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AN INTRODUCTION TO CHILD & ADOLESCENT MENTAL HEALTH

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CONTENTS

2

CHILD AND ADOLESCENT MENTAL HEALTH CONDITIONS

Maddie Burton and Clive Sealey

Overview

- An overview mental health conditions affecting children and young people including
    - Depression
    - Anxiety
    - Suicidal behaviour
    - Self-harm
    - Eating disorders
    - Early onset psychosis (EOP)
    - Substance misuse
    - Neuro-developmental conditions

INTRODUCTION

This chapter provides an overview of child and adolescent mental health conditions. When talking about mental health conditions, it is important to acknowledge that while there are different definitions for mental ill health, the most authoritative classifications of mental health conditions are the World Health Organization (WHO, 2022) *International Classification of Diseases 11th Revision* (typically referred to as *ICD-11*) and the American Psychiatric Association (2022) *Diagnostic and Statistical Manual of Mental Disorders* (typically referred to as *DSM-5-TR*). It is the case that these manuals are primarily focused on adult mental health, but they nevertheless do allow us to consider similar child and adolescent mental health conditions. It should also be noted that while both *ICD-11* and *DSM-5-TR* do provide a guide to traits that determine a mental health diagnosis, behavioural symptoms can be experienced differently from these guides, as a consequence of human experience and relationships, particularly the family.

It is generally understood that it is a combination of *nature* and *nurture* theories which help us to inform and understand human development, and also offer the most clear and logical explanations for understanding child and adolescent mental health conditions. This focuses on 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).

When trying to determine mental health conditions, these are questions and issues that are continually evident and need to be considered. These are discussed in more detail in Chapter 3.

The rest of this chapter provides a brief outline of the main child and adolescent mental health conditions, such as depression, anxiety, suicide, self-harm, eating disorders, EOP, substance misuse and neurodevelopmental conditions. Child and adolescent mental health is a large area, and it is difficult to fully explore all conditions equally within the confines of a chapter, so some areas have a larger focus here than others. By the end of this chapter, you should have a basic understanding of the main mental health conditions that can affect children and adolescents.

DEPRESSION

People's mood changes from hour to hour and from day to day, and this is normal. However, according to the World Health Organization (WHO, 2023), depression occurs where individuals are experiencing low mood or loss of interest or pleasure in activities that they would normally enjoy for most of the day, for nearly every day for a period of at least two weeks. Similarly, in *ICD-11* and *DSM-5-TR*, 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. The criteria are similar for children and adults but with important differences (Rice et al., 2019). 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, and also to understand sadness as a passing human condition. If sadness became persistent over time, this would be different.

Depression is now recognised as a major public health problem in the United Kingdom and worldwide. Lim et al. (2018) estimate that depression affects up to 15% of the population in high-income countries, and 11% of the population in low-income countries. In the United Kingdom, this would translate to up to 10 million people.

According to NICE (2020) depression is one of the most common mental health disorders in young people. NICE estimates that 1 in 13 children aged 12 years and older have had moderate to severe depression. It is during adolescence that the onset of depression typically occurs (Rice et al., 2019). Childhood depression is linked with a range of negative outcomes, including impaired social adjustment, academic difficulties and increased risk of suicide (Young Minds, 2024). Depression is a risk factor in suicide, and undiagnosed or untreated depression can heighten that risk.

There are gender differences in depression beginning in puberty and continuing into adulthood, with higher prevalence in females than males (Salk et al., 2017). Clear determinants are far from established, but Salk et al. (2017) identify a number of possible gendered reasons for this, such as inequality, poverty and violence affecting women more than men. There may be a link to the fact of girls tending to internalise stress and boys externalising stress (Lavoie et al., 2019). 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 (Lucas et al., 2019), a reminder of the nature and nurture debate and the implications for these infants and their psychological and emotional development.

ANXIETY

Anxiety is a feeling of threat experienced in anticipation. Emotional development is a challenge for all human beings. In practice, *fears* and *anxieties* are frequently intermingled. Fear is feeling a sense of threat in the presence of a particular person, situation or object. Anxiety can be considered as either normal or abnormal depending on the context and degree of the anxiety. It is an essential emotion protecting us from danger. Fears and anxieties are normal developmental challenges facing the maturing individual. Reasonable levels of anxiety help us to function. For example, 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.

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 et al., 2003). There are *different fears for different years*. For example, separation anxiety would be considered normal for infants (leaving a primary carer) but less so for a teenager.

During adolescence, autonomy and independence are major developmental challenges, as expressed in the balance between compliance with rules and expressing independent autonomy. It is normal to experience conflict at some level, but the challenge posed by the emerging desire for autonomy can trigger or exacerbate interpersonal problems that require negotiation with the accompanying anxiety. 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 many variations of anxiety and the accompanying symptomatic presentations. Separation anxiety usually begins in the preschool years any time after the attachment period but typically in late childhood or early adolescence. Animal phobias such as a fear of spiders or dogs usually begin in childhood. Other fears such as the dark and then, as the imagination develops, ghosts and monsters also appear. Performance anxiety can emerge in late childhood and social anxiety in adolescence.

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.

There are many different types of typical anxiety disorders, which are detailed below.

