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Chapter 15

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646 Chapter 15 Child and adolescent psychiatry Introduction Child and adolescent psychiatry is a stimulating and varied specialty. Working with children, young people, and families across all ages and stages of de velopment with a multitude of different presentations, while at the same time

thinking about their difficulties in the context of the wider system, adds to the challenges and complexities of the specialty. Children and young people are an interesting, diverse, and, at times, challenging population with which to engage. Building a therapeutic relationship is essential for effective practice, and strategies used show a greater reliance on play, playfulness, imagination, and creativity. There is more of a focus on MDT working, and close liaison with other agencies and disciplines is also important. We now know that there is a strong association between adverse childhood experi ences and longer-term mental and physical health problems. Improving the mental health of infants, children, and young people is therefore one of the most important interventions for improving health globally, and child and adolescent psychiatrists are in an ideal position to lead the way in this field. The origins of Child and Adolescent Mental Health Services It is strange to think that until early into the twentieth century, children were essentially considered to be ‘small adults’; there was limited aware ness of concepts with which we are all now very familiar such as theories of cognitive and psychological development, effects of immaturity, attach ment theory, genetics, the impact of trauma, etc. Reflecting the ideas of the times, children with behavioural disorders were considered as having ‘moral problems’, which were treated with punishment. Also, the classification of mental health ‘derangements’ for young people was similar to those used for the adult population. Child psychiatry as a specialty began to develop in the early 1920s from the fusion of a number of disparate professions and agencies that had con tact with troubled young people, including the medical profession, educa tion, psychology, and the criminal courts. This led to the formation of child guidance clinics, established in response to an increasing awareness that psychological problems start in childhood and that early intervention is the best way to prevent future mental illness. The first child guidance clinic in Europe was founded in the East End of London in 1927, and thereafter their formation spread rapidly. These services tended to be community-based, with limited provision of hospital-based services. Early treatments focused on the psychoanalytic theories of Anna Freud and Melanie Klein and play therapy, with concurrent guidance being offered to the parent. The integra tion of behavioural approaches, family therapy, and psychopharmacology were later developments, reflecting advances in other areas of psychiatry. A subsequent merging of child guidance clinics and inpatient services in the 1970s led to the formation of community services, although these were still disparate and variable in their approach and organization. In the 1990s, a model was proposed of Child and Adolescent Mental Health Services (CAMHS) provision being organized into four different tiers, and this con tinues to be the present-day structure of services in the UK.

Introduction The term CAMHS is used in two different ways: • The first is a generic term for all services that support young people with emotional, psychological, and mental health difficulties. • The other applies more specifically to specialist CAMHS, identified as Tiers 2, 3, and 4 in the tiered concept of CAMHS. The remit of specialist CAMHS has expanded in many areas to provide input up to the age of 18 and, in some areas, to transfer care of young people with learning disabilities into CAMHS. The tiered concept of CAMHS • Tier 1—workers in primary care or universal services, e.g. GPs, health visitors, school nurses, social workers, teachers, youth workers, etc., who come into contact with young people and whose main role and training are not in mental health. • Tier 2—specialist mental health clinicians with training in child development who work individually with young people and their families, usually in community clinics. Their focus is on mild to moderate mental health difficulties and may include direct contact with young people or consultation to Tier 1. • Tier 3—clinicians working as part of an MDT who see young people with more complex, moderate to severe mental health problems, which may be of an acute onset or more chronic and

enduring in nature. Input can include consultation. • Tier 4—specialist teams working with young people with severe and/or complex difficulties requiring a combination or intensity of interventions that cannot be provided by Tier 3, e.g. specialist outpatient teams, day patient services, and inpatient units. The multidisciplinary team The importance of a multidisciplinary approach in child and adolescent psychiatry cannot be overemphasized. The professional groups repre sented in teams vary but may include psychiatry, psychology, nursing, family therapy, child psychotherapy, social work, OT, and speech and language therapy. A newer group of primary mental health workers has also been developed, largely operating at Tier 2, but having links with Tier 3 CAMHS. Within teams, the complementary skills and expertise that each profession brings to the assessment/treatment of a case is recognized, and reflecting this, there is often less of a sense of 'hierarchy' within the MDT, compared to other areas of psychiatry, while leadership is still maintained. Consultation Traditionally, specialist CAMHS has always offered consultation to other agencies that work with young people, helping to provide a mental health perspective on their difficulties, and this continues to be an important role for them. Whether providing direct or indirect input, there is a focus on CAMHS being part of a child-centred, integrated network of services, all working together to best meet the needs of the child or young person.

 Assessment 1: principles The biopsychosocial model This concept is central to the approach taken when working with a child or young person presenting with mental health or behavioural difficulties. It highlights that to be able to fully understand their difficulties and formu late an effective management plan, we need to consider the different bio logical, psychological, and social factors at play, which might be contributing to the young person's presentation in a variety of ways. It is important to remember that several factors may interact with each other too, giving rise to symptoms. It is helpful to hold the biopsychosocial model in mind throughout all stages of assessment and intervention. Children, young people, and their families It is unusual for a young person, especially a child, to come into contact with CAMHS at their own request. More commonly, they have been re ferred because someone else is concerned about them—often a parent, but sometimes a teacher or social worker—and the young person does not necessarily acknowledge they need help or agree to referral. It is important to remember this from the outset; the identified 'patient' may be a reluctant attendee at an appointment, experiencing a variety of different emotions, including anger and irritation about being 'dragged along', or fear and un certainty about what to expect, all of which have implications for fostering engagement and therapeutic relationships. The situation can be very similar where a family has been referred against their will to CAMHS by statutory agencies such as social work. Children and young people do not exist in isolation—they are dependent on others as caregivers and interact with other people as part of their daily lives, whether at home, at school, or as part of social activities. When carrying out an assessment of a young person's difficulties, it is important to gather additional information from people who know them well, while still working within the statutes of confidentiality and consent appropriate to that young person. Reflecting this, it is usual for a first assessment appointment to be at tended by a number of different people, usually at least a parent, siblings, and/or a close relative, although the family may also bring a neighbour, a social worker, a respected community figure, etc. These different people frequently have contrasting experiences of, and views about, the young person's problem and what they think needs to change. It can seem a daunting task at first, working to ensure that everyone present—including the young person—feels they have had the opportunity to be heard and say what they think is important. The clinician needs to be sensitive to any dynamics or tensions

arising within the interview and work to manage and contain these effectively, while at the same time remaining objective and somewhat ‘neutral’ (i.e. not being seen to be taking sides). It is useful to remember that while families usually attend their first ap pointment wanting help, they may also harbour feelings of failure, guilt, or blame about the young person having difficulties. They might find it awk ward having to talk about these or think they are being judged, and it is

Assessment 1: principles important to acknowledge this and let the family know they are being lis tened to and their concerns taken seriously. Also, it is not unusual at the start of an assessment for a parent to take this as an opportunity to offload their worry and feelings of frustration and anxiety, which can be heard by the young person as blaming and ‘pointing the finger’ at them. While it is important to acknowledge and reframe this as parental concern, the clin ician needs to demonstrate they are interested in hearing everyone’s point of view and are not ‘taking sides’. A little advance preparation is essential, thinking about the information given in the referral and the areas you want to cover in the first meeting; an interview that is structured and set at a pace that allows everyone to feel they are able to say what is important will help to contain a family’s anxieties much more effectively than one that is disorganized and unfocused. Being able to be flexible in your approach is a valuable skill in CAMHS. As was previously mentioned, we never know exactly who will attend a first appointment. Usually—but not always—the child or young person will come along, accompanied by an adult. However, it should not automatic ally be assumed this is a parent, and a potential faux pas can be avoided by asking the young person to tell you who they have brought along with them. Increasing diversity in society expands the notion of the ‘nuclear family ‘and includes single parents, same-sex parents, reconstituted families, kinship care, and professional foster care. In circumstances where a referral indicates prominent input from another agency, e.g. social work, it can be helpful to suggest they attend the appoint ment, too, both to support the family and to add to an understanding of their difficulties. Challenges to be mindful of A number of factors need to be kept in mind when thinking about how to gather the information required from a family most effectively. These include: • The age and developmental stage of the child—it goes without saying that a younger child will not be able to tolerate a lengthy interview and requires a different approach to an adolescent. • The presence of mental or physical disorder in the young person or a parent, e.g. hyperactivity, difficulties with memory, mobility problems. • Communication difficulties, e.g. hearing impairment. • Use of an interpreter if there is not a shared spoken language.

650 Chapter 15 Child and adolescent psychiatry Assessment 2: considerations Initial considerations • Introduce yourself, and find out who is in the room with you. Often the only information you have about attendees is the name of the referred child or young person; it can be helpful to use this as a means to engage the young person and invite them to tell you who they have brought with them. This also lets the young person know that you are interested in what they have to say. Remember, not all family members may share the same surname—it is useful to check this out in advance before making a mistake. • Take a few minutes to set the scene and orientate everyone to the purpose of the meeting, making reference to the initial referral and how long the appointment will last. This can make a huge difference, helping to allay anxieties and foster engagement. It can be helpful to reflect that many families are unsure about what to expect when they first attend CAMHS and to check out with individual family members how they felt about coming to the appointment. • Explain the format of the meeting, i.e. you asking the family questions and talking with everyone present to better understand the young person’s difficulties, and the outcome; this is usually a

letter to the referrer and/or GP, often copied to the family too. • It is important to raise the issue of confidentiality and its limits, particularly in relation to child protection concerns. Also, sometimes adults in the room do not want to talk about certain topics in front of other younger family members, and you should let them know that if this situation arises, they should indicate they would prefer to discuss these matters in private. Similarly, for adolescents, it is important to give them the opportunity to have some individual time with you (although not all take up this offer). • A 45-min meeting can seem a very long time for younger family members. It is helpful if age-appropriate toys and drawing materials are provided, with permission given for them to be used when people want to. This can give valuable clinical information about concentration and organizational skills, and it is always interesting to observe how the family negotiates the task of tidying up at the end of the session. It is important to remember that most young people are very good at multitasking, i.e. engaging in drawing and playing while, at the same time, listening to what others are talking about. • Some CAMHS teams like to gather information before an initial appointment, which can focus the assessment and help children and families feel heard, e.g. using the Development And Well-Being Assessment (DAWBA). Tips for taking a history • The pace and duration of the interview and communication styles used will vary greatly, depending on the ages of the young people present, but it is important to keep everyone as involved as possible throughout the interview. This can be achieved by checking out with different family members if they agree with what someone else has said or if they see things differently.

Assessment 2: considerations • Try to get a clear description of the problem as each person sees it; it may well be that there are a number of different views expressed which can then be explored further. Remember not to appear to be ‘taking sides’, but it is acceptable to challenge someone’s viewpoint, which then enables you to understand it better. • It is also important to ask about times when the problem is less in evidence and if there is anything the family have tried that helped, e.g. taking a firm stance with the young person, or the involvement of other agencies. • Asking about family composition and family history is a useful way to gather information about the relationships between different family members, their own upbringings, and any mental and physical health difficulties. Recording this as a genogram can be a helpful way of condensing a wealth of information into a more accessible, visual form. • Asking the young person about school, their hobbies/interests, and friendships shows you are interested in them and helps to get a good understanding of their general level of functioning. As with any psychiatric assessment, it is important to ask about any recent changes in functioning, including the presence of worries or fears, experiences of bullying, feelings of low mood or hopelessness, abnormal experiences, thoughts of self-harm/suicide, etc. Because of developmental immaturity, some may not be able to articulate their experiences, and corroborative information is essential. Also, remember that children and young people can present very differently when anxious, depressed, or psychotic, compared to adults. • The importance of gathering a detailed developmental history as part of a full assessment cannot be overemphasized; while it may be that this is not focused on at a first meeting, a careful developmental history obtained at a subsequent meeting can uncover a wealth of information about the origins of the problem. • With adolescents, remember to enquire about substance use and any forensic history (this may be something that is explored during individual time with the young person). Mental state assessment • Follows a similar framework to that used with adults, but with allowances made for the level of development. For children under the age of 12, you can still comment on what you have observed such as: the level of activity and attention; physical and cognitive development; the mood and emotional state; the quality of their social

interaction with family members (familiar people) and you (a stranger); and the response to boundary setting. • Notice how the family functions/interacts during the meeting; look out for patterns of communication, degrees of warmth, power dynamics, alliances between family members, etc. Is the young person's viewpoint validated or dismissed within the family? • Sometimes, a physical examination might be needed as part of the first meeting, e.g. low-weight anorexia, and it is usual to have a parent or other chaperone present for this.

652 Chapter 15 Child and adolescent psychiatry Assessment 3: practice points The importance of additional information • In addition to gathering corroborative information from family members, a full and comprehensive assessment usually involves obtaining consent from the young person or an adult to liaise with other agencies involved with them. Examples include: • School—remember, some young people present differently within the educational setting, compared to home, and classroom observation or conversation with teaching staff or the educational psychologist (if involved) is very useful. Also, some standardized rating scales, e.g. Connor's Questionnaires, are designed for teachers to complete. • Other caregivers—these include health professionals (e.g. the child's GP, a paediatrician, or the health visitor) and social agencies such as social work. The latter may have become involved in supporting the young person and/or their family on a voluntary or statutory basis. • Consider using rating scales appropriate to the age and stage of the young person [e.g. Connor's Questionnaire, Moods and Feelings Questionnaire, Children's Yale–Brown Obsessive–Compulsive Scale (CY-BOCS), Kiddie Schedule for Affective Disorders and Schizophrenia (K-SADS), as indicated]. • Sometimes it may be necessary to request additional assessments to get a better understanding of the young person's difficulties, e.g. speech and language, OT, neuropsychology, etc., or to arrange for physical investigations, e.g. haematology, biochemistry, chromosome studies, EEG, CT. Constructing a formulation and management plan • When beginning to formulate and construct a management plan, it is important to think about the young person's difficulties in terms of the biopsychosocial model (E The biopsychosocial model, p. 648) and to consider how these relate to the 5 Ps: Presenting problems, Predisposing, Precipitating, Perpetuating, and Protective factors (see Box 15.1). • It is often possible to identify areas of overlap in all domains, which then inform potential management strategies. • Remember to incorporate risk assessment within your management plan. Keeping the young person and their family involved in this process helps to ensure the best outcomes. Confidentiality, consent, and capacity Good medical practice principles of confidentiality and con sent extend across the age range and apply to children and young people.1,2,3 Effective communication involves listening carefully to the child or the young person and their family. Clear age-appropriate communication is important in ensuring the rights of children and young people. In general, 1 General Medical Council. 0–18 years: guidance for all doctors. M http://www.gmc-uk.org/guidance/ethical_guidance/children_guidance_contents.asp [accessed 13 July 2018]. 2 Mental Welfare Commission for Scotland. M http://www.mwcscot.org.uk/ [accessed 13 July 2018]. 3 Care Quality Commission. Mental Health Act. M http://www.cqc.org.uk/content/mental-health- act [accessed 13 July 2018].

Assessment 3: practice points most of what children and young people say can be kept confidential. Exceptions to this would be if there is a risk of serious harm to the child or young person or to someone else, or if there was a legal requirement to dis close certain information. If confidentiality has to be breached, it is always best practice to discuss this with the child and their family when possible. Clear documentation of discussions around confidentiality, consent, and

capacity is very important, and a multidisciplinary approach is best. The child protection team and legal advice should be sought early where any dif ficulties arise. The GMC in the UK has a useful document outlining doctors' responsibilities and giving guidance for working with 0- to 18-year olds.1 A young person aged over 16 is presumed to have capacity to consent to treatment, while a child aged under 16 can consent if they are deemed competent. Capacity involves assessing whether the child or young person understands what the treatment or investigation is, why it is needed, the pos sible outcomes of treatment, and what could happen if they do not receive treatment. A child can consent if they are able to understand and retain the information, weigh up the decision, and are able to communicate this back to others. Capacity assessments are decision-specific, and so a child may be able to consent to some aspects of their care and treatment, but not to others. Points to remember • If a child is unable to consent, then parental consent can be used. • For 16- and 17-year olds in England, Wales, and Northern Ireland, parents can consent to treatment that is in the young person's best interest. In Scotland, 16- and 17-year olds who do not have capacity to consent can be treated under the Adults with Incapacity (Scotland) Act 2000. • Emergency treatment can be given without consent, to save a child or young person's life or to prevent serious deterioration in their health. • A parent cannot override a decision that a competent child makes which clinicians think is in their best interest. • The Mental Health Act should generally be used for any patient treated against their will for a mental disorder. • Different legislation exists in different parts of the UK. Box 15.1 Formulation—the 5Ps approach Formulation is one of the key skills required in child and adolescent psych iatry. It is about collaboratively making sense of someone's story to create a meaningful representation, which helps both understanding and man agement. Commonly, the 5Ps approach is used: • Presenting problems—the reasons for consulting in the first place. • Predisposing factors—which lead a person to be vulnerable to mental health problems such as genetics, family history, and temperament. • Precipitating factors—which trigger the problems such as stress, substance misuse, and trauma. • Perpetuating factors—which keep the problem going such as maladaptive coping strategies/styles and ongoing precipitating factors. • Protective factors—which reduce the effect of mental health problems such as resilience, strengths, and social support.

