Chapter 25: Child and Adolescent Psychiatry

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Introduction

Child and adolescent psychiatry is concerned with mental health problems occurring in individuals from birth to between 16 and 25 years of age. The field may be further subdivided into perinatal and infant, child, and adolescent or youth psychiatry. Child and adolescent psychiatrists are trained to deal with patients across the age spectrum but may choose to focus on one or other of these subspecialty areas.

How Does Child and Adolescent Psychiatry Differ from General Adult Psychiatry?

Child and adolescent psychiatry is not miniaturised adult psychiatry. Child and adolescent psychiatry differs from general adult psychiatry in several important ways. Child and adolescent psychiatry is especially dynamic because disorders are often expressed differently at different ages, and disorders evolve over time. Child and adolescent psychiatry is related to adult psychiatry in the same way embryology is related to gross anatomy. There is an opportunity to intervene early and positively influence the trajectory of patients who are maturing.

Classification of Mental Disorders Affecting Children and Adolescents

Psychiatric diagnoses are limited in young people by the lack of criterion validity (biological markers of illness), understanding of aetiology and pathophysiology. A lack of diagnostic stability is exaggerated in child and adolescent psychiatry. The same child (with the same brain!) may transition through enuresis, separation anxiety disorder, oppositional defiant disorder, substance use disorder and major depressive disorder.

Child and adolescent psychiatric disorders are diagnosed according to ICD-11 and DSM-5-TR. To use these classifications, note the following:

1. Problems are seen in the context of normal development, i.e. what is common for 1-year-olds can be maladaptive for 7-year-olds (e.g. nocturnal enuresis, separation anxiety).
2. Disorders are often about a failure to achieve developmental milestones. The difference therefore between normality and disorder is less clear-cut than in adult psychiatry.
3. Symptoms may be diagnosable because of their intensity or persistence; thus temper tantrums are common in pre-schoolers, but deemed problematic only if they occur frequently, are of long duration and lead to functional impairment.

Table 25.1. Mental disorders that can affect children and adolescents.

Category	Disorder
Conditions restricted to childhood	Elimination Disorders (enuresis, encopresis)
	Separation Anxiety Disorder
	Selective Mutism
Conditions that have their onset in childhood but may affect adult adjustment	Intellectual Disabilities
	Communication Disorders
	Autism Spectrum Disorder
	Attention-Deficit/Hyperactivity Disorder
	Specific learning Disorder
	Motor Disorders (coordination, stereotyped movements)
	Disruptive Mood Dysregulation Disorder
	Tic Disorders
	Gender Dysphoria
	Oppositional Defiant Disorder
	Conduct Disorder
	Intermittent Explosive Disorder
Conditions that can recur across the lifespan	Depressive Disorders
	Anxiety Disorders (other than separation, mutism)
	Obsessive-Compulsive and Related Disorders
	Trauma-and Stressor Related Disorders
	Dissociative Disorders
	Somatic Symptom and Related disorders
	Anorexia Nervosa
	Sleep-Wake Disorders
	Pyromania
	Delirium
Conditions usually associated with adulthood but which may have their onset in childhood or adolescence	Schizophrenia Spectrum and Other Psychotic Disorders
	Bipolar and Related Disorders
	Bulimia and Binge-Eating Disorders
	Sexual Dysfunctions
	Substance-Related and Addictive Disorders
	Dementia
	Personality Disorder
	Paraphilic Disorders

Many of the mental disorders described in this chapter will be familiar to you from previous chapters in this book. Other conditions are either only seen early in life, or are described differently in children than they are in adults. An example

of the latter is conduct disorder, which if persistent in adulthood is called antisocial personality disorder. One way of grouping mental health problems of childhood is to think about: 1) conditions restricted to childhood such as selective mutism, 2) conditions that have their onset in childhood but may affect adult adjustment, such as attention deficit hyperactivity disorder, 3) conditions that can recur across the lifespan such as anxiety and 4) conditions usually associated with adulthood but which may have their onset in childhood or adolescence, such as bipolar disorder. Table 25.1 lists the mental disorders that can affect children and adolescents according to this grouping. Cross-sectionally a very simple way to organise mental disorders affecting children and adolescents is into Internalising and Externalising problems.