Generalised Anxiety Disorder (GAD)

- Tendency to be worried or anxious about many areas of life, with a feeling that something bad is going to happen to you or your loved ones.
- 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

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

Social Phobias

- An exaggeration and persistence of the normal phase of stranger anxiety (normal up to 30 months, as discussed in Ainsworth and Bell's 'Strange Situation' discussed in Chapter 3).
- 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.
- More than shyness, characterised by fear of humiliation or embarrassment.
- Poor prognosis if left untreated.

Separation Anxiety Disorders (SAD)

- 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, and may have nightmares with themes of separation or sleeping alone.
- At ages 9–12, there is severe distress on separation, withdrawal and physical symptoms such as stomach pain and short breath.
- During adolescence, there are physical symptoms such as headaches, chest pains.

Scolionophobia (fear of school)

- An intense fear of school that goes on for a long time, usually characterised by physical symptoms such as headaches, stomach ache, diarrhoea and vomiting.
- Often used with 'school refusal', although this implies that the child is actively refusing to go to school.
- Many reasons including separation anxiety, bullying, poor relationships or academic underachievement.

Panic Disorder

- Having multiple panic attacks, usually without warning with no specific trigger.
- Physical symptoms include shortness of breath, palpitations, dizziness, chest pain, fear of losing control, etc.
- More common in adolescence.

Post-traumatic Stress Disorder (PTSD)

- A reaction to a serious traumatic event in which the child was extremely afraid or injured.
- While normal to display some anxiety for a few weeks after the event, PTSD symptoms must be present for up to six months after the event.
- Examples include physical, sexual abuse and or neglect events, or events in the immediate and wider community such as local, national or global disasters.
- May keep having flashbacks and avoiding situations that remind them of the trauma.
- Jumpy, sleep difficulties and nightmares, intrusive images.

Obsessive Compulsive Disorder (OCD)

- Present when there are certain actions or thoughts that are repeated over and over again, often for long periods, such as cleaning, washing, checking or ordering.
- 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 but purposeful behaviours.
- Parents and others often become caught up in complex rituals to avoid upsetting the child.

Activity 2.1: Scolionophobia

Consider both the short-term and long-term effects that the scolionophobia described below is having on Jean and her family.

> Jean is 15 and was referred to CAMHS by her GP. She was seen by the consultant child and adolescent psychiatrist and diagnosed with scolionophobia. 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.

SUICIDAL BEHAVIOUR

The term 'suicidal behaviour' includes suicide and attempted suicide indicating an attempt to die with sufficient lethality (Berman and Jobes, 1991). Suicide is often seen as a solution to intolerable overwhelming feelings rather than an explicit wish to die. Suicide attempts provide an active response to triggers acting as stressors. Suicide attempts can be about a last sense of control over feelings of helplessness with the corresponding relief then experienced. The case of Shafilea Ahmed in 2003 highlights how overwhelming stressors can lead to suicide. When on a visit to Pakistan, Shafilea swallowed bleach in order to avoid a forced marriage, 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 Shafilea's case, the most pressing and immediate intervention would have been to ensure her safety from a child protection position.

It is also worth reminding ourselves that in the United Kingdom until the *Suicide Act 1961*, suicide was illegal. This meant that people who died by suicide were deemed to be criminals, and if they survived their suicide attempt, they could be prosecuted and imprisoned. For example, *The Berrows Worcester Journal* (https://static.premiersite.co.uk/23415/docs/7078864_1.pdf) detailed two cases in 1858 where this happened. In the first case, a woman was charged with 'attempting to commit suicide' by jumping into the canal, and remanded in police custody for a week. In another case the following month, another woman was admitted to hospital for attempted suicide by cutting her throat with a knife. The stigma surrounding suicide largely occurs from the influence of religion, and the belief that suicide is a sin, a belief that remains today among religions (Cook, 2014). The term 'committing suicide' is also symptomatic, and the preferred term nowadays is completed suicide. There continues to be ongoing stigma and shame and often negative attitudes towards those who attempt suicide (Pitman et al., 2016).

According to the Samaritians (nd), around 200 young people die by suicide every year, approximately four every week. This is a significant increase over a 20-year period, indicating rising suicide rates among adolescents in England and Wales (Bould et al., 2019).

People under 20 do have the lowest suicide rate of all ages, but among men aged 20–34, suicide is the leading cause of death in England (Baker, 2024). More specifically, in contrast to depression, males have higher suicide rates than females for all age groups (*ibid.*). 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, 1998). Outside the adolescent period, the only other time in life where such rapid changes occur, initiated by the hypothalamus, is in the womb (Waddell, 2002: 139).

Looked after children are more at risk of death by suicide than to other young people not looked after (Göbbels-Koch, 2023). Young people are particularly more vulnerable to 'suicide cluster', which refers to where three or more suicides occur in a particular place or over a particular time, or both (Hawton et al., 2019). Hawton et al. (2019) identify the role of the media as having a significant influence in the development of suicide clusters. Suicide clusters are not a new phenomenon, with Berman and Jobes (1991) identifying it occurring where people are 'bonded' together, with the death of one compelling the death of another. It may also occur where with the suicide of a high-profile celebrity (Hawton et al., 2019).