654 Chapter 15 Child and adolescent psychiatry Development Infancy Brain development begins in utero, and in the first few years of life, the brain goes through a fascinating period of rapid growth and development. Positive attachment to a caregiver, stimulation, and nurturing are crucial for development. Both genetic and environmental factors influence brain de velopment and the strength of nerve networks and pathways. Myelination seems to follow a particular pattern through different brain regions, and this is reflected in patterns of physical, social, and emotional development. Childhood By the age of 5 or 6, the brain will be at around 90% of its adult weight. Childhood is a time of transition and change, and this brings with it social complexity and both physical and cognitive demand. Childhood experi ences shape the structure of the brain, and so learning, social interaction, play, and positive relationships and attachments are crucial at this time. Adolescence The WHO identifies adolescence as the period in human growth and de velopment that occurs after childhood and before adulthood. It is a time of rapid development and is distinct from being a 'mini-adult'. The average age of onset of puberty has fallen, and this means that particularly in the developed world, individuals achieve physical and sexual maturity before they assume adult roles. There are a number of biological, psychological, and social changes that occur over these years, and it is a time of transition and adaption for young people and those around them. This time of change involves both exploration and experimentation of rules,

boundaries, and expectations. Coupled with changes in brain development, this can bring with it positive experiences, but also vulnerability and risk. Brain development continues throughout childhood, adolescence, and young adulthood, and we are learning more about this though structural and functional imaging. Some of the biggest changes in adolescent brain development are in the prefrontal cortex, to do with cognitive processes, planning, impulse control, and risk-taking. The limbic system, which is asso ciated with memory and emotion, is also under development at this time. This goes some way to explaining the experience of adolescence. The ado lescent brain goes through both a period of synaptic pruning, where lesser- used brain connections are removed, and a process of myelination where nerve connections are strengthened. This process can be influenced by bio logical, environmental, social, and emotional experiences. There is growing evidence that stress during this sensitive period of development can affect neural connections, and therefore brain maturation. Stress during this im portant period can contribute to the development of mental illness and may be significant in the vulnerability to disorder.

Development Assessing development Assessment involves thinking about children in the context of their age and stage of development. Every child or young person needs to be seen within the context of their family and society as a whole. Each child is unique, but there are developmental pathways, norms, and milestones which can be used as a guide in assessment. A child may exhibit behaviour that is out with the conventional norms without having any disorder or difficulty. However, it is essential to hold in mind a normal developmental trajectory when assessing children, young people, and their families, taking into account ethnicity, culture, and religion. Thinking about development includes thinking systemically about transitions and change, both for the individual and for those around them. In assessing a child's development, it is helpful to consider: • Physical development: gross and fine motor. • Language: expressive and receptive. • Emotional development: recognition and differentiation, expression, and regulation. • Social development: social reciprocity, play, awareness of cues, sharing, friendships, and communication. • Theory of the mind: the idea that another has a separate mind with separate thoughts and feelings. Being able to 'tune in' to others. Develops over time, but most have by the age of 4. For further information, see 'Sally Anne test' in Baron Cohen et al.4 • Cognitive development: understanding, problem-solving, memory, rationalizing, conceptualizing, inference, development of schemas. For further reading, see the work by Jean Piaget,5 although bear in mind this is largely based on observation of his own children. • Moral development: involves pro-social behaviour, empathy, right and wrong, justice, responsibility, and reasoning. For further reading, see Kohlberg's stages of moral development.6 'You see a child play, and it is so close to seeing an artist paint, for in play a child says things without uttering a word. You can see how he solves his problems. You can also see what's wrong.' Erik Erikson 4 Baron-Cohen S, Leslie AM, Frith U (1985) Does the autistic child have a 'theory of mind'? Cognition 21:37–46, 5 Piaget J (1936) Origins of Intelligence in the Child. London: Routledge & Kegan Paul. 6 Kohlberg L (1984) The Psychology of Moral Development: The Nature and Validity of Moral Stages (Essays on Moral Development, Volume 2). San Francisco, CA: Harper & Row.

656 Chapter 15 Child and adolescent psychiatry Resilience Definition 'Resilience refers to the process of, capacity for, or outcome of, successful adaptation despite challenging or threatening circumstances.' Masten et al. 1990. Resilience and development: Contributions from the study of children who overcome adversity. Development and Psychopathology. 1990;2:425–444. (See Fig. 15.1.) Nature and nurture Not all children experience adversity in the same way, and the

concept of ‘orchids and dandelions’ has been used to illustrate this. Orchids are sensi tive flowers that can struggle when not treated well but flourish in optimal conditions, while dandelions seem to bloom wherever they grow. This con fers the notion of genetic risk but also highlights that the most sensitive children can thrive in the right environment. This may also go some way in helping us think about why some children develop mental health problems and others do not, despite significant adversity. Interventions or strategies to promote resilience and the ability to ‘bounce forward’ is therefore an important task for anyone working with children or young people in the prevention and treatment of mental health problems. Factors promoting resilience • Child: easy temperament and good nature; ♀ gender (prior to adolescence) and ♂ gender (during adolescence); higher IQ; good social skills; feeling of empathy with others; sense of humour; attractiveness to others; awareness of strengths and limitations; sense of identity and agency; positive values; good self-esteem and self- efficacy; good problem-solving skills.7 • Family: secure base; warm and supportive caregivers; good parent–child relationship; parental harmony; a valued social role, e.g. helping siblings; where parental conflict exists, a close relationship with one parent or other attachment figure. • Environment: supportive extended family; successful school experiences; valued social role, e.g. job, volunteering, helping neighbour; a close relationship with an unrelated mentor; membership of a religious or faith community; extracurricular activities. 7 Belsky J, Pluess M (2009) Beyond diathesis-stress: differential susceptibility to environmental influ ences. Psychol Bull 135:885–908.

Resilience Resilience Adversity Vulnerability Protective Environment Fig. 15.1 The Resilience Matrix. Source: data from The Child’s World: Assessing Children in Need, Training and Development Pack (Department of Health, NSPCC and University of Sheffield 2000).

658 Chapter 15 Child and adolescent psychiatry Attachment John Bowlby laid the foundations for the development of the attachment theory. Early relationships with attuned, responsive, and available caregivers are crucial to an infant’s brain development and help them to get a sense of who they are, explore the world around them, and develop a positive in ternal working model of a relationship. Good-quality relationships, based on sensitive, reliable, and consistent caregiving, help children build a positive at tachment or bond with the people closest to them. At times of stress, infants seek comfort and soothing. If they receive attuned care, their levels of stress hormone decrease. Children who do not have caregivers able to help soothe distress can have high levels of cortisol, which can cause damage to neurons. A child’s ability to safely understand and regulate their emotions, understand the emotions of others, and trust in relationships can also be greatly affected.8 Mary Ainsworth (1970)9 devised the Strange Situation experiment with 12- to 18-month-old infants, which categorized infant–parent relationships into three distinct groups: secure, insecure avoidant, and insecure ambiva lent. This experiment involves separations and reunions with caregivers and observes response. A fourth category, disorganized, was added by Mary Main in 198610 (see Table 15.1). It is important to remember that categorizing attachment is based on the relationship, and not the child. A child can have a secure attachment with one person and an insecure attachment with another. For further informa tion, watch Tronick’s’ Still face’ video11 and Ainsworth’s Strange Situation experiment. Reactive attachment disorder Reactive attachment disorder (RAD) is an under-recognized and under- diagnosed disorder, which is associated with significant psychiatric comorbidity. It describes a difficulty in social relatedness and functioning, often associated with maltreatment. ICD-10 describes two forms of RAD: the inhibited, emotionally withdrawn, hypervigilant type and the dis inhibited, indiscriminately friendly

type. There is also emerging evidence for coexistence of these types in some children. DSM-5 describes two distinct disorders: RAD (inhibited form) and disinhibited social engagement dis order. These have been placed in a new chapter ‘Trauma- and stressor- related disorders’, which groups childhood- and adult-onset trauma- and stressor-related disorders together (ICD-11 also places RAD and disinhib ited social engagement disorder in a new section ‘Disorders specifically as sociated with stress’). 8 National Institute for Health and Care Excellence (2015) Children’s attachment: attachment in chil dren and young people who are adopted from care, in care or at high risk of going into care. NICE guide line [NG26]. M http://www.nice.org.uk/guidance/ng26 [accessed 13 July 2018]. 9 Ainsworth MD, Bell SM (1970) Attachment, exploration and separation: Illustrated by the behavior of one-year-olds in a strange situation. Child Dev 41:49–67. 10 Main M, Solomon J (1986) Discovery of a new, insecure-disorganized/disoriented attachment pattern. In: Yogman M, Brazelton TB (eds). Affective Development in Infancy, pp. 5–124. Norwood, NJ: Ablex. 11 Tronick E, Als H, Adamson L, Wise S, Brazelton TB (1978) The infant’s response to entrap ment between contradictory messages in face-to-face interaction. J Am Acad Child Psychiatry 17:1–13.

Attachment As recognition of attachment difficulties has slowly i, so too has the availability of attachment-based interventions that are developing a growing evidence base. Examples of attachment-based interventions include: video interaction guidance, attachment and bio-behavioural catch-up, circle of se curity, parent child/infant psychotherapy, and therapeutic play. Table 15.1 Attachment styles

Attachment style Percentage of children Features in strange situation Secure 60–70 Distressed by separation but can quickly be soothed on reunion. Associated with attuned parenting Insecure-avoidant 15–20 Seems unconcerned at separation or reunion. Associated with unresponsive parenting Insecure- ambivalent 10–15 Distress at separation and resistance to comfort on caregiver return. Associated with inconsistent parenting Disorganized 5–10 Confused and at times contradictory behaviour as if does not know what to do. Often associated with maltreatment or parental trauma

660 Chapter 15 Child and adolescent psychiatry Infant mental health The first years of life are times of active and dynamic brain development where neural connections and pathways are made, providing the founda tions for future physical, emotional, and social well-being. There is mounting evidence that suggests that neglect and maltreatment disrupts the structure, biochemistry, and functioning of the brain. Maltreatment and adverse life experiences in childhood are associated with poorer outcomes, including enduring physical and mental illness.12,13 Very young babies do not show the classical signs of mental illness, but they reveal a wide range of emotions through their behaviour. Classification systems for early years do exist such as the DC 0-5 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood). By the pre-school period, however, disorders more typical of later stages of development are evident.14 Most infant mental health problems can be understood in terms of dis turbances in early relationship experiences. Sensitive and attuned caregiving is crucial to the development of secure attachments, which support infants to explore, interact, and relate to their wider world, express feelings, and learn how to regulate emotions safely. One of the most important inter ventions in infant mental health is therefore ensuring they receive this kind of care as soon as possible. Interventions targeting the parent/carer–infant relationship can be successful, lead to healthy brain

development, and have a growing evidence base, and therefore rely on professionals recognizing mental health problems in this age group. Awareness and identification of infant mental health problems, as well as knowledge and skills in effective intervention, are an important component of training in psychiatry and in other specialties that come into contact with infants. The field of infant mental health is growing, and the potential to help change children's trajec tory is enormous. 'Recovery from the effects of early maltreatment can be rapid and remarkable if safe nurturing care is achieved early enough—ideally in the first year of life and because the window of opportunity for this kind of recovery is small, early identification and focused intervention are imperative.' NSPCC 2016 12 Felitti VJ, Anda RF, Nordenberg D, et al. (1998) Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med 14:245–58. 13 Teicher M, Samson J (2016) Annual Research Review: enduring neurobiological effects of child hood abuse and neglect. J Child Psychol Psychiatry 57:241–66. 14 Egger HL, Angold A (2006) Common emotional and behavioral disorders in preschool chil dren: presentation, nosology, and epidemiology. J Child Psychol Psychiatry 47:313–37.

662 Chapter 15 Child and adolescent psychiatry An approach to behavioural problems Sometimes children and young people present with behavioural problems, rather than complaints of stress or depression. They may not have the ne cessary level of development to recognize and then express these feelings; and they are sometimes brought to services, rather than referring them selves; therefore, it is the observable problem, i.e. the behaviour, that is presented. Differential diagnosis of various behavioural 'symptoms' Common behavioural presentations include; hyperactivity, inattention, separation problems, moodiness, peer/social problems, aggression/ oppositionality, sexually inappropriate behaviour, regressed behaviour, somatization, tantrums, and rituals. Since individual symptoms can occur in more than one disorder, it is worth considering a differential diagnosis for the presenting behavioural symptom. It is also extremely important to differentiate a clearly maladaptive behav iour from one that is developmentally or situationally appropriate. 'Normal' behaviours also include those that form part of the child's expected testing and experimentation of the world. Assessment of behavioural disorders—general principles • Identify the problem behaviour/s—obtain a full description (from parents, child, teachers, etc.) of the problem behaviour/s. This should include the evolution of the behaviour, a chronology of the child's typical daily activities, the setting in which the behaviour occurs, its effects on family, school, relationships, etc., and attitudes of others to the behaviour/s. It is always important to speak to the child alone (if possible) to establish their views, desires, and mental state. • Think about other difficulties—assessing for other psychiatric disorders is important, and they can often be masked by the presenting problems. Use of a questionnaire, such as the DAWBA, can be very useful and avoid the situation where the entire assessment interview is taken up with hearing various versions of the same behaviour, while not getting a chance to hear about other symptoms such as fears, obsessions, compulsions, tics, etc. • Determine the parental strategy—it is important to find out how the parents deal with the behaviour/s. Do they agree with each other? This also includes information about their expectations, philosophy of parenting, interpretation of the behaviour/s, and moral, religious, and cultural views on parenting, etc. How do the parents react or respond to the behaviour/s? How do they discipline or punish? What do they tolerate? Are they permissive or restrictive? Are they over-protective or uninvolved? Do they feel empowered or impotent, helpless,

and incompetent as parents? How do they manage their frustrations, anger, etc.? What coping mechanisms do they have? • Family history and dynamics—as well as gathering a full family history of health, psychiatric problems, social and cultural circumstances, and support structures, it is also important to assess parental and sibling relationships, the presence of any significant stressors or losses, and how the problem behaviour interacts with family dynamics.

An approach to behavioural problems • Social behaviour—the evolution of the child's social, including social developmental, behaviour, attachment behaviour, imaginary play, reading of social cues, relationships, and language use. • School behaviour—attendance, changes in school, separation issues, performance, peer and teacher interactions and responses, friendships, bullying, etc. • Child's health and development—pregnancy, birth, and developmental milestones. Was the child planned? How did siblings react? How did parents and siblings cope? Any postpartum problems? Was any professional support required? Also, child's temperament, illnesses, treatment, etc. • Direct observation of parent–child interaction—during the interview, it is important to note how the child behaves and how parents respond and interact with the child. If siblings can be present, their behaviour and interactions can also be evaluated. A home and/or school visit may add additional information about the behaviour in these settings. • Collateral information—teachers, extended family, and social services may be able to provide important input, and permission should be sought to contact and involve them where appropriate. • Getting a sense of the antecedents, behaviour, and consequences (ABC charts)—can be a useful tool to use with families. Management This will be informed by the assessment, but generally it is useful to help the child and family understand the thoughts and feelings contributing to the behaviour. This aids in both reducing negative interpretations of the behav iour and in helping to change the problem behaviour. More specific man agement issues are addressed under topic headings. Prevention is covered in Box 15.2. Box 15.2 Prevention strategies and policy implications • Preschool child development programmes—identifying parents/families at risk and instituting home visits and support. • School programmes—identifying children at risk and instituting classroom enrichment, home visits, and parent and teacher training. • Community programmes—identifying children and adolescents through their involvement with social agencies and instituting interventions such as enhanced recreation programmes, parent training, and adult mentoring of youth. • Social and economic restructuring—to reduce poverty and improve family and community stability.

