

An Introduction to
**Child and Adolescent
Mental Health**

Maddie Burton, Erica Pavord and Briony Williams



Los Angeles | London | New Delhi
Singapore | Washington DC

1

CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH

MADDIE BURTON

Overview

- Child and adolescent mental health – strategic view
- Child and adolescent mental health – context today
- Defining child and adolescent mental health
- Theoretical models
- Risk and resilience
- Mental health conditions:
 - Depression
 - Anxiety
 - Self-harm
 - Suicidal behaviour
 - Eating disorders
 - Early onset psychosis and substance misuse
 - Emerging personality disorder
- Neuro-developmental conditions

INTRODUCTION

This chapter will provide an overview of child and adolescent mental health problems and services. Psychological, biological, social and environmental theories inform our understanding of mental health problems. It is generally understood that a combination of *nature* and *nurture* theories, used to inform an understanding

of human development, also offer the most likely theoretical explanations for understanding child and adolescent mental health. It is about the inter-play and inter-relation between:

- Biological factors (brain development and genetics);
- Psychological variables such as coping mechanisms;
- Genetic and physiological characteristics;
- Environmental circumstances (positive or negative).

Another way of thinking about this is that an individual's inherent genes are triggered by experiences in childhood. Alternatively, positive experiences can mitigate or offset genetic factors. The nature and process of risk and resilience theory also requires exploration in order to understand the complex interplay between all these theoretical models. Child and adolescent mental health encompasses a large area and it is difficult to fully explore them all within the confines of a chapter; so some areas have a larger focus here than others.

CHILD AND ADOLESCENT MENTAL HEALTH: A STRATEGIC VIEW

Child and adolescent mental health is a relatively new psychiatric healthcare specialism; the Child and Adolescent Mental Health Services (CAMHS) we have today were commissioned and established following the *Together We Stand* Health Advisory Service Report (1995). Prior to that date child psychiatry was commonly situated in Child Guidance Clinics or Child Behaviour Clinics, with children being typically referred with symptoms such as larceny, masturbation and conduct disorder. Child Guidance Clinics were based on local commitment rather than explicit government policy. Young people with conditions including eating disorders and psychosis were treated in adult in-patient psychiatric hospitals and units. Since 2010 hospital managers now have an obligation to provide age appropriate facilities (Barber et al., 2012).

Current CAMHS provision as established in 1995 includes a tiered strategic service:

Tier 1: a primary level of care; professionals include:

- GPs
- Health visitors
- School nurses
- Social workers
- Teachers
- Juvenile justice workers
- Voluntary agencies
- Social services.

Tier 2: a service provided by professionals relating to workers in primary care; professionals include:

- Clinical child psychologists
- Paediatricians (especially community)
- Educational psychologists
- Child and adolescent psychiatrists
- Child and adolescent psychotherapists
- Community nurses/nurse specialists
- Family therapists.

Tier 3: a specialised service for more severe, complex or persistent disorders; professionals include:

- Child and adolescent psychiatrists
- Clinical child psychologists
- Nurses (community or in-patient)
- Child psychotherapists
- Occupational therapists
- Speech and language therapists
- Art, music and drama therapists
- Family therapists.

Tier 4: essential tertiary level services such as day units, highly specialised out-patient teams and in-patient units. All of the above Tier 3 professionals would be included in this tier.

CHILD AND ADOLESCENT MENTAL HEALTH TODAY

Many mental health problems have origins in childhood (Dogra et al., 2009). Half of lifetime mental health problems (excluding dementia) begin to emerge by age 14 and three-quarters by the mid-twenties (Department of Health, 2011a). The prevalence of many childhood mental health disorders has increased in the western world during the last 25 years, particularly conduct disorders, anxiety and depression (Street et al., 2007).

Ten per cent of five to fifteen year olds have a diagnosable mental health disorder. This suggests that around 1.1 million children and young people under eighteen would benefit from specialist services. There are up to 45,000 young people with a severe mental health disorder. Around forty per cent of children with a mental health disorder are not currently receiving any specialist service. (*National Service Framework, 2004: Rationale 2.2*)

Activity

Why do you think there is an increase in reports of mental health problems for children and young people in Britain today?

There is a mixed picture of theories with no definitive answers! There is increased recognition and alertness to the possibility of mental health problems. Mental health is now perhaps considered as an explanation and understanding of presenting behaviours. The mental health agenda is now much more publicised than previously, in part due to the media and to government health awareness programmes. This has led to a more open discourse and together with all other health issues information is now much more readily available via the internet. Both parents and children are in some cases more likely to ask for help than in the past. Some Early Years settings professionals are now taking more interest in emotional and mental health. Children's centres which began with Sure Start in the last decade are paying more attention and recognising the significance of poor emotional and mental health in children, their carers and families. They have instigated active programmes and links with health care professionals such as health visitors and local child and adolescent Tier 2 and 3 services. The Healthy Child Programme: Pregnancy and the First Five Years of Life (Department of Health, 2009) has a strong emphasis and commitment to improving attachment quality between parents and children, a strong indicator of the now recognised importance of attachment and improved social and emotional wellbeing. Early Years, teacher training programmes and social work training are rather slower in catching up with infant, child and adolescent mental health issues and understanding, as integral parts of their training. It is unfortunately at the moment patchy and in some areas non-existent. However the health driven agenda has raised awareness in education settings with programmes such as the three-year Targeted Mental Health in Schools (TaMHS) from 2008 to 2011 (Chimat, 2012), although this was a trial in specific areas in the country and only covered the 5–13 age group. Other initiatives have included Social and Emotional Aspects of Learning (SEAL, 2010) and Personal, Social and Health Education (PSHE, 2011).

CONTEXT OF CHILD AND ADOLESCENT MENTAL HEALTH

Science now evidences that infants are not too young to experience mental health problems. Those who have experienced significant maltreatment exhibit clinical symptoms of post-traumatic stress disorder (PTSD) (National Scientific Council on the Developing Child, 2004: 3). How these difficulties can be ameliorated does however offer hope for repair and will be discussed in Chapter 6.

Mental ill health is an interpretation of illness and the medicalisation of behaviours considered to be beyond the norm. What we are often presented with is a set of

behaviours which could be seen to be *acting out* of the individual internal working model. So behaviours can be understood from a psychological perspective rather than a tendency for an interpretation of illness as such. Acting out is a process which aims to get the hurt addressed and is a defence mechanism (see Chapter 2), defending one from anxiety. Acting out is an emotional and externally visible response to feelings which are unmanageable.

Children and young people referred to CAMHS at Tier 2 and above are always thought about systemically; within their current and previous contexts of family or carers and including other systems around the child or young person, such as educational and community settings. It is important for all those working with children and young people throughout all tiers to be mindful of the child or young person's context. Professionals and clinicians will be attentive in history taking a full developmental history of the individual and the family beginning at a point prior to conception. Almost always a history provides the clues with which to help understanding of behaviours and other presentations.

A diagnosis of conditions would be agreed, for example the signs and symptoms recognised in depression and eating disorders. Any condition has been with a child or young person for a relatively shorter time period than if the condition was presenting for the first time in adulthood. There is an important window of opportunity for intervention which would ideally be systemic and include the system around the child. The resulting changes brought about by interventions have more chance of success and for changes to be successful before the condition exacerbates, continuing into adulthood and becoming more concrete and difficult to treat.

One of the differences between a CAMHS and adult mental health model is that CAMHS is always a combination of medical and psychological interpretations and interventions, whereas an adult mental health model has been primarily medical in both interpretation and intervention. It is also relevant at this point to state that only GPs (although this is now less likely), and child and adolescent psychiatrists make clinical diagnoses. So it is important for children and young people where there are concerns over their mental health to be referred to a Tier 2 or 3 CAMHS team for a thorough assessment.

DEFINING CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH

Mental health is a broad concept, culturally determined, which can be complicated to interpret. It is also important to remember that meanings around mental health are culture bound and are subject to change. Universally it includes freedom from persistent problems with emotions, behaviour and social relationships (Kurtz, 1992, cited in *Together We Stand*, 1995: 18).

Mental health is aptly defined for children and young people by Hill (cited in *Together We Stand*, 1995: 15) as:

Not being easy to maintain within a context of ever changing circumstances and events which are dependent on individual potential and experience. It involves the capacity to develop in the following areas:

- Physically, emotionally, intellectually and spiritually
- The ability to initiate, develop and sustain mutually satisfying personal relationships
- The ability to become aware of others and empathise with them
- The ability to use psychological distress as a developmental process, so that it does not hinder or impair further development.

In children and young people mental health is more specifically indicated by:

- A capacity to enter into and sustain mutually satisfying personal relationships.
- Continuing progression of psychological development.
- An ability to play and learn so that attainments are appropriate for age and intellectual level.
- A developing moral sense of right and wrong.
- The degree of psychological distress and maladaptive behaviour being within normal limits for the child's age and context.

Examples of potential mental health problems would include somatising features (physical symptoms with psychological origins) such as headaches, enuresis and encopresis (faecal soiling), tummy aches and sleep disturbances, self-harm, suicidal behaviours, risk taking, mood changes, behaviour changes, relationship and attachment difficulties, substance misuse, changed eating patterns, isolation and social withdrawal.

Examples of mental illness/disorder include eating disorders, anxiety disorders, depression, psychosis, conduct disorder, neuro-developmental conditions, such as attention deficit hyperactivity disorder (ADHD) and autistic spectrum disorders (ASD) – although it is now considered more appropriate to use the term autistic spectrum conditions (ASC) – developmental disorder, habit disorder, post-traumatic stress disorder and somatic disorders.

Mental health problems are relatively common but include mental health disorders, as above, which tend to be more persistent. There is a considerable overlap across the range, with 'emotional' being an element throughout. Severity and impact can span a wide range. Some children have both physical illness and mental health problems combined. For example a young person with diabetes may place themselves at risk of complications through non-compliance with treatment. Terminology such as 'disorder' can feel quite stigmatising, however it is important to recognise children and young people who may be experiencing problems, so that appropriate interventions can be organised.

All presentations also need to be thought of in the context of normal development, which is on a continuum of constant change. Any of the above illnesses and disorders can either lead to or be associated with other behaviours and problems. For example

conduct disorder may precede substance misuse. It is important to remember that risk taking behaviours and mood changes are thought of as normal in adolescent behaviour. Potential symptoms need to be considered from a developmental perspective but also the context of the child or young person.

However many significantly impaired children do not meet diagnostic criteria or they meet symptomatic criteria but they are not impaired. It is about making a clinical judgement regarding diagnosis. Diagnosis is about bringing together illnesses with the same features although most 'disorders' are multi-factorial in causation. Diagnosis is about symptoms and signs of a disorder but not necessarily about treatment, although it helps inform treatment choices.

THEORETICAL MODELS

The different theoretical models used to understand and interpret an individual's presenting features of mental ill health consist of several overlapping and interrelated domains including:

Medical or biological theory: illness is determined by an individual's genetic make-up. Illness is classified according to ICD 10 and DSM 5. Traditionally adult mental health is more firmly positioned here.

