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EDITORIAL

Clinical Pearls

In this issue of the Journal, each article delivers a clinical pearl to readers. It is interesting to note that all the pearls come from Canadian universities.

Two clinical case rounds on patients who struggle with eating highlight the importance of clinical detective work about children's potential reasons for not eating. Probably in both cases neither the child nor the parent had specific knowledge as to why the child could not eat. Dosanjh and colleagues formulated their young patient's problem from a classical conditioning framework and Couturier and colleagues sought to question what cultural influences may have shaped the family's resistance to an explanation of psychological origin. These papers highlight the flexibility that is necessary for clinicians working in children's mental health to implement effective treatments on a case by case basis.

Papers by Alavi and colleagues and LeBoeuf and colleagues explored clinical databases to identify their pearls. Alavi found that youth presenting with suicidal ideation in the ER were 19 times more likely to have experienced multiple types of bullying than those without suicidal ideation. They suggest that clinicians working with youth in crisis should consider how to build support to protect youth from bullying as part of their suicide risk management plan. It is indeed likely that much of this work will need to focus on cyber-bullying as opposed to other types. LeBoeuf's team showed that depressed adolescent girls who have experienced abuse are more likely to struggle with relationships with parents and to self-injure than their non-abused, depressed clinical peers. This information is important as both groups did not differ on most other clinical parameters they measured, suggesting that important clinical heterogeneity in mood disorder clinics for youth may be predicted by abuse history. So ask about it, and tailor treatments accordingly.

Duda and colleagues provide an important reminder that not all practice guidelines are of equal quality. They reviewed guidelines from the National Guideline Clearinghouse – a reputable source – for youth internalizing disorders and note that half of those published there were of poor quality. Fortunately, the authors note that the NGC is seeking to employ an indicator of guideline quality either to rate guidelines they publish or to decide which to include. This information will be important for us as we seek to generate Canadian Practice Guidelines for treatment of youth mental health disorders.

I am pleased to report that I have received emails from readers and a Letter to the Editor. One point I was asked to consider was a comment from my previous editorial about prescribing antidepressants. One of our colleagues was concerned that my comment "there is still no evidence for the use of antidepressants for treatment of depression in children (i.e. not adolescents)" might suggest that they should not be prescribed. While I did not state that they should not be prescribed, the decision to do so rests on clinical judgements about their appropriateness which are similar for adolescents, and were presented in the lead article by Garland et al. (2016). Greater clinical observation and scrutiny is necessary for younger children.

As a final note, in observance of the recent release of the Netflix series "13 Reasons Why" and an observable increase in youth presenting for support with suicide related behaviours, I direct readers to online resources to share with patients and their friends. We can provide important direction in regards to how and when to talk about suicidal thoughts and behaviours and to help parents and teachers learn what youth are thinking.

https://www.jedfoundation.org/wp-content/uploads/2017/03/13RW-Talking-Points-JED-SAVE-Netflix.pdf

www.suicideprevention.ca

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