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 (v) Anxiety 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:

- Anxiety Disorders in general,
- School Refusal/ Separation Anxiety Disorder
- Somatisation Disorders
- Stress-related Disorders
- Obsessive-Compulsive Disorders,

Anxiety Disorders in general

Cognitive behavioural therapy (CBT) aims to teach children to identify and regulate their emotions. However, when working with children it is essential that these skills are delivered in a developmentally appropriate way. Play therapy techniques and parenting skills training are highly valuable in ensuring children are engaged and understanding skills, and it is important that parents have the knowledge to reinforce coping at home. There are specific treatment components to give skills to families and teachers in order to maximise positive treatment gains. Both individual and group formats have proven to be effective, with the key target of normalisation, rather than stigmatisation, being emphasised in both formats.

Childhood anxiety disorders are frequently comorbid with each other and with other forms of psychopathology. Thus, it is common that children with SAD also present with other anxiety disorders or other conditions such as depression, disruptive behavior disorders or attention-deficit hyperactivity disorder.

School Refusal/ Separation Anxiety Disorder

There are three key characteristics of separation anxiety disorder:
• Excessive and persistent fears or worries before and at the time of separation.
• Behavioral and somatic symptoms before, during and after the separation, and
• Persistent avoidance or attempts to escape the separation situation.

The child *worries* that something may happen to his parents (e.g., that they will disappear, get lost or forget about him) or that the child will get lost, kidnapped or killed if he is not near his parents. *Behavioral symptoms* include crying, clinging, complaining upon separation, and searching or calling for the parent after their departure. *Physical symptoms* are similar to those in a panic attack or somatization disorder.

Due to these physical symptoms, SAD is a frequent cause of school absenteeism and multiple visits to the family doctor or pediatrician to rule out a medical problem. Symptoms only appear on school days and usually disappear as soon as the parents decide the child will stay at home. Separation anxiety symptoms appear more frequently in situations such as a change of school, starting a new school term (after summer vacation, or when starting high school), changing friends, experiencing adverse events such as being bullied, or suffering a medical illness.

Behavioral management is indicated in all cases. It consists of informing family members and significant caregivers, how to manage mild symptoms and maladaptive attitudes such as avoidant behaviors or cognitive biases. It may be the only treatment required in cases of mild separation anxiety (which generally occur during pre-school). This should be combined with other therapies if there is no improvement or symptoms are moderately severe, or cause moderate dysfunction or distress. The main objective of behavioral management is to provide the child a flexible and supportive environment to overcome his separation anxiety symptoms.

Somatisation disorder

In somatic symptom and related disorders, there are physical symptoms suggesting a medical condition; however, no medical disease, substance misuse or other mental disorder can be found to account for the level and impact of the physical (somatic) symptoms. The symptoms cause significant distress or impairment in social, occupational or other areas of functioning. The physical symptoms are usually not intentional, with the exception of factitious disorder where there is deliberate falsification of physical or psychological symptoms (Munchausen syndrome).
The somatizing disorders most commonly seen in children and adolescents are:

- Somatic symptom disorder, especially pain syndromes
- Disorder of bodily distress, including pseudocyesis
- Dissociative disorders
- Conversion disorder and
- Chronic fatigue syndrome.

A thorough diagnostic assessment should be undertaken as described in PE4. Consider somatic symptom and related disorders when the following are present:

- There is a time relationship between psychosocial stressor and physical symptoms

• The nature and severity or handicap from the symptom are out of keeping with the pathophysiology
• There is a concurrent psychiatric disorder.

Somatic symptom disorders can also coexist with organic disorders. If there is a medical illness, it is important to establish what physical symptoms are congruent with the organic illness and what are more likely to be attributed to identified psychosocial stressors.
A certain amount of health anxiety is normal and it is appropriate to investigate symptoms. It is only considered a disorder if the anxiety interferes with functioning.

Stress-related disorders

Reactions to trauma exposure are defined according to their timeframe: immediate or peri-traumatic (lasting minutes to hours), Acute Stress Disorder [ASD] (lasting between two days and one month), and Post Traumatic Stress Disorder [PTSD] (when symptoms persist for more than one month).

The diagnosis of PTSD includes the same exposure criteria as ASD (i.e., exposure to death or threatened death, actual or threatened serious injury, or actual or threatened sexual violation). In addition, the adult and adolescent PTSD diagnosis requires: • One symptom of intrusion (criterion B) including recurrent distressing dreams, recurrent distressing memories of the trauma, dissociative reactions (e.g., flashbacks), or intense psychological or physiological reactivity to reminders of the trauma; • Persistent avoidance of internal or external stimuli associated with the trauma (criterion C); • Two symptoms of negative alterations in cognitions and mood associated with the trauma (criterion D) including persistent, distorted blame of self or others, persistent negative emotional state (e.g., fear, horror, anger, shame or guilt), diminished interest or participation in significant activities, detachment or estrangement from others, or persistent inability to experience positive emotions (e.g., emotional numbing); and • Two symptoms of alterations in arousal and reactivity (criterion E), including irritability or aggressive behaviour, reckless or self-destructive behaviour, hypervigilance, exaggerated startle, problems with concentration, or sleep disturbance. The diagnosis also requires symptoms to last more than one month, to be associated with clinically significant distress or impairment, and not to be associated with the effects of a substance or medical condition. In addition, a subtype of PTSD for preschool children aged six or younger highlights significant differences including the still developing abstract cognitive and verbal expression capacities.

PTSD can present concurrently with mood and anxiety symptoms.
Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) has been shown to reduce PTSD symptoms, trauma-related depression, and improve adaptive functioning in a variety of populations, including children and teens traumatized by sexual abuse, terrorism, domestic and community violence, and traumatic loss.

Obsessive-Compulsive disorder

When OCD is suspected, a comprehensive clinical evaluation – including detailed interviews with parents and, if possible, teachers – is required in order to assess the compulsions, obsessions and sensory phenomena. In younger children, OCD features might appear subtly during play activities or drawing. It is vital to differentiate between obsessive compulsive symptoms and normal childhood ritualistic behavior, typical of specific developmental phases, such as mealtime or bedtime rituals. In

this regard, detailed information about degree of distress, impairment and time consumed performing rituals should provide enough data to decide whether or not treatment is warranted. Moreover, it is also important to assess insight and the family's perception of the symptoms, as well as how family members deal with the patient.

Rating scales are useful to obtain detailed information regarding OCD symptoms, tics, and other aspects relevant to the diagnosis. Symptoms may remain undisclosed unless specifically questioned. Scales are also used to assess severity at baseline and to evaluate improvement in a more objective way during follow up treatment. The most widely used scale is Children's Yale-Brown Obsessive-Compulsive Scale (CYBOCS).

Treatment of OCD in children and adolescents relies on cognitive behavioral therapy (CBT), medication and psychoeducation. Both selective serotonin reuptake inhibitors (SSRIs) and CBT have been systematically studied and empirically shown to be useful. CBT is the only psychological therapy shown to be effective in the treatment of childhood OCD. Treatment of pediatric OCD should preferably start with CBT for mild to moderate cases, or a combination of CBT and pharmacotherapy for more severe cases, or when CBT is not available.

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