Other considerations of risk and trigger factors for suicide among young people focus on a number of external influences, including neglect and abuse, alcohol and drug misuse, social media, online bullying, exam and lifestyle stress and increasing insecurity (Wardle and McManus, 2021). The suicide of Molly Russell in particular highlights the role that social media can play in young people's suicide. In 2017, Molly was 14 years old when she completed suicide after viewing self-harm and suicide content on social media. According to Meaker (2022), Molly had viewed or saved more than 2000 posts related to suicide or self-harm in the six months before her death. The coroner subsequently recorded that she did not die from suicide but that 'She died from an act of self-harm while suffering from depression and the negative effects of online content' of posts on *Instagram* and *Pinterest* (Meaker, 2022).

Bell (2001) makes the important point that the cause given of suicide 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 the trigger (the argument, exam failure) for 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.

The most recent *Suicide Prevention Strategy for England* (Department of Health and Social Care, 2023) included goals to reduce the suicide rate and support those who have been bereaved by suicide. The Strategy identifies children and young people as a priority for tailored and targeted support. This is intended to include:

- funding to improve the general mental health of children and young people;
- providing support in schools, colleges and universities;
- research to better understand suicide in children and young people.

The Strategy also identified social isolation and loneliness as a key factor in suicide ideation and behaviour. It identifies expanding social prescribing (as detailed in Chapter 6) to children and young people as a key strategy for limiting the effect of loneliness and therefore preventing loneliness.

History has taught us that reducing and preventing suicide is possible, with specific steps. For example, reductions in pack sizes of analgesics after 1998 led to a significant reduction in liver damage and completed suicides (Hawton et al., 2019). Analgesics including paracetamol are now only 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. This is relevant as 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.

SELF-HARM

The NHS (2023) defines self-harm as when somebody intentionally damages or injures their body. This can include *physical* self-harm such as hitting yourself or things and cutting yourself, *neglectful* self-harm such as excessive alcohol or illegal drug use or having repeated unsafe sex, and *emotional* self-harm such as having repeated negative thoughts. Self-harm must be taken seriously and never minimised because there is evidence of a clear link between self-harming and suicide or suicidal thoughts, with 30- to 50-fold risk of suicide following self-harm in the year after presentation at hospital (NICE, 2022).

According to the 2014 Adult Psychiatric Morbidity Survey for England (NHS, 2016), self-harm is particularly high among young women, with 27.5% of women aged 16–24 reporting having self-harm at some point, compared with 9.7% of young men of the same age, and 6.4% in the general population. It should be noted that these figures are very likely an underestimate of the true extent of self-harm, as people do not always report it but prefer to keep it hidden (NICE, 2022). Like suicide, self-harm is stigmatised, which is one of the reasons that it remains hidden, and this can lead to guilt and shame often compounded by the reactions of others (Aggarwal et al., 2021). Certain groups of young people are also more likely to self-harm, such as LGBTQ+ young people, looked after young people and autistic young people (Townsend, 2021). There is evidence that self-harm is on the rise among young people (NICE, 2022). This growth has been linked to the parallel growth of the internet and social media, through the risks of social influencing and bullying (Townsend, 2021).

Like suicidal behaviours, self-harm is a response to stress. 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. In a suicide attempt, the wish for self-preservation against physical danger is lacking, while self-harm is in part about taking control over feelings of helplessness with the corresponding relief thereby then experienced. 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. The skin becomes a medium for communication (Gardner, 2001), where reasons motivating modifications to the external 'skin' or surface may be found 'under the skin', within the internal world (Lemma, 2010: 2). Consider other powerful body modification similarities where the skin becomes a medium of communication through decoration with tattooing and piercing. 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 shock that occurs from self-harming communicates the rawness of emotions and impulses and is an essential aspect of the behaviour (Gardner, 2001: 8).

Edmondson et al. (2016) identified the most common reasons given for self-harm in studies, and this is shown in Table 2.1.

Table 2.1 Most Common Reasons for Self-Harm (Edmondson et al., 2016)

Reason for Self-Harm	Percentage of Studies
To manage stress, such as to calm down or to relieve or distract from another kind of pain to	93%
To bring attention to their state, such as to seek help from someone or letting others know what is happening in their life	87%
To punish themselves or others, such as for specific acts or thoughts	63%
To disassociate from what is happening, such as to produce a feeling numbness or to stop a feeling of numbness	48%

Table 2.1 Most Common Reasons for Self-Harm (Edmondson et al., 2016) *(Continued)*

Reason for Self-Harm	Percentage of Studies
To invoke a sensation, such as to create a feeling of excitement, exhilaration or adrenaline rush	20%
To avert suicide, such as a mediating factor between more serious self-harm	15%
To maintain or explore boundaries, such as a boundary between themselves and others	7%
To express and cope with sexuality, such as to provide a sexual release or pleasure	6%

Table 2.1 supports the point made above that self-harm tends to be about coping, as the prime reasons refer to coping or seeking help for a situation. 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.

Activity 2.2: Self-Harm Stress Factors

Look at the case study of James below. Consider the following questions:

- What are the stress factors that are contributing to James' self-harm?
- Which of the reasons for self-harm in Table 2.1 are most appropriate to James?

James is 14 and was referred to Tier 3 CAMHS by his GP for assessment. James was self-harming by burning his fingertips. There were concerns over suicidal ideation and possible clinical depression. James 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, James' mum had been bullied by an overbearing father.

