research Questions**

1. Do young children with elevated symptom levels of anxiety and depression behave in characteristic ways with peers? Do peer group behaviours predict the later development of internalizing problems?
2. How do peers behave and respond towards young anxious and depressive children?
3. What is the impact of peer relations on the development of anxiety and depression in childhood? How might peers act as a risk or protective factor for young children prone to internalizing problems?

**Recent Research Results**

*Social behaviours of anxious and depressive young children*

Results from a growing number of studies suggest that young children prone to internalizing problems display characteristic socially withdrawn behaviours amongst peers.[8] That is, when faced with opportunities for social interaction, be it at preschool, playgroup, or on the playground, anxious and depressive children tend to keep to themselves, refrain from talking, and rarely initiate social exchanges with other children. As well, both anxious and depressive young children demonstrate deficits in social skills (e.g., making eye contact, initiating conversational requests) that may further impede their abilities to participate in peer activities.[9,10,11]

Although anxious children might be interested in social interaction, this desire to approach others is often inhibited by social reticence. As a result, they tend to spend more time watching other children without joining and hovering on the edge of social groups.[8] Although less studied, there is some evidence to suggest that young depressive children also experience social impairment.[12] For example, children who display greater depressive symptoms are more likely to avoid social interactions.[13] Moreover, symptoms of depression in early childhood are associated with negative peer experiences, including peer rejection, exclusion, and victimization.[14,15,16] There is also

substantial longitudinal evidence linking social withdrawal in childhood with the later development of more significant internalizing problems.[17,18,19] For example, Katz and colleagues[20] followed over 700 children from early childhood to young adulthood and described a pathway linking social withdrawal at age 5 years – to social difficulties with peers at age 15 years – to diagnoses of depression at age 20 years.

*Peer responses to anxious and depressive children*

Even in early childhood, anxious and depressive children tend to experience negative responses from peers.[21] For example, as mentioned earlier, young children who display symptoms of internalizing problems are more likely to be disliked, excluded, and victimized by peers.[14,15,16] There is also evidence (predominantly with older children) that anxious and depressive children have fewer friends, and that their friendships tend to be of lower quality.[5,22] Furthermore, children (for various reasons) tend to have friends with similar levels of anxious or depressive symptoms,[23,24] which may exacerbate their own social difficulties.[25] Although it has been suggested that symptoms of anxiety and depression can be difficult to detect in childhood,[26] it seems clear that the group behaviours of anxious and depressive children do not go unnoticed by peers. It is likely the behavioural characteristics of anxious and depressive children evoke more negative responses from peers. For instance, social withdrawal and other socially unskilled behaviours (regardless of whether they arise from feelings of anxiety/depression) are strong predictors of concurrent and subsequent peer rejection and victimization.[27,28]

*Impact of peer relations on the development of anxiety and depression*

Being excluded, rejected, and victimized by peers can have long-term negative consequences for young children.[1] In particular, the experience of peer victimization or having no friends in early childhood can promote the later development of anxiety and depression.[29,30] Unfortunately, not only are anxious and depressive children more prone to experience problematic peer relations, they also appear to be particularly vulnerable to the negative impact of these experiences.[31,32] For example, Gazelle and Ladd[33] found that kindergarten children displaying early signs of anxiety who were also excluded by peers were more likely to remain anxious and develop depressive symptoms through the 4$^{th}$ grade. In contrast, young anxious children who were not excluded were less likely to remain anxious and did not tend to develop signs of depression. However, there is also at least some evidence to suggest that socially withdrawn, anxious and depressive children can also particularly benefit from positive peer relationships.[34,35,36] For example, Laursen and

colleagues[37] reported that having at least one close friend attenuated links between social isolation and the development of internalizing problems in early childhood.

**Research Gaps**

Despite increased attention towards the early signs of internalizing problems in young children, there remains limited research specifically examining the potentially important role of peers, particularly in relation to depressive symptoms.[38] Indeed, although there has been some movement towards assisting young anxious and depressed children,[39] there remains little research explicitly acknowledging the potentially important role that peers might play in early intervention programs.