Psychological theory: cognitive and emotional factors including attachment theory. Insecure attachment can increase risks to mental health in infants, children and adolescents and throughout the life span (World Health Organization, 2012). Secure attachment (Bowlby, 2008 [1988]) leads to feelings of safety being internalised whereas disorganised attachment (Main and Solomon, 1986) leaves the individual with nothing to draw on in terms of a safe internal working model, with external experiences having an enduring significance throughout life.

Systemic, social and environmental theories: the impact of context – family stressors, poor social support, poverty, housing, income, parenting style, parental mental health, cultural influence, peer rejection and stressful life events including bereavement and loss. Relationship patterns and links between family members need to be considered as these will be relevant to informing understanding; also areas of parental conflict, quality of sibling relationships, the relationship of both parents with the child and the parents' own early experiences, or as aptly described by Karr-Morse and Wiley (1997), the 'ghosts from the nursery'.

RISK AND RESILIENCE MODEL

The risk and resilience model was identified by Pearce (1993, cited in *Together We Stand*, 1995). He defined three areas of risk which were: environmental/contextual, the family and the young person/child as follows:

Environmental/contextual

- Socioeconomic disadvantage
- Homelessness
- Disaster
- Discrimination
- Violence in the community
- Being a refugee/asylum seeker
- Other significant life event.

Family

- Early attachment/nurturing problems
- Parental conflict
- Family breakdown
- Inconsistent/unclear discipline
- Hostile and/or rejecting relationships
- Significant adults' failure to adapt to child's changing developmental needs
- Physical, emotional, sexual abuse
- Parental mental and/or physical illness
- Parental criminal behaviour
- Death and loss, bereavement issues relating to family members or friends.

Child/young person

- Genetic influences
- Low IQ or learning difficulties
- Specific developmental delay
- Communication difficulties
- Difficult temperament
- Gender identity conflict
- Chronic physical illness
- Neurological disorder
- Academic failure/poor school attendance
- Low self-esteem.

Resilience factors as identified by Pearce (1993, cited in *Together We Stand*, 1995) are as follows:

Resilience factors

- Secure attachments
- Self-esteem

- Social skills
- Familial compassion and warmth
- A stable family environment
- Social support systems that encourage personal development and coping skills
- A skill or talent.

Activity: risk and resilience model

Take a look at the case study below and consider which area of risk is evident. Are there any potential resilience or protective factors?

Jane is 14. Her grandmother has taken her to the GP. She has been feeling low and tearful for several months.

This started after losing the family home. After years of domestic violence towards Jane's mum from her partner they shared the house with, Jane's mum was courageous enough to insist he leave the family home. With him left the financial support and Jane's mum was no longer able to afford the mortgage repayments and lost the house. They lived in Bed and Breakfast for several weeks and then moved to a one bedroom flat. One of their dogs had to be given away; a neighbour took the other dog. There was no space at the B&B or provision for pets. Most personal possessions were lost; Jane left her home with the only possessions she could fit into a bin bag. Jane feels they have lost everything and feels guilty about it; she was using the phone a lot and ran up some big bills. Jane does not want to talk to her mother as her mother is depressed.

She is crying herself to sleep, not sleeping well and waking frequently. Appetite is poor and she is hardly eating anything. Sometimes she says it hurts so much inside she does not know what to do and has cut herself at times and spends a lot of time usually in her room. Prior to these events Jane won a literary award prize for story telling in the 11–13 years category in a schools competition. Now Jane has secret books where she is drawing lots of sad and angry pictures. On one of the pages she has drawn a gravestone for herself and her dog and has written 'I wish I wasn't here'. School work has started to be affected as she cannot be bothered to do anything.

Areas of evident risk for Jane

Family: Mum has *mental health problems* (clinically depressed). There has been *parental conflict and violence*. *Loss* in terms of Jane's pet dog (she'd had him since he was a puppy) and *loss* of her home.

Environment/context: *Homeless, socioeconomic disadvantage, significant life events.*

Child/young person: *Genetic influences* (parent with mental health problems), *school work* now affected.

(Continued)

(Continued)

Resilience and protective factors for Jane: Mum has modelled that she will no longer tolerate an abusive partner and has taken an active step to break the cycle of violence even though this has led to her and Jane losing their home. Clearly Jane has a *skill* or a *talent* for writing demonstrated by her literary prize.

Despite major adversity and overwhelming odds, many young people cope well. The key is *resilience*, which acts as a protective factor. Rutter (1985, 2006) described this as a dynamic evolving process and not just about static factors. The model of risk and resilience is not based on risk and protective factors in themselves but rather on how they interact. The emphasis is on the process of resilience across developmental pathways. Some young people may tick all the boxes in relation to risk factors being present early on in life. Multiple family transitions can increase risk with a cumulative effect on educational achievement, behaviour and relationships in general.

Identifying a skill or a talent as cited above should not be underestimated. Mo Farah the Olympic champion was a migrant from Somalia, escaping the civil war and arriving in London aged 8 and speaking very little English. His potential athletic talent was spotted by his PE teacher and the rest is history. The story had the potential to be so different.

It is relevant to consider strategies for promoting resilience and it has to be remembered that resilience can only develop through some exposure to risk or stress. Prior to Pearce (1993, cited in *Together We Stand*, 1995), Rutter (1985) identified that resilience develops through exposure to risk or stress at a *manageable level of intensity* at developmental points where protective factors can operate. The major risk factors for children and young people tend to operate within chronic and transitional events such as continuing family conflict, chronic and persistent bullying, long-term poverty and multiple school and home changes. Children and young people seem to show greater resilience when faced with more single one-off acute risk and adversity events, such as bereavement (Coleman and Hagell, 2007). Promoting resilience and reducing a child's exposure to risk is an important consideration. Newman (2004, cited in Coleman and Hagell, 2007: 14) suggests a three-point strategy approach:

- *Strategy one:* reduce the child's exposure to risk: school meals, after school clubs for children with no alternative but to play on the street.
- *Strategy two:* interrupt the chain reaction of negative events; if one risk factor increases others will probably follow.
- *Strategy three:* offer the child or young person positive experiences: ways of enhancing self-esteem and developing relationships with positive adults.

Highly targeted therapeutic and educational support is required for identified at risk groups including, for example, looked after children (Schofield et al., 2012). There were over 67,000 children looked after by local authorities in England as of March

2012 (Department for Education, 2013). Given such significant numbers this is a huge task. Looked after children and care leavers have a five-fold increased risk of mental, emotional and behavioural problems and a six- to seven-fold increased risk of conduct disorders (Department of Health, 2011a). A good care giving relationship can act as a protective factor and can mitigate other social and environmental factors such as poverty and disability.

For young people in the secure estate (young offender institutions) figures are even more alarming, with 29% of adolescent girls diagnosed with major depression (four to five times higher than general youth population), and 10.6% of adolescent boys diagnosed with major depression. The incidence of young people with psychosis is 10 times higher than the general population. With one in 10 boys and one in five girls having a diagnosis of ADHD, which equates to 10 to 20 times higher for girls in detention and five times higher for boys in detention than the general adolescent population (Fazel, 2008). Figures published by the Department of Health (2011b) state that since January 2002, six young people in the secure estate have killed themselves.

CLASSIFICATION SYSTEMS

There are different definitions for mental ill health. Terms such as mental disorders, mental illness and mental health problems are used interchangeably. Disorders and illness tend to include those defined by the *International Classification of Diseases* (ICD 10; World Health Organisation, 2013) – ICD 11 is due for completion by 2015 – and the *Diagnostic and Statistical Manual* (DSM 5) published in 2013 (American Psychiatric Association, 2013). Disorders include emotional, conduct and hyperkinetic (neuro-developmental). Mental health problems include a broad range of conditions and presentations which tend to also include emotional and behavioural presentations (British Medical Association Board of Science, 2006; Dogra and Leighton, 2009: 9). Variations in behaviour can be defined by ICD 10 and DSM 5 whereas behavioural symptoms can also be differently understood within a context of human experience and relationships, particularly the family.

SIGNIFICANT MENTAL HEALTH CONDITIONS

Depression

Depression was once thought to be limited to adults. Children and young people were overlooked in the past. Children who were taken to behaviour clinics may have suffered from depression but clinicians did not take notice or ask children about their feelings and moods. Kendall (2000) agrees that quiet, withdrawn children were and can often be ignored.

Childhood depression is linked with a range of negative outcomes including: impaired social adjustment, academic difficulties and increased risk of suicide.

Depression is a risk factor in suicide, and undiagnosed or untreated depression can heighten that risk. Depression is now recognised as a major public health problem in the UK and worldwide. It accounts for 15% of all disability in high-income countries. In England one in six adults and one in 20 children and young people at any one time are affected by depression and related conditions, such as anxiety. Up to 80% of adults with depression and anxiety disorders first experience them before the age of 18 (Department of Health, 2011a).

According to ICD 10 and DSM 5, depression is characterised by an episodic disorder of varying degrees of severity with depressed mood and loss of enjoyment persisting for several weeks. There must also be a presence of other symptoms including: depressive thinking, pessimism about the future, suicidal ideas and biological symptoms such as early waking, weight loss and reduced appetite (Harrington, 2003).

The criteria are similar for children and adults but with important differences (Keenan and Evans, 2009). With children and young people developmental perspectives are highly relevant. For example, eating and sleeping disturbances often present as potential symptoms, but these would be common in childhood anyway. Tearfulness and crying have a very different meaning and incidence in childhood compared with adulthood. It is also common to feel depressed. It is also important to 'normalise' sadness as a passing human condition. If sadness became persistent over time this would be different.

There are gender differences beginning in puberty and continuing into adulthood, with higher prevalence in females than males. Clear determinants are far from established (Piccinelli and Wilkinson, 2000). There may be a link to the fact of girls tending to internalise stress and boys externalising stress. Together with biological and hormonal differences there is a likelihood of more conduct and behavioural problems with boys and depressive, anxiety symptoms and eating disorders in girls.

Teenage mums experience higher rates of depression, being three times more likely to experience postnatal depression and to experience poor mental health for up to three years after the birth (Department of Health, 2007), a reminder of the nature and nurture debate and the implications for these infants and their psychological and emotional development.

Anxiety

Emotional development is a challenge for all human beings. In practice, *fears* and *anxieties* are frequently intermingled. Anxiety can be considered either normal or abnormal depending on the context and degree of the anxiety. It is an essential emotion protecting us from danger. Reasonable levels of anxiety help us to function; think of the last minute rush to hand in assignments if you are a student, or meet deadlines, or even get to school and work on time and run for the bus. Interestingly, Pearce (2004) points out that the word anxious resembles the Latin word *angere* and is the origin for the word anger, which suggests a link between anxiety and anger. Conduct disorders often operate in conjunction co-morbidly with anxiety and anger may form a link between anxiety and depression. Anxiety becomes pathological when the fear is out of

proportion to the context of the life situation and, in childhood, when it is out of keeping with the expected behaviour for the developmental stage of the child (Lask, 2003). Fear is feeling a sense of threat in the presence of a particular person, situation, or object. Anxiety is a feeling of threat experienced in anticipation of an undesirable event even if the specific nature of what may happen is not known.