James' father lives with his third wife. James' father was in care as a child. James and his brother visit them once a week and sometimes stay over. James 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 James ran away from home and dad wondered if James should go into care. James has a passion for music, both writing and playing the guitar. Therefore, burning his finger tips is significant for James and also very punishing. James 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

(Continued)

(Continued)

of James being bullied. He often becomes over-involved in sorting out other friends' problems.

James: Stress Factors

James' presentation will be interpreted as illness 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 James' parents' experiences. James 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 James' 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. James' father is only partially available for James with an imminent sense of unavailability present.

EATING DISORDERS

The NHS (2024) defines an eating disorder as a mental health condition where you use the control of food to cope with feelings and other situations. This expresses itself either in the form of eating too little or too much, and/or excessive concern with weight or body shape, or avoiding certain foods and/or restricting the amount of food eaten overall. The most commonly known eating disorders are anorexia nervosa, bulimia and binge eating disorder. However, the most common eating disorder is where a person's symptoms do not exactly fit the symptoms of any specific eating disorder. This is known as other specified feeding or eating disorder (OSFED). Table 2.2 provides a list of the main eating disorder, together with their symptoms and effects.

Table 2.2 Main Eating Disorders, Symptoms and Effect

Name	Symptoms	Effects
Anorexia (nervosa)	Limiting how much is eaten, excessive exercising, inducing vomiting after eating, bingeing and then purging, regularly checking body weight or avoiding checking body weight, having a distorted image of the body	Low body weight, a deep fear of gaining weight, loss of muscle strength, reduced bone strength, social withdrawal, reduction in size and physical development

Table 2.2 Main Eating Disorders, Symptoms and Effect *(Continued)*

Name	Symptoms	Effects
Bulimia (nervosa)	Eating large quantities of food (bingeing) and then vomiting (purging)	Frequent vomiting, tiredness, bloating, constipation, abdominal pain, irregular periods
BED – binge eating disorder	Eating large quantities of food over a short period of time without getting rid of it, eating food fast, eating food to overfullness, eating large quantities when not hungry, eating in private	Weight gain, high blood pressure, high cholesterol, type 2 diabetes, heart disease
OSFED – other specified feeding or eating disorder	Excessive focus on food, secretive behaviour around food, eating at night, less frequent bingeing and purging	Self-consciousness of eating in front of others, low confidence and self-esteem, poor body image, irritability and mood swings, tiredness, social withdrawal, feelings of shame, guilt, difficulty concentrating, poor body image
ARFID – avoidant restrictive food intake disorder	Avoiding certain types of food, only eating certain types of foods, or restricting the amount of food eaten	Poor physical health, failure to gain weight, slower physical growth, nutritional deficiencies leading to needing nutritional supplements or tube feeding

Source: Adapted from Beat (2024).

As Table 2.2 shows, eating disorders can involve a range of symptoms from avoiding eating food, to eating too much. It can also result in a range of effects, from low body weight to poor physical health.

A key point about eating disorders is that they are more likely to begin in adolescence and young adults than older people. Figure 2.1 shows the rate of possible eating problems by age for England.

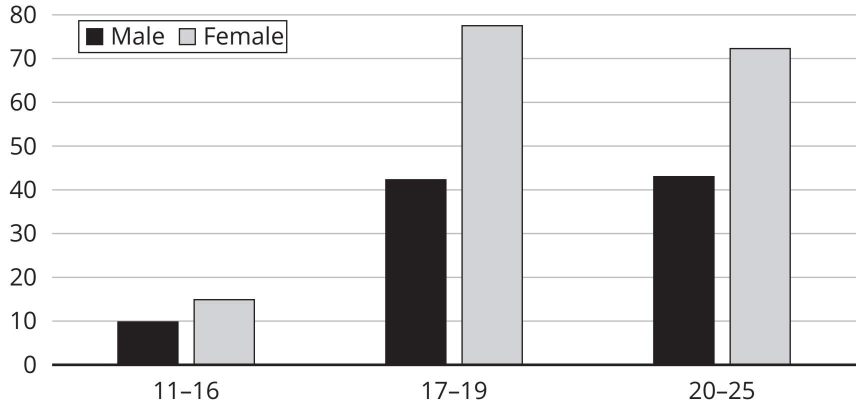

Figure 2.1 Rate of Possible Eating Disorder by Age (England)
Source: NHS England (2023).

Figure 2.1 shows the rate of possible eating disorder increases for both boys and girls as age increases. Figure 2.1 also shows that while the rate of possible eating disorders is similar in the 11–16 age range, girls are much more likely to have a possible eating disorder between the ages of 17–19 and 20–25, with 17–19 being the peak age. This highlights that it is girls and young women who are primarily affected by eating disorders, with anorexia up to 12 times more likely in females than males (NICE, 2024). However, Gorrell and Murray (2019) argue that this could be because of a historic tendency to consider eating disorders as a female-centric disorder, meaning that its incidence in boys and men being underestimated. They argue further that stigma and different perceptions of eating disorders may contribute to an underestimation, such as the fact that having a six-pack is seen as a good thing for boys but may be classified as symptomatic of having an eating disorder for girls.

