Werry Workforce
WHĀRAURAU

Psychotic Disorders (including Bipolar Disorder)

Fast facts

- Schizophrenia is rare in childhood, and generally emerges in mid adolescence.
- There are very few robust studies into the effectiveness of interventions for children and adolescents with schizophrenia.
- The most effective intervention for schizophrenia appears to be a combination of talk therapy and medication, alongside family intervention.
- Bipolar disorder is a relatively contentious diagnosis in childhood, with international differences in diagnosis and treatment.

Interventions that work – at a glance

This table represents a compilation of information from several different sources (Fonagy et al. (2015), The Matrix (2015), McLellan at al., (2013) and Dunnachie (2007)) and is designed to provide an overview only. Directly consulting these sources will provide considerable additional information.

	Gold [?]	Silver [?]	Bronze [?]	Not recommended [?]
Schizophrenia	Individual CBT in combination with psychotropic medication Atypical or second-generation neuroleptic medication Family interventions	Traditional neuroleptic medication	Cognitive remediation Electroconvulsive Therapy (ECT)	Counselling, or supportive psychotherapy as a stand-alone intervention
Bi-polar disorder	Cognitive Behavioural Therapy (CBT) Pharmacotherapy for the acute phase	Family Interventions Interpersonal Therapy (IPT)		

The fine print

1. Psychological interventions for schizophrenia are usually **more effective when combined with psychotropic medication**, and it has been suggested that **medication ought to always accompany talk therapy** for schizophrenia (The Matrix, 2015). However side effects of medication, such as weight gain, can lead to poor treatment compliance. Engaging young people with schizophrenia in psychosocial interventions is also often challenging. Actively treating any substance use difficulties, and establishing social networks may help with engagement (Fonagy et al, 2015).

2. Family interventions which provide psycho-education and support the reduction of expressed emotion may decrease the likelihood of later institutional care, even if relapse rates remain the same (Fonagy et al., 2015). They should be offered to all families of children and young people with schizophrenia (NICE, 2013).

3. There is some evidence that **cognitive remediation may improve planning ability and cognitive flexibility** in young people with schizophrenia (McLellan et al., 2013), but there is also evidence that it is not an effective stand-alone treatment for children and adolescents with schizophrenia (Fonagy et al., 2015).

4. Side effects can be serious and must be regularly monitored (McLellan et al., 2013). There is strong evidence that children may be more sensitive to the serious side effects than adults (Fonagy et al., 2015).

5. Traditional neuroleptic medication has been shown to reduce acute "positive" symptoms (Fonagy et al., 2015).

6. While ECT has not been systematically studied in young people with schizophrenia (Fonagy et al., 2015), it has been effective with adults, and may be useful for severely impaired adolescents with treatment-resistant symptoms (McLellan et al., 2013).

7. Counselling or supportive psychotherapy should not be offered as a standalone intervention for schizophrenia (NICE, 2013).

8. Family interventions involving psychoeducation, communication skills, stress reduction and problem-solving may help reduce symptoms (Fonagy et al., 2015).

9. Refer to Malhi et al., (2015) for detailed information.

Description and demographics

Schizophrenia

In New Zealand, the terms "psychosis" and "schizophrenia" are often used interchangeably. In fact, schizophrenia is a mental illness that causes psychosis (broadly, a disconnection from reality), and psychosis is only one symptom of schizophrenia. In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), a diagnosis of schizophrenia requires the presence of a combination of delusions, hallucinations, disorganised speech, very disorganised (or catatonic) behaviour, combined with "negative" symptoms such as apathy, reduced speech, incongruent emotional responses and social withdrawal (American Psychiatric Association, 2013; Fonagy et al., 2015). Another way of conceptualising these difficulties is by considering groups of symptoms (Fonagy et al., 2015) namely,

- **abnormalities of thought processes** (e.g. thought insertion, or thought broadcasting)
- **abnormal beliefs** (which may relate to beliefs about the self, or beliefs relating to political or religious ideas)
- **abnormal experiences** (such as hallucinations)
- **"negative" symptoms** (see above)

School achievement, social relationships and self-care are usually noticeably impacted in young people experiencing schizophrenia.

Very few studies have specifically explored the effectiveness of interventions for children and adolescents with schizophrenia. Given that schizophrenia tends to present similarly in young people and adults, findings from adult studies have tended to be extrapolated to children and adolescents.