For example, separation anxiety would be considered normal for infants (leaving a primary carer) but less so for a teenager. In a relatively short time span, in comparison to the full length of human life, children move from a state of limited emotional understanding to becoming complex individuals. The number and complexity of emotional experiences together with modulation of human expression increase with age. It is therefore not surprising that some children and young people are easily overwhelmed and experience emotional disorders, which if they persist are debilitating and require intervention. There are *different fears for different years*. In infancy if secure attachment is accomplished fear of separation from care gives diminishes. Separation anxiety usually begins in the preschool years any time after the attachment period but typically in late childhood or early adolescence. Other fears such as the dark and then as the imagination develops ghosts and monsters can appear. Animal phobias such as a fear of spiders or dogs usually begin in childhood. Performance anxiety can emerge in late childhood and social anxiety in adolescence. Fears and anxieties are normal developmental challenges facing the maturing individual. During adolescence autonomy and independence are major developmental challenges, endeavouring to balance between compliance with rules and expressing independent autonomy. It is normal to experience conflict at some level, but the challenge posed by emerging autonomy can trigger or exacerbate interpersonal problems that require negotiation with the accompanying anxiety.

There are many variations of anxiety and the accompanying symptomatic presentations. The common underlying factor throughout differing presentations is of anxiety being the underlying driver resulting in an array of symptoms pursuing a solution to overwhelming anxiety. Children can experience anxiety in the following ways:

Mental processes or thoughts: worries about being hurt, either themselves or someone close to them; worries they will be laughed at.

Physically: increased heart rate, stomach ache, headache, vomiting, diarrhoea (*fight or flight response*).

Behaviour: fidgeting, pacing, crying, clingy and often some type of avoidance.

Typical anxiety disorders include:

Generalised anxiety disorder:

- Tendency to be worried or anxious about many areas of life;
- Unrealistic, excessive and persistent generalised anxiety about everyday situations, occurring most days;
- Accompanied by fatigue, restlessness, sleep disturbance;
- Leading to impairment in many areas of functioning.

Specific phobias:

- These can be common in childhood, different fears emerge at different ages;
- Fear described as a phobia when it is avoided persistently and daily function is impaired;
- Expressed by crying, tantrums, panic, freezing, clinging.

Social phobias:

- An exaggeration and persistence of the normal phase of stranger anxiety (normal up to 30 months, remember Mary Ainsworth's [1970] 'Strange Situation' discussed in Chapter 2);
- More than shyness, characterised by fear of humiliation or embarrassment;
- In the form of panic, freezing, withdrawal and autonomic arousal such as sweating, blushing, tremor, increased heart rate, some children are mute in certain situations;
- Poor prognosis if left untreated.

Separation anxiety disorders:

- Developmentally inappropriate persisting and excessive anxiety concerning separation;
- Often follows a stressful event such as an accident, bereavement or loss. In a domestic violence context a young person may not be prepared to leave the parental victim;
- Young children are more clingy, nightmares with themes of separation, sleeping alone;
- Age 9–12: severe distress on separation, withdrawn, somatic complaints;
- Adolescence: physical symptoms and somatisation features.

School phobia:

- More of a symptom than disorder often used with 'school refusal';
- Many reasons including separation anxiety, bullying, poor relationships, academic underachievement.

Panic disorder:

- A fear or worry about having panic attacks;
- Recurrent unexpected attacks;
- Discrete episodes;
- Physical symptoms include: shortness of breath, palpitations, dizziness, chest pain, fear of losing control, etc.;
- More common in adolescence.

Post-traumatic stress disorder:

- A reaction to a serious traumatic event in which the child was extremely afraid or injured;
- Examples include physical, sexual abuse and or neglect events; events in the immediate and wider community such as local, national or global disasters;
- Normal to display some anxiety for a few weeks after the event, usually disappears, symptoms must be present for up to six months after the event;

- May keep having flashbacks and avoiding situations that remind them of the trauma;
- Jumpy, sleep difficulties and nightmares, intrusive images.

Obsessive compulsive disorder:

- Present when there are certain actions or thoughts that are repeated over and over again often for long periods;
- Can be quite complex and combined with tics and neurological problems and other extreme and unusual behaviours;
- Affected children will attempt to ignore, or suppress by 'performing compulsions' which are repetitive, purposeful behaviours often stereotypically;
- Parents often become caught up in complex rituals to avoid upset.

Activity

Anxiety case study: consider theoretical theories that can be applied.

Jean is 15 and was referred to CAMHS by her GP. She was seen by the consultant child and adolescent psychiatrist and diagnosed with school phobia/refusal. Jean was also diagnosed with clinical depression and commenced on anti-depressant medication and referred for some individual therapeutic work. The GP referred Jean to the incontinence service as she was unable to leave the house or travel far from home as she experienced urgency to pass urine. Jean was terrified of having an accident and not being able to get to a toilet on time. If she did venture out Jean would have worked out where the public toilets were on a shopping trip and how long car journeys would take, etc. She felt embarrassed by this which led to her avoiding going to friends' houses, not only from the point of view of the journey, but about having to ask to use the toilet at their homes. Jean was becoming more and more isolated and was tearful and distressed. She told a story of being attacked by some boys on a school trip a year ago. Police were called to the incident at the time. Jean's parents decided not to press charges and the matter was dropped.

There were other bullying incidents which took place at school and on journeys on the school bus. One serious incident concerned Jean being nearly strangled by another pupil on the school bus, using the seat belt. She managed to fight him off but did not tell her parents or anyone else about the incident.

Jean became more and more anxious about going to school and felt scared and unsafe.

Jean's parents were aware of the first assault but Jean did not tell them or anyone else about subsequent attacks. Both her parents tended to be accepting of whatever life 'dealt out' and tended not to challenge authority figures.

(Continued)

(Continued)

Social theory factors: school experiences, parenting style and stressful life events in terms of acute episodes and chronic bullying. School not deemed to be safe and understandably becoming a place to avoid, which seems a normal response.

Biological/medical theory: school phobia/refusal as defined by DSM 5 and ICD 10. Incontinence, problems with urinary retention. Depression similarly diagnosed and treatment including anti-depressant medication and talking therapies.

Psychological theory: Jean does have a capacity for safety seeking as she refuses to attend school, yet it has resulted in a clinical diagnosis.

SUICIDAL BEHAVIOUR AND DELIBERATE SELF-HARM

Historical note

It is worth reminding ourselves that until 1961 in the UK, suicide was illegal. Historically a suicide completer would not be buried in consecrated ground. In medieval times bodies would be buried at crossroads. The superstitious medieval population was fearful of death if the last rites had not been administered, which may mean the individual would be a potential threat to the living (Anderson, 1998). Interestingly a local paper reproduced two news items from 1852 and 1908 respectively, referring to suicide attempts. One item referred to a male who attempted 'self-destruction' by hanging. He was rescued by a neighbour when the man's wife raised the alarm. He was taken before the magistrate and admonished for the wickedness of his attempt and sent to prison for a week. The other article referred to a young woman of 23 before the city police court. She was charged with attempting to commit suicide by cutting her throat with a razor. Despite acknowledgement of her depression she was fined £10 together with an undertaking her husband looked after her (Grundy, 2008). These ideas remain around today with the tendency to describe a completed suicide as having been 'committed', referring to the custodial sentence applied if one survived.

There continues to be ongoing stigma and shame and often negative attitudes towards suicide attempters in emergency room and accident and emergency settings (Mental Health Foundation, 2006; NSPCC, 2009). Later in the 20th century the phrase 'death trend' became adopted in the late 1950s and early 1960s where a study observed a large proportion of suicide attempters had experienced the loss of a significant figure, often tragically, prior to or during their own adolescent period. If self-destructive tendencies are a reaction to inner conflict, it may help to explain what links suicidal activity, becoming a chain reaction within populations, examples of which exist throughout history (Moss and Hamilton, 1963 [1957], cited in Alvarez, 2002).

Considerations of risk and trigger factors tend to focus largely on external influences. The suicide cluster amongst young people in Bridgend, Wales, in 2008 established a link between internet sites and irresponsible media attention and was mooted as one of the reasons (Mickel, 2009). A similar view exists in the USA where recommendations for media responses have been developed to minimise the likelihood of copy-cat suicides. Similar proposals with regard to the media and internet are incorporated into the latest suicide strategy, Preventing Suicide in England (HM Government, 2012). Suicide clusters amongst young people are not new phenomena. Young people are often 'bonded' together, with the death of one compelling the death of another (Berman and Jobs, 1999 [1991]). Risk may also increase when young people identify with people who have taken their own life, whether they are a high-profile celebrity or another young person (Department of Health, 2011b).

The term 'suicidal behaviour' includes suicide and attempted suicide indicating an attempt to die with sufficient lethality (Berman and Jobs, 1999 [1991]). Deliberate self-harm includes, for example, poisoning, cutting, excessive alcohol, illegal drugs, hitting or burning oneself (Royal College of Psychiatrists, 2012a).

Adverse and abusive experiences in childhood are associated with an increased risk of suicide (Department of Health, 2011b). Looked after children are more at risk of experiencing mental health problems and they also potentially carry an increased risk of self-harming behaviours. Research by Hurry and Storey (1998, cited in NSPCC, 2009) showed that even though looked after children represent 1% of the population they represent 10% of children and young people presenting to accident and emergency departments following an act of deliberate self-harm.

Suicide attempts provide an active response to triggers acting as stressors. Suicide is often seen as a solution to intolerable overwhelming feelings rather than an explicit wish to die. The differences in self-harming behaviour, as opposed to deliberate self-harm or a suicide attempt are that with self-harm the person is in touch with their body through the physical reality of pain. Suicide attempts can be about a last sense of control over feelings of helplessness with the corresponding relief then experienced.

Consider the case of Shafiea Ahmed (Carter, 2012), whose parents were found guilty of murdering Shafiea in 2003. When on a visit to Pakistan Shafiea swallowed bleach, which would be regarded as attempted suicide. There was no evidence to suggest she was mentally ill but rather it was undoubtedly a response to overwhelming stressors and for her, seen as a solution to an intolerable situation. Interestingly and sadly in Shafiea's case the most pressing and immediate intervention would have been to ensure her safety from a child protection position.

The National Inquiry into Self-harm among Young People (Mental Health Foundation, 2006) suggests caution in viewing self-harm as a greater problem for young women. Young males engage in different sorts of self-harm such as hitting or breaking bones, which receives a different sort of attention and can sometimes be explained by an accident or a fight (Mental Health Foundation, 2006).

A survey of 6000 15- to 16-year-olds in England found that 6.9% engaged in self-harming behaviours with 12.6% of these presenting at a hospital for treatment. The

survey found that self-harm is more common in females than males, at 11.2% and 3.2% respectively. Self-cutting accounted for 64% and self-poisoning for 30.7% as the main method used (Hawton et al., 2001). The majority of suicide attempters have already expressed their thoughts to others and 75% of completed suicides have had no contact with mental health services (Mental Health Foundation, 2006). According to the *National Service Framework for Children, Young People and Maternity Services* (Department of Health and Department for Education, 2004), 1985–95 saw an increase of 28.1% in teenage deliberate self-harm, which is often unidentified. Up to half were also likely to have a major depressive disorder and carry an increased risk of suicide. Suicide was noted as the most frequent cause of death amongst men and the third most frequent cause of death among women aged 15–24.