Eating disorders in general have a high mortality rate compared with other mental health illness. For example, anorexia has a higher mortality rate than any other mental health illness, with 5 people per 1,000 affected with it dying, and 20% of these deaths from suicide (NICE, 2024). One reason for this is that recovery from eating disorders can take a long time and vary considerably. For example, Eddy et al. (2017) calculated that recovery from bulimia took an average of 3.8 years, while recovery from anorexia could take over 10 years. This is supported by Dobrescu et al.'s (2020) observation of a 10-year period for having anorexia.

Young people with anorexia 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 their 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. Re-feeding in a specialist unit or hospital to a healthy weight is only a relatively minor aspect of what is long-term treatment.

Eating disorders are sometimes seen as a disease of affluence, but according to Huryk et al. (2021), there is no evidence of this, with eating disorders present across a wide range of socioeconomic backgrounds.

The higher rate of possible eating disorders during adolescence as shown in Figure 2.1 indicates that biologically, the onset of puberty is an important contributory factor to its incidence. There are also adverse life events which socially can also contribute to this incidence, such as bereavement, parental divorce and sexual abuse, together with a psychological vulnerability. Genetic vulnerability has been identified as a significant cause of eating disorders, with Bulik et al. (2019) identifying for example that female relatives of individuals with anorexia being 11 times more likely to develop anorexia than relatives of individuals without anorexia. However, eating disorders have also been observed as having an environmental cause, such as insecure attachment and less caring or protective parents (Lukas et al., 2022). This would suggest anorexia nervosa is a combination of both biological, social and genetic factors, and not a lifestyle choice. This 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).

There are also similarities between eating disorders and self-harm and suicidal behaviour in that there is always a contextual background of either relationship or attachment difficulties, even if they are not immediately apparent. 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 that are 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, as is demonstrated here by the following case study.

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 are demonstrated below in Activity 2.2.

Activity 2.3: Anorexia

Consider the biological, social and genetic factors that contribute to Jane's anorexia in the case study below.

> 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, her BMI was less than the 5th percentile for her age, gender and height, and she 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 eight 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

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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. Her father has also been diagnosed with depression. Jane remained in hospital for a year and was discharged to her local Tier 3 CAMHS team.

Biological factors: 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.

Genetic factors: There may well be a genetic component from the fact that her father has been diagnosed with depression, which can be a trigger for anorexia.

Social/ environmental factors: 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 (EOP)

Psychosis describes a group of symptoms when there is an alteration to a person's perception, thoughts, mood and behaviour to the extent that they have a problem realising what is real and what is not real (Mind, 2024). Symptoms can include hallucinations (usually in the form of voices), delusions (such as that other people, objects or things are being controlled by others) or confused and disturbed thoughts (such as rapid or constant speech, or switching from one topic to another).

Symptoms of psychosis typically occur between the ages of 18 and 25, but they can sometimes occur before 18, and this is known as early onset psychosis (EOP). EOP affects between 11% and 18% of patients with psychosis (Perdahli Fis and Gumustas, 2018). When EOP does occur, early detection is important as treatment is most effective when in this initial period (Lundin et al., 2024). In addition, there is an increased risk of suicide in the first year after the first episode of psychosis occurs (Coentre et al., 2021). This means that children and young people who seem to be experiencing a psychotic episode need urgent assessment, risk assessment and treatment. However, Kular et al. (2019) note that psychotic disorders are one of the most stigmatised mental health conditions, and this stigmatisation acts as a barrier to accessing treatment and care.

The two main forms of psychotic illness are 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. 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. There is however a view that a diagnostic term such as schizophrenia is unhelpful and unreliable given the changing range of problems that come under this term.

The main features of bipolar affective disorder are extreme changes in the mood, energy, activity and concentration levels of an individual. This means that on the one hand, the individual can appear to be very active, excited or happy, which are referred to as manic episodes. On the other hand, they can appear as inactive, sad or hopeless, referred to as depressive episodes.

There is no single cause for psychosis, but rather a probability of multiple gene factors (*biological model*) articulating with environmental factors (*social environmental model/theory*) which then leads to psychosis. Risk factors for psychotic illness include a family history, with stress or extreme life events acting as a trigger factor. For example, schizophrenia has an increased risk if there is a diagnosis of a close relative such as a parent or sibling (Lim et al., 2018). Trauma can also be a significant risk. Giannopoulou et al. (2023) detailed that those who experience trauma in childhood are three times more likely to develop a psychotic disorder than those who do not experience the same. In young people, common triggers of psychosis include substance misuse, life events such as a relative or friend dying or having another serious mental illness (Royal College of Psychiatrists, 2024). It is a common feature to have co-morbidity between psychosis and other mental health illnesses, such as depression, post-traumatic stress disorder or anxiety (Bhavsar et al., 2021).

Activity 2.4: Early Onset Psychosis

Look at the following case study and consider whether there are biological and/or social/environmental factors evident in Tyler's life that contribute to EOP.

> Tyler is 17 and has been experiencing unusual ideas and experiences for about 18 months, alongside a deterioration in his daily functioning and an increase in his cannabis use. 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. The assessment shows that 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 is no one in particular that has a problem with him, but 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 would not 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.

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Tyler dropped out of school before completing his exams. 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 has not 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.