664 Chapter 15 Child and adolescent psychiatry Conduct disorders Conduct disorders (CDs) are characterized by a repetitive and persistent pattern of antisocial, aggressive, or defiant behaviours that violate age- appropriate societal norms.15 CDs can be divided into CD and oppositional defiant disorder (ODD). DSM-5's 'Disruptive, impulse-control, and con duct disorders' groups CD and ODD with intermittent explosive disorder, antisocial personality disorder, pyromania, and kleptomania, whereas ICD- 11 places them in their own section 'Disruptive behaviour or dissocial dis orders' (E [ICD-11 proposals vs DSM-5, p. 1121). Conduct disorder Epidemiology More common in boys and urban populations. Prevalence 5–7% in the UK. Clinical features Depend on age/stage of the child: aggression/cruelty to people and/or ani mals, destruction of property, bullying, deceitfulness, lying/blaming others, theft, fire setting, truancy/running away from home, severe provocative or disobedient/defiant behaviour, forced sexual activity, use of a weapon. Behaviours significantly impact on family, peer relationships, and schooling. ICD-10 3+ features from the severe category, one of which must have oc curred for 6mths. Subtypes: confined to family context, unsocialized,

and socialized. DSM-5 requires three characteristic features over 12mths, with one for at least 6mths, and has a specifier ‘limited pro-social emotions’, i.e. callous and unemotional interpersonal style across multiple settings/rela tionships (associated with severe CD). Associations Social disadvantage: poverty, low socio-economic class, overcrowding, homelessness, social isolation, high rates of deviancy, truancy, unemploy ment. Parenting: parental criminality, parental psychiatric disorder and substance misuse, inconsistent and critical parenting style/attachment dif ficulties, parental conflict, domestic violence, child maltreatment. Child: possible genetic role, perinatal complications, low IQ, neurodevelopmental problems, brain damage, epilepsy, temperament, attachment problems, and poor interpersonal relationships. Comorbidity ADHD; learning difficulties (especially dyslexia); substance abuse; depres sion; anxiety disorder; ASD. Differential diagnosis Adjustment disorder; ADHD; ASD; normal child (but parents/teachers have unrealistic expectations); PTSD; anxiety disorder; depression; learning difficulty; psychosis. 15 National Institute for Health and Care Excellence (2013) Antisocial behaviour and conduct disorders in children and young people: recognition and management. Clinical guideline [CG158]. M https://www.nice.org.uk/guidance/cg158/ [accessed 13 July 2018].

Conduct disorders Course and outcome • Can be a persistent disorder, especially when onset younger. Many with adolescent onset do not develop antisocial features as young adults. • Around half will receive a diagnosis of antisocial personality disorders as adults. Substance misuse, mania, schizophrenia, OCD, major depressive disorder, and panic disorder are also seen in adult life. There is an i risk of early death, often by violent and sudden means. • i risk of social exclusion, poor school achievement, long-term unemployment, criminal activity, and poor interpersonal relationships, including those with their own children. Assessment • See the family and child, and establish a positive therapeutic relationship. • Full history, with collateral from the school, social worker, and legal system. • Consider use of the Strengths and Difficulties Questionnaire (SDQ).16 • Identify causal, risk, and protective factors—including comorbidity, e.g. ID, mental illness, neurodevelopmental disorder, and substance misuse. • Formulate the problem, and establish a management plan. Management of conduct disorder This will be planned on a case-by-case basis and is likely to require multi- agency communication and cooperation. Possible components include: • Parent management training (PMT) (E Parent management training, p. 673). NICE recommends group-based parent training/education programmes in children aged 12yrs or younger, e.g. Webster–Stratton incredible years programme, positive parenting programme (Triple P). Individual-based programmes are recommended only where there are difficulties in engaging with the parents or where the needs are too complex to be met by group programmes. • Functional family therapy. • Multisystem therapy—family-based, including school and community. Highly resource-intensive, but good outcomes (see Box 15.2). • Child interventions—social skills, problem-solving, anger management, confidence building. • Treat comorbidity, e.g. ADHD. • Education—liaison with the school regarding additional support needs. • Address child protection concerns (E Child maltreatment 2: the duty of care, p. 714). • Do not routinely prescribe medication—with specialist advice, risperidone can be considered for short-term management of severely aggressive behaviour (e.g. explosive anger, severe emotional dysregulation) when psychosocial interventions are unsuccessful. Discontinue if no improvement in 6wks. 16 SDQ. M http://bjp.rcpsych.org/content/177/6/534 [accessed 13 July 2018].

666 Chapter 15 Child and adolescent psychiatry Oppositional defiant disorder Essence An enduring pattern of negative, hostile, and defiant behaviour, without serious violations of societal norms or

the rights of others, usually in children aged <10yrs. DSM-5 recognizes three types: angry/irritable mood, argumentative/defiant behaviour, and vindictiveness; has no CD exclusion cri teria; specifies behaviour must occur most days for 6mths (if <5yrs) or once a week for at least 6mths (if >5yrs); and recognizes mild/moderate/severe forms. Behaviour may occur in one situation only (e.g. home) and be most evident in interactions with familiar adults or peers. Epidemiology More common in boys and in childhood, rather than in adolescence. Prevalence 2–5%. Outcome 25% show no symptoms later in life, but many progress to CD and/or substance abuse. Management Same management principles as for CD.

Conduct disorders 667

668 Chapter 15 Child and adolescent psychiatry Attention-deficit/hyperactivity disorder 1: overview ADHD is characterized by the three core symptoms of inattention, hyper activity, and impulsiveness. ICD-10 describes these symptoms together as hyperkinetic disorder, while DSM-5 (and ICD-11) recognizes three sub types: a combined subtype where all three features are present, an inatten tive subtype [attention deficit disorder (ADD)], and a hyperactive–impulsive subtype. Symptoms should be at developmentally inappropriate levels and be present across time and in different situations (e.g. home and school) for at least 6mths, and starting before 7yrs (DSM-5 criteria now state several inattentive or hyperactive–impulsive symptoms present before the age of 12yrs and allows for diagnosis in adults). Five per cent of UK schoolchil dren would meet DSM-5 ADHD diagnostic criteria, and 1% would meet criteria for ICD-10 hyperkinetic disorder. It is at least 2–3 times more common in ♂. Aetiology ADHD has a heritability of 70–80%, and the risk of ADHD in siblings is 2–3 times i. Rates are i in low-birthweight babies, in babies born to mothers who used drugs, alcohol, or tobacco during pregnancy, following head in jury, and in some genetic and metabolic disorders. Differential diagnosis Age-appropriate behaviour in active children; attachment disorder; hearing impairment; learning difficulty; high-IQ child insufficiently stimulated/chal lenged in mainstream school; behavioural disorder; anxiety disorder; medi cation side effects; brain injury. Comorbidity ADHD is highly comorbid, with 50–80% of children having another dis order, including: specific learning disorders, motor coordination problems, ASD, tic disorders, CD, ODD, substance abuse, anxiety, depression, and bipolar disorder. Clinical features • Inattention—careless with detail, fails to sustain attention, appears not to listen, fails to finish tasks, poor self-organization, loses things, forgetful, easily distracted, and avoids tasks requiring sustained attention. • Hyperactivity—most evident in structured situations, fidgets with hands or feet, leaves seat in class, runs/climbs about, cannot play quietly, and ‘always on the go’. • Impulsiveness—talks excessively, blurts out answers, cannot wait turn, interrupts others, and intrudes on others. Problems associated with ADHD • Short-term: sleep problems, low self-esteem, family and peer relationship problems, reduced academic achievement, and i risk of accidents.

Attention-deficit/hyperactivity disorder 1: overview • Longer term: development of comorbid problems (E Comorbidity, see opposite), reduced academic and employment success, i criminal activity, and antisocial personality disorder. ADHD symptoms may persist into adulthood (20–30% with full ADHD syndrome, and 60% with one or more core symptoms). Impulsivity–hyperactivity remits early, while inattention often persists. Studies show a pattern of psychopathology, cognition, and functioning in adults similar to that in children and adolescents. A poorer prognosis is associated with social deprivation, high-expressed emotion, parental mental illness, predominantly hyperactive–impulsive symptoms, CD, learning difficulty, and language disorder. Assessment •

Interview the family and child. • Observe the child, preferably in more than one situation, e.g. clinic and school. • Collateral information from the school and other involved parties. • Rating scales may be useful, e.g. Connor's rating scale, SDQ. • Screen for comorbidity. • Physical examination, including neurological examination. Management • Psychoeducation. • Medication (E Attention-deficit/hyperactivity disorder 2: medication, p. 670). • Behavioural interventions, e.g. encouraging realistic expectations, positive reinforcement of desired behaviours (small immediate rewards), consistent contingency management across home and school, breaking down tasks, reducing distraction. • School intervention/liaison. • Treat comorbidity. • Evidence base for dietary changes and fish oils poor at present. • Voluntary organizations/online resources, e.g. the Attention Deficit Disorder Information and Support Service (ADDISS) (M http:// www.addiss.co.uk, accessed 13 July 2018)—information and resources about ADHD for parents, sufferers, teachers, and health professionals; ADDers (M http://www.adders.org, accessed 13 July 2018)—ADHD online information. • Controversy is covered in Box 15.3. Box 15.3 Controversy of ADHD The concept of ADHD has been criticized as medicalizing a social problem. It is said to be over-diagnosed and that it undermines parents. The long-term benefits of medication remain unclear. Nevertheless, there is recognition that symptoms can continue into adult life and that, un treated, there are poor outcomes. Children and their families who have experienced a good response to medication usually want to continue with it despite long-term uncertainty.

670 Chapter 15 Child and adolescent psychiatry Attention-deficit/hyperactivity disorder 2: medication The currently available drug treatments for ADHD are symptomatic—they treat the core symptoms but do not cure them. Seventy per cent of affected children will show symptomatic response to medication, as demonstrated by: i on-task behaviour; reduced fidgeting, finger-tapping, and interrupting; reduced impulsiveness; i performance accuracy; reduced aggression; im proved compliance; improved parent–child interactions; and improved peer status. Commonly prescribed drugs Methylphenidate A CNS stimulant licensed for treatment of ADHD in children over 6yrs. Available as an immediate-release preparation lasting around 4hrs (Ritalin®, Medikinet®, Tranquilyn®), and as modified-release preparations lasting 8 or 12hrs (Equasym XL®, Concerta XL®, Medikinet XL®, Xenidate XL®, Xaggitin XL®, Matoride XL®, Delmosart XL®, Ritalin- SR®). Modified-release preparations have the advantage that the medication does not need to be administered at school. Side effects: abdominal pain; nausea and vomiting; dry mouth; anxiety; insomnia; dysphoria; headaches; anorexia; and reduced weight gain. Growth suppression may be a long-term outcome of high doses over long periods—growth monitoring is advised. Dexamfetamine/lisdexamfetamine (Elvanse®, Amfexa®, Dexedrine®) A CNS stimulant licensed for the treatment of ADHD in children whose symptoms are refractory to other drugs. Side effects: similar to those of methylphenidate. Atomoxetine (Strattera®) A non-stimulant NARI licensed for the treat ment of ADHD. Taken od, providing 24-hr cover. May take up to 6wks to have full effect. Side effects: anorexia; dry mouth; nausea and vomiting; headache; fatigue; dysphoria; jaundice (liver damage); and suicidal thoughts. Guanfacine (Intuniv®) A non-stimulant α2a receptor agonist. Indicated in children for whom stimulants are not suitable, not tolerated, or ineffective. Side effects: sedation, hypotension, bradycardia, GI side effects, depression, mood lability, and anxiety. Clonidine α2 agonist. Unlicensed for this use in children. Side effects: hypotension; bradycardia; sedation, dizziness, and risk of rebound hyper tension if stopped suddenly. Principles of prescribing in ADHD • The diagnosis of ADHD should be based on a comprehensive assessment conducted by a psychiatrist or a paediatrician with expertise in ADHD.17 It should also involve the child, parents, and carers, and the child's school, and take into account cultural factors in the child's environment.

• Multidisciplinary assessment, which may include educational or clinical psychologists and social workers, is advisable for children who present with indications of significant comorbidity. 17 National Institute for Health and Care Excellence (2018) Attention deficit hyperactivity dis order: diagnosis and management. NICE guideline [NG87]. M https://www.nice.org.uk/guidance/NG87 [accessed 13 July 2018].

Attention-deficit/hyperactivity disorder 2: medication • The use of ADHD medication should be part of a comprehensive treatment programme involving advice and support to parents and teachers and which could include specific psychological treatments. While this wider service is desirable, any shortfall in its provision should not be used as a reason for delaying the appropriate use of medication. • ADHD medication should only be initiated by psychiatrists or paediatricians with expertise in ADHD, but continued prescribing and monitoring may be performed by GPs, under shared-care arrangements with specialists. • The choice of drug should be guided by: the presence of comorbid conditions; the different adverse effects of the drugs; specific issues regarding compliance identified for the individual child or adolescent; the potential for drug diversion and/or misuse; and the preferences of the child or adolescent and/or their parent or guardian. If there is a choice of more than one appropriate drug, the drug with the lowest cost is prescribed. • Caution is required in prescribing for children and young people with epilepsy, psychotic disorders, or a history of drug or alcohol dependence. • Prior to commencing medication, height, weight, pulse, and BP should be obtained and plotted in centile charts where appropriate. A history should be gathered for any significant past medical history, family history, and symptoms of syncope or breathlessness. A full cardiovascular examination should be carried out. An ECG should be carried out if there is any personal or family history of cardiac problems or any abnormal physical signs. • Careful titration is required to determine the optimal dose level and timing. The medication should be discontinued if improvement of symptoms is not observed after appropriate dose adjustment. • Regular monitoring is required. When improvement has occurred and the child's condition is stable, treatment can be discontinued at intervals, under careful specialist supervision, in order to assess both the child's progress and the need for continuation of therapy. Medication monitoring • Most adverse effects will disappear within a couple of weeks. • There have been some concerns about small growth restriction in children taking psychostimulants, With this in mind, some children choose to have 'drug holidays' in order to catch up in terms of growth. • Appetite suppression is a common side effect from stimulants, and children should have their weight monitored very carefully and dietitian advice sought, if necessary. Children and young people should be monitored for height, weight, BP, and pulse in the initial medication titration and then 6-monthly once on a stable dose. • If there are difficulties with insomnia, melatonin is sometimes helpful for young people with neurodevelopmental problems.

672 Chapter 15 Child and adolescent psychiatry Attention-deficit/hyperactivity disorder 3: adults ADHD tends to improve with age but can continue into adulthood.18,19 Over-activity often lessens, but impulsivity, poor concentration, and risk- taking can worsen. Problems arise with work, education, family, and so cial interactions. Comorbid depression, anxiety, low self-esteem, and drug misuse are common. Adults presenting with symptoms of ADHD in pri mary care or general adult psychiatric services, who do not have a child hood diagnosis of ADHD, should be referred for assessment by a mental health specialist trained in the diagnosis and treatment of ADHD or a spe cialist service, if locally available. Points to note (E Neurodevelopmental disorders in adulthood, p. 136.) • Drug treatment for adults with ADHD should always form part of a comprehensive

treatment programme that addresses psychological, behavioural, and educational or occupational needs. • None of the currently available drug treatments are licensed for initiation in adults, although atomoxetine is licensed for continuation treatment into adulthood. • It would be unusual to stop other effective treatments just because an individual has turned 18 yrs old. • Most guidelines suggest methylphenidate as first-line treatment for adults, provided it is not contraindicated. • The need for long-term medication should be closely monitored and reviewed at least annually. • Specific guidance on dosing can be found in NICE guideline NG8720 and the BNF. 18 Royal College of Psychiatrists (2015) ADHD in adults (a useful leaflet that can help signpost newly diagnosed adults. M http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/adhdinadults.aspx [accessed 13 July 2018]. 19 The UK Adult ADHD Network (M http://www.ukaan.org. accessed 13 July 2018) is a pro fessional body that supports the NICE guidelines and looks to establish clinical services for adults in the UK. 20 National Institute for Health and Care Excellence (2018) Attention deficit hyperactivity dis order: diagnosis and management. NICE guideline [NG87]. M https://www.nice.org.uk/guidance/ NG87 [accessed 13 July 2018].

Parent management training Parent management training PMT has, until very recently, been described as a group of treatment pro cedures in which parents are trained to modify their child's behaviour.21 More recent definitions of PMT encompass its broader power in improving communication within families. PMT is not simply about generically chan ging a child's behaviour, which is achieved mostly by improving the quality of communication within the family. More importantly, PMT helps foster meaningful mutual understanding within the family and helps create an en vironment that fosters healthier psychological development for children. The treatment is conducted primarily with the parents/caregivers (both parents when possible, but it can be conducted only with one parent or caregiver). PMT can be offered as its own therapeutic intervention or as one component of family therapy, or it can be combined with pharmaco logical treatments (as in the case of children with ADHD). Significantly, the therapist works only with the parents, and therefore, all the changes in a child's behaviours are mediated by the changes in the ways that parents/ caregivers communicate with their children. Typically, PMT is offered in 8- to 25-weekly sessions. It can be offered in very different settings—from school meetings to paediatricians' offices—or it can even be integrated into psychiatric practice. Techniques • The main goal of PMT is to help parents promote pro-social behaviours and decrease deviant behaviour for their children. To accomplish that, the parents are trained to identify and conceptualize their children's problem behaviours in new ways. Hands-on practices/rehearsals are typically part of the training. • Parents are taught to use positive reinforcement contingently, frequently, and immediately when children demonstrate 'good' behaviours. • Mild punishment can also be used, but harsh or severe punishments are discouraged. Indications • PMT is the main component of the treatment of children with oppositional behaviour disorder. It is helpful in the treatment of ADHD. • It has been recognized more recently to be very helpful also in the treatment of children with anxiety disorders. • Its preventative potential has also been demonstrated, as PMT decreases the chance of children evolving with delinquent and antisocial behaviours when their parents receive the intervention. 21 For additional information, see: The Incredible Years (M http://www.incredibleyears.com) or Positive Parenting Programme/'Triple P' (M http://www.triplep.net) [both accessed 13 July 2018].