Peer difficulties are likely only part of a more complex process linking other behaviours and skills (e.g., conduct problems, executive functioning) to internalizing problems.[40,41] There is also growing evidence suggesting that there may be other factors to consider that may heighten or lower risks for negative outcomes related to peer difficulties and internalizing problems among young children. For example, having lower inhibitory control and fewer perceived positive relationships appears to increase the risk for internalizing problems among those who are victimized at a young age.[42] In contrast, there is some indication that engaging in prosocial behaviours,[43] having friends and supportive parents,[44] and having high emotion regulation[30,45] can buffer (or protect) bullied, victimized, and rejected youth from internalizing problems. Future research is needed to further understand the pathways and processes linking peer relations and internalizing problems among children in order to better inform prevention and intervention efforts. For example, it may be beneficial for intervention programs to simultaneously target internalizing and peer problems,[14] as well as other potentially relevant factors, in order to address at-risk children's needs.

**Conclusions**

Peers play an important and unique role in children's development. The peer group is also a common setting for young children to display early signs of internalizing problems, such as anxiety and depression. Anxious and depressive young children often experience significant challenges in their social relationships with peers. To begin with, young children prone to such internalizing problems tend to be quiet and withdrawn in the company of peers and may also display poor social skills. Perhaps as a result, young children with internalizing problems are more frequent targets for peer exclusion and victimization. In and of themselves, such negative peer

experiences carry an increased risk for a host of later social, emotional and academic difficulties. Unfortunately, young children prone to internalizing problems also appear to be particularly vulnerable to these negative effects – which often heighten symptoms of anxiety and depression. This can create a negative cycle that serves to exacerbate risk for longer term maladaptive outcomes. However, there is at least some preliminary evidence (particularly among older children) that positive peer relationships (e.g., a close friendship) can help to protect anxious and depressive children from some of the negative consequences of early internalizing difficulties.

**Implications**

Some potentially important implications can be derived from this review for parents, early childhood educators, teachers, and practitioners. First, we need to continue to raise awareness about the early emergence of anxiety and depression in young children, as symptoms of internalizing problems can often go unnoticed by others. Second, parents, teachers, and others should monitor young children's early social interactions as a potential window into their emotional well-being. For example, a child who frequently displays quiet, reticent and socially withdrawn behaviours when amongst peers may warrant closer attention. Similarly, early evidence of peer group difficulties such as exclusion or victimization should not be allowed to continue unaddressed. In this regard, peer group behaviours can serve as potential 'marker variables' (i.e., early warning signs) of internalizing problems. Finally, appropriate early intervention has been shown to effectively decrease symptoms of internalizing problems in young children.[46,47,48] The peer group may provide an important context for supporting these early intervention approaches. Moreover, building social skills and promoting positive peer relationships may have direct benefits for young anxious and depressive children.

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# Treatment of Clinical Anxiety and Depression in Early Childhood

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## Introduction

Relatively little is known about anxiety and depression in early childhood, and diagnosis and treatment options for both are limited. However, interest in the area is growing.

## Subject

There is increasing recognition that young children do experience symptoms of anxiety and depression, and are capable of experiencing these at clinical levels of severity. However, research into these conditions in young children has lagged substantially behind that of older children and adolescents.

## Problems and Research context

Despite symptoms of anxiety and depression being common in this age group, we have very few treatment options specifically targeted to young children. Treatment research that has included this age group has often also included much older children and has not reported the results separately for different age groups. Therefore, treatments that, superficially, appear appropriate for younger children, may not be so.

The question of whether we need to treat young children with these symptoms also remains. While in older children there appears to be some moderate degree of continuity of symptoms into adolescence and adulthood,[1,2] we simply do not know whether this is the case for younger children. Although unlikely, it is possible that younger children's symptoms remit with time and that treatment is an unnecessary burden. Similarly, while experiencing early anxiety and depression is associated with difficulties in other areas, such as academic and interpersonal functioning,[3] it is not known whether this is a cause or a consequence of the child's mental health difficulties, nor whether these difficulties remit with successful treatment.

**Key Research Questions**

1. Should we treat symptoms of anxiety and depression in younger children?
2. How should we treat anxiety and depression in younger children?