SUBSTANCE MISUSE

Substance misuse (also known as drug abuse) is a broad term referring the use of any psychotropic substance, in amounts which or with the intention of harm to themselves or others. The substance here can include alcohol, caffeine, pain medication and illicit drugs. Such use is usually, but not always, regarded as a problem if there is evidence of dependence. Figure 2.2 shows the trends in substance misuse in England among secondary school children over the last 20 years.

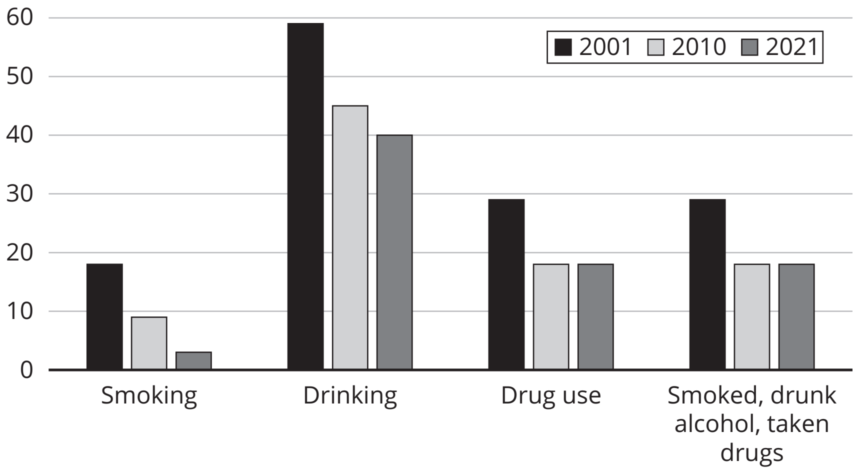

Figure 2.2 Trends in Substance Misuse Among Years 7–11 Secondary School Pupils (England)

Source: NHS Digital (2023).

Figure 2.2 shows that the general trend is for falling substance misuse among secondary school pupils. The most noticeable fall has been in drinking, but even smoking and drug use have fallen. The Office for Health Improvements and Disparities (2024) reports other important trends in substance misuse among young people. These are:

- Cannabis use generates the most demand for treatment in adolescents, followed by alcohol;
- 15 years old is the most common age of young people receiving treatment for substance misuse;
- Girls reported early onset of substance use earlier than boys, meaning they started using substances earlier than boys.

Where young people use substances, they are at greater risk of the effects of substance misuse because their brain is still developing and so the substances have a larger effect on their brain. As an example of this, research has shown that teenagers who smoke cannabis are at a greater risk of developing psychosis (Royal College of Psychiatrists, 2024a). However, the actual effect that cannabis has on young people is disputed, with some studies reporting it having a negative effect on cognitive functioning, while others reporting no difference or better social functioning, as well as fewer depressive symptoms (Pardo et al., 2021). Regular substance misuse can also lead to serious disruption in education, relationships and long-term physical and emotional health. Further on, adult mental health problems and social disruption are linked to early onset substance misuse, meaning that where substance misuse occurs in early adolescence, there is more likelihood that they will develop substance use problems in later life (Jordan and Andersen, 2017).

Young people have *individual* characteristics which make them vulnerable to substance misuse during adolescence, such as 'a strong inclination toward experimentation, curiosity, susceptibility to peer pressure, rebellion against authority, and poor self-worth' (Nawi et al., 2021: 2). These factors also affect the ability to treat substance misuse when it occurs. Nawi et al. (2021) also identified *family* and *community* factors which increased the risk of substance misuse. These include:

- parental negligence;
- parental style, such as lack of parental controls;
- pre-natal substance abuse;
- low parental education;
- substance misuse within the family;
- association with peers who substance misuse;
- lack of structured activities in the community.

Activity 2.5: Substance Misuse

Refer back to **Activity 2.4: Early Onset Psychosis**, and consider which of the individual, family and community substance misuse risk factors from above are likely to have contributed to Tyler's EOP.

NEURO-DEVELOPMENTAL CONDITIONS

Neuro-developmental conditions are those which occur as a consequence of late or non-development of the nervous system. This is where either in the womb or early in life after birth, the brain or the spinal cord either do not develop at all or develop at a rate that is slower than typical. This leads to a large group of 'disorders' commencing in early life and persisting into adulthood. Terminology fluctuates between conditions, disorders and difficulties and is interchangeable. Within the context of this chapter, the focus is on attention deficit hyperactivity disorder (ADHD) (sometimes referred to as hyperkinetic disorder), conduct disorder (CD) and autistic spectrum disorder (ASD), as these are the most frequent and more common conditions you are likely to come across.

Attention Deficit Hyperactivity Disorder

NICE (2024a) defines ADHD as where behaviour can be characterised by hyperactivity, impulsivity and inattention to greater or lesser extents. Hyperactivity refers to restlessness, constant fidgeting or talking too much; impulsivity refers to difficulty with self-control or acting without thinking; inattention refers to inability to stay focused or pay attention.

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, and it is possible that you are likely to display all of the above. The key factors for an ADHD diagnosis is:

- Length of behaviour – symptoms have to be present for at least six months.
- Wide in existence – symptoms have to be present in at more than one setting, such as school and home, or work and social situations.