674 Chapter 15 Child and adolescent psychiatry Autism spectrum disorders ASD are a group of lifelong developmental disorders characterized by their effect on social and communication skills,

as well as by a restricted, stereo typed, repetitive repertoire of interests and activities.22,23 DSM-5 (and ICD- 11) now uses ‘Autism spectrum disorder’ as an umbrella term in the chapter on ‘Neurodevelopmental disorders’ for the former separate diagnoses that remain in ICD-10: autistic disorder (autism), Asperger’s disorder, childhood disintegrative disorder, and pervasive developmental disorder not other wise specified (PDD-NOS). Although 80% of individuals with childhood autism have learning disability, about 80% of the population with ASD are of normal intellectual ability. (For a more detailed description of autism and other PDDs, see E Chapter 17, Intellectual disability: E Pervasive devel opmental disorders, p. 820; E Autism, p. 822.)
Clinical features Difficulties with social relationships • Few or no sustained relationships. • Persistent aloofness or awkward interaction with peers. • Unusually egocentric, with little concern for others or awareness of their viewpoint and limited empathy or sensitivity. • Lack of awareness of social rules and reciprocity. Problems in communication • Odd voice, monotonous and perhaps at an unusual volume, talking at (rather than to) you, with little awareness of your response. • Language is superficially good, but too formal, stilted, or pedantic and with difficulty in catching any meaning other than the literal. • Impassive appearance, with few gestures and abnormal gaze (i.e. limited non-verbal communicative behaviour). • Awkward or odd posture and body language. Restrictive and repetitive patterns of behaviour, activities, or interests • Intensely pursued and unusually circumscribed interests. • A set approach to everyday life; unusual routines or rituals; change often upsetting. • Focus on rules. Sensory sensitivity • Can be under-sensitive or oversensitive—to sound, light, pressure, texture, smell, taste, and proprioception. Comorbidity Depression, anxiety, bipolar disorder, psychosis, ID, OCD, ADHD, tic dis orders, dyspraxia, impaired cognition in various domains (e.g. perception, executive functioning), visual/auditory impairment, epilepsy. 22 National Institute for Health and Care Excellence (2013) Autism spectrum disorder in under 19s: support and management. Clinical guideline [CG170]. M http://www.nice.org.uk/guidance/ cg170 [accessed 13 July 2018]. 23 Scottish Intercollegiate Guidelines Network (2016) SIGN 145: assessment, diagnosis and inter ventions for autism spectrum disorders. M http://www.sign.ac.uk/assets/sign145.pdf [accessed 13 July 2018].

Autism spectrum disorders Assessment—key areas • Assessment should be considered in all children aged <3yrs who have regression in language or social skills, as well as those with clear features. • History of specific problems (E Autism spectrum disorders, Clinical features, see opposite), level of distress and impairment in all aspects of life, comorbidity, cognitive ability, and impact on parents/carers and sources of support (obtain information from as many sources as possible). • Consider referral for specialist assessment: speech and language, educational psychology (via school), OT (including sensory assessment), and physiotherapy. • Observation of child. • Consider use of diagnostic tools, e.g. Autism Diagnostic Interview– Revised (ADI-R), Diagnostic Interview for Social and Communication Disorders (DISCO), Developmental Dimensional and Diagnostic Interview (3di), and Autism Diagnostic Observation Schedule (ADOS). • Medical investigation as appropriate, e.g. karyotyping, DNA, fragile X analysis, audiological examination, investigation for recognized aetiologies (e.g. tuberous sclerosis). • A multidisciplinary approach is preferred (especially complex cases), and diagnosis is made by a variety of professionals, including psychiatrists, paediatricians, speech and language therapists, and psychologists. Management Effective management is informed by thorough assessment of the individual child’s and family’s needs and is likely to involve more than one agency. • Information (verbal and written) and support regarding the diagnosis. • Liaison with education services regarding appropriate support and school placement. Educational psychology can provide advice in this area. • Parenting programmes

specific to ASD. • Adaptation of the child's environment, activities, and routines, e.g. visual timetabling. • Communication interventions. • Sensory sensitivity adaptations or interventions. • Treat comorbidity—ASD may alter the treatment approach and prognosis. • An antipsychotic, e.g. risperidone, for short-term treatment of significant aggression. Monitor closely, and discontinue if no benefit in 6wks. • Melatonin for sleep disturbance when behavioural measures alone have not been successful. • Wider family/sibling support, including respite care, eligibility for benefits, and social work assistance. • Inform about additional sources of information/support, e.g. National Autistic Society (M http://www.autism.org.uk/, accessed 13 July 2018). Autism in girls Girls may be able to mask some of their difficulties through learned re sponses, behaviour, and imitation. Special interests can be fairly typical of other girls their age, but the intensity is very different. Girls with ASD can also have a greater sense of imagination or fantasy play than boys. Diagnostic criteria do not reflect gender differences in presentation.

676 Chapter 15 Child and adolescent psychiatry Tic disorders (See also E Movement disorders in psychiatry, p. 132) Epidemiology 2:1 ratio of boys to girls in community-based samples. Prevalence 5–10/10,000 in European and Asian populations. Aetiology Thought to involve interaction of genetic and environmental factors. Multiple vulnerability genes implicated and link with chromosome 2. Association with psychosocial stress well known, and heightened HPA axis and noradrenergic system reactivity demonstrated. Likely disturbance in the DA system also suggested. Other possibilities include gestational and perinatal insults, exposure to androgens, heat, fatigue, and post-infectious autoimmune mechanism (E Box 15.6, p. 691). Clinical features Tics are sudden, repetitive, stereotyped, and involuntary movements or sounds. They are frequently associated with antecedent sensory phe nomena, including inner tension and premonitory urges, and tic perform ance may result in fleeting relief. ICD-10 (and ICD-11) divides tic disorders into different durations and types: • Tourette's syndrome: multiple motor tics and one or more vocal tics, although they do not need to occur at the same time. Sometimes associated with copropraxia. Occurs for over 12mths. • Chronic motor/vocal tic disorder: either motor or vocal, but not both for over 12mths. • Transient tic disorder: tics do not persist for longer than 12mths. Most common form of tic and often seen in younger children. • Tic disorder not otherwise specified. DSM-5 has slightly different terms, but similar criteria for diagnosis. Motor tics often begin between the ages of 3 and 8yrs, a few years before the onset of vocal tics. Typically, tics vary over time, with more complex tics emerging after some years. The severity of tics waxes and wanes, with exacerbations often related to fatigue, emotional stress, and excitement. Tic severity usually peaks in early adolescence, with most showing a marked reduction in severity by the end of adolescence. Coprolalia is strongly asso ciated in the public mind with this disorder, but it is actually uncommon and not required for diagnosis. Comorbidity OCD and ADHD common; depression, anxiety, learning difficulties, ASD, migraines. Associated problems include sleep difficulties, poor impulse-control, and disruptive behaviours. Key aspects of assessment • Assess the degree of interference with the child's family, school, and social life. • Careful perinatal, developmental, family, and medical history. • Screen for associated difficulties.

Tic disorders Management • Psychoeducation for the child and family and lifestyle adjustment: what tics are, realistic expectations, stress reduction, caffeine reduction. • Close liaison with school and educational interventions. • Behavioural interventions—habit reversal training looks promising. Consists of awareness training, self-monitoring of tics, relaxation training, competing response training, and motivational techniques. An extension of this is exposure and

response training • If tics are severe and impairing, consider medication, e.g. antipsychotics, α2 agonists. Beware the tendency of tics to wax and wane, regardless of treatment. • Treat comorbidity. SSRIs may be helpful in comorbid OCD. Methylphenidate is no longer contraindicated in comorbid ADHD. • Information and support can be gained from Tourettes Action (M http://www.tourettes-action.org.uk, accessed 13 July 2018) and Tourette Scotland (M http://www.tourettescotland.org, accessed 13 July 2018).

678 Chapter 15 Child and adolescent psychiatry Language, learning, and motor coordination disorders Speech and language delay and disorder A distinction is drawn between speech and language delay and disorder. Delay indicates that speech and language acquisition is occurring at a slower rate, but in the expected sequence. Disorder implies that speech and lan guage development is not following the usual sequence, suggesting specific difficulties in an aspect of the language system that is impacting on the child's overall language development. Disorders include specific speech articulation disorder, expressive lan guage disorder, and receptive language disorder. Both delay and disorder are commonly multifactorial in aetiology. They can impact on a child's learning and literacy, social development, and emotional well-being and may initially present with behaviour problems. Assessment by a speech and lan guage therapist is indicated. Learning disorders Generally, the educational psychologist is ideally placed to identify and ad vise on the management of these disorders. However, it is not unusual for the first presentation of these disorders to be to CAMHS as behavioural problems. Reading disorder (dyslexia) Difficulty with reading, in most cases involving a deficit in phonological pro cessing skills. Four per cent of school-age children. ♂ predominance. There is often a family history of dyslexia. Twenty per cent have comorbid ADHD or CD. Management includes one-to-one supported teaching, and parent involvement improves long-term outcome. Disorder of written expression Often coexists with dyslexia and manifests as difficulties with spelling, syntax, grammar, and composition. Occurs in 2–8% of school-age children, with a 3:1 ♂ predominance. Difficulties may first emerge with a shift from narrative to expository writing assignments. Mathematics disorder ♀ predominance and occurs in 1–6% of school-age children. Often asso ciated with visuospatial deficits and attributed to right parietal dysfunction. Developmental coordination disorder • Developmental coordination disorder (DCD) and dyspraxia are generally held to be synonymous and refer to an impairment of, or difficulties with, the organization, planning, and execution of physical movement with a developmental, rather than acquired, origin.

Language, learning, and motor coordination disorders • It can be comorbid with disorders of learning and behaviour. Over half have attention difficulties, of which a minority will meet criteria for a diagnosis of DAMP: this disorder features Deficits in Attention, Motor control, and Perception, and there are overlaps with ODD and ASD. • Can impact on self-esteem, family and peer relationships, and school life. • DCD prevalence 6%, more common in ♂. Premature and low-birthweight babies at i risk. • First presentation may be to CAMHS with behavioural difficulties. More usually seen in paediatrics and primary care. Assessment and input from OT and physiotherapy may be necessary.

680 Chapter 15 Child and adolescent psychiatry Enuresis The normal variation in the age of acquisition of bladder control makes it difficult to demarcate the disorder. By the age of 5yrs, only 1% children have troublesome daytime wetting. Nocturnal enuresis, however, continues to affect 15–22% of boys and 7–15% of girls at the age of 7yrs. Primary (never dry) and secondary

(previously dry) types are distinguished. Enuresis can impact on self-esteem and family and peer relationships and restrict activ ities. There is a reduction in rates of enuresis with time, but a small minority will continue to experience problems into adult life. Aetiology Nocturnal enuresis has a strong genetic component. Both psy chosocial and pathophysiological associations have been demonstrated. Diurnal enuresis is more likely to be associated with structural and func tional disorders of the urinary tract, and less likely to predict that other family members will have shown enuresis. Management The majority of children will be managed in primary care or by specialist enuresis clinics in the UK. Referrals to CAMHS are usually reserved for cases where enuresis is part of a wider disturbance of emotion and behaviour, or where serious psychological consequences have devel oped in an enuretic child. • Careful assessment will inform management. • Psychoeducation for the child and parents. • Treat organic causes, e.g. structural abnormality, infection. • Nocturnal enuresis: there is robust evidence to support the use of enuresis alarms. 'Night lifting', reward systems (e.g. star charts), and medication may also be helpful. • Diurnal enuresis: body alarms, watch alarm to remind the child to use the toilet, medication, specific psychological approaches, e.g. anxiety management if related to fear of toilet. • ERIC (Enuresis Resource and Information Centre): provides information and resources to improve childhood continence (M http://www.eric. org.uk, accessed 13 July 2018).

Encopresis Encopresis Again, determining what is abnormal is problematic, but soiling more frequently than once a month after the fourth birthday is regarded as an elimination disorder if it is not attributable to a general medical condition. Primary and secondary forms are recognized as for enuresis. Constipation and soiling are common presentations to paediatrics, with only a small mi nority being referred to CAMHS. These latter children tend to have sig nificant psychological problems, in addition to soiling—an association with emotional abuse. There can be considerable impact on self-esteem, family and peer relationships, and social activities. Most soiling will cease by the age of 16yrs. Types of soiling • 95% present with functional constipation with retention and overflow. Both physical (persistent faecal loading leading to loss of sensation of rectal filling, anal fissure) and psychological (toilet fears, fear of painful defecation) factors may be relevant. • Never toilet-trained. • Frightened to use the toilet. • Deliberately depositing faeces in inappropriate places. Management As most cases are likely to have multifactorial causes, a comprehensive biopsychosocial assessment is necessary to guide management. Possible elements of treatment include: • Lifestyle changes, e.g. adequate fluid and dietary fibre. • Education of the child and family, and assistance to view the child more positively. • Medical management, e.g. laxatives. • Behavioural approaches, e.g. star charts. • Family therapy, e.g. Sneaky Poo—a narrative therapy and an externalizing approach that helps to unite the family against the problem of soiling, which is personified as the character 'Sneaky Poo'.

682 Chapter 15 Child and adolescent psychiatry Sleep disorders Classified as for adult sleep disorders (E Introduction, p. 432). The main syndromes that manifest in children and adolescents are: nightmare disorder (E REM-related parasomnias, p. 464); sleep terror disorder (E Disorders of arousal (from NREM) (G47.59), p. 460); and sleepwalking disorder (E Sleepwalking (somnambulism) (F51.3), p. 460). Sleep is essential for the healthy development of children. Sleep disturb ance is a frequent problem and can have a very negative impact on a child's and family's level of functioning and quality of life. It is important to ask children, young people, and families about any difficulties getting to sleep or staying asleep, as well as asking about any unusual night-time activity or day time tiredness. A clear history of current bedtime routine, including time,

pattern of sleep, activity before bed, and eating/drinking before bed, is helpful. Evidence is building for the detrimental effect of electronic devices on children's sleep due to the effect of blue-wavelength light on melatonin. The physiology of sleep changes from birth through adolescence, as does the sleep requirement. The prevalence of sleep disorders in the CAMHS population is not clear, as they do not always fulfil the full diagnostic criteria for disorder as for adult sleep disorders. High rates of sleep disturbance are seen in anxiety, trauma, depression, neurodevelopmental disorder, ID, substance misuse, and some physical health disorders. This can be a symptom of the disorder itself or a side effect of treatments offered. Other reasons include narcolepsy, RLS, night mares, night terrors (young children, shortly after falling asleep, appear highly distressed and seem awake but are still asleep), and sleepwalking. Management involves treating any physical cause or iatrogenic side effect, sleep hygiene, behavioural work, and sometimes medication under spe cialist advice.

Anxiety disorders: overview Anxiety disorders: overview Anxiety and fear are an inherent part of the human condition and, in times of danger, are often adaptive. As a result of changing developmental and cognitive abilities during childhood, the content of normal fears and anx ieties shifts from concerns about concrete external things to abstract anx ieties. Anxiety disorders are characterized by an irrational fear or worry, causing significant distress and/or impairment in functioning, and their rela tive prevalence reflects this shift in content. Thus, specific disorders appear more common during specific stages of development. Epidemiology Anxiety disorders are among the most common psychiatric disorders in youth. Prevalence rates range from 5% to 15%, with 8% requiring clinical treatment. Age of onset varies for each disorder. Separation anxiety dis order and specific phobia usually have onset in early childhood, and GAD occurs across all age groups, while OCD, social phobia, agoraphobia, and panic disorder tend to occur in later childhood and adolescence. Aetiological factors Genetic vulnerability; temperament that exhibits 'behavioural inhibition' (timidity, shyness, and emotional restraint with unfamiliar people or situ ations); insecure attachment; stressful or traumatic life events; high social adversity; over-protective/critical/punitive parenting. Organic causes of anxiety Medical conditions: hyperthyroidism; cardiomyopathy; arrhythmias; respira tory and neurological diseases. Substances: alcohol; caffeine; cocaine; am phetamines; cannabis; SSRIs; LSD; ecstasy; NPS, etc. Presentation of anxiety in children and adolescents • Particularly in children, it is difficult to obtain a history of cognitive, emotional, and physical symptoms. Often somatic symptoms are the only feature that the child will be able to readily describe. Nevertheless, with sensitive questioning, fears and worries can be elicited. • Behavioural presentations include over-activity, inattention, sleep disturbance, separation difficulty, regression, school refusal, social withdrawal, aggression, ritualistic behaviours, and somatization. General principles of management • Use the ABC (antecedents, behaviour, and consequences) approach to help the child and family understand what happens when the child feels anxious. • Show how others' reactions are influencing anxiety. • Stress reduction, including relaxation. • Psychoeducation regarding anxiety, e.g. connection between physical, cognitive, and emotional components. • Age-appropriate CBT approaches.

