BEST PRACTICE

PROJECT EVIDENCE for Treatment of Mental Disorders. The project coordinator is Dr Allan Mawdsley. The version can be amended by consent. If you wish to contribute to the project, please email admin@mhyfvic.org

[6] Standard Treatment

a) Outpatient psychotherapies, medication and procedures
b) Inpatient psychotherapies, medication and procedures
c) Ancillary support services

[6 a] Outpatient psychotherapies, medication and procedures

All disorders in childhood require wholistic management involving caregivers. See PE4 for a general outline of case identification and assessment and PE2a(i) for infant mental health. See PE6a(ix) for a general outline of case management for young people.

BP6a (iv) Mood Disorders

The general principles of clinical assessment and case planning mentioned in the preceding paragraph are modified in each of the subgroupings because of the need for specialist expertise in the management of specific disorders. This is described in the Project Evidence subsections. The subsections are:

Primary:

Bipolar Disorders
Depressive Disorders

Secondary:

Premenstrual Dysphoric Disorder
Substance-induced mood disorder
Mood disorder due to a medical condition such as endocrine disorders.

Bipolar Disorders

The presence or history of mania/hypomania is the defining element of bipolar disorders and distinguishes them from depressive disorders. Mania or hypomania are rarely encountered in childhood but may emerge in adolescence or young adulthood. The excitable behaviour of children with Attention Deficit Disorders, Conduct Disorders and substance abuse problems should not be misinterpreted as manic symptoms. Most individuals will also have experienced one or more major depressive episodes, which often precede the onset of mania. Because of this, it may take five or more years before the definitive diagnosis is established.

As the onset of depressive disorders in children occurs most commonly in the context of stressful relationship and situational events, that require appropriate psychosocial intervention, an underlying biological predisposition may not be evident in early stages. Successful response to psychosocial interventions does not rule out the possibility of predisposition. Any episode of depression should be

assessed and managed as necessary. If there are recurring episodes that have stronger physiological symptoms, the possibility of emerging bipolar disorder should be kept in mind. This is important in adolescence when the propensity for suicidal ideation heightens.

Depressive Disorders

Major Depressive Disorder (MDD) shows the features described above, without a history of manic features. It may vary in intensity from mild to severe. Two related disorders share some of the features; Adjustment disorder with depressed mood results from identifiable life stressors; Dysthymic disorder is a fluctuating mood state in which a person experiences depressed mood for more days than not over a period of two years (or one year in children and adolescents) and is closely linked to personality style.

Biological Treatments

The biological treatments commonly used in adult psychiatry have very little place in child and adolescent services. There is no indication for ECT (with a possible exception for catatonic psychotic states), no evidence for the use of Transcranial Magnetic Stimulation, and minimal usefulness of medication. Mood stabilizer medication is only relevant after a diagnosis of bipolar disorder has been established, which is generally not until adulthood.

A trial of anti-depressant medication is reasonable for cases that have strong physiological symptoms (sleep disturbance, appetite disturbance, weight loss, anergia, anhedonia) poorly responsive to psychosocial interventions. If used, it is a component in a case management plan, avoiding any message that "problems are solved by pills". *A*n adequate trial of an antidepressant should be a minimum of three weeks at the recommended therapeutic dose. If no improvement is apparent, the use of medication should be re-considered (rather than increasing dosage or switching to alternative anti-depressants, as is usually done with adult patients).

Psychological Treatments

Cognitive Behavioural Therapy
Interpersonal therapy
Family therapy
Play therapy

Though there is little evidence for differential effectiveness across the various psychotherapies, this does not imply that unstructured or eclectic approaches are supported in the psychological treatment of depression. There is strong clinical consensus that treatment is best guided by well-trained therapists using an evidence-based treatment manual, tailored to the individual patient, and with proper attention to the therapeutic relationship.

Social Treatments

Family psychoeducation
Family/friends
Formal support groups
Community groups
Caregivers
Schooling/ employment/ housing

Lifestyle Treatments

There is evidence that lifestyle issues can adversely affect the onset, severity and duration of depression and, conversely, can play a role in ameliorating depression. A discussion with patients about lifestyle issues can assist overall engagement with care and help build rapport. This is not telling them what to do, but exploring with them the meaning of the issue and what would empower them to get the best outcome for themselves. Personal cleanliness, grooming, diet and exercise are closely related to their mastery of their circumstances as well as being central to self-image.

The discussion issues could include Diet, Exercise, Smoking cessation, Alcohol cessation, Ceasing drugs, Sleep.

If done within a family context such discussions have a high risk of derailment from personal development into authority and control battles. However, with care, such discussions could assist both personal development and family functioning.

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