Part of the assessment process includes collecting information from parents and from educational settings, to exclude the possibility of other conditions, such as depression and anxiety. Most studies show that ADHD affects 5% of children (NICE, 2024b). Boys are more commonly diagnosed with ADHD than girls, with a proportion of up to 5 boys to 1 girl diagnosed (NICE, 2024). Previously, this was thought to be because of the neurological differences, however more recently the cause of these differences has come to be viewed as because of an 'underdiagnosis' within girls (Attoe and Climie, 2023). Table 2.3 shows the differences in ADHD presentation in boys and girls.

Table 2.3 Differences in ADHD Presentation in Boys and Girls

Boys (Source: Berkeley Psychiatrists, 2024)	Girls (Source: Devon Adult Autism and ADHD Service, 2024)
• Disorganisation and forgetfulness	• Daydreaming quietly in class
• Difficulty following instructions	• Feeling anxious or sad
• Frequent interruptions	• Exhibiting silliness or apparent ditziness
• Excessive movement or fidgeting	• Being shy or inattentive
• Managing emotions, i.e. mood swings	• Trouble maintaining friendships
• Have trouble sitting still	• Picking at cuticles or skin
• Be unable to wait their turn	• Being a perfectionist
• Interrupting a lot	
• Blurting out answers	

Table 2.3 shows that there are key differences in the way that ADHD presents in boys and girls. The presentation in boys tends to be more disruptive and affect the social interaction with others, especially in the classroom context, while the presentation in girls tends to be inattentive and affect the personal interactions with others. These differences in presentations likely affect the way that they are diagnosed, and therefore the rate at which they are diagnosed (Martin, 2024).

ADHD is a lifetime condition that can lead to lifetime impairment affecting work, carrying out daily activities such as shopping and organising household tasks, making and keeping friends, and intimate relationships (Pitts et al., 2015). For children and young people in particular, ADHD can impact significantly on making and keeping friends, intimate relationships and their educational experiences and attainment, through its negative effect on the ability to regulate their activity and to evaluate their responses beforehand or subsequently. This can lead to exhortations from those who teach them to 'try harder' or 'learn to concentrate', which are impossible to fulfil and lead to behaviours that are viewed as problematic (Russell et al., 2023). Consequently, children with ADHD are eight times more likely to be excluded from school than those without ADHD (Parker et al., 2019). They are also disproportionately represented in the youth justice system (Russell et al., 2023).

There is no known cause of ADHD. However, there is a strong genetic heritability for ADHD, as the parent and siblings of someone with ADHD are more likely to have ADHD too (Faraone and Larsson, 2018), although there is no single specific gene that has yet been identified that causes ADHD. Estimates of heritability are at about 80% (Balogh et al., 2022), meaning that there is an 80% chance that someone with ADHD has inherited it from a parent. There are also environmental risk factors, many of which focus on maternal pre-pregnancy factors such as maternal pre-pregnancy obesity, maternal pre-pregnancy eclampsia, smoking during pregnancy and maternal drug and alcohol use in pregnancy (Kim et al., 2020). Psychologically, the existence of parental mental health problems has been seen as a risk factor for ADHD (Wüstner et al., 2019) as well as poor quality relationships within the family (Weyers et al., 2019), as ADHD is more prevalent in families where there are disruptive relationships.

Conduct Disorders (CD)

CD is a broad name for a range of different disorders that exhibit as repeated disruptive behaviours. NICE (2023) states that CD are characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age-appropriate social expectations. Often, there is little guilt or consideration of the actions taken. Oppositional defiant disorder (ODD) is perhaps the best-known CD. According to NICE (2023: 3a), CD 'are the most common mental and behavioural problems in children and young people', with a prevalence rate of 5%, and are also the most common reason for referral to CAMHS.

The difference between ADHD and CD is that while ADHD might be disruptive, it is not usually characterised by aggression and violence, which is the case for CD. NICE (2023) provides examples of CD behaviours as:

- Aggression towards people or animals.
- Destruction of property (for example breaking other children's toys, breaking windows or damaging cars).
- Deceitfulness or theft.
- Serious violations of rules (for example, children or adolescents repeatedly staying out all night despite parental prohibitions, repeatedly running away from home, or skipping school without permission).
- The behaviour must be recurrent with multiple incidents of the types of behaviours above, and persisting for at least a year.
- The behaviour results in significant impairment of personal, familial, social, educational, occupational or other important areas of functioning.

CD is likely to impair a child's development and bring increased risks in later life including antisocial behaviours, violence and criminal acts, substance misuse and gang involvement (Royal College of Psychiatrists, 2015). Later on in life, CD is associated with poor health, low educational attainment, work problems and interpersonal issues (Fairchild, 2018).

As with ADHD, there is substantial genetic heritability for CD, although not as high, at 40%–70% (Demontis et al., 2019). Again, little is known about how this genetic heritability works in practice. Environmentally, children with CD are likely to have experience of low parental education and bullying (Tesli et al., 2024), as well as permissive, neglectful and harsh parenting practices, low socioeconomic status and exposure to community violence (Chan et al., 2023). Furthermore, looked-after children, those who have been abused and those on child protection or safeguarding registers are more likely to have a CD diagnosis (NICE, 2023a). The psychological risk factors for CD are very similar to those for ADHD, such as parental mental health problems and poor-quality relationships within the family, as well as moderating impulsive behaviour (Chan et al., 2023). In addition, biological explanations have also been observed for CD, such as a lack of connectivity between the subcortical and cortical regions of the brain (ibid.).