684 Chapter 15 Child and adolescent psychiatry Separation anxiety disorder, generalized anxiety disorder, and panic disorder/ agoraphobia Separation anxiety disorder Essence Characterized by i and inappropriate anxiety around separation from attachment figures or home, which is developmentally abnormal and results in impaired functioning. It occurs in about 3.5% of children and 0.8% of adolescents. Normal separation anxiety Separation anxiety is a normal feature of

development. Anxiety in a 2-yr old who is being separated from his/her parent into the care of a stranger is normal since, at this developmental stage, the child may perceive the attachment figure as the only source of safety. On the other hand, disabling separation anxiety in a 7-yr old is con sidered abnormal since the child has achieved a level of cognitive develop ment at which he/she should have learnt that many non-attachment figures might be considered ‘safe’. Causes Genetic vulnerability; anxious, inconsistent, or over-involved parenting; and regression during periods of stress, illness, or abandonment. Symptoms Anxiety about actual or anticipated separation from, or danger to, attachment figure; sleep disturbances and nightmares; somatiza tion; and school refusal. Comorbidity Depression; anxiety disorders (panic with agoraphobia in older children); ADHD; oppositional disorders; learning disorders; and de velopmental disorders. Management Psychological approach, with emphasis on relaxation and managing anxiety, using an age-appropriate CBT approach. Generalized anxiety disorder of childhood Essence Characterized by developmentally inappropriate and excessive worry and anxiety on most days about things not under one’s own control. Commonly in relation to performance, health, well-being, and non-specific ‘free-floating worries’. Severe enough to cause distress and/or dysfunction. Strong need for reassurance. Affected children are often perfectionist and self-critical. The most common anxiety disorder of adolescence, with 74% prevalence in this group. More common in ♀ during adolescence. Only one-third seek treatment. Symptoms Present for at least 1mth. Excessive worry; restlessness, irrit ability, and fatigue; poor concentration; sleep disturbances; muscle tension. In children: somatic symptoms (headache; stomach pains or ‘irritable bowel’; rapid heartbeat; shortness of breath); nail biting and hair pulling; and school refusal. Comorbidity Very high rates—up to 90%. Other anxiety disorders, de pression, CDs, and substance abuse are the most common.

685 SEPARATION ANXIETY DISORDER, GAD, & PANIC DISORDER Management • Good evidence for the use of CBT. This can be individual, group, or family-based, and it may be especially beneficial for parents to be involved in younger children or when parental anxiety is high. • Psychoeducation regarding the nature and treatment of anxiety disorders, along with supportive listening and clarification. • Formulation may indicate the use of other psychosocial approaches. • Although not supported by a great deal of research evidence, use of SSRIs may be considered. Panic disorder/agoraphobia Essence Panic attacks are recurrent and often ‘out-of-the-blue’ experi ences of severe anxiety, with both psychological and physiological features. Anticipatory anxiety is also a feature, with fear of another attack. A panic attack is described as a discrete period of i fear, peaking at about 10min and lasting about 30min to 1hr. Symptoms Sweating, flushing, trembling, palpitations and tachycardia, chest pain, shortness of breath and choking, nausea and vomiting, dizziness, paraesthesiae, depersonalization and derealization, and a fear of dying. Note: in young children, somatic symptoms predominate, rather than classic symptoms. Agoraphobia may or may not coexist with the disorder but is usually present. The essential feature is anxiety about being in a situation in which escape would be difficult or help unavailable, should a panic at tack occur. This leads to avoidance of places or situations and may result in school refusal and separation anxiety. Epidemiology Panic disorder has an estimated prevalence of 3–6% and is more common in ♀ post-puberty. Peak onset is 15–19yrs. Comorbidity Depression, substance abuse, and other anxiety disorders (especially social phobia) are the most common. Management As for GAD.

686 Chapter 15 Child and adolescent psychiatry Social phobia, simple phobias, and selective mutism Social phobia Essence Extremely common and often undiagnosed. It is

characterized by marked fear of one or more social or performance-related situations where the person is exposed to scrutiny and in which embarrassment may occur. Exposure to social situations usually causes an anxiety reaction (may be a panic attack) that is distressing. Thus, situations are either avoided or en dured with discomfort. This may lead to agoraphobia and, in severe cases, school refusal. Epidemiology Social phobia is most common in adolescents, with an es timated prevalence of 5–15%, as opposed to only 1% in children. It is more common in girls, and the average age of onset for both genders is 12yrs. Family studies demonstrate a 2-fold i risk for social phobia in the rela tives of social phobia probands, while twin studies show a 3-fold i risk in MZ twins. Comorbidity High rates of other anxiety disorders (especially GAD, simple phobia, and panic disorder) in 730–60% of cases, with mood dis orders (20%) and substance abuse also frequent comorbidities. Prognosis Although the prognosis for treated social phobia is fair to good, comorbid conditions may persist and hinder educational and social progress. Those who experience symptoms in two or more situations have a poorer outcome than those experiencing symptoms in a single situation only. Management • Good evidence for the use of CBT exists. This can be individual, group, or family-based, and it may be especially beneficial for parents to be involved in younger patients or when parental anxiety is high. • SSRIs can be considered where CBT alone has failed. • Psychoeducation regarding the nature and treatment of anxiety disorders, along with supportive listening and clarification. • Formulation may indicate the use of other psychosocial approaches. Simple phobias Essence Excessive fear of an object or a situation with distress and phobic avoidance. There may be anticipatory anxiety, and exposure can precipitate a panic attack. Aetiology Probable interaction of genetic influence, inhibited tempera ment, parental influence, and specific conditioning. Epidemiology Very common (10% in some studies). Comorbidity Depression; substance abuse. Subtypes Animal phobias; natural environment phobias (especially 5- to 10-yr olds); blood/infection/injury phobias; situational phobias (e.g. lifts, closed spaces); other. Management • Involve the family and, if appropriate, others, e.g. teacher. • CBT, including desensitization, modelling, contingency management, relaxation training, and self-statements.

Social phobia, simple phobias, and selective mutism Selective mutism Essence A consistent failure to speak in social situations in which there is an expectation for speaking (e.g. at school) despite speaking in other situations. It has been considered both as an anxiety and an oppositional disorder. Epidemiology Rare, affecting 3–8/10,000 in the UK, unlike extreme shy ness which is common in the first year at school. Slightly more common in girls. Comorbidity Many children who develop selective mutism have pre morbid speech and language problems. Comorbidity with developmental delay/disorder, communication disorder, elimination disorders, and anxiety disorders observed. Management Difficult to treat. There is a small evidence base for use of behavioural therapy, CBT, SSRIs, and individual psychotherapy. Involve the family and school in treatment.

688 Chapter 15 Child and adolescent psychiatry Post-traumatic stress disorder Essence A syndrome characterized by a triad of symptoms: intrusive re-experiencing of a traumatic event; avoidance; and hyperarousal.24,25 Recognized in children since the 1980s. Symptoms variable in young chil dren, but similar to adult pattern in older children (E Post-traumatic stress disorder 1: diagnosis, p. 402). Traumatic event Requires exposure to a situation or event which is cata strophic or highly threatening. Epidemiology Prevalence varies according to age but develops in 73–6% of children exposed to trauma. Most exposed do not develop the disorder, and those who are affected usually have a pre-existing vulnerability (i.e. ‘an unnatural response to an unnatural

event'). Clinical presentation in young children Identification of PTSD in children presents particular problems but can be improved by asking the child directly about their experiences. Do not rely solely on the caregiver's history. Scheeringa criteria26 • Compulsive repetitive play representing part of the trauma and failing to relieve anxiety. • Recurrent recollections of the event. • Nightmares, night terrors, and difficulty going to sleep. • Constriction of play. • Social withdrawal. • Restricted affect. • Loss of acquired developmental skills, especially language regression and toilet training. • d concentration and attention. • New aggression. • New separation anxiety. Note: post-traumatic stress symptoms that do not meet PTSD criteria can still be very disabling and deserve attention in their own right. Comorbidity Common in PTSD, with depression, anxiety disorders, and substance abuse frequent in adolescents. Behavioural disorders common in young children. See Box 15.4 for NICE guidelines on treatment of PTSD. Complex trauma is discussed in Box 15.5. 24 Perrins S, Smith P, Yule W (2000) The assessment and treatment of post-traumatic stress dis order in children and adolescents. J Child Psychol Psychiatry 41:277–89. 25 Yule W (2001) Posttraumatic stress disorder in the general population and in children. J Clin Psychiatry 63(Suppl 17):23–8. 26 Scheeringa MS, Gaensbauer TJ (2000) Post-traumatic stress disorder. In: Zeanah CH (ed). Handbook of Infant Health, pp. 69–81. New York, NY: Guilford Press.

Post-traumatic stress disorder Box 15.4 NICE guidance on treatment of PTSD in children and adolescents* Interventions in the first month after a trauma • Offer trauma-focused CBT to older children with severe post- traumatic symptoms or severe PTSD in the first month after the event. Interventions >3mths after a trauma • Offer children and young people a course of trauma-focused CBT adapted, as needed, to suit their age, circumstances, and level of development. (This should also be offered to those who have experienced sexual abuse.) • For chronic PTSD in children and young people resulting from a single event, consider offering 8–12 sessions of trauma-focused psychological treatment. When the trauma is discussed, longer treatment sessions (90min) are usually necessary. • Psychological treatment should be regular and continuous (usually at least once a week) and delivered by the same person. • Do not routinely prescribe drug treatments for children and young people with PTSD. • Involve families in the treatment of children and young people where appropriate, but remember that treatment consisting of parental involvement alone is unlikely to be of benefit for PTSD symptoms. • Inform parents (and, where appropriate, children and young people) that apart from trauma-focused psychological interventions, there is no good evidence for the efficacy of other forms of treatment such as play therapy, art therapy, or FT.

- Source: data from NICE Clinical guideline (CG26) Post-traumatic stress disorder: management. Mar 2005. https://www.nice.org.uk/guidance/cg26 [M accessed 13 July 2018]. Box 15.5 Complex trauma (E Exceptional stressors and traumatic events, p. 390.) Essence: a diagnosis utilized clinically (and allowed in ICD-11 as com plex PTSD) when dealing with those who have experienced prolonged periods of abuse and have PTSD symptoms plus difficulties in regulating emotion and maintaining relationships and an impaired sense of self. Treatment: often using a trauma-based model involving: • Psychoeducation, stability, and safety work, e.g. grounding for dissociation and anxiety. • Trauma processing. • Reintegration work (re-establishing social and cultural connections).

690 Chapter 15 Child and adolescent psychiatry Obsessive–compulsive disorder Essence OCD is characterized by ego-dystonic obsessions or compulsions. Compulsive behaviours, either physical or mental, often serve to reduce anxiety and prevent something bad from happening, as in

‘magical thinking’. ICD-10 criteria require obsessions and,or compulsions present most days for at least 2wks. They are ego-dystonic, the person’s own thoughts, and an attempt is made to resist the acts. Symptoms have to be severe enough to impair functioning and lead to distress. DSM-5 has a chapter on disorders involving obsessional thoughts such as OCD, body dysmorphic disorder, and trichotillomania. ICD-11 similarly includes body dysmorphic disorder, olfactory reference disorder, hypochondriasis, hoarding disorder, and body- focused repetitive behaviour disorders in ‘Obsessive–compulsive and related disorders’ (E Obsessive–compulsive disorder 1: clinical features, p. 384) Epidemiology Prevalence in adolescents 1–3.6%. May occur as early as 5yrs of age, and the mean age of onset is around 10yrs. ♂ predominance (♂:♀ = 3:2) in childhood, with equal gender distribution in adolescence. Mild subclinical obsessions and compulsions are common in the general population (4–19%), and the disorder merges with normality. This is a per sistent disorder, which is often veiled in secrecy—the mean delay to pres entation is 2yrs. Aetiology Associated with chromosome 3 and serotonin systems. Genetic and non-genetic factors probably equally important. Only 15% have a clearly identifiable precipitating factor. Clinical features • Obsessions: intrusive, repetitive, and distressing thoughts or images. Common themes: contamination, harm coming to others, sexual, aggressive, religious. • Compulsions: repetitive, stereotyped, unnecessary behaviours. Common rituals include washing, checking, repeating, ordering, and reassurance seeking. Rituals may involve parents and are part of normal development, especially in 3- to 7-yr age groups. More likely to be OCD if the rituals or thoughts distress the child, they take up a lot of time, and they interfere with the child’s everyday life. • Multiple obsessions and compulsions common. • Poor insight more common in child cases. Differential diagnosis Normal developmental rituals; Tourette’s/tic disorder; depression; ASD; eating disorder; psychosis. Comorbidity Seventy per cent have at least one comorbid disorder. Includes other anx iety disorders, ADHD, ODD, Tourette’s syndrome, ASD, mood disorders, Sydenham’s chorea (see Box 15.6), and PANDAS.

Obsessive–compulsive disorder Assessment • Family and individual assessment where possible. • The young person may be reluctant to discuss aspects of obsessions/ compulsions. • CY-BOCS may be useful both as a rating scale and to obtain a clear picture of obsession/compulsion. • Screen for comorbidity. Treatment • Consider guided self-help for mild impairment in the first instance. • If more severely affected, offer developmentally appropriate CBT and ERP in group or individual format. Involve the family, where possible, in planning and process of treatment, and the school, etc., as necessary. • Following multidisciplinary review, consider SSRI, in addition to CBT and ERP, if no response. Monitor closely, and advise of delay in onset of medication action of up to 12wks. After remission, continue medication for at least 6mths, then consider gradually withdrawing medication. • If SSRI fails, consider change to different SSRI/clomipramine. Need ECG prior to clomipramine treatment. • In specialist settings, augmentation with antipsychotic may be appropriate. • Consider inpatient care in the most severe cases associated with major impairment and distress unresponsive to outpatient care. Also where there is significant self-neglect or suicide risk. • Absence of comorbidity and good insight increase chances of successful outcome. Box 15.6 Neuropsychiatric causes of OCD symptoms PANDAS (paediatric autoimmune neurological disorder associated with Streptococcus) An autoimmune syndrome associated with OCD and/or tic disorder, with pre-pubertal onset, characterized by episodic exacerbations of symptoms in association with evidence of group A β-haemolytic strepto coccal infection.1 PANS (paediatric acute-onset neuropsychiatric syndrome) A newer term used to describe all cases of abrupt-onset OCD, and not just those associated with streptococcal infections. Sydenham’s chorea Post-Streptococcus, acute-onset movement disorder affecting the basal ganglia and often with

associated psychiatric presentation such as OCD symptoms, tics, and changes in mood and behaviour. It can also affect other body systems, including the heart and joints.2 1 M https://www.nimh.nih.gov/labs-at-nimh/research-areas/clinics-and-labs/pdnb/web.shtml [accessed 13 July 2018]. 2 M http://www.sydenhamschorea.org.uk [accessed 13 July 2018].

692 Chapter 15 Child and adolescent psychiatry Eating disorders 1 Eating disorders in children and adolescents include anorexia nervosa, bu limia nervosa, and their variants characterized by disturbed or inadequate eating patterns associated with abnormal preoccupation with weight and shape. Anorexia nervosa Essence Weight loss associated with abnormal beliefs and preoccupation regarding weight and/or shape. ICD-10 and DSM-5 criteria are used (E Anorexia nervosa 1: overview, p. 410), but the 'weight criterion' of BMI <17.5 is problematic in children and adolescents who are still developing. Calculating the percentage weight for height can also be a very useful measure, and a weight for height of <85% is concerning. Epidemiology Prevalence 0.3% in adolescent ♀. Lower rates in boys and pre-pubertally. Assessment • Family and individual—often secrecy around behaviour. • Eating—intake, weight control measures, attitude to weight/shape. • Assessment of factors contributing to, and maintaining, the disorder, e.g. acute life stress, obesity, parental weight concerns, peers, psychological factors such as perfectionism, and personal ineffectiveness. • Comorbidity. • Detailed and thorough risk assessment. • Full physical assessment and investigations, as appropriate, e.g. bloods, ECG, bone density [dual-energy X-ray absorptiometry (DEXA)], ovarian ultrasound scan (USS). • Motivation to change. • The Junior MARSIPAN,27 published by the Royal College of Psychiatrists, provides clear guidance for assessing the level of risk and informing management. Management Involves physical, psychological, educational, and social aspects and will usu ally require a multidisciplinary approach. • Complications of eating disorders can be life-threatening, and paediatric admission can be required for stabilization. • In general early intervention leads to better outcomes. • Treatment should normally involve the whole family, and the effects of anorexia nervosa on other family members should be recognized. • Restoration of healthy weight, allowing further growth and development, and treatment of physical complications. • Meal plans should be agreed carefully with dietitian input. 27 Royal College of Psychiatrists (2012) Junior MARSIPAN: management of really sick patients under 18 with anorexia nervosa. M https://www.rcpsych.ac.uk/docs/default-source/improving-care/ better-mh-policy/college-reports/college-report-cr168.pdf?sfvrsn=e38d0c3b_2 [accessed January 2019].