The suicide rate among young people continues to fall and is below that in the general population. However, young people are vulnerable to suicidal feelings. The risk is greater when they have mental health problems or behavioural disorder, misuse substances, have family breakdown or mental health problems or suicide in the family (Department of Health, 2011b).

The earlier Suicide Prevention Strategy for England (Department of Health, 2002) included various goals including a national collaboration for monitoring non-fatal deliberate self-harm and a pilot scheme targeting mental health promotion for young men. There was a proposal to reduce the availability and lethality of methods, with special reference to safer prescribing of anti-depressants and analgesics. There would be regular monitoring of suicides by age and gender (Department of Health, 2002). In the UK the most common form is poisoning (Royal College of Psychiatrists, 2012a).

In the same year the Royal College of Psychiatrists (2002) suggested a greater emphasis on prevention and earlier detection. Reductions in pack sizes of analgesics after 1998 led to a significant reduction in liver damage and completed suicides (Hawton et al., 2001). Analgesics including paracetamol are available as an over the counter medicine in pack sizes limited to 16 tablets per blister pack with additional limits on only being able to purchase two packs in a single transaction. If you consider, an overdose act takes a longer time period to accomplish if tablets have to be removed from blister packs and collected as opposed to swallowing a handful of tablets from an amount in a container. However seemingly minor, these are important considerations and offer restraint in suicidal acts with potential for a review and change of mind. Intent and motivation are key factors, which are mentioned below, and will be further discussed in Chapter 6.

The significance of high numbers of suicide attempts within the adolescent period no doubt has links with the developmental process. Adolescence is the most turbulent developmental period since infancy with the biggest challenges and changes in all three areas of biological, psychological and social change. Predisposing vulnerabilities can be activated during the adolescent phase (Anderson, 2008). Outside the adolescent period the only other time in life where such rapid changes, initiated by the hypothalamus, occur is in the womb (Waddell, 2002: 139).

Triggers influencing self-harm and suicidal behaviour include:

- Bullying
- Difficulties with parental and peer relationships
- Bereavement
- Earlier abusive experiences
- Difficulties with sexuality
- Problems with ethnicity, culture, religion
- Substance misuse and low self-esteem.

Contextual triggers include:

- Adverse family circumstances
- Dysfunctional relationships
- Domestic violence, poverty and parental criminality
- Time in local authority care
- Frequent punishments
- Family transitions.

All of the above become compounded by adolescent developmental pathology (Beautris, 1996, cited in Hider, 1998; Harrington, 2003). Bell (2000) describes that the cause given is actually the trigger precipitating suicidal behaviour. But it will often be the reason given by the young person, their families, and even doctors and other clinical staff. Reasons given might include an argument with a close friend or family member or failing exams. The notion of a trigger as an explanation often leads to a minimising of the level of seriousness surrounding the suicide attempt and is *never* about the stated reason. The reason identified is perhaps more of a rationalisation of the event rather than an explanation and it may be a frightening prospect for all concerned to even consider a serious mental disturbance. This is a very important point to bear in mind and is the key to understanding suicidal ideation. For example not all individuals who have arguments and fail exams make attempts on their lives, therefore those that do so for those reasons given are responding to a trigger (the argument, exam failure) to much deeper underlying intolerable problems. Suicide and suicidal ideation almost always take place within the context of relationships, which is the challenge to explore and understand. There is an emotional and psychological component. Exceptions are those responding to delusions or hallucinations linked to drug misuse or psychosis. Use of triggers as an explanation can lead to collusion and denial of the seriousness of the event, not only by family members but clinical staff also, and therefore it is highly risky in itself not to take the attempt seriously.

Deliberate self-harm including suicide attempts must be taken seriously and never minimised by describing somewhat trivial reasons such as relationship disagreements or exam failure. Those are triggers.

SELF-HARM

Self-harm and suicidal behaviour are emotional disorders on a similar continuum as both are in response to stress. A young person engaging in suicidal behaviour may wish to die or be ambivalent, whereas young people engaging in self-harming behaviour such as cutting do not necessarily have an active wish to die. Self-harm tends to

be about coping whereas suicide is about giving up. It is worth noting that adolescents who self-harm carry a 100 times greater risk than that of the general population of completing a suicide in a subsequent year and that half of all completed suicides each year will have previously self-harmed (NICE, 2002). A research study of over 2000 pupils aged 15–16 years at secondary schools in Scotland showed that prevalence of self-harm was similar to England despite the suicide rate being twice as high. The report identified girls are three times more likely to report self-harm than boys. The most common motive described was to get relief from ‘a terrible state of mind’. Almost 4 in 10 teenagers in the study reported they wanted to die (O’Connor et al., 2009). Self-harm is a major public health issue with estimates that as many as one in 15 young people self-harm in the UK, higher than the rest of Europe. There is universal misunderstanding about self-harm by the people closest to them often leading to poor responses (Mental Health Foundation, 2006). Self-harm continues to be stigmatised, often remaining hidden, which can lead to guilt and shame often compounded by the reactions of others (NSPCC, 2009). The differences in self-harming behaviour, as opposed to an intention to kill oneself, are that with self-harm the person is in touch with his/her body through the physical reality of pain. When the wish for self-preservation against physical danger is lacking, as in a suicide attempt, leading to an attack on the body, it is in part about taking control over feelings of helplessness with the corresponding relief thereby then experienced.

As will be discussed in Chapter 2, infantile experiences are internalised and attachment patterns laid down, affecting later relationships. Events that trigger self-harming behaviour are actions rooted in old patterns and wounds. However these are not necessarily about trauma as not all who self-harm have been victims of abuse or trauma in childhood. The skin becomes a medium for communication (Gardner, 2001). Consider other powerful body modification similarities where the skin becomes a medium of communication through decoration with tattooing and piercing. Where reasons motivating modifications to the external ‘skin’ or surface may be found ‘under the skin’, within the internal world (Lemma, 2010: 2). Physical pain is often easier to manage than emotional pain, and when inflicted can change mood which in turn can be habit forming. Cutting releases endorphins into the system providing a brief calming effect combined with serotonin as a mood enhancer and therefore experienced as a form of relief. There is also something about first aid ‘patching up’ and ‘repairing’ either by the individual or helpers, with these repairing acts experienced as therapeutic. Very often the shocking quality communicates the rawness of emotions and impulses and is an essential aspect of the behaviour (Turp, 1999, cited in Gardner, 2001: 8).

Activity

Have a look at the following case study. Consider Jim in relation to the risk and resilience model discussed earlier in the chapter. Similarly think about the theoretical models in relation to the information about Jim.

Jim is 14 and was referred to Tier 3 CAMHS by his GP for assessment. Jim was self-harming by burning his finger tips. There were concerns over suicidal ideation and possible clinical depression.

Jim lives with his mother, younger brother and stepfather. His brother has a significant physical illness requiring a lot of medical interventions and hospitalisations. As a child Jim's mum had been bullied by an overbearing father.

Jim's father lives with his third wife. Jim's father was in care as a child. Jim and his brother visit them once a week and sometimes stay over. Jim would like to spend more time with dad but dad is very rigid around routines and the times they spend and stay with each other. There was a recent incident where Jim ran away from home and dad wondered if Jim should go into care.

Jim has a passion for music, both writing and playing the guitar. Therefore burning his finger tips is significant for Jim and also very punishing.

Jim feels guilty, thinking he is the only 'well' member of the household, stating his one wish for his brother was not to be ill, feeling they could all be happy again then.

There have been reported incidents from school of Jim being bullied. He often becomes over-involved in sorting out other friends' problems. There is a real sense of him trying to repair others in the absence of being able to repair his family.

Risk and resilience factors for Jim

For Jim the risk factors mainly sit in his family and contextual and systemic factors: parental conflict, family breakdown, rejecting relationships (dad), potential bereavement issues regarding Jim's brother (loss of potential for normal health), significant life events, whether dad has been able to adapt to Jim's changing developmental needs. An evident potential resilience factor is his musical talents. Jim's mum is trying to get help for him.

Jim: theoretical interpretations

Jim's presentation will be interpreted as illness (medical theory) and he is likely to have a diagnosis of clinical depression, he may also have been traumatised through bullying and family breakdown experiences. There is limited information regarding psychological theories but we can be curious about attachment perhaps given both Jim's parents experiences. Jim feels a responsibility to be 'well' and feels responsible for 'repair'. He seeks to repair others (peers) in the absence of repairs in his family. Social, systematic and environmental theories are strongly evident in this case and probably represent the most significant model. There is the context of Jim's family: illness, family breakdown, relationship patterns and stressful life events. Parental experiences and generational issues cannot be ignored either. Mum has an experience of bullying in her childhood. Dad has been in care. Both parents bring to their own family, becoming parents themselves, their own 'ghosts from the nursery' or early experiences. Jim's father is only partially available for Jim with an imminent sense of unavailability present.

EATING DISORDERS

Terminology

Eating disorders comprise a collection of disorders including anorexia nervosa, bulimia nervosa and binge eating disorder in DSM 5; in ICD 10 similarly and also atypical eating disorders and eating disorder, unspecified.

Prognosis

Sixty per cent of individuals treated for anorexia nervosa will have a good outcome, 30% will have an intermediate outcome and 10% will have a poor outcome (Bryant-Waugh, 2003). There are similar statistics for both adults and young people. The average duration of illness is five years. It has a mortality rate which is twice the level of any other illness and the highest death rate of any mental illness (Treasure and Alexander, 2013). It is extremely serious and can be persistently difficult to treat, requiring specialist interventions which at times also may include sectioning under the Mental Health Act 2007. There is no lower age limit for the use of compulsory powers under the Act. The Mental Capacity Act 2005 applies to over-16s. Young people with anorexia nervosa have the highest bed occupancy in Tier 4 in-patient CAMHS and for the longest periods of time. The average in-patient stay is 12 months, so there are obvious implications not only in terms of resources but the psychological and sociological components and impact for both the young person and his/her family. In-patient units are a specialised centralised regional provision around the country so often young people requiring admission find themselves a long way from home. Even with successful treatment and recovery, patients can be left with long-term problems of physical health including osteoporosis, infertility and depression (Nunn, 2013). It must be remembered re-feeding in a specialist unit or hospital to a healthy weight is only a relatively minor aspect of what is long-term treatment.

Prevalence

The most frequent age of onset is between 15 and 35 years and approximately 0.3–0.5% of the population up to 18 develops anorexia nervosa. Figures for bulimia are 1% although bulimia is rare under 12 with an average onset of 15–18 years compared to 15 years for anorexia. Gender ratio is female to male 4:1 for under 12 years and 9:1 for the age range 13–18 years. Anorexia nervosa is not a disease of the middle classes as is sometimes thought and crosses all cultural and social backgrounds. There is increasing global recognition especially in countries experiencing economic change alongside the changing roles of women in these countries (Cullen, 2011). It is interesting to note that in the parts of the world where food is in short supply eating disorders are virtually unknown (Lawrence, 2008).