A child or young person presenting with CD is doing so in a context of all of the risk factors. 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 4 about the Edlington case of two brothers who both had a diagnosis of CD.

Autism/Autistic Spectrum Disorders (ASD)

Autism, or ASD, is defined by NICE (2023b) as ‘qualitative differences and impairments in reciprocal social interaction and social communication, combined with restricted interests and rigid and repetitive behaviours, often with a lifelong impact’. This means that those living with autism communicate and interact with others and the world in ways that impact all of their life. This can affect how they learn about, behave in and respond to social situations. These differences can range from having mild effects, such as finding lights too bright, to severe effects requiring 24-hour care. This is why autism is described as a spectrum disorder, as it indicates that while sharing the same condition, there is a wide range of difficulties experienced in different ways. To exemplify, on a spectrum of 0–100 going from minor to severe effect, a social and communicative person would appear at zero. Further along the spectrum someone with a few autistic traits such as a need for routine would appear between 0 and 30. 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.

Estimates of the number of autistic people are that it affects 1 on 100 people, or 1% of the population, although this may be an underestimate due to difficulty in getting a diagnosis (National Autistic Society, 2024). It is more prevalent in boys than girls, although this may be due to successful ‘camouflaging’ of symptoms, such as through ‘assimilation’, ‘masking’ and ‘compensation’ (McQuaid et al., 2022).

People living with autism often display ritualistic interests and behaviours. These are usually evident from infancy, although they may not be recognised as such at that point. For example, repetitive playing with the same thing or drawing the same thing are often signs. Also, a lack of interaction or only monosyllabic interaction can also be evident, as well as not being able to bear physical touch such as hugs. When given hugs, autistic children may lash out, which may be seen as a sign of aggressive behaviour, but is only a response to not liking being touched. Autistic people often experience sensitivity to sounds, touch, tastes, smells, light or colours (National Autistic Society, 2013). There may also be accompanying learning disabilities. Autism is also often linked with other conditions, such as ADHD, epilepsy, intellectual disabilities and obsessive compulsive disorder (Matusiak, 2019).

Autistic traits can have positive as well as negative effects. For example, Russell et al. (2019) outline how participants described traits such as the ability to hyper focus, attention to detail, good memory and creativity as having both negative and beneficial outcomes in everyday life. Another trait is honesty: never ask an autistic person *'does my bum look big in this*?' if you are not prepared for an honest response, or if the truth is going to hurt! Similarly, language needs to be straightforward, if you ask a person living with Asperger's to 'hold your horses', i.e. slow down, you will have a puzzled response, wondering – where exactly are the horses? This orients autism as 'a difference not a deficit', and also as a crucial aspect of identity and not as something that is separate from identity.

The exact cause of autism is unknown, but it has been linked to a biological origin, specifically abnormalities in a part of the brain known as the amygdala. More recently, the focus has been on the combination of genetic factors through genetic mutations, and environment factors such as prenatal exposure to pollutants, maternal obesity or immune disorders as the cause of an increased risk of autism (Sauer et al., 2021).

Activity 2.6: Diagnosing Neuro-Developmental Conditions

Read the case study of Joshua below and consider what possible neuro-developmental diagnosis could have been made (ADHD, CD, ASD) from the initial assessment, and what needs to happen to ensure a correct diagnosis.

> Joshua is age 7 and has been referred for an assessment in Tier 2 CAMHS. He was referred by a paediatrician over concerns about aggressive behaviour (he had kicked the dinner ladies at school). Joshua has 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 from the first CAMHS meeting with him and his dad, it was very clear quite quickly 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 the practitioners in a conversational way and only in monosyllabic answers. He also spoke in an American accent. CAMHS 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.

SUMMARY

This chapter has provided a brief outline of key mental health conditions affecting children and young people. Three key points can be made from this chapter. First, while the range of conditions that children and young people can present with is broad and varied, it may be the case that the condition presented is a normal part of growing up and so practitioners have to be prepared to eliminate this possibility before diagnosing a specific mental health condition. This should only be done after a thorough consideration of the symptoms and possible alternative conditions. Never ask a young person 'what is wrong with you?', instead 'what has happened to you?'. Always maintain curiosity with compassion.

Second, there does appear to be a disparity between boys and girls in terms of the types of conditions that they are more likely to be diagnosed with. For girls, this is in the form of eating disorders, and for boys it is in the form of ADHD. However, more recent evidence is emerging that these disparities may be artefacts of measurement, expectations and culture, the best example of this being the difference in diagnosis rates in ADHD. Another possible reason for this is the stigma and shame that exists, meaning that people are less likely to come forward for diagnosis. The examples of eating disorders and ADHD above provide good examples of this again, but in a converse way this time. For boys, there is a stigma associated with having an eating disorder, and for girls there is a stigma associated with having ADHD. Practitioners need to be aware and careful that when making diagnoses, these artefacts of measurement are limited as far as is practicably possible and there is awareness of how this stigma and shame affects young people coming forward with conditions.

Finally, for many of the disorders, the cause is not clear or unknown. The cause is often a combination of genetic, environmental, psychological or biological factors, to greater or lesser extents. Investigation of all the possible causes of the condition that presents is essential to come to as accurate a diagnosis as possible, to provide the most effective treatment.

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