Eating disorders 1 • Prevention and recognition of refeeding syndrome is essential (E Refeeding syndrome, p. 417) • Provide education on nutrition and healthy eating. Carers should be included in any dietary education or meal planning. • Patients should be offered family interventions that directly address the eating disorder, and also individual sessions to provide support, improve motivation, and address core maladaptive thoughts, attitudes, and feelings, e.g. family-based therapy. • Treat comorbidity. Note psychological symptoms often improve with weight gain. • The balance of responsibility for treatment between parents and young people will vary according to the age of the young person. Nevertheless, where young people refuse necessary treatment, parental right to override this must be considered, as well as use of MHA legislation. • Where the young person is at serious risk, e.g. through physical compromise or suicidality, or is not progressing in outpatient treatment, specialist inpatient or day patient care in age-appropriate settings should be considered. • Liaison with school, e.g. graded return if has been absent. • Relapse prevention. Bulimia nervosa Essence Disorder characterized by recurrent binges and

purges, a sense of lack of control, and morbid preoccupation with weight and shape. Rarely occurs pre-pubertally, much more common in girls, often comorbid with depres sion. Many people with bulimia are of a normal weight. Management • Work with the family to establish clear structures and boundaries. Strike a balance between individual work and family work. • Adolescents with bulimia nervosa may be treated with CBT adapted, as needed, to suit their age, circumstances, and level of development, and including the family as appropriate. • Address physical health concerns, e.g. due to frequent vomiting. • No clear evidence to support drug treatments in this age group, but fluoxetine could be a useful adjunct in older adolescents.

694 Chapter 15 Child and adolescent psychiatry Eating disorders 2 Many children present with clinically significant disorders, which do not fit diagnostic criteria. Children and adolescents may also present with other types of clinical eating disturbance, including the following. Avoidant/restrictive food intake disorder (ARFID) DSM-5 (and ICD-11) diagnosis—eating or feeding disturbance, as mani fested by persistent failure to meet appropriate nutritional and/or energy needs, leading to one or more of the following: • Significant weight loss (or failure to achieve expected weight gain or faltering growth in children). • Significant nutritional deficiency. • Dependence on enteral feeding or oral nutritional supplements. • Marked interference with psychosocial functioning. It is not characterized by disturbance of thoughts regarding weight and shape or by weight loss behaviours, and it cannot be attributed to a medical condition or better explained by another mental health disorder. Pica This is a common condition (in ICD-10/11 and DSM-5) where there is per sistent (>1mth) eating of non-nutritive substances at a developmentally in appropriate age (>1yr). Common substances are: dirt, stones, hair, faeces, plastic, paper, wood, string, etc. It is particularly common in individuals with developmental disabilities and may be dangerous or life-threatening, depending on the substance ingested. Consequences may include toxicity, infection, or GI tract ulceration/obstruction. Typically occurs during second and third years of life, although young pregnant women may exhibit pica during pregnancy. Hypothesized causes include: nutritional deficiencies; cul tural factors (e.g. clay); psychosocial stress; malnutrition and hunger; and brain disorders (e.g. hypothalamic problem). Rumination disorder DSM-5 (and ICD-11: rumination–regurgitation disorder) diagnosis charac terized by voluntary or involuntary regurgitation and re-chewing of par tially digested food. Occurs within a few minutes postprandial and may last 1–2hrs. Regurgitation appears effortless and is preceded by belching. Typical onset 3–6mths of age; may persist for several months and then spontan eously remit. Also occurs in older individuals with ID. May result in weight loss, halitosis, dental decay, aspiration, recurrent respiratory tract infection (RTI), and sometimes asphyxiation and death (5–10% of cases). Causes in clude: ID; GI tract pathology; psychiatric disorders; and psychosocial stress. Treatment includes physical examination and investigations, behavioural methods, and nutritional advice.

Eating disorders 2 Other disorders • Selective eating characterized by long-standing restriction of the types of food eaten: rarely harmful but can result in social difficulties. • Pervasive refusal/pervasive arousal withdrawal syndrome (not in DSM/ ICD): a rare disorder defined as ‘a profound and pervasive refusal to eat, walk, talk, or engage in self-care’. May require inpatient treatment. • Eating disturbance may also be a feature of other disorders (e.g. depression, OCD) or part of a physical disorder where there is a psychological component to the presentation.

696 Chapter 15 Child and adolescent psychiatry Depression in children and adolescents Epidemiology The 12-mth point prevalence is 1% pre-pubertal and 3% post-pubertal. No sex

difference pre-pubertal, more common in ♀ thereafter. Risk factors ♀, post-pubertal, parental history of depression, personally undesirable life events resulting in permanent change of interpersonal relationships in friends or family, past history of depressive symptoms, high trait levels of neuroticism or emotionality, ruminative style of thinking. Aetiology Stress vulnerability model useful in understanding the development of de pression. Vulnerability (genes, endocrine, early family factors) interacts with social stressors (poverty, family discord, etc.) to provoke depression at time of life stress. Clinical features Children and young people can present in a different way to adults, although diagnostic criteria remain the same in terms of mild, moderate, and severe depressive disorder and a duration of at least 2wks with symptoms present most of the time. • Mood changes: unpleasant mood—may not be described as sadness, but as 'grumpy', 'irritable', or 'down'; also anhedonia. • Thought changes: reduced self-esteem, confidence, concentration, and self-efficacy. Hopelessness, guilt, indecisiveness. Suicidal thoughts must be taken seriously. Rarely psychotic symptoms. • Physical/behavioural changes: reduced energy, motivation, self-care. Fatigue, apathy, withdrawal, appetite and sleep change, aches and pains, self-harming, and suicidal behaviour. • Results in impairment of functioning—school, social, family, etc. • Recovery: 10% at 3mths, 50% at 1yr, 70–80% at 2yrs. Treatment shortens the duration of illness. • 30% recurrence within 5yrs; 3% risk of suicide over the next 10yrs. Chronic/recurrent illness significantly impairing all aspects of life. • 20% will later manifest bipolar disorder. Comorbidity Fifty per cent to 80% meet criteria for additional non-depressive disorder, including CD/ODD, separation anxiety, OCD, ADHD, eating disorder, and other anxiety disorders. Differential diagnosis Physical health conditions; certain medication, substance misuse; adjust ment disorders; other psychiatric disorders. Assessment • Family and individual interviews. Assess whether depression is present, contributing factors to development and maintenance, presence of comorbidity, and suicide risk.

Depression in children and adolescents • Collateral from teachers, GP, social services, etc. • Consider use of rating scales, e.g. Moods and Feelings Questionnaire. • Physical examination and laboratory investigations, as indicated. Treatment (Based on NICE guidance.)28 Mild depression—usually at Tier 1 or 2 • Up to 4wks of 'watchful waiting'—stay in contact with the family. • If symptoms continue, offer 2–3mths of individual non-directive supportive therapy, group CBT, or guided self-help. • If unresponsive, refer for Tiers 2/3 review, and treat as for moderate to severe. Moderate to severe depression—Tiers 2–4 • Offer individual CBT, IPT, or family therapy for at least 3mths as first-line treatment. • If unresponsive after 4–6 sessions, multidisciplinary review and consider alternative/additional psychological therapy and pharmacotherapy. • If unresponsive after further six sessions, comprehensive multidisciplinary review and consider alternative psychotherapy, including child psychotherapy. • Consider inpatient treatment if the child/young person is at high risk of suicide, serious self-harm, and self-neglect, or when the required intensity of treatment (or supervision) is not available elsewhere, or for intensive assessment. Pharmacotherapy/electroconvulsive therapy Medication should be combined with psychological therapy. Ensure a full discussion of the rationale, delayed onset of action, time course, need to take regularly, and risks/benefits of drug with the family, and provide written information. Monitor for side effects and benefits. Limited evi dence SSRIs increase the risk of suicidal ideation and/or behaviour and of discontinuation of treatment due to adverse events. Fluoxetine is recom mended first line (10mg daily, increase if necessary to 20mg after 1wk). Second line: sertraline or citalopram. TCAs, venlafaxine, and St John's wort are not recommended. Continue medication for at least 6mths after re mission, then phase out over 6–12wks. In psychotic depression, consider

augmentation with atypical antipsychotic. Only consider ECT for young people (12–18yrs) with very severe depression and either life-threatening symptoms or intractable and severe symptoms that have not responded to other treatments. Monitor regularly for 1yr for the first episode or 2yrs for a recurrent episode. If at high risk of relapse, consider follow-up work as prevention or to promote the child's and family's identification and manage ment of early warning signs. 28 National Institute for Health and Care Excellence (2005, updated 2015) Depression in children and young people: identification and management. Clinical guideline [CG28]. M http://www.nice.org.uk/guidance/cg28 [accessed 13 July 2018].

698 Chapter 15 Child and adolescent psychiatry Suicide and self-harm in young people This section should be read alongside E Assessment after suicide, p. 848 in Chapter 18 . Asking about self-harm and suicidal thoughts must be part of all psychi atric assessments. Sometimes young people will ask clinicians not to tell parents about their suicidal thoughts or self-harming. At the beginning of each assessment, discussion should be had around confidentiality. Young people should be encouraged to share information around self-harm and suicide with parents or carers. Information cannot be kept confidential if there is a serious risk of harm to the young person or to others.29 Epidemiology There has been an overall increase in self-harm and suicide during the twen tieth century, and suicide now represents the third cause of death in adoles cents. Completed suicide is more common in ♂; however, suicide attempts and self-harm are more common in ♀ and include self-poisoning, cutting, burning, swallowing things, and head banging. Factors increasing the risk of completed/attempted suicide • Persistent suicidal ideas. • Previous suicidal behaviour. • High lethality of method used and ongoing availability of lethal method. • High suicidal intent and motivation, e.g. planning, stated wish to die. • Ongoing precipitating stresses, e.g. interpersonal conflict, legal problems. • Mental disorder: mood disorders, psychosis, substance misuse, CD, anxiety disorders, PTSD, eating disorders. • Poor physical health. • Psychological factors: impulsivity, neuroticism, low self-esteem, hopelessness. • Parental psychopathology and suicidal behaviour. • Physical and sexual abuse. • Disconnection from major support systems, e.g. school, family, work. Self-harm Around 1 in 12 young people will self-harm at some point, and it can be an important sign of high emotional distress that requires exploration and intervention. Some young people self-harm as a release from difficult feel ings, while others may self-harm to regain a sense of control or to punish themselves. Young people can often become caught in a cycle of feeling initial relief through self-harm, followed by feeling guilt, which then increases the chance of further self-harm. Most young people who self-harm do not intend to kill themselves. 29 Useful links for the management of self-harm in young people include: M https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr192.pdf?sfvrsn=abcf1f71_2 [accessed 16 Jan 2018]; M http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/self-harm.aspx [accessed 13 July 2018]; and M http://www.youngminds.org.uk/for_children_young_people/whats_worrying_you/self-harm [accessed 13 July 2018].

Suicide and self-harm in young people Among adolescents who harm themselves, the factors that are most likely to be associated with a higher risk of later suicide include: • ♂ gender. • Older age. • High suicidal intent. • Psychosis. • Depression. • Hopelessness. • Having an unclear reason for the act of self-harm. Prevention • Screening and treating psychiatric disorders. • Crisis lines/access to help. • Promoting positive mental health in schools. • Education of parents, the public, and the media. • Intervene in cluster situations (e.g. several suicides in a school). • Reduce access to means, e.g. limits on paracetamol purchase. Management Parents/carers have a responsibility to

ensure the safety of their child, and they should be involved in assessment and management. Good risk assess ment, management plans, and crisis intervention can make a significant dif ference to the outcomes for children and young people. • Safe care planning may involve several agencies, including: child and adult medical and mental health services, social work, police, education, and voluntary agencies. Writing down the safety plan and giving copies to young people and their families is useful. • NICE guidelines and guidance from the Royal College of Psychiatrists advise admission to an age-appropriate medical bed following self-harm, to allow both medical treatment and a full psychosocial assessment to be carried out at an appropriate time by trained professionals. • Mental health risk assessment by a specially trained staff member, with ready access to psychiatric opinion, is essential. • A minority will need inpatient psychiatric care. This should be in an age-appropriate unit. • It is usually appropriate to refer on to the local CAMHS to allow a fuller assessment and ongoing support, including work in establishing safer coping skills and strategies. • Where assessment reveals abuse issues, these need to be tackled according to the local procedure.

700 Chapter 15 Child and adolescent psychiatry Bipolar disorder in children and adolescents Epidemiology Bipolar affective disorder is rare in prepubescent children; prevalence in adolescents is 71%. Familial factors are important, with a four times greater risk of mood disorder in the offspring of parents with bipolar affective disorder. Presentation Will depend on the phase of the disorder. See E Depression in children and adolescents, p. 696 for depression. A hypomanic/manic child may pre sent as over-active, has a reduced need for sleep, and be full of self-belief, grandiose, and challenging of authority. They are often irritable with pres sured speech and racing thoughts and can become aggressive or violent. Poor concentration affects school performance. Overspending, sexual dis inhibition, and risk-taking behaviour may feature. Psychotic symptoms may be present. Mixed affective states are also recognized. Diagnosis Adult criteria are used (E Introduction, p. 316), but: • Mania must be present. • Euphoria must be present most days, most of the time (for 7 days). • Irritability is not a core diagnostic criterion. • Symptoms must be developmentally inappropriate and out with the normal for that child. • Do not diagnose solely on the basis of a major depressive episode in a child with a family history of bipolar disorder, but follow up such children carefully. • DSM-5 now includes ‘Disruptive mood dysregulation disorder’ (DMDD) in the ‘Depressive disorder’ chapter for children up to the age of 18yrs who exhibit persistent irritability and frequent episodes of extreme behavioural dyscontrol (to combat the over-diagnosis of childhood bipolar disorder). Differential diagnosis • ADHD or CD. Seek history of clear-cut episodes of elated mood, grandiosity, and cycles of mood. Mood cycles may also help distinguish bipolar affective disorder from schizophrenia. • Substance misuse. • Organic causes. • Sexual, emotional, and physical abuse may manifest as disinhibition, hypervigilance, or hypersexuality. Comorbidity ADHD (70%), substance abuse (40%), ODD 40%), anxiety disorders (30%), Tourette’s syndrome (8%), bulimia nervosa (3%).

Bipolar disorder in children and adolescents Outcome Early-onset bipolar affective disorder and treatment delay have a poorer outcome. There is commonly a family history, suggesting that this is a highly genetic form of bipolar affective disorder. The course is often chronic and less responsive to treatment, with atypical and rapid-cycling features espe cially difficult to treat. Suicide risk is high in bipolar disorder, with rates of completed suicide of 710%. Assessment: key areas • Individual and family. • Thorough developmental history, family history of mood disorder, pattern of mood changes. • If psychotic symptoms are present, referral to an early intervention psychosis

service is recommended. • Comorbidity. • Impact of disorder on life—family, friends, school, etc. • Collateral information from school, etc. • Physical examination and appropriate investigations. • Level of risk—suicide, exploitation, violence. • Capacity/consent/legislation. Management30 • Involve parents/carers in developing care plans, so they can give informed consent, support treatment goals, and help ensure adherence. • Consider inpatient or day patient admission to age-appropriate services or more intensive community treatment for patients at risk of suicide or other serious harm. • Acute mania: NICE recommends aripiprazole31 as a possible treatment (for up to 12wks) for moderate to severe manic episodes in young people aged 13yrs and older with bipolar I disorder. Other treatment recommendations are as for adults (E Treatment of acute manic episodes, p. 340). Start at lower doses than for adults, using the children's BNF as a guide. Medication monitoring must be carried out, as per guidelines. Valproate should not routinely be used in girls of childbearing age. • Depression: if mild, monitor and support. If moderate to severe, offer psychological therapy first, e.g. CBT, IPT, for at least 3mths. If the episode is severe, consider medication, as per adult guidance, but with dose reduction (E Treatment of depressive episodes, p. 342). • Long term: consider an atypical antipsychotic associated with less weight gain and no increase in prolactin levels. As second line, consider lithium for ♀ patients and valproate or lithium for ♂ patients. • Psychological interventions include: psychoeducation/relapse prevention and support to individual and family; CBT; IPT, family therapy. • Education and vocational training, school liaison, additional support. • Voluntary organizations and support groups. 30 National Institute for Health and Care Excellence (2014, updated 2016) Bipolar disorder: assess ment and management. Clinical guideline [CG185]. M http://www.nice.org.uk/guidance/cg185 [ac cessed 13 July 2018]. 31 National Institute for Health and Care Excellence (2013) Aripiprazole for treating moderate to se vere manic episodes in adolescents with bipolar I disorder. Technology appraisal guidance [TA292]. M http://www.nice.org.uk/guidance/ta292 [accessed 13 July 2018].