The approach has scientific validity as factor analysis of common symptom items has shown that problems do cluster roughly into these two categories. Internalising problems refer to emotional symptoms such as worry or sadness while Externalising problems refer to behavioural symptoms such as aggression or hyperactivity. Later in the chapter, when we discuss a few disorders in more detail, we have grouped them according to the Internalising/Externalising dichotomy. Note, however, that it is common for children with Externalising problems to also experience Internalising symptoms. In addition, this simple classification does not work so well for rare symptoms such as odd and eccentric beliefs or dissociation.

Epidemiology of Mental Disorders Affecting Children and Adolescents

The prevalence rates of common psychiatric conditions in major epidemiological studies are summarised in Table 25.2. Rates vary from study to study owing to the diagnostic criteria and research instruments used, as well as characteristics of the population surveyed. Internalising problems are more common in girls, while Externalising problems are more common in boys. Some conditions such as attention-deficit/hyperactivity disorder (ADHD) occur less frequently with increasing age, in others such as depression, prevalence goes up with age. The recent Australian survey made a distinction between mild, moderate and severe problems based on impairment and suicidality. About 5.5% of those surveyed fell into the moderate or severe range of impairment, and represent the group most likely to need specialist child and adolescent mental health care. Children in out of home care, juvenile detention and immigration detention have higher rates of mental health problems than the general population, as do Aboriginal and Torres Strait Islander Australian children, and children with chronic medical illnesses or intellectual disability. Offspring of parents with a mental disorder also have higher rates of problems. Rates of depression and conduct problems are rising in the population, while rates of ADHD remain stable.

Impact of Mental Disorders Affecting Children and Adolescents

Over the lifespan serious mental illnesses cause a high burden of disease with reduced life expectancy of more than ten years and severely impaired social and economic functioning (Lothgren, 2004). In 2010 mental illnesses were responsible for 7.4% of DALYs (disability-adjusted life years) and 22.9% of YLDs (years lived with disability) worldwide. This particularly affects the young, with the highest total proportion of DALYs in those aged between 10 and 29 years (Whiteford et al., 2013). The top five ranked causes of YLDs worldwide in 10-14 year olds include unipolar depressive disorders and anxiety disorders. In 15-19 year olds alcohol use disorders are added to the list, becoming the number two cause of YLDs in 15-19 year old males. In total mental illnesses are responsible for nearly 50% of YLDs in adolescents 10-19 years. When adolescents themselves are surveyed they rate mental health problems as their highest concern (World Health Organisation, 2012).

Mental illnesses greatly increase the risk of long-term disability not only because of severity but also because these disorders tend to present early in life - of those with mental health problems at 26, half met criteria for diagnosis at 15 and 75% by their late teens (Kim-Cohen et al., 2003). Both emotional and behavioural disorders lead to poor self-esteem, peer difficulties and reduced academic performance, as well as reducing family wellbeing, with increasing severity and number of diagnoses increasing the risk of difficulty (Sawyer et al., 2000). Young people with mental illness are at risk of dropping out of school, becoming involved with delinquent peers, and family breakdown. In addition, in later life severe mental illness reduces life expectancy because of the higher risk of chronic physical ill health (Fagiolini et al., 2008; Heald, 2010).

Mental illnesses are also a major cause of mortality in the younger age groups, as the suicide rate in mental illness is at least nine times higher than the general population (Inskip et al., 1998). Worldwide, suicide was one of the five leading causes of death in adolescents in 2012 (World Health Organisation, 2012). In developed countries including Australia and the United States of America suicide is one of the three leading causes of death in adolescents and young adults (United States Census Bureau, 2016).

Table 25.2. Prevalence of common child psychiatric conditions in major epidemiological studies.