**Recent Research Results**

Although we know that some temperament styles are associated with increased risk of mental health difficulties later on, we know very little about the predictive validity of early symptoms of anxiety and depression. This difficulty is compounded by the fact that, in early life, it can be difficult to distinguish between features of a healthy but inhibited temperament, and symptoms of emotional difficulties or anxiety, and in reality the edges are very blurred. For example, high levels of shyness can be part of the personality of a healthy child, or symptoms of a nascent social anxiety disorder.  While we might wish to treat a child with an anxiety disorder, it might be inappropriate to pathologize a quiet temperament. Where early intervention is offered, it needs to be done sensitively.

*Cognitive Behaviour Therapy-based approaches*

Initially, researchers attempted to “downsize” adult treatments for anxiety and depression, in particular, cognitive behaviour therapy (CBT).[4] CBT for children has focussed on teaching them to recognize and challenge problematic thoughts, and using techniques such as exposure and behavioural activation, which are borrowed and modified, from the adult literature. These studies have tended to report fairly positive results[5,6] with an average of around 50-60% of children recovering from their primary diagnosis. However, these studies have generally included a wide range of ages, and, due to limited sample sizes, have been unable to look specifically at outcomes for younger children. In the case of depression, studies have typically not included children younger than nine years of age. However, there is some evidence from the anxiety literature that when applied sensitively, standard CBT approaches might be effective in children aged as young as six[7,8] and, when adapted further, using a play-based approach, to as young as four.[9]

*Parenting-based approaches*

A second approach, particularly in the anxiety literature, has been to work with parents of these young clients to enable families to provide a style of parenting that is best suited to their child’s temperament. For example, one parent-based intervention targeted at symptoms of anxiety in

preschool children with a behaviourally-inhibited temperament, reduced diagnoses of anxiety disorders in participants.[10] Another parenting-based approach is Parent Child Interaction Therapy (PCIT), a play-based, parent and child therapy informed by behavioural and social learning theories, that has shown some promise in the treatment of anxiety in young children.[11] Similarly, a parent-only, group-based cognitive-behavioural parenting intervention, aimed at providing young anxious children with a warm, calm, consistent parenting environment yielded significant reductions in anxiety diagnoses compared to an untreated group.[12] These parenting-based approaches tend to have been applied to the younger end of the age spectrum.

In practice, both the parenting-based and the cognitive behaviour therapy-based approaches tend to employ elements of the other: Parenting-based approaches usually coach parents in CBT-based exposure techniques, and most CBT interventions involve parents to some extent, teaching them some basic anxiety- or behaviour-management skills. However, despite evidence of high risk of family dysfunction in families of depressed children, few approaches to the treatment of depression that involve the family have been developed for young children.

*Medication*

Medication for anxiety and depression is generally recommended only as a last resort in young children. Although research has shown some efficacy for medication in depressed children aged as young as 6 years, safety concerns have led some national regulatory authorities to restrict or prohibit the use of SSRIs (selective serotonin reuptake inhibitors) in childhood.[13]

Unlike treatments for adults, and sometimes adolescents, treatments aimed at younger children tend to be quite generic, aiming to treat all types of anxiety or depression, rather than focussing on sub-diagnoses. This is probably quite appropriate, given our limited understanding of the validity of the different diagnostic categories in this age group.

**Research Gaps**

There is little research in this area, so there are many large gaps. We urgently need to know more about how and when symptoms of anxiety and depression in young children predict future mental health problems, and if so, at what stage we should attempt to intervene. In particular, we need to know when a normal, quiet temperament, which should be nurtured and celebrated, tips over into a disabling condition. If intervening, we need to know which approach works best for this age group. Input from cognitive developmental psychologists is likely to be beneficial in this

endeavour, guiding the therapist towards features of the developmental process that have gone awry, and helping them to develop techniques that are most appropriate for clients at each developmental stage.

All of the promising psychological approaches to treating young children that are described above (with the exception of standard cognitive behaviour therapy) have thus far reported only a single small trial, wherein the intervention was compared to a no-treatment control. Further larger studies, from external research groups, employing placebo, and preferably other active treatment conditions, are needed.

Substantially more research into the treatment of depression in younger children is needed, as there are currently no interventions that have been tested for children younger than 9 years.