702 Chapter 15 Child and adolescent psychiatry Psychosis32,33 Psychosis in adolescence is uncommon, and very uncommon in children. Psychosis is an umbrella term for a range of experiences affecting thoughts, feelings, behaviour, and perception and is a constellation of signs and symp toms, rather than diagnosis. Disorders include: schizophrenia, schizoaffective disorder, and delusional disorder. Diagnosis is on the basis of standard ICD- 10 or DSM-5 criteria (E The diagnosis of schizophrenia, p. 184). Psychosis in children and adolescents Psychotic illnesses are rare in young children and present a particular chal lenge in both diagnosis and management. Very young children under 6yrs have preoperational cognitions, and thus 'reality testing' is blurred by a range of normal fantasy material. Imagined friends, transient hallucinations under stress, and loose associations may all occur within the normal spec trum of development. There is also growing evidence for an association between trauma and psychosis. Differential diagnosis There are many causes of apparent psychotic symp toms in children and adolescents. This means that assessment of a child with symptoms requires extreme care and thoroughness. Possible explanations include • Normal experience. • Organic conditions (e.g. TLE, thyroid disease, SOL, automimmune disorders, WD, encephalitis, and substance misuse disorders). • Mood disorders. • Pervasive developmental disorder/autism. • OCD. • Schizophrenia. • Bipolar affective disorder. • Language disorders. • Dissociative disorders. • Culture-bound syndromes. Schizophrenia Prevalence One in 10,000 children, increases with age, peak onset 15yrs onwards. Clinical features • More often insidious than acute onset. • Often up to 12mths of prodromal phase with transient symptoms. • Associated with poor premorbid function with developmental delay. • Negative symptoms often precede positive symptoms and are prominent. • Comorbidity common—conduct and developmental

problems, substance misuse. 32 National Institute for Health and Care Excellence (2013, updated 2016) Psychosis and schizo phrenia in children and young people: recognition and management. Clinical guideline [CG155]. M http://www.nice.org.uk/guidance/cg155 [accessed 13 July 2018]. 33 National Institute for Health and Care Excellence (2011) Aripiprazole for the treatment of schizo phrenia in people aged 15 to 17 years. Technology appraisal guidance [TA213]. M http://www.nice.org.uk/guidance/ta213 [accessed 13 July 2018].

703 PSYCHOSIS • Strong family history of schizophrenia/psychosis. • Poorer outcome than adult-onset schizophrenia. Poor premorbid functioning, negative symptoms, 'disorganized' clinical presentation, and longer duration of untreated psychosis predict worse outcome. Assessment: key areas • Good engagement important. • Detailed developmental history. • History from multiple informants, including family and school. • Ask about negative symptoms. • Screen for comorbidity, including substance misuse. • Risk assessment. • Physical examination and medical investigations may include CT/MRI/ EEG brain and psychosis screen bloods. Consider testing serum for VGKC antibodies and NMDA receptor antibodies. ECG important if wanting to start medication. • Consider use of rating scale, e.g. K-SADS. • 5Ps formulation helpful for thinking about stress and vulnerability. Management • Inpatient, day-, or outpatient care? Will depend on complexity, level of risk, likely engagement/concordance, and likely effect on the child of being away from the family. Care should be in age-appropriate setting. Early intervention psychosis services are becoming more common. • Medication—age-specific evidence base limited. SGA favoured over FGA. Choice of antipsychotic can be influenced by side effect profile, and patients should be made aware of this, e.g. potential weight gain with olanzapine. Risperidone is usually first line, and aripiprazole second line (if risperidone has not been tolerated, contraindicated, or ineffective).33 • Children must be monitored closely, following local guidelines. • 'Treatment resistance' defined as ineffective trials of at least two atypical antipsychotics at optimum dosage for around 6–8wks. Clozapine may be useful, and around two-thirds of patients will benefit. • BDZs or antipsychotics may be useful in managing acute behavioural disturbance not responsive to non-pharmacological measures (ESevere behavioural disturbance, p. 1048). • Antipsychotic medication will likely need to be continued for at least 18–24mths post-recovery. • Supportive, psychoeducational, and specific psychotherapeutic individual work, e.g. CBT for psychosis, social skills training. • Family support, education, and therapeutic work, as appropriate. • Manage comorbidity. • Ongoing risk assessment and management. • Educational/vocational input, e.g. reintegration package to school, specialist education provision, supported college/work placements. • Awareness of consent/capacity/legal issues. • Voluntary sector—Young Minds website, Mind. • Help with access to advice regarding benefits, housing, and other supports. • Thoughtful and measured transition to adult services.

704 Chapter 15 Child and adolescent psychiatry Gender identity disorder Gender identity disorder (GID) in young people was, until a few years ago, thought to be an extremely rare condition. Recently, however, there has been a huge increase in the number of referrals to specialist young people's gender services, and it is not unusual for generic CAMHS to work with young people with gender issues, either as a referral for assessment or to monitor any con current mental health difficulties. GID (or gender dysphoria) refers to distress about incongruence between an individual's sex assigned at birth and their perceived gender. Diagnostic criteria, prognosis, and interventions offered differ, depending on the age of presenta tion (see also E Gender identity and gender dysphoria 1: overview, p. 508). Gender identity disorder in childhood (F64.2) • Pre-pubertal child;

♂:♀ ratio ranges between 6:1 and 3:1. • An aversion to ♂/♀ anatomical structures and insistence they want to be, or are, the opposite sex. • A preoccupation with interest/activities, peer group, and clothing more stereotypically associated with the opposite sex. • Dysphoria must be present for at least 6mths. • <20% of cases persist into adolescence, and onset of puberty can lead to a resolution or intensifying of dysphoria. Therefore, it is important the child experiences early puberty and medical management is supportive— 'watchful waiting'—allowing for the possibility of change. Some parents elect to support their child by allowing them to transition to their perceived gender, either full time or on a more intermittent basis, e.g. on holiday or in safe spaces, such as home. • When puberty starts, if dysphoria persists there may be a role for puberty blockers (GnRH analogues) (E Staged process of intervention, see below). Gender identity disorder in adolescence and adulthood (transsexualism—F64.0) • Post-pubertal; ♂:♀ ratio is close to 1:1. • The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make their body as congruent as possible with the preferred sex, and usually accompanied by a desire to change their body and how they present to others. • Dysphoria is not a symptom of another mental disorder or a chromosomal abnormality. • Almost 100% of cases persist into adulthood. • Depending on the age and stage of the young person, a number of different interventions can be considered. Staged process of intervention The World Professional Association for Transgender Health (WPATH) Standards of Care34 advocates a 'staged process' of medical intervention, moving in a step-by-step manner from fully reversible interventions to 34 WPATH (World Professional Association for Transgender Health) website: M http://www. wpath.org – go to 'Publications' tab and select 'Standards of Care' [accessed 13 July 2018].

Gender identity disorder partially reversible and, finally, irreversible interventions. This allows for as similation of change and reflects the possible fluidity of gender. The age at which interventions can be initiated varies between countries, reflecting the differences in legal systems and the age of majority. • Stage 1—assessment/exploration—taking a detailed, comprehensive history, including the young person's understanding/experience of 'gender'; questionnaires, such as the Utrecht Gender Dysphoria Scale, may be used. If dysphoria is 'persistent, consistent, and insistent', physical interventions can be considered; evidence of this might include the young person starting to progress with 'social transitioning', i.e. adopting on an identity more congruent with their perceived gender. • Stage 2—'Puberty blockers' (GnRH analogues) may be initiated by endocrinology to halt further pubertal development or in advance of initiating gender affirming hormones. These are fully reversible and give the young person 'space' and time to consider their options without ongoing physical body changes. • Stage 3—gender-affirming (also known as 'cross-sex') hormones can be considered if dysphoria persists. Some of their physical effects are irreversible, e.g. deepening of the voice, and the negative impact of hormones on a young person's fertility also needs to be considered prior to their initiation. Consent and capacity also need to be assessed. • Stage 4—Gender-affirming surgery. These irreversible procedures include bilateral mastectomy and chest reconstruction surgery, and genital (or gender reassignment) surgery—the latter is not offered to adolescents. Young people's gender identity services encourage a collaborative network approach, maintaining close links and regular liaison with other professionals involved with the young person. Associated mental health difficulties Young people with gender dysphoria experience high rates of depression, self-harm, and suicidal ideation, most likely as a consequence of bullying and stigmatization. Accepting the recent increase in the number of referrals to gender services, it is likely that a growing number of these young people will also have contact with local CAMHS teams. It is also increasingly recognized that there is a much higher

prevalence of ASD in the gender dysphoric population than would be expected, and with less of a ♂:♀ ratio differentiation. The reasons for this are unclear and require further research—are these separate or co-occurring conditions? Is dysphoria a reflection of ASD 'restricted interests'? Assessment can be more protracted in such cases, but a diagnosis of ASD does not preclude an individual also meeting the criteria for a diagnosis of gender dysphoria. ICD-11 renames GID 'Gender incongruence (of childhood; of adoles cence or adulthood)' and shifts the concept outside of 'Mental, behavioural, or neurodevelopmental disorders' and into 'Conditions related to sexual health'. There is increasing awareness that gender is not a binary concept (i.e. ♂/♀), and some people identify as non-binary; this will need to be reflected in future revisions of operational criteria.

706 Chapter 15 Child and adolescent psychiatry Substance misuse in children and adolescents Substance misuse is increasingly common in young people. It affects 13% of adolescents referred to mental health services. The characteristics of use and the approach to management can be different to those in adults. Comorbidity is common—conduct problems, depression and other emo tional disorders, ADHD, and eating disorders. Types of use include: • Experimentation/exploration—usually social, about adventure. • Social use—social acceptance important. • Emotional/instrumental use—for the 'high' or to suppress unpleasant feelings and deal with stress. • Habitual use—salience, tolerance, and negative consequences on life become prominent. • Dependence—full dependence syndrome (E The dependence syndrome, p. 574). Assessment: key areas • Involve the family where possible. • Substance—types, routes, quantity, cost, context. • Consequences of use—family, friends, development, education, employment, physical and mental health, criminal activity. • Attitude to referral—Prochaska's theory of change. • Link with other agencies, e.g. social services, education, youth justice. • Risk—to self, others, child protection. Management • Brief interventions may be sufficient for young people with less severe substance misuse problems. The developmental stage and a shorter history mean rapid changes can be made. • More severe problems are addressed by coordination of multiple agencies, e.g. mainstream CAMHS, social and education services. • Structured treatment by specialist young people's substance misuse treatment services is recommended for the under-18s who have significant substance misuse problems (normally polydrug and alcohol misuse). This could include harm reduction interventions, psychosocial treatments (motivational therapies, cognitive behavioural treatments, family-based supports and treatment), and occasionally pharmacological interventions. Again this occurs in the context of interventions to address all of the young person's health, social, family, and educational needs, and therefore involves multiple agencies. The involvement of a young person's family or those with parental responsibility is considered good practice and may be required with regard to consent.

Paediatric liaison psychiatry Paediatric liaison psychiatry Paediatric liaison psychiatry is a subspecialty of child and adolescent psych iatry, bringing together mental health clinicians with their paediatric col leagues, so that children who present with emotional distress through physical symptoms and those who experience psychiatric disorder asso ciated with chronic paediatric conditions can have all of their health needs met. This may include: responding to children presenting with psychiatric crises in acute medical settings; management of unexplained symptoms; treating anxiety and mood disorders which are comorbid with chronic paediatric and life-limiting conditions; and diagnosing and managing children with complex neuropsychiatric disorders. Mental health disorders are more prevalent in children with chronic paediatric

conditions, particularly neurological, e.g. >35% of children with epilepsy will have an associated psychiatric disorder. Families appreciate that their children benefit from having all of these difficulties understood and treated in the one setting. A paediatric liaison service is not simply a CAMHS service located within a paediatric setting, but rather an MDT fo cusing on supporting paediatric practice through clinical discussions, joint work, teaching, and research activities. Children and young people present to paediatric settings with self-harm, and in addition to supporting their psychiatric assessment and follow-up, paediatric liaison psychiatry clinicians have an important role in training paediatric staff, so that their response is compassionate and timely and supports the management of risk in this vulnerable population. NICE guid ance supports young people who self-harm being offered an overnight stay which allows for a cooling-off period, as well as facilitating a comprehen sive assessment the following day, ideally by a service which will provide follow-up. Other acute presentations can include acute anxiety, depressive disorder with suicidality, eating disorders, and psychosis, which will require a full psychiatric assessment and potentially a referral to community-based or inpatient CAMHS. In addition to what psychiatric expertise can bring to paediatric neur ology services, there is increasing evidence of the need for neurological expertise in the assessment of psychiatric presentations in children (such as anti-NMDA encephalitis which may present as psychosis). Neurological symptoms, such as Tourette's syndrome and Sydenham's chorea, which present to neurology may require significant therapeutic intervention with psychiatric medicines and/or psychological therapies. With ABI which may be due to trauma, cancer, or infection, there is a recognized pattern of acute and chronic neuropsychiatric vulnerability that requires a team ap proach to rehabilitation, involving a range of mental health skills in nursing, psychology, and psychiatry. Often a joint assessment involving both a psych iatrist and a neurologist is the most efficient way to make a case formulation and plan further investigation and therapy. A similar approach is required for medically unexplained symptoms (MUS) which can affect any system in the body, with children and young people regularly presenting with non- epileptic seizures and motor or sensory difficulties.

 Children and young people with intellectual disabilities Children and young people with ID have disproportionately higher rates of mental health and behavioural difficulties, physical comorbidities, adverse life events, and poverty than their typically developing peers. Around 40% will have a comorbid mental health disorder. These can be more difficult to recognize, especially if the patient has limited or no verbal communication. Diagnostic over-shadowing can lead to significant changes in presentation being misattributed to ID, rather than comorbid mental, physical, or psy chological disorder. Patients may present in crisis or distress on a background of longer-term changes in presentation. Biopsychosocial assessment is particularly im portant for patients with IDs. It is always important to exclude underlying physical health causes, e.g. pain, acute infection, or constipation. This is especially important if the ID is the result of a disorder with recognized medical complications, e.g. tuberous sclerosis. There is increasing informa tion available about genetic disorders which also have a behavioural pheno type, i.e. characteristic patterns of motor, cognitive, linguistic, and social abnormalities.35 Multidisciplinary assessment is often required to provide a formulation which confirms diagnoses but also identifies additional protective factors or issues that can support or might hinder therapeutic interventions, e.g. sensory impairments/processing abnormalities, social and communication difficulties, sleep abnormalities, and psychosocial or iatrogenic factors. Interventions are rarely uni-modal and should be specific and targeted to realistic goals. They should be developed in collaboration with the patient and their family/carers and within the context

of involved services, e.g. may require additional community-based resources from social services. They should be culturally sensitive and appropriate to the patient's physical and mental health needs. Psychoeducation should be accessible to the patient and family to help them understand the IDs and comorbid difficulties. There is often pressure on doctors to prescribe medication, especially at times of crisis. The cost–benefit ratio for prescribing any medication should be carefully considered. Medication is only helpful if it is appropriately tar geted to a significant underlying symptom, e.g. anxiety. Short-term sedation in the absence of a clear assessment and care plan can further reduce the patient's adaptive functioning and opportunities for learning. If medication is required, it is often used off licence. It is therefore important to: • Identify any relative and absolute contraindications to medication, based on the patient's current presentation and past history. • Identify symptoms that can be successfully managed, and include baseline assessments. • Identify what other appropriate interventions might be needed. e.g. psychological. 35 Waite J, Heald M, Wilde L, et al. (2014) The importance of understanding the behavioural pheno types of genetic syndromes associated with intellectual disability. Paedatr Child Health 24:468–72.

Children and young people with intellectual disabilities Medication should be proposed as a trial, bearing in mind its mode of action, adverse effects (which may be more likely in a patient with IDs), and potential interactions with other medication the patient may be taking. It should also be in a preparation acceptable to the patient, e.g. whether they can swallow it or tolerate the smell/taste. This can be especially problem atic for patients on the autism spectrum. Informed consent should be sought from the patient, and if they are deemed not to have capacity to give it, the necessary legislation should be used. The outcomes of any interventions should be monitored by reviewing the presence of target symptoms, the impact of potential adverse effects and the patient's adaptive functioning.