Diagnosis

Diagnostic criteria for anorexia nervosa according to ICD 10 includes a body weight maintained at least 15% below that expected or a BMI (body mass index) of 17.5 or less. BMI is calculated differently for children and young people as compared to adults. There must be self-induced weight loss by avoidance of fattening foods and at least one of the following: self-induced vomiting, self-induced purging, excessive exercise, use of appetite suppressants and/or diuretics. Diagnostic criteria also include body image distortion in females and absence of more than three menstrual cycles (Treasure and Karwautz, 2004). In DSM 5 (American Psychiatric Association, 2013) the requirement for amenorrhoea has been eliminated (previously included in DSM IV). Individuals are required to be at a significantly low body weight for their developmental stage. If the onset of anorexia nervosa is pre-pubertal puberty becomes delayed or arrested.

Diagnostic criteria for bulimia include: persistent preoccupation with eating and an irresistible craving for food often consuming vast amounts in a short space of time. The patient tries to counteract the fattening effects by self-induced vomiting, purgative abuse, alternating periods of starvation or use of drugs as appetite suppressants or diuretics. There will be a morbid dread of fatness and often a previous history of anorexia nervosa. The similarities between anorexia nervosa and bulimia are diets, food rules, binges and intense exercising.

Theoretical models and anorexia nervosa

It is generally considered, as with other mental health disorders, that eating disorders arise from a combination of theoretical models, namely biological, psychological and social, systemic and environmental factors. These will be demonstrated below with a case study.

Genetic vulnerability has been identified, with female relatives of sufferers of anorexia being 11.4 times as likely to suffer as the control group and 3.7 times more likely for bulimia (Strober et al., 1999). More recent research also suggests a strong genetic link and predisposition, with neuro-imaging showing differences in brain structure in anorexia nervosa patients. This would suggest anorexia nervosa is a disease combination of both biological and psychological features. The research demonstrates that anorexia nervosa is not a lifestyle choice but rather an inherent gene which is most probably present and becomes vulnerable when exposed to other factors (Lask et al., 2012). Again this new research underpins the nature versus nurture discussion, in that development and mental health and ill health take place within a contextual combination of inherent characteristics and it is about how these articulate with the environment and experiences. This rather undermines an argument often presented that western societal values and media representations of thin role models and association with positive attributes of attractiveness and popularity predict development of eating disorders (Stice, 2002). Anorexia has previously been referred to as the 'slimmer's disease'. Dieting in itself does not cause anorexia, although many who do go on to develop anorexia will have started out by dieting which then seems to act as a trigger for some individuals.

There are undoubtedly certain high-risk groups. Vulnerable individuals are not helped by internet websites promoting anorexia, especially amongst those groups working in areas which emphasise a fit or thin body such as sport and fashion (Lawrence, 2008). With perfectionism implicated as both a risk and a maintaining factor (Fairburn and Harrison, 2003) activities such as sport and fashion may well appeal to those with perfectionist traits, something which McDougall (1989) referred to as the 'theatre of the body'.

Other predisposing factors centre on the negotiation of transitional points, for example the negotiation of adolescence in combination with an adverse life event such as bereavement, parental divorce and sexual abuse, together with a psychological vulnerability. There are also similarities with self-harm and suicidal behaviour in that there will always be a contextual background of either relationship or attachment difficulties, even if they are not immediately apparent. Anorexia nervosa could also be regarded as self-harming behaviour, which it is and it must be also remembered that sadly it also takes some young people and adults ultimately to their deaths.

There are similarities with the 'triggers' described in relation to suicide attempts and the 'trigger' being the reason often given. So the media and societal attitudes towards thinness often cited as '*reasons*' are not reasons in themselves but rather act as contributing factors or triggers. These are social theory factors and they would not operate in isolation of psychological and biological theories but rather as a combination of contributing factors from all domains. The interaction of these models is unique to each individual in terms of their life story and circumstances. The task is to understand this articulation, which will be discussed in more detail in Chapter 6 and is demonstrated here by the following case study.

Activity

Consider the application of theoretical models to the following case study:

Jane is 13 and has been admitted to a Tier 4 child and adolescent in-patient unit, following a diagnosis of anorexia nervosa. On admission she had a BMI of 11.9 and had not yet commenced menstruation. Prior to this there had been a two-year history of restricted eating and weight loss. As a child Jane had attended ballet and dance classes, and she would recall her dance teacher saying she was too fat to be a ballet dancer; Jane was 8 at the time. Jane began to restrict her food intake when she was 11 and this coincided with her transition to secondary school. Unfortunately Jane was not able to go to her choice of school. Both of Jane's parents are working in professional occupations and Jane has two younger siblings.

Jane has a distorted body image, has perfectionist traits, does not believe she is 'good enough' and finds criticism difficult to deal with. Jane does not seem to 'act out' in any traditional 'teenagey' ways. She does not easily express how she feels and tends to keep everything to herself.

During her in-patient stay Jane was diagnosed with depression and prescribed anti-depressant medication. Jane remained in hospital for a year and was discharged to her local Tier 3 CAMHS team.

Medical/biological theory: Jane has been diagnosed with anorexia nervosa. There may well be a genetic component if there were other family members with anorexia, perhaps from previous generations.

Psychological theory: Jane may find negotiating a transition point difficult when moving to secondary school and combined with emerging adolescence. This is also seen in her not appearing to be very 'teenagey'. In addition, Jane has perfectionist traits and low self-esteem, tending to internalise rather than externalise feelings.

Social and environmental theories: Factors such as Jane's dance teacher telling her she was too fat may have acted as a trigger leading to development of AN when combined with other psychological factors as above.

EARLY ONSET PSYCHOSIS

Psychosis describes an individual as being out of touch with reality and is a collection of signs and symptoms describing a particular mental state (Dogra et al., 2009). Psychotic illness is serious and can affect all age groups although a first episode/early onset psychosis typically occurs in young adulthood. The peak age of onset is 15–19 in both males and females and there is controversy about prevalence in pre-pubertal children, accepted rates are much higher after puberty. Early onset is rare, but 60% of adult cases reported to have childhood onset (James, 2003: 121). The national average annual incidence is about 15 per 100,000 (Vostanis, 2007). Early onset psychosis is relatively rare but nevertheless very serious. Current diagnostic criteria only applies to adults, so there are limitations when applying to young people (NICE, 2006). A single episode of psychosis does not necessarily preclude schizophrenia or an affective disorder. Anyone experiencing a psychotic episode needs urgent assessment, risk assessment and treatment (Dogra et al., 2009). There are high rates of completed suicides and 20% of sufferers make a significant suicide attempt within a five-year period following diagnosis (Strober et al., 1999).

There are two forms of psychotic illness: schizophrenia and bipolar affective disorder (formerly known as manic depressive disorder). Schizophrenia is the most common form of psychosis. It is a serious mental disorder affecting thinking, emotions and behaviour. There is however a view that a diagnostic term such as schizophrenia is unhelpful and unreliable given the changing range of problems coming under one umbrella term. Not only that, there are significant stigmatising problems for sufferers (Gaughan, 2011). Symptoms of schizophrenia are described as either 'positive', 'added to the person', or 'negative', 'taken away from the person', and sufferers usually experience a combination. 'Positive' symptoms include delusions, thought disorder and hallucinations. 'Negative' symptoms include being withdrawn, a loss of interest, poor hygiene, isolation and problems with concentration. The main features of bipolar affective disorder are extreme mood changes.

Risk factors for psychotic illness include a family history, with stress or extreme life events acting as a trigger factor. Schizophrenia has an increased risk if there is a diagnosis of a close relative such as a parent or sibling. In young people common triggers of

psychosis include substance misuse, medical reasons such as fever or epilepsy, or side effects from prescribed medication (Dogra et al., 2009). Substance misuse includes particularly cannabis, LSD, ecstasy and speed (Royal College of Psychiatrists, 2012b, 2012c).

Trauma can significantly impact on development. Schreier et al. (2009, cited in Gaughan, 2011) found that the risk for psychosis was doubled if bullying was persistent and long-standing, which is in line with the risk and resilience model discussed earlier in the chapter. Whitfield et al. (2005, cited in Gaughan, 2011) found a significant connection between childhood trauma and hallucinations. In both schizophrenia and bipolar disorder there are abnormalities in brain chemistry. There is no single cause but rather a probability of multiple gene factors (*biological model*) articulating with environmental factors (*social environmental model/theory*) which then leads to psychosis.

It is a common feature to have other co-morbidities: 70% of hospitalised adolescents with bipolar disorder have a diagnosis of ADHD; 39% have substance abuse and dependence; 30% suffer with anxiety disorders and may have been previously diagnosed with schizophrenia (Strober et al., 1999).

Zubin and Spring's (1977) 'Stress Vulnerability Model', despite its age, usefully demonstrates how we are all vulnerable to psychosis, but some are more vulnerable than others. An individual's vulnerability is the *disposition* of the person to manifest symptoms of serious mental illness.

Inborn vulnerability: genetically determined, reflected in the neurophysiology of the organism (biological/medical).

Acquired vulnerability: specific to individual life experience; can include specific disease, perinatal complications, family experience, adolescent peer interactions, previous life events (psychological and social environmental).

So as we will discuss in Chapter 2, potential innate vulnerability such as inherent temperament, genetic predisposition and how these articulate with social and environmental factors and how these are experienced are all contributing factors.

SUBSTANCE MISUSE

Substance misuse is a broad term encompassing the harmful use of any psychotropic substance, including alcohol and either legal or illicit drugs. Such use is usually, but not always, regarded as a problem if there is evidence of dependence. Forty per cent of people with psychosis misuse substances at some point in their lifetime, at least double the rate seen in the general population (NICE, 2011). It is also worth remembering that emerging personality disorders do so from a context often of self-harm, depression, eating disorders and substance misuse. Diagnosis is unlikely to take place until adulthood due to the complexity of adolescent pathology. There is also stigma attached to 'labelling' anyone at an early age, given the implications (Mind, 2012; NICE, 2009).

Young people experience a wide range and diversity of substance misuse with multiple effects and wider societal implications. Adult services tend to focus on

dependence and management whereas young people's services have a focus on harm reduction with concerns on developmental processes. Single episodes can have serious life-threatening outcomes (Brodie and Reed, 2011; Crome, 2004, cited in Brodie and Reed, 2011). Regular substance misuse leads to serious disruption in education, relationships and long-term physical and emotional health. Most adult substance misuse and dependence begin in early adolescence. Adult mental health problems and social disruption are linked to early onset substance misuse.

Young people are less likely than adults to present at services with substance misuse problems. Substance use can also be thought of as a normal part of adolescent risk taking behaviour. Brodie and Reed (2011: 241) have some useful definitions.