There is very little current information on the prevalence of schizophrenia in children and adolescents in New Zealand. Previous research estimates that schizophrenia is virtually non-existent in children under 5 years of age, then occurs in around 2 per 10,000 children aged between 5-12 years (Spencer & Campbell, 1994, cited in Fonagy et al., 2015) and in 1 in 1000 children to mid adolescence, when the prevalence increases five- to ten-fold into early adulthood (Anderson & Werry, 1994, cited in Fergusson et al., 1997). Overall prevalence of mental health disorders is higher for Māori young people than non-Māori (Fergusson et al., 1997), and rates of admission and re-admission to hospital for psychiatric disorders are also higher in 15-19 year olds (Fergusson et al., 1997), though more research using community-based samples is required to more accurately establish the rates of schizophrenia in children and adolescents in New Zealand.

While no interventions for schizophrenia designed specifically for Māori, by Māori have been identified, the importance of culturally appropriate and informed care is emphasised in several recent guidelines – refer to Galletly and colleagues' 2016 guidelines for more information, including on working with Pacific people with schizophrenia.

Bipolar Disorder

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5, American Psychiatric Association, 2013) describes Bipolar I disorder, and Bipolar II disorder. The first represents a combination of manic episodes (a period of abnormally and consistently elevated or irritable mood and persistently increased activity or energy levels; combined with other symptoms including grandiosity, distractibility, racing thoughts, decreased sleep), with periods of depression (American Psychiatric Association, 2013). Bipolar II disorder describes a course of recurring depressive and mood episodes.

Internationally, there is some international inconsistency regarding bipolar disorder in children (Malhi, 2016), with rates of diagnosis higher in the United States of America than in Australasia (Allison et al., 2016). It is only recently that diagnostic criteria have been refined, and as such there is little cohesive research into the condition. The diagnostic criteria remain somewhat controversial – some have pointed out that irritability and mood lability occur frequently in childhood, and that childhood bipolar disorder may be a collection of these 'symptoms' (arising from a number of different causes), rather than a 'disease' as such (Allison et al., 2016). In Australia and New Zealand, the majority of child psychiatrists have adopted a very cautious approach with regard to diagnosis of childhood bipolar disorder and treatment with adult medications (Allison et al., 2016).

References

Allison, S., Parry, P., Roeger, L., Bastiampillai, T. (2016). What are the dangers of treating a hypothetical disorder as a real disease? Australian and New Zealand Journal of Psychiatry 51(1), 98.

American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V). Arlington, VA: American Psychiatric Association.

Dunnachie, B. (2007). Evidence-based Age-appropriate Interventions – A guide for child and adolescent mental health services (CAMHS). Auckland: The Werry Centre for Child and Adolescent Workforce Development.

Fergusson, D. M., Horwood, J., Lynskey, M. (1997). Children and Adolescents. In Ellis, P. M., & Collings, S. C. D. (Eds). Mental Health in New Zealand from a Public Health Perspective. Wellington: Ministry of Health.

Galletly, C., Castle, D., Dark, F., Humberstone, V., Jablensky, A., Killackey, E., Kulkarni, J., McGorry, P., Nielssen, O., & Tran, N. (2016). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the management of schizophrenia and related disorders. Australian and New Zealand Journal of Psychiatry 50(5), 1-117.

Fonagy, P., Cottrell, D., Phillips, J., Bevington, D., Glaser, D., & Allison, E. (2015). What Works for Whom? A critical review of treatments for children and adolescents (2nd Ed). New York: Guilford.

Malhi, G. S. (2016). Bipolar disorders: Key clinical considerations. The Lancet 387, 1492–1494.

Malhi, G. S., Bassett, D., Boyce, P., Bryant, R., Fitzgerald, P. B, Fritz, K., Hopwood, M., Lyndon, B., Mulder, R., Murray, G., Porter, R., & Singh, A. B. (2015). Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. Australian and New Zealand Journal of Psychiatry 49(12), 1-185.

McLellan, J., Stock, S., & the American Academy of Child and Adolescent Psychiatry Committee on

Quality Issues. (2013). Practice parameter for the assessment and treatment of children and adolescents with schizophrenia. Journal of the American Academy of Child & Adolescent Psychiatry 52(9), 976-990.

National Institute for Health and Care Excellence (NICE; 2013). Psychosis and schizophrenia in children and young people: Recognition and management. Clinical Guideline (CG155).

The Matrix (2015). A Guide to Delivering Evidence-based Psychological Therapies in Scotland. Scotland: NES.