**Conclusions and Implications**

Much research is still needed to understand anxiety and depression in young children. Even when anxious and depressed young children are identified, many do not receive effective treatment. Although we are making some headway in understanding the causes of these conditions, and the contextual factors that influence them, evidence-based treatment options for this younger age group are very limited. Treatment research seems to have lagged behind the basic science, and rather than being based on our new-found understanding of the development of these conditions, has often developed downsized versions of adult treatments, such as cognitive behaviour therapy. While there is some modest evidence for the utility of these approaches in older children and adolescents, the research has not really focussed on young children, and there is considerable room for improvement. For depression in particular, where contextual factors (family breakdown, parental mental health, social and educational factors) have been shown to be critical in the development of the disorder, these have not generally been the focus of the treatments that appear in the research literature.

Although currently not clearly demonstrated, it seems very likely that significant symptoms of anxiety and depression at this age are predictive of future psychological disorders, and of social, academic, occupational and physical wellbeing. Therefore, it is likely that effective identification and treatment strategies that are focussed on early childhood will have substantial benefits not just for the individual, but at an economic and societal level too, and are, therefore, worth investing in. The most effective approaches are likely to involve parents, clinicians and child care

settings working in partnership, in order to provide the most supportive environment for the child.

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# Early Intervention and Prevention of Anxiety and Depression

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## Introduction

The World Health Organisation predicts that by 2030 depression will be second only to HIV/AIDS in international burden of disease.[1] Mental health problems that are first identified in adolescence and adulthood, including debilitating depression, anxiety disorders and drug misuse, can have their origins in pathways that begin much earlier in life with childhood mental health problems.[2,3,4]

## Subject

In childhood, mental health problems primarily consist of emotional and behavioural problems. Australia's national youth mental health survey reported that these affect one in every seven children aged 4-17 years.[5] Similar rates are reported internationally.[6,7,8] Emotional problems include anxiety and depression. Characterised by inner emotional distress that may not be obvious to others, these disorders are also known as "internalising" problems.

## Problems

Cost-benefit economic studies show that, as a general rule, intervening earlier in the life course can be cheaper and more effective than later treatment.[9] Studies following children in the community over time have highlighted persistence of internalising symptoms, from early- to mid-childhood[10,11] and from childhood into adolescence and adulthood.[12,13]

## Research Context

While emotional functioning continues to develop from childhood into adulthood, the early years constitute a potential window of opportunity for early intervention and prevention. Children's internalising problems are in part inherited and in part due to environmental[14] factors. Longitudinal research studies show that the single strongest precursor of internalising problems in young children is "temperamental inhibition," manifested as fearfulness and a tendency to withdraw

from new situations.[15,16,17,18] Additional known risks for young children's internalising problems are harsh and/or overprotective parenting interactions, and parents' own internalising problems.[11,18,19,20,21,22,23]

## Key Research Questions

What is the best way to intervene very early in children's emotional trajectories to prevent anxiety and depression? This article presents current evidence for this question. Preventive intervention in the early childhood years focuses primarily on optimising the child's environment, with a view to managing or preventing the development of internalising difficulties. Parenting interactions have been shown to be the most important environmental factor to influence a young child's behaviour. Parental over-involvement/protection (i.e., shielding from natural challenges in life) and/or harsh discipline (i.e., smacking and yelling) predict young children's internalising symptoms.[19,24] Therefore the main goal of early intervention and prevention programs is to develop parents' skills to identify and respond to their child's emotionally distressed behaviours in effective ways.

## Recent Research Results

A recent systematic review of evidence-based preventive interventions for internalising problems among young children (ages 0-8 years)[25] identified randomised controlled trials as the 'gold standard' methodology to assess program effectiveness. The review highlighted that relatively few preventive interventions specifically attended to internalising problems compared to a large evidence-base that exists for child behaviour (externalising/conduct) problems.

Regarding interventions commencing in infancy, Early Start[26,27] had the best balance of evidence for reducing child internalising problems.[25] Early Start is a individual home visiting program in New Zealand that targets at-risk and stressed mothers over two to three years. Services in primary care screened all families for risk, and then coordinated weekly home visits by family support workers given five weeks training. One randomised trial evaluation with a three-year follow up found this intervention improved child internalising problems, parenting interactions (including abuse) and preschool attendance.