710 Chapter 15 Child and adolescent psychiatry Forensic child and adolescent psychiatry This is a small subspeciality within child and adolescent psychiatry, which deals with the mental health of young people who pose a significant risk of offending or behaving violently. Forensic Child and Adolescent Mental Health Services (FCAMHS) across the country have been set up to de liver assessment and treatment to a complex population in whom multiple comorbidities, social and educational disadvantages, higher incidence of physical ill health, and frequent drug and alcohol problems are present. Looked after and local authority-accommodated, young people are more likely to have a mental disorder (46%) than a matched socially disadvantaged control group (15%) living in private households.36 Young people in secure care have higher rates (three times) of mental disorder than controls in the community.37 Apart from CDs, other psychiatric comorbidities include affective disorders, psychosis, anxiety disorders, ADHD, substance misuse disorder, and personality disorders. One study38 showed that ♀ sentenced young offenders had a 32% (16% in ♂) lifetime history of suicidal attempt. Many studies have shown that the peak age for a minor offending is 17–18yrs, of whom only a minority (5–10%) who are more likely to have experienced over a prolonged period of time severe family adversity and coercive parental style persist into adulthood.39 Callous and unemotional personality traits may arise as a result of multiple genetic, perinatal, and early developmental factors (early attachment difficulties, poor peer re lationships, and serious early life child sexual abuse).40 A few longitudinal studies have shown that children with CD at the age of 7yrs are ten times more likely to be involved in criminality in adulthood.41 Childhood adversity (physical neglect, poor parental supervision, disrupted family, large family size, a convicted parent, mother with depression) between the ages of 8 and 10yrs is a good

indicator of later antisocial traits.42 Secure CAMHS services A range of services are available to offending adolescents, including adoles cent inpatient services, secure hospitals, forensic CAMHS, general CAMHS, youth offender institutions (YOIs), youth offending teams (YOTs), secure training centres (STCs), specialist schools, social services, secure children's 36 Ford T, Vostanis P, Meltzer H, et al. (2007) Psychiatric disorder among British children looked after by local authorities: comparison with children living in private households. Br J Psychiatry 190:319–25. 37 Jacobson J, Bhardwa B, Gyateng T, et al. (2010) Punishing disadvantage: a profile of children in custody. London: Prison Reform Trust Publications. M http://www.prisonreformtrust.org.uk/portals/0/documents/punishingdisadvantage.pdf 38 Chitsabesan P, Kroll L, Bailey S, et al. (2006) Mental health needs of young offenders in custody and the community. Br J Psychiatry 188:534–40. 39 Moffitt TE, Caspi A (2001) Childhood predictors differentiate life-course persistent and adoles cent limited antisocial pathways among males and females. Dev Psychopathol 13:355–75. 40 Vizard E, French L, Hickey N, et al. (2004) Severe personality disorder emerging in childhood: a proposal for a new developmental disorder. Crim Behav Ment Health 14:17–28. 41 Fergusson DM, Horwood LJ, Ridder EM (2005) Show me the child at seven. II: Childhood intel ligence and later outcomes in adolescents and young adulthood. J Child Psychol Psychiatry 46:850–8. 42 Farrington D (2005) The importance of child and adolescent psychopathy. J Abnormal Child Psychol 33: 489–97.

Forensic child and adolescent psychiatry homes (SCHs), voluntary sector, and adult mental health services. Services widely vary across the UK. Forensic adolescent consultation and treatment service (FACTS) There are three such Tier 4 services in England and Wales, and they provide specialist consultation, assessment, and treatment to mostly 10- to 18-year olds who present with high-risk behaviours in the community in the context of significant mental health needs. These teams have emerged from, and are usually aligned to, local medium secure units. Community-based forensic teams (FCAMHS) These Tier 3 and 4 community teams have emerged from local CAMHS services and provide specialist assessment, treatment, and consult ation service to courts, YOIs, YOTs, STCs, CAMHS, Looked After and Accommodated Children (LAAC) services. Secure inpatient services The majority of secure CAMHS inpatient services meet medium secure standards, but they look after young people who, on one hand, may be ready for transition to community services and, on the other, meet high- secure referral criteria (there is no high-secure provision for young people). Referral to medium secure units is through the National Commissioning Group (NCG)43 that meets weekly to consider referrals nationally. There are also low-secure units both in the NHS and in the independent sector. All the above units are mostly based in England. Scotland does not have se cure inpatient services for adolescents and refers patients to England via the NCG. However, there have been recent developments that aim to address this gap. 43 Centre for Mental Health (2010) Directory of services for high-risk young people. M https:// www.centreformentalhealth.org.uk/directory-services-high-risk-young-people [accessed January 2019].

712 Chapter 15 Child and adolescent psychiatry Child maltreatment 1: general issues Maltreatment We now have a greater understanding of the effect of maltreatment on the developing brain, and there is evidence that abuse and neglect can lead to structural and functional changes.44,45 Children who have been maltreated are more likely to have mental health and physical health problems in the future. Child maltreatment is any action or inaction, which causes significant harm to a child. Abuse of power, responsibility, and grooming are often factors in maltreatment. The

WHO46 estimates that a quarter of all adults have been physically abused, and 1 in 5 women and 1 in 13 men have been sexually abused. Many people will have also experienced emotional abuse. It is likely that if a child experiences abuse, it will be of more than one type. Types of abuse Domestic abuse Witnessing (seeing, hearing, noticing injuries) domestic violence or being involved in an abusive relationship. This can include physical and sexual vio lence, threats, psychological abuse, financial abuse, and taking control over all aspects of another's life. Physical abuse Hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffo cating, or otherwise causing physical harm to a child [includes fabricated/ induced illness (previously known as Munchausen syndrome by proxy (see Box 15.7)]. Neglect The persistent failure to meet a child's basic physical/psychological needs, likely to result in serious impairment of the child's health and development. Includes failure to provide adequate: food, clothing, shelter, and supervi sion; protection from harm or danger; and access to appropriate medical care. Also includes substance misuse during pregnancy. Emotional abuse Persistent emotional maltreatment resulting in severe effects on the child's emotional development. Includes denigration, humiliation or rejection, emotional neglect, developmentally inappropriate expectations, repeated separations, and mis-socialization of the child. Other types of abuse are likely to result in emotional abuse. 44 HM Government (2015) What to do if you're worried a child is being abused. London: HMSO. M https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_ data/file/419604/What_to_do_if_you_re_worried_a_child_is_being_abused.pdf [accessed July 2018]. 45 National Society for the Prevention of Cruelty to Children. Child abuse and neglect. M http:// www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect [accessed 13 July 2018]. 46 World Health Organization. Child maltreatment (child abuse). M http://www.who.int/topics/ child_abuse/en [accessed 13 July 2018].

Child maltreatment 1: general issues Sexual abuse Forcing or persuading a child into sexual activity. This can include contact and non-contact abuse. This may include penetrative and non-penetrative physical acts, and noncontact activities such as involving children in looking at, or producing, sexual images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways. There has been an in crease in sexual abuse and exploitation with the rise in Internet use. Online abuse Any form of abuse occurring on the Internet and can include cyberbullying, sexual abuse, and grooming. Female genital mutilation Partial or total removal of the genitalia, with no medical reason. Child trafficking Removal of children from their homes to be sold and/or exploited for work, sexual abuse, or criminal activity. Box 15.7 Fabricated or induced illness • Manifest by a person feigning or inducing illness in a child (or others) in order to obtain medical attention. • A form of child abuse in that it subjects the child to emotional abuse, unnecessary medical procedures, hospitalization, or other treatments that are harmful to the child. • Can be very difficult to detect as the perpetrating (and colluding) adult/s often deny and disguise their behaviour. • It is essential for professionals to be alert to it, especially where a child repetitively presents for medical attention. • Undetected, this form of abuse can result in very serious consequences (including fatality) for the child. • DSM-5 and ICD-11 both use the term 'Factitious disorder imposed on another'.

 Child maltreatment 2: the duty of care All healthcare professionals have a duty to safeguard and promote the wel fare of children. It is important to remain alert to the possibility of abuse or neglect. The assessment of risk and interventions to protect children require a multidisciplinary and multi-agency approach. In general,

the duty to patients, including that of confidentiality, is overridden by the duty to protect children. Referrals regarding possible abuse will usually be made to social work services or the police. Making a child protection referral • Know how to access your local multi-agency child protection procedures and follow them. • It is good practice to discuss the referral with the child, as appropriate to their age and understanding, and with their parents, to seek agreement to the referral, unless such discussion would place the child at risk of significant harm. It is not necessary to have agreement to make the referral. • Ensure that you carefully document all concerns, discussions, decisions made, and reasons for these decisions. • Discuss the situation with a senior colleague. • Follow up oral communications in writing. • Have as much information regarding the child and your concerns available as possible. • Do not do anything that may jeopardize a police investigation, e.g. asking a child leading questions or attempting to investigate the allegations of abuse. If in doubt, seek advice. Child maltreatment—where does CAMHS fit in? • Being alert to abuse, responding to concerns expressed by individuals and families, and making a child protection referral. • Involvement in multi-agency discussion and planning for the child. • Assessment of mental health problems, including neurodevelopmental disorders. • Therapeutic work, as appropriate. Mental health outcomes of abuse Children who are abused have an extremely high rate of psychiatric dis orders, both during the abuse and later on. Some of the most common disorders/difficulties associated with previous abuse include: • PTSD/complex trauma. • Attachment disorder. • Dissociative disorders. • Conversion disorders. • Emotional dysregulation. • Depression. • Substance misuse. • Self-harm. • Neurodevelopmental disorders.

Looked-after children Looked-after children ‘Looked after’ is the term used to describe all children in public care, including those in foster or residential homes and those still with their own parents/family but subject to care orders.47 The majority have become ‘looked after’ because of abuse or neglect. Outcomes for looked-after children In general terms, young people have significantly poorer outcomes in terms of education, employment, and physical and mental health. Mental health of looked-after children Children and young people who have been looked after have often ex perienced many risk factors for the development of mental health prob lems: abuse or neglect, family dysfunction, parental ill health or substance misuse, changes of carer, high socio-economic disadvantage, discrimination, and trauma. Adverse childhood experiences are closely related to the de velopment of physical and mental health problems. Mental health problems in LACs are common, and >1 diagnosis is often present. Common presentations include: depression, anxiety disorders, behav ioural difficulties, self-harm, emotional dysregulation, substance misuse, at tachment disorder, PTSD, ADHD, and ASD-like difficulties. Working with looked-after children This requires multi-agency cooperation, as multiple needs must be met. • A stable and secure environment for the child where their physical, emotional, and social developmental needs are met is fundamentally important. • A positive attachment with a caregiver is essential. • Even if a change of environment is unavoidable, continuity in the form of attending the same school and retaining the same workers is important. • Support to the child’s carers—social work services, CAMHS, and other agencies may all play a role. • Individual CAMHS work with the child can be helpful in the context of these needs being met. • Placement instability is not a reason to withhold CAMHS input. • Important RCTs are under way to investigate the impact of infant mental health teams for young children who have been maltreated. ‘The test of the morality of a society is what it does for its children.’ Dietrich Bonhoeffer (1906–1945) German Protestant theologian and anti-Nazi activist 47 Pritchett R, Hockaday H, Anderson B, et al. (2016) Challenges of assessing maltreated children coming into foster care. Scientific World J 2016:5986835. M

https://www.hindawi.com/journals/ tswj/2016/5986835/ [accessed 13 July 2018].

716 Chapter 15 Child and adolescent psychiatry Prescribing in children and adolescents • Children and adolescents are not small adults! This is particularly important in regard to the dynamics and kinetics of medication.48,49 Some drugs are metabolized faster, while others more readily cross the blood–brain barrier. Susceptibility to side effects also varies with age (e.g. children are more likely to develop dystonias and less likely to develop akathisia with neuroleptic treatment). • Medication should be considered as just one component of treatment— it should be accompanied by psychological, social, and educational interventions. • Medication is often prescribed for symptoms, rather than syndromes (e.g. stimulants for hyperactivity symptoms in a variety of disorders). • Drug trials in children are problematic, both ethically and practically, so there are inadequate data regarding safety and efficacy for many psychotropics. Clinicians are often faced with ethical decisions regarding the use of medication not licensed for use in these age groups. • The decision to prescribe needs to take into account both the young person's and the parents' attitudes to medication, and to consider issues of consent and capacity. • Potential benefits and risks have to be weighed up in each case, fully discussed with families and recorded in the notes. Often providing written information can be helpful. • Start low and go slow. Starting doses with children and adolescents are often at least half that of what would be prescribed in adults. • Dose titrations are done gradually, with close attention to side effects. • Avoid polypharmacy where possible. • Some children and young people can also have paradoxical reactions to medication, e.g. BDZs can cause severe agitation. • Drug monitoring in accordance with local and national guidelines should always be carried out, e.g. antipsychotic medication, ADHD medication. 48 For an interesting historical review, see Zito JM, Derivan AT, Kratochvil CJ, et al. (2008) Off-label psychopharmacologic prescribing for children: history supports close clinical monitoring. Child Adolesc Psychiatry Ment Health 2:24. M http://www.capmh.com/content/2/1/24 [accessed 13 July 2018]. 49 Riddle MA, Kastelic EA, Frosch E (2001) Pediatric psychopharmacology. J Child Psychol Psychiatry 42:73–90.

Prescribing in children and adolescents

718 Chapter 15 Child and adolescent psychiatry Family therapy While FT or systemic practice is a treatment we tend to associate more specifically with child and adolescent psychiatry nowadays, its origins ac tually stem from research in adult psychiatry carried out in the 1940s and 1950s looking at the impact of different patterns of communication and interaction in families where a member had a diagnosis of schizophrenia.50 FT has been influenced by many different schools of thought since then, including psychodynamic theory, general systems theory, social construc tionism, feminist ideas, and attachment theory. While there are an increasing number of different approaches used in FT, they all recognize the 'interrelatedness' of the person with the problem and other family members, and the role of the family 'system' in helping to re solve the problem and share the idea that 'the whole of the system is more than the sum of its individual parts'. In addition, the causality of a problem is described as 'circular', rather than linear. By the general systems theory, all systems strive to maintain homeostasis, i.e. resist change. However, all families are constantly experiencing change, as individual family members grow, develop, and individuate (or not); this is described as the family life cycle. These changes present challenges for all families, e.g. an emerging adolescent striving for independence, and prob lems arise when the family becomes 'stuck' and is not able to resolve suc cessfully these transitions. FT can be used wherever

it is recognized there are difficulties in family relationships. Depending on the problem, it may be used as the main treat ment in child and adolescent psychiatry or concurrently with other treat ments such as individual therapy and/or medication. Key elements of some different family therapy models Structural FT Minuchin proposed that clear rules govern optimal family organization and structure, with a focus on hierarchy, subsystems, and boundaries. Challenges to this structure results in problems which the family attempts, with success, to address. In this model, the therapist takes a directive, ‘expert’ stance to change family behaviours and re-establish the preferred structure. Strategic FT In this model, developed by Haley, problems always arise be cause of difficulties with hierarchy within the family system. Haley suggested that rather than attempting to resolve this, the family was ambivalent about having the problem, as it provided some gain for them. Reflecting this idea, the therapist takes a more strategic stance to overcome their resistance, such as using ‘paradox’, e.g. suggesting the problem may not be resolvable, and setting family tasks such as ‘prescribing’ or ‘pretending’ the problematic symptom. In these early models of FT, the therapist was very much the ‘expert’, with a focus only on behaviour. Failure to comply was interpreted as re sistance, and there was no acknowledgement of a family’s beliefs, feelings, or past experience. Subsequent models of FT began to address this power imbalance, recognizing the family as the real ‘experts’ in what might be ef fective, with more of a focus on collaboration as the therapist works with the family to jointly explore their difficulties. 50 Carr A (2012) Family Therapy: Concepts, Process and Practice. Chichester: John Wiley and Sons.

Family therapy Milan systemic FT This model was developed in the early 1970s in re sponse to the closure of large psychiatric institutions in Italy. There is increasing emphasis on family beliefs and meanings, and the idea of there being no single objective truth about the problem. The Milan model intro duced the concepts of ‘re-framing’ the problem and hypothesizing, as well as ideas about neutrality and curiosity, with the therapist taking more of a ‘not-knowing’, non-expert stance. More recent developments in FT reflect the influence of social con structionism. There is also recognition that the family is the expert—the therapist ‘joins’ them to work collaboratively to resolve the problem—and more of a focus on the use of language; examples include: Narrative FT Difficulties are a reflection of unhelpful, dominant, ‘problem-saturated’ narratives (or stories) we hold about ourselves. The therapist helps to highlight ‘unique outcomes’ to challenge this narrative and, through the use of ‘externalization’, i.e. separating the problem from the person, helps to rewrite this to a more helpful one. Solution-focused FT This is the opposite of taking a ‘problem-focused’ medical history, with an interest on exceptions and solutions. Goals and scales are used, and the ‘Miracle Question’, problem-free talk, and comple ments are important elements of this approach. Circular questioning Karl Tomm highlighted that the different way a ques tion is asked about a problem—either ‘circular’ or’ linear’—can be a thera peutic intervention in itself, serving to either add additional information and open new possibilities of change for the family or maintain the restricted status quo, respectively. Most FT practitioners work using an integrated approach, incorporating elements of many different models, which allows for flexibility and best ‘fit’ with each family. Also, some therapists work as part of a team using a one- way mirror. Use of the reflecting team lets the family observe the team ‘reflect’ on their prior conversation with the therapist, so allowing new per spectives and possibilities to emerge.

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