The following indicate areas of vulnerability to developing a substance abuse problem:

- Parental substance misuse and parental mental health problems.
- Pregnant drug users are at increased risk of postnatal mental health problems, affecting attachment.
- Demands of substance dependence with an infant with neonatal abstinence syndrome can negatively affect formation of secure attachment.
- Children raised in substance misusing households believe exposures to high-risk situations are normal.
- Concentrated in areas of high social deprivation, inadequate housing, poverty and low employment.
- Substance misuse does not exist as an independent problem but rather as part of a cluster of other difficulties which must be addressed.

Activity

Have a look at the following case study and consider where the areas of vulnerability are using the theoretical models:

Tyler is 17 and has been experiencing unusual ideas and experiences for about 18 months, alongside deterioration in his daily functioning and an increase in his cannabis use. He dropped out of school before completing his exams.

His mother became increasingly concerned about his state of mind over the past year and about three months ago finally convinced him to visit his GP; who referred him on to the local CAMHS Tier 3 team; who in turn passed his case to a local Early Intervention in Psychosis Service. They have just completed an assessment with him.

Tyler is presenting with paranoid and anxious thoughts about other young people in his community, some of whom he believed had also harassed and bullied him during school. He believes that people are out to get him, though reports from his mother suggest there isn't anyone in particular that has a problem with him but

(Continued)

(Continued)

this increasingly strange behaviour has led to people making comments. He has reported some intermittent hearing of a voice that tends to criticise him. Tyler has experienced low mood and has had some suicidal thoughts on occasions but says he wouldn't act upon these. On the whole, though, he feels numb to feelings other than anxiety. He is quite socially isolated but is a member of a darts team that he goes to with his father sometimes.

Tyler's family and developmental history

Tyler's parents divorced 10 years ago. He is of dual heritage with his mother being Sri Lankan and his father being white British. He has an older brother of 30, Jason, with a diagnosis of schizophrenia. Jason was in a psychiatric hospital during his twenties. Family life had been frequently stressful and often orientated around Jason's needs and intermittent involvement with the family.

Soon after his 16th birthday Tyler's relationship with his mother deteriorated following high levels of conflict and he was thrown out, leading to an independent living flat in his neighbourhood – a relatively deprived area of an otherwise largely affluent town. Tyler experienced what he describes as persistent bullying in school and feels this continues in his locality. Some of this has related to people's knowledge of Jason. He had some friendships during school but hasn't maintained these relationships. He briefly hung around with a group of young people but was worried about increasing police attention they were receiving and now does not see them in a friendship capacity.

Inborn vulnerability: Tyler may have a genetic predisposition to developing psychosis as there is a close family member with a diagnosis (his brother) (biological/medical).

Acquired vulnerability: Tyler is also at risk here due to traumatic life events such as bullying, parental discord and family breakdown (social and environmental factors).

Tyler is exhibiting concerning signs of potential psychosis coinciding and combined with an increased use of cannabis. The two may be interrelated, meaning psychotic symptoms may be as a result of cannabis use or they may have emerged without substance misuse as he has a close family member with a diagnosis.

NEURO-DEVELOPMENTAL CONDITIONS

Neuro-developmental conditions include a large group of 'disorders' commencing in early life and persisting into adulthood. There can be some confusion with the term 'learning difficulties', which is also seen in service provision with an overlap of children and young people with neuro-developmental conditions presenting in either CAMHS tiers, community paediatric or learning disability services. Terminology fluctuates between conditions, disorders and difficulties and is interchangeable. Within the context of the chapter the focus will be on attention deficit hyperactivity disorder

(ADHD) (sometimes referred to as hyperkinetic disorder), conduct disorder (CD) and autistic spectrum conditions (ASC), as these are the most frequent and more common conditions you are likely to come across. Although it should be noted there are several other classifications including pervasive developmental disorder, pervasive oppositional defiant disorder, attention deficit disorder, dyslexia and so on.

ATTENTION DEFICIT HYPERACTIVITY DISORDER

ADHD can best be understood as a neurological difficulty which interferes with an individual's availability for learning (Silver, 1990).

More recently, extensive biological investigations of both ADHD and hyperkinetic disorder have yielded some neuroimaging and molecular genetic associations; neurocognitive theories have emerged; and there is a better understanding of the natural history and the risks that hyperactive behaviour imposes. Nevertheless, the disorder remains one that is defined at a behavioural level, and its presence does not imply a neurological disease. (National Collaborating Centre for Mental Health, 2009: 15)

There is a case study (Joe) in Chapter 2 which demonstrates this potential. Characteristics of ADHD include a triad or constellation of impairments in the following three areas:

- Poor concentration
- Hyperactivity
- Impulsiveness.

It is important to recognise that displaying the above behaviours does not necessarily mean ADHD is the explanation. These behaviours may indicate psychological causes. Think about how you might behave if you were in a stressful situation, experiencing stress and anxiety; all of the above areas are likely to show changes. A key factor is the persistence and frequency in all domains.

A problem for children and young people is that their ADHD impairments can impact significantly on educational experiences and attainment. Young people with ADHD have a higher rate of behavioural and disruptive disorders and as we have already seen earlier in this chapter they are disproportionately represented in the youth justice service. Children with ADHD often fail to regulate activity and they are less able to evaluate their responses beforehand or subsequently. Exhortations to 'try harder' or 'learn to concentrate' are impossible to fulfil and these are often made repeatedly by those who teach and look after them.

The range of possible lifetime impairment extends to educational and occupational underachievement, dangerous driving, difficulties in carrying out daily activities such as shopping and organising household tasks, in making and keeping friends,

in intimate relationships (for example, excessive disagreement) and with child care (NICE, 2008: 5).

As with other disorders ADHD is classified in both ICD 10 (hyperkinetic disorder) and in DSM 5. Severe ADHD corresponds approximately to the ICD 10 diagnosis of hyperkinetic disorder. This is defined as when hyperactivity, impulsivity and inattention are all present in multiple settings, and when impairment affects multiple domains in multiple settings. Part of the assessment process would include collecting information from parents and from educational settings. Diagnosis is a matter of clinical judgement which considers the severity of impairment, pervasiveness, individual factors and familial and social context (NICE, 2008).

There are strong genetic influences and often history taking reveals other family members exhibiting ADHD traits that are undiagnosed; this is significantly so in earlier generations where ADHD was unrecognised. No single gene has yet been identified.

Environmental factors include maternal drug and alcohol use in pregnancy. In addition, ongoing effects of individual and parental substance misuse and poor or hostile parenting also need to be considered. In the UK, a survey of 10,438 children between the ages of 5 and 15 years found that 3.62% of boys and 0.85% of girls had ADHD (Ford et al., 2003, cited in National Collaborating Centre for Mental Health, 2009: 26). ADHD seems to be approximately four times more common in boys than girls. Globally there are variations of between 1 and 20% which may be explained by cultural differences and how symptoms are measured. Overall a figure of 5% is thought to be more accurate (Jones and Claveirole, 2011).

It is thought that diagnostic and treatment criteria are influenced by social and cultural factors. In the USA ADHD has been long recognised and treated more robustly than in other parts of the world. This may well be a reflection of a strong diagnostic medical model which interprets and classifies behaviours. In Britain there can be a reluctance to diagnose children and resistance to treatment interventions as these usually include medication. Parents and young people can be understandably concerned about this.

Psychological factors include severe early psychosocial deprivation such as experienced in poor institutional care. ADHD is more prevalent in families where there are disruptive relationships (National Collaborating Centre for Mental Health, 2009: 29). You can see there is correlation between all theoretical domains. Risk factors do not occur in isolation, nor can they be explained by a single theory but rather it is about the interaction and articulation between all domains.

A pharmacological approach is recommended as first line treatment (in conjunction with parenting and individual programmes) for ADHD using a prescribed psychostimulant (methylphenidate) (NICE, 2008). Medication can help children with concentration so has a valid use in supporting children in school settings. Young people I have known have been successfully treated with methylphenidate and tell me it buys them *thinking time* so impulsivity is reduced and that it does help significantly with concentration. It can help with symptom (triad of impairments) control, and does not remain in the system for more than a few hours. Treatment 'holidays' can be taken so for example the young person may not wish to take medication at

the weekend or in the school holidays. There are however side effects including loss of appetite and difficulty getting to sleep. Children and young people need close medical monitoring as there are implications in terms of physical development if appetite and subsequently diet is suppressed.

A multifaceted and multi-agency approach in the management of ADHD includes parent and teacher training in behavioural techniques as well as individual support for the young person. It can be helpful to reframe the negative symptoms of ADHD in terms of positive aspects. It is not always helpful to focus on reducing 'unwanted' behaviours, alternatively it is better to harness the positives (remember the resilience model and having a skill or talent). There is potential for these young people as they usually have energy and enthusiasm by the bucket load. They have a 'feet first' activist approach which during childhood and adolescence can get them into trouble but needs to be seen as also having advantages. But it can be difficult to 'fit into systems' especially the demands of education, which can be stacked against a child or young person with ADHD.

CONDUCT DISORDERS

Conduct disorders, and associated antisocial behaviour, are the most common mental and behavioural problems in children and young people. The Office of National Statistics (ONS) surveys of 1999 and 2004 reported that their prevalence was 5% among children and young people aged between 5 and 16 years. Conduct disorders nearly always have a significant impact on functioning and quality of life. The 1999 ONS survey demonstrated that conduct disorders have a steep social class gradient, with a three to fourfold increase in prevalence in social classes D and E compared with social class A. The 2004 survey found that almost 40% of looked-after children, those who had been abused and those on child protection or safeguarding registers had a conduct disorder. (NICE, 2013: 4)

Conduct disorder refers to aggressive, destructive and disruptive behaviours in childhood that are serious and likely to impair a child's development. In DSM 5 there is a distinction between oppositional defiant disorder (characterised by recurrent negativistic defiant, disobedient and hostile behaviours) and conduct disorder which includes a presence of repetitive persistent violations of societal norms and other people's basic rights. In ICD 10 oppositional and conduct problems are both included under the heading of conduct disorder. Many behaviours included in the diagnosis are common in normal child development, but when they are persistent and frequent they bring increased risks in later life including: antisocial behaviours, a range of psychiatric disorders, educational and work failure and relationship difficulties (Moffitt et al., 2002). Conduct disorder is more common in boys than girls (NICE, 2013). There is frequently co-morbidity with other illness including substance misuse, anxiety and ADHD. It is considered there is substantial heritability but little is known about the mechanisms. Children with conduct disorder are likely

to have: lower IQ, poor verbal skills, low tolerance of frustration, lack of anxious inhibition or rule breaking, problems of hyperactivity and executive function, impaired attention and concentration (Henry et al., 1996). Individual risk factors include low school achievement and impulsiveness; family risk factors include parental contact with the criminal justice system and child abuse; social risk factors include low family income and little education (NICE, 2013). Parenting practices in families of conduct-disordered children are reported as often hostile, critical, with harsh discipline, a lack of consistent rules, low monitoring of behaviours and parental disagreements.