Regarding interventions commencing at preschool age, two programs had the best balance of evidence for reducing internalising problems.[25] In Canada, a brief (three month) psycho-educational group-based program tested in a controlled trial with parents of children exhibiting behavioural problems was found to also reduce child anxiety. However, the wait-list control design

of this trial means that program effectiveness beyond a few weeks is unknown. In Australia, Cool Little Kids is a brief (three month) program targeting parents with temperamentally-inhibited preschool-age children.[28,29,30] Two randomised trial evaluations including six month and three year follow up showed the program effectively prevented child internalising disorders.

In the Cool Little Kids trials, parents of temperamentally-inhibited preschool age children were invited to participate in fortnightly 1.5 hour parenting groups delivered by a clinical psychologist. Targeting child inhibition and overprotective parenting, this program aims to build preschool children's resilience to situational fears and distressing worries. It teaches parents strategies to modify their preschool child's fear and distress, as well as their own (if relevant). The first trial demonstrated that intervention children developed significantly fewer anxiety disorders than controls by age five years (50% vs. 64%), with even larger effects by age seven years (40% vs. 69%). The second trial targeted parents with anxiety disorders and again found the program significantly impacted inhibited preschool children's anxiety disorders (53% intervention vs. 93% controls). Cool Little Kids is thereby the first (and only, thus far) effective early childhood prevention program for internalising disorders.

**Research Gaps**

Very few effective interventions exist for young children's internalising problems. With a focus on anxiety, Cool Little Kids is at the cutting edge of early intervention research in the field. Long-term effectiveness data (more than 5 years) need to be collected for relatively brief prevention programs such as Cool Little Kids, which requires sufficient research funding. Another challenge is to assess the effectiveness of the program when delivered across large population representative samples.[31] The potential to systematically screen "at risk" children (temperamentally-inhibited) via a universal preschool service platform and deliver this intervention is currently being investigated in a population-level randomised trial. Further, few studies have reported economic evaluations for early intervention programs for children's mental health.[7,25,32] Such evaluations could include implementation service costs (training, program materials, provider salaries), costs to families (time off work, transport costs), and later health/welfare costs saved from implementing an early intervention.

A very new area for research is identifying depression at preschool age and designing innovative early intervention programs. While the existence of depressive disorders as early as preschool age is gaining recognition,[33,34] a recent review of prevention programs for child depression did not

include such young children.[35] Very recently the first pilot work has been conducted on Parent-Child Interaction Therapy as a potential early intervention for preschool children's depression.[33] An absence of treatment programs for young children's depression, together with increasing rates of antidepressant medications being prescribed to children with unknown efficacy, highlight the urgent need to develop and evaluate psychotherapeutic interventions.[33]

**Conclusions**

Since the 1990s, recognition has grown that young children can experience internalising problems (anxiety and depression), with debilitating effects when they persist over time. Key known risks for young children's internalising problems include both inherited and environmental components (i.e., child temperamental inhibition, parental anxiety/depression, overprotective and/or harsh parenting interactions). An evidence base of preventive early intervention programs for young children's anxiety and depression is starting to develop. The current volume of research on preventive intervention for young children's internalising problems remains small, in comparison to 30 years of research on early intervention for behaviour (conduct) problems. Further research is urgently needed on early prevention for both anxiety and (especially) depression. For anxiety, to date the Cool Little Kids parenting program has the best evidence supporting its efficacy. Advantages of this program include its brevity, targeted approach and evidence that it prevents later anxiety disorders. A population level randomised trial of Cool Little Kids is currently underway in Australia.[31] The existence of depression in preschool age children has only recently been recognised, and the development of innovative early intervention is urgently required.[33]

**Implications**

Current knowledge of early intervention and prevention for internalising problems has implications for parents, services and policy. Parents can be reassured that effective early intervention for young anxious children exists. Health and education services could plan staff development to implement only early intervention programs with a sound evidence-base.  Policy makers could prioritise funding to a) disseminate evidence-based programs and b) conduct more quality early intervention research for young children's anxiety and depression. To disseminate preventive interventions, Geisen and colleagues[36] note the following important principles:

- Programs should have staff that are properly trained and adhere to program content.

- Intervention “dosage” should be maximised by providing out-of-hours sessions for working parents and on-site childcare.
- It is essential that a professional consultant experienced with the program works closely with new providers, to ensure that components essential for effectiveness are maintained while minimal aspects are tailored to local needs.
- The ability to reduce children’s anxiety and depression problems early in life could narrow cumulative disparities in mental health and disadvantage later in life.

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