A child or young person presenting with conduct disorder is doing so in a context of all of the theoretical domains. Where there is a combination of inherited vulnerability plus negative parenting, especially early negative affect and intrusive control these factors contribute to the development and persistence of conduct problems. These are often highly vulnerable young people and can be a risk to themselves and others. There is a discussion in Chapter 3 about the Edlington case of two brothers who both had a diagnosis of conduct disorder. Lord Carlile in his review noted a lack of robustness in agencies working together (Carlile, 2012). NICE (2013) guidelines now recommend a combination of person-centred care. For example, parent training and other multi-modal interventions such as family therapy and methylphenidate for management of the ADHD aspects.

AUTISTIC SPECTRUM CONDITIONS

Autistic spectrum conditions or disorders form a very broad variation in presentation. 'Spectrum' indicates that while sharing the same condition there is a wide range of difficulties experienced in different ways. On a scale of 0–100 on the spectrum and starting at zero, a social and communicative person would appear. Moving further along the spectrum someone with a few autistic traits such as a need for routine would appear. The stronger the autistic traits the further along the spectrum, so at 100 there would be a person with no speech and limited responses to others (Muggleton, 2012: 31). There may be accompanying learning disabilities. It is a lifelong condition and unlike all the other conditions discussed in this chapter has a biological origin and is a disorder of development. Autistic people often experience sensitivity to sounds, touch, tastes, smells, light or colours (National Autistic Society, 2013).

Autism is characterised by a triad of features related to functioning in all situations:

- Impairment of social communication
- Impairment of social understanding
- Impairment in social imagination and play.

There are also accompanying and ritualistic stereotyped interests and behaviours. These are usually evident from infancy although they may not be recognised at that

point. Play is often a preoccupation with repetitive activities. I recall meeting a referred boy age 7 for an assessment in Tier 2 CAMHS. He had been referred by a paediatrician over concerns about aggressive behaviour (he had kicked the dinner ladies at school). The boy had very sadly lost his mother who died after a long fight with cancer. Understandably it was thought his behaviour may have been a response to that and that he would benefit from some help. However when my colleague and I first met with him and his dad it was very clear quite quickly to us that he was demonstrating some autistic traits. There were lots of toys in the room but he spent the whole time taking apart and putting together a transformer toy. He did some drawing at one point but these were of train engines. Dad said that was the only thing he would draw and he only played with a transformer toy at home. He did not really interact with us in a conversational way and only in monosyllabic answers. He also spoke in an American accent. We referred him on to the learning disabilities service for children where he was assessed and diagnosed as on the autistic spectrum. The problem had been that the dinner ladies and other school staff were, as an act of kindness, giving him a hug. He could not bear the physical touch and as an autistic characteristic was sensitive to touch. To get away from them he would lash out. Quite a long time later he was still speaking in an American accent. Having a diagnosis does not in itself change anything but it can help parents and teachers to understand a child's needs and put in place supportive measures.

Autism in Britain was first labelled as childhood psychosis at the beginning of the 20th century. In 1944 it was named 'Kanner's syndrome', and then in the latter part of the 20th century 'autism' (Wing, 1996). Asperger's syndrome was identified in 1944 although it took until 1979 for Asperger's work to be translated from German to English. It wasn't until 1991 that the term Asperger's syndrome was recognised in Britain. The difference between autism and Asperger's syndrome is that 'Aspies' are of average or higher intelligence and develop language skills in the normal developmental way, while the reverse is true for autistic people (Bradshaw, 2013: 55).

Again as with children and young people with ADHD it is helpful to consider positives for Asperger's children. Although it has to be acknowledged they are often the victims of bullying and misunderstanding. Their strengths can be in individual sports for example. Another trait is honesty; never ask '*does my bum look big in this?*' If you are not prepared for an honest response, do not ask if the truth is going to hurt! Similarly language needs to be straightforward, if you ask an 'Aspie' to 'hold your horses', i.e. slow down, you will have a puzzled response, wondering – where exactly are the horses?

CONCLUSION

As we have seen child and adolescent mental health covers many areas, some of which have only been touched upon in the chapter. Children and young people are at significant risk of developing mental health problems within the context of a developing individual. This is certainly the case for particularly vulnerable children

such as looked after children. CAMHS and accompanying interventions provide a window of opportunity to address problems before these proceed into adulthood, where they will be much more resistant, complex and harder to deal with. In keeping with Winnicott's quote, 'there is no such thing as an infant ... show me someone caring for the baby', children and young people presenting with difficulties are always thought of systemically and contextually which is where the clues will lie if we are able to find them. Always be curious.

REFERENCES

- Ainsworth, M. (1970) Attachment, Exploration, and Separation: Illustrated by the Behavior of One-year-olds in a Strange Situation. *Child Development*, 41 (1): 49–67.
- Alvarez, A. (2002) *The Savage God: A Study of Suicide*. London: Bloomsbury.
- American Psychiatric Association (2013) *Diagnostic and Statistical Manual of Mental Disorders*, 5th edn. Arlington, DC: American Psychiatric Association. Available from: www.psychiatry.org/dsm5 (accessed July 2013).
- Anderson, R. (1998) *Facing it Out: Clinical Perspectives on Adolescent Disturbance*. London: Karnac.
- Anderson, R. (2008) A Psychoanalytic Approach to Suicide in Adolescents. In Briggs, S., Lemma, A. and Crouch, W. (eds) *Relating to Self-Harm and Suicide: Psychoanalytic Perspectives on Practice, Theory and Prevention*. Hove: Routledge, pp. 61–71.
- Barber, P., Brown, R. and Martin, D. (2012) *MH Law in England and Wales: A Guide for Mental Health Professionals*. London: Sage.
- Bell, D. (2000) Who is Killing What or Whom? Some Notes on the Internal Phenomenology of Suicide. *Psychoanalytic Psychotherapy*, 15 (1): 21–37.
- Berman, A. and Jobs, D. (1999 [1991]) *Adolescent Suicide Assessment and Intervention*. Washington, DC: American Psychological Association.
- Bowlby, J. (2008 [1988]) *A Secure Base*. London: Routledge.
- Bradshaw, S. (2013) *Asperger's Syndrome – That Explains Everything: Strategies for Education, Life and Just About Everything Else*. London: Jessica Kingsley.
- British Medical Association Board of Science (2006) *Child and Adolescent Mental Health: A Guide for Healthcare Professionals*. London: BMA.
- Brodie, L. and Reed, J. (2011) Misuse of Substances. In Claveirole, A. and Gaughan, M. (eds) *Understanding Children and Young People's Mental Health*. Chichester: Wiley-Blackwell, pp. 239–55.
- Bryant-Waugh, R. (2003) Eating Disorders. In Skuse, D. *Child Psychology and Psychiatry: An Introduction*. Oxford: The Medicine Publishing Company.
- Carlile, Lord (2012) *The Edlington Case: A Review by Lord Carlile of Berriew CBE QC at the Request of The Rt Hon Michael Gove MP Secretary of State for Education*. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/177098/The_Edlington_case.pdf (accessed August 2013).
- Carter, H. (2012) Shafiea Ahmed's Parents Jailed for her Murder. *The Guardian*. Available from: www.guardian.co.uk/uk/2012/aug/03/shafiea-ahmed-parents-guilty-murder (accessed August 2012).
- Chimat (Child and Maternal Health Observatory) (2012) *Targeted Mental Health in Schools (TaMHS)*. Available from: www.chimat.org.uk/camhs/schools/tamhs (accessed August 2012).

- Coleman, F. and Hagell, A. (eds) (2007) *Adolescence Risk and Resilience Against the Odds*. Chichester: John Wiley.
- Cullen, G. (2011) Eating Disorders. In Claveirole, A. and Gaughan, M. (eds) *Understanding Children and Young People's Mental Health*. Chichester: Wiley-Blackwell, pp. 149–64.
- Department for Education (2013) *Children Looked after in England (including Adoption and Care Leavers) Year Ending 31 March 2012*. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/219210/sfr20-2012v2.pdf (accessed July 2013).
- Department of Health (2002) *Suicide Prevention Strategy for England. Executive Summary*. Available from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009474 (accessed August 2012).
- Department of Health (2007) *Teenage Parents Next Steps: Guidance for Local Authorities and PCT's*. Available from: www.changeforchildren.co.uk/uploads/Teenage_Pregnancy_Next_Steps_For_LAs_And_PCTs.pdf (accessed August 2012).
- Department of Health (2009) *Healthy Child Programme: Pregnancy and the First Five Years of Life*. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/167998/Health_Child_Programme.pdf (accessed September 2013).
- Department of Health (2011a) *No Health without Mental Health: A Cross Government Mental Health Outcomes Strategy for People of all Ages*. Available from: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766 (accessed August 2012).
- Department of Health (2011b) *Consultation on Preventing Suicide in England*. Available from: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_128463.pdf (accessed August 2012).
- Department of Health and Department for Education (2004) *National Service Framework for Children, Young People and Maternity Services*. London: DH and DfE.
- Dogra, N. and Leighton, S. (2009) *Nursing in Child and Adolescent Mental Health*. Maidenhead: Open University Press.
- Dogra, N., Parkin, A., Gale, F. and Frake, C. (2009) *A Multidisciplinary Handbook of Child and Adolescent Mental Health for Front-line Professionals*, 2nd edn. London: Jessica Kingsley.
- Fairburn, C.G. and Harrison, P. (2003) Eating Disorders. *The Lancet*, 361: 407–16.
- Fazel, S. (2008) *Poor Mental Health Found among Young Offenders*. University of Oxford. Available from: www.ox.ac.uk/media/news_stories/2008/080903.html (accessed July 2013).
- Gardner, F. (2001) *Self-harm: A Psychotherapeutic Approach*. Hove: Routledge.
- Gaughan, M. (2011) Early Onset Psychosis. In Claveirole, A. and Gaughan, M. (eds) *Understanding Children and Young People's Mental Health*. Chichester: Wiley-Blackwell, pp.165–90.
- Grundy, M. (2008) *The Worcester Journal*. Available from: www.worcesternews.co.uk/archive/2008/02/11/2033956.February_9_16/ (accessed July 2013).
- Harrington, R. (2003) Depression and Suicidal Behaviour. In D. H. Skuse (ed.) *Child Psychology and Psychiatry An Introduction*. Oxford: The Medicine Publishing Co, pp. 125–28.
- Hawton, K., Townsend, E., Appleby, L., Gunnell, D., Bennewith, O. and Cooper, J. (2001) Effects of Legislation Restricting Pack Sizes of Paracetamol and Salicylate on Self-poisoning in the UK: Before and after Study. *British Medical Journal*, 19 May 2001. Available from: www.bmj.com/content/322/7296/1203 (accessed July 2013).
- Henry, B., Casp, A., Moffitt, T. and Silva, P. (1996) Temperamental and Familial Predictors of Violent and Non-violent Criminal Convictions from 3–18. *Developmental Psychopathology*, 32: 614–23. Available from: <http://psycnet.apa.org/journals/dev/32/4/614/> (accessed November 2013).
- Hider, P. (1998) *Youth Suicide Prevention by Primary Healthcare Professionals*. Christchurch, New Zealand: New Zealand Health Technology Assessment Clearing House. Available from: www.otago.ac.nz/christchurch/otago014022.pdf (accessed August 2012).

- HM Government (2012) *Preventing Suicide in England: A Cross Government Outcome Strategy to Save Lives*. London: HM Government. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf (accessed July 2013).
- James, A.C. (2003) Bipolar Disorder. In D.H. Skuse (ed.) *Child Psychology and Psychiatry*. Oxford: The Medicine Publishing Co, pp. 121–4.
- Jones, L. and Claveirole, A. (2011) ADHD. In Claveirole, A. and Gaughan, M. (eds) *Understanding Children and Young People's Mental Health*. Chichester: Wiley-Blackwell, pp. 191–216.
- Karr-Morse, R. and Wiley, M. (1997) *Ghosts from the Nursery: Tracing the Roots of Violence*. New York: Atlantic Monthly Press.
- Keenan, T. and Evans, S. (2009) *An Introduction to Child Development*. London: Sage.
- Kendall, P.C. (2000) *Childhood Disorders*. Hove: Psychology Press.
- Lask, B. (2003) *Practical Child Psychiatry: The Clinicians Guide*. London: BMJ Publishing Group.
- Lask, B., Frampton, I. and Nunn, K. (2012) Anorexia Nervosa – A Noradrenergic Dysregulation Hypothesis. *Medical Hypotheses*, 78 (5): 580–4.
- Lawrence, M. (2008) *The Anorexic Mind*. London: Karnac.
- Lemma, A. (2010) *Under the Skin: A Psychoanalytic Study of Body Modification*. London: Routledge.
- McDougall, J. (1989) *Theatres of the Body: A Psychoanalytical Approach to Psychosomatic Illness*. London: Free Association Books.
- Main, M. and Solomon, J. (1986) Discovery of an Insecure-Disorganized/Disoriented Attachment Pattern. *Affective Development in Infancy*. Westport, CT: Ablex Publishing, pp. 95–124.
- Mental Health Foundation (2006) *Truth Hurts Report of the National Inquiry into Self Harm Among Young People*. Available from: www.mentalhealth.org.uk/content/assets/PDF/publications/truth_hurts.pdf?view=Standard (accessed August 2012).
- Mickel, A. (2009) Suicide Watch Bridgend Suicides the Lessons Learnt. *Community Care*. Available from: www.communitycare.co.uk/Articles/21/07/2009/112140/Bridgend-suicides-the-lessons-learnt.htm (accessed August 2012).
- Mind (2012) *Understanding Borderline Personality Disorder*. Available from: www.mind.org.uk/assets/0002/1635/Understanding_bpd_2012.pdf (accessed September 2013).
- Moffitt, T.E., Caspi, A., Harrington, H. and Milne, B.J. (2002) Males on the Life Course Persistent and Adolescence-limited Antisocial Pathways: Follow up at Age 26. *Developmental Psychopathology*, 14 (1): 179–207. Available from: journals.cambridge.org/action/displayFulltext?type=1&fid=100938&jid=DPP&volumeId=14&issueId=01&aid=100937 (accessed August 2013).
- Muggleton, J. (2012) *Raising Martians – From Crash Landing to Leaving Home: How to Help a Child with Asperger Syndrome or High-functioning Autism*. London: Jessica Kingsley.
- National Autistic Society (2013) *What is Autism?* Available from: www.autism.org.uk/about-autism/autism-and-asperger-syndrome-an-introduction/what-is-autism.aspx (accessed August 2013).
- National Collaborating Centre for Mental Health (2009) *ADHD: The NICE Guideline on Diagnosis and Management of ADHD in Children, Young People and Adults*. London: The British Psychological Society and the Royal College of Psychiatrists.
- National Institute for Clinical Excellence (2002) *Scope*. Available from: www.nice.org.uk/nicemedia/pdf/Self-HarmScopeFinalV3140502.pdf (accessed July 2013).
- National Institute for Clinical Excellence (2006) *Bipolar Disorder: The Management of Bipolar Disorder in Adults, Children and Adolescents in Primary and Secondary Care*. Available from: www.nice.org.uk/nicemedia/pdf/CG38niceguideline.pdf (accessed August 2012).

- National Institute for Clinical Excellence (2008) *Attention Deficit Hyperactivity Disorder: Diagnosis and Management of ADHD in Children, Young People and Adults*. Available from: www.nice.org.uk/nicemedia/live/12061/42059/42059.pdf (accessed August 2013).
- National Institute for Clinical Excellence (2009) *Borderline Personality Disorder: Treatment and Management*. Available from: www.nice.org.uk/nicemedia/live/12125/42900/42900.pdf (accessed September 2013).
- National Institute for Clinical Excellence (2011) *Psychosis with Coexisting Substance Misuse: Assessment and Management in Adults and Young People*. Available from: www.nice.org.uk/nicemedia/live/13414/53729/53729.pdf (accessed August 2013).
- National Institute for Clinical Excellence (2013) *Antisocial Behaviour and Conduct Disorders in Children and Young People: Recognition, Intervention and Management*. Available from: www.nice.org.uk/nicemedia/live/14116/63310/63310.pdf (accessed August 2013).
- National Scientific Council on the Developing Child (2004) *Children's Emotional Development is Built into the Architecture of Their Brains*, Working Paper No. 2, Center on the Developing Child, Harvard University, USA. Available from: www.developingchild.net (accessed July 2013).
- NSPCC (2009) *Young People who Self-harm: Implications for Public Health Practitioners*. Available from: www.nspcc.org.uk/Inform/research/briefings/youngpeoplewhoselfharm-pdf_wdf63294.pdf (accessed August 2012).
- Nunn, K. (2013) The Sensitivities that Hinder and the Sensitivities that Heal. In Lask, B. and Bryant-Waugh, R. (eds) *Eating Disorders in Childhood and Adolescence*, 4th edn. London: Routledge, pp. 3–11.
- O'Connor, R., Rasmussen, S., Miles, J. and Hawton, K. (2009) Self-harm in Adolescents: Self Report Survey in Schools in Scotland. *British Journal of Psychiatry*, 194: 68–72. Available from: bjp.rcpsych.org/content/194/1/68.full (accessed July 2013).
- Pearce, J. (2004) Emotional Disorders in Young People. In Aggleton, P., Hurry, J. and Warwick, I. (eds) *Young People and Mental Health*. Chichester: Wiley-Blackwell, pp. 47–72.
- Piccinelli, M. and Wilkinson, G. (2000) Gender Differences in Depression. *British Journal of Psychiatry*, (177): 486–92. Available from: <http://bjp.rcpsych.org/content/177/6/486.full?sid=14c09e5a-1b4a-4931-aa79-db987459ea0d> (accessed November 2013).
- Preventing Suicide in England: A Cross Government Outcome Strategy to Save Lives* (2012) Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/216928/Preventing-Suicide-in-England-A-cross-government-outcomes-strategy-to-save-lives.pdf (accessed July 2013).
- PSHE (2011) *Personal, Social and Health Education*. Available from: www.education.gov.uk/schools/teachingandlearning/curriculum/primary/b00199209/pshe (accessed August 2012).
- Royal College of Psychiatrists (2002) *Department of Health Suicide Prevention Strategy for England: College Response*. London: Royal College of Psychiatrists.
- Royal College of Psychiatrists (2012a) *Mental Health and Growing Up, Fourth Edition; Self-harm in Young People: Information for Parents, Carers and Anyone who Works with Young People*. Available from: www.rcpsych.ac.uk/mentalhealthinformation/mentalhealthandgrowingup (accessed August 2012).
- Royal College of Psychiatrists (2012b) *Cannabis and Mental Health*. Available from: www.rcpsych.ac.uk/mentalhealthinfo/youngpeople/cannabis.aspx (accessed August 2012).
- Royal College of Psychiatrists (2012c) *Mental Health and Growing Up, Fourth Edition; Alcohol and Drugs: What Parents Need to Know*. Available from: www.rcpsych.ac.uk/mentalhealthinfo/mentalhealthandgrowingup/alcoholdrugsparents.aspx (accessed August 2012).
- Rutter, M. (1985) Resilience in the Face of Adversity: Protective Factors and Resistance to Psychiatric Disorders. *British Journal of Psychiatry*, 147: 589–611.

- Rutter, M. (2006) Implications of Resilience Concepts for Scientific Understanding. *Annals of the New York Academy of Science*, 1094: 1–12.
- Schofield, G., Ward, E., Biggart, L., Scaife, V., Dodsworth, J., Larsson, B., Haynes, A. and Stone, N. (2012) *Looked After Children and Offending*. Centre for Research on the Child and Family, University of East Anglia. Available from: www.tactcare.org.uk/data/files/resources/52/lac_and_offending_reducing_risk_promoting_resilience_fullreport_200212.pdf (accessed August 2012).
- SEAL (2010) *Social and Emotional Aspects of Learning*. Available from: www.education.gov.uk/publications/standard/publicationDetail/Page1/DFE-RR049 (accessed August 2012).
- Silver, L.B. (1990) Attention Deficit-Hyperactivity Disorder: Is it a Learning Disability or a Related Disorder? *Journal of Learning Disabilities*, 23 (7): 394–7.
- Stice, E. (2002) Risk and Maintenance Factors for Eating Pathology: A Meta-analytic Review. *Psychological Bulletin*, 128(5): 825–48.
- Street, C., Anderson, Y. and Plumb, J. (2007) *Maintaining the Momentum: Towards Excellent Services for Children and Young People's Mental Health*. London: NHS Confederation.
- Strober, M., Schmidt-Lackner, S., Freeman, R., Bower, S., Lampert, C. and DeAntonio, M. (1999) Recovery and Relapse in Adolescents with Bipolar Affective Illness: A Five Year Naturalistic, Prospective Follow-up. *Journal American Academy Child Adolescent Psychiatry*, 34(6): 724–31.
- Together We Stand: The Commissioning, Role and Management of CAMHS, Health Advisory Service Report*. (1995) London: HMSO.
- Treasure, J. and Alexander, J. (2013) *Anorexia Nervosa: A Recovery Guide for Sufferers, Families and Friends*. London: Routledge.
- Treasure, J. and Karwautz, A. (2004) Eating Disorders. In Aggleton, P. Hurry, J. and Warwick, I. (eds) *Young People and Mental Health*. Chichester: Wiley-Blackwell, pp. 73.
- Vostanis, P. (2007) Mental Health and Mental Disorders. In Coleman, F. and Hagell, A. (eds) *Adolescence Risk and Resilience: Against the Odds*. Chichester: John Wiley, pp. 89–107.
- Waddell, M. (2002) *Inside Lives: Psychoanalysis and the Growth of the Personality*. London: Karnac.
- Wing, L. (1996) *The Autistic Spectrum*. London: Constable.
- World Health Organization (2012) *Risks to Mental Health An Overview of Vulnerabilities and Risk Factors*, Geneva, Switzerland, World Health Organization, available from: www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf (accessed November 2013).
- World Health Organization (2013) *International Classification of Diseases 10 (ICD 10)*. Available from: www.who.int/classifications/icd/en/ (accessed July 2013).
- Zubin, J. and Spring, B. (1977) Vulnerability: A New View of Schizophrenia. *Journal of Abnormal Psychology*, 86 (2): 103–26.