Study	Sample	Measures	Prevalence
Second Australian Child and Adolescent Survey of Mental Health and Wellbeing (Australia, 2015)	5500 participants aged 4 to 17	Strength and Difficulties Questionnaire; Diagnostic Interview Schedule for Children, version IV (DISC-IV; some modules)	Any mental health problem (last 12 months): 13.9% Severe mental health problem (last 12 months): 2.1% DSM-IV diagnoses: anxiety disorders 6.9%; depressive disorders 2.8%; CD 2.1%; ADHD 7.4%
Great Smoky Mountain Study of Youth (US, 1993–2000)	1420 children from North Carolina aged 9 to 13 assessed annually to age 16	Child and Adolescent Psychiatric Assessment (CAPA)	DSM-IV diagnoses (3-month prevalence): any diagnosis 13.3%; anxiety disorders 2.4%; depressive disorders 2.2%; CD 2.7%; ODD 2.7%; ADHD 0.9%
British Child and Adolescent Mental Health Survey (UK, 1999)	10438 participants aged 5 to 15	Development and Well-Being Assessment (DAWBA)	DSM-IV diagnoses (current): any diagnosis 9.5%; anxiety disorders 3.8%; depressive disorders 0.9%; CD 1.5%; ODD 2.3%; ADHD 2.2%
Puerto Rico (US, 2000)	1886 children aged 4 to 17	Diagnostic Interview Schedule for Children, version IV (DISC-IV)	DSM-IV diagnoses (last year): any diagnosis 16.4%; anxiety disorders 6.9%; depressive disorders 3.4%; CD 2.0%; ODD 5.5%; ADHD 8.0%
South-eastern Brazil (2000–01)	1251 children aged 7 to 14 attending school	Development and Well-Being Assessment (DAWBA)	DSM-IV diagnoses (current): any diagnosis 12.7%; anxiety disorders 5.2%; depressive disorders 1.0%; CD 2.2%; ODD 3.2%; ADHD 1.8%

Services to Treat Mental Disorders Affecting Children and Adolescents

Children and adolescents make up almost a quarter of the population (Australian Bureau of Statistics, 2015; United States Census Bureau, 2016), yet they access only 6% of mental health services and only one percent of mental health

inpatient beds (Morris et al., 2011). It would be nice to think that the low utilisation of specialist mental health resources by young people was a result of lower rates of morbidity compared with adults, but the data tell us otherwise. Some young people are receiving mental health care outside of the mental health system, but others are not receiving treatment at all. Mental health services for children and young people are organised through a network of agencies and facilities based on the Tier nomenclature developed by the National Health Service in the UK.

Tiers of mental health service

- **Tier 1** – Practitioners who are not mental health specialists e.g., GPs, teachers, social workers.
- **Tier 2** - Child and Adolescent Mental Health Services (CAMHS) specialists working in the community in a uni-disciplinary way e.g., psychologists funded through the Better Access scheme.
- **Tier 3** - Specialist multi-disciplinary teams working in the community or outpatient clinics to address severe, complex and persistent disorders.
- **Tier 4** – Services for young people with the most serious problems such as inpatient units, day units and highly specialised community teams.

Schools are in a good position to observe warning signs such as behavioural deterioration or academic withdrawal and refer to school counsellors who can triage to other appropriate services or assess in more depth, as needed. School services also serve as the most common point of referral to Child and Adolescent Mental Health Services (CAMHS). General practitioners are often the first port of call for families and may refer to more widely available services such as paediatricians, particularly for neurodevelopmental disorders such as autism spectrum disorders or attention deficit hyperactivity disorder. Other private practitioners such as clinical psychologists provide evidence-based therapies including cognitive behavioural therapy or family interventions for many mental disorders. Many non-government agencies also provide counselling or family support. Welfare services and juvenile justice provide care for young people whose mental health problems have become so severe that they live in out of home care or are involved in the forensic system.

In the absence of access, or knowledge about access to community-based mental health services children and adolescents with mental health issues may present to hospital emergency departments. This is unavoidable when there is a medical complication such as poisoning, a laceration or delirium, or when there is

imminent danger of suicide. The emergency department is not a good environment, however, to conduct a comprehensive biopsychosocial assessment of other issues. It is better, if possible, to divert the patient to an urgent (within 24 hours) review by a community Child and Adolescent Mental Health Service (CAMHS). Some health services have specialized mobile teams who will visit young people in their homes or other non-hospital settings to conduct an assessment and initiate or coordinate treatment.

Interviewing a Family

Interviewing family members is essential to the practice of child and adolescent psychiatry. It is rare to see children without their parents or carers, and the assessment of an adolescent is not complete until parents or carers have been involved in the consultation. Family involvement has several practical aspects associated with it. Parents possess the historical information about the child's disorder and development the clinician will need to accurately assess the problem. For a child under 16 years of age the parents have the legal power to initiate assessment and consent to treatment. In addition, parents typically provide financial and practical resources (such as transport) to enable the patient to access care. An advantage for young people who attend the clinic with other family is that they are not the sole focus of attention. Of course there are exceptions. We sometimes agree to see young people 16 years and older without parental knowledge if this is the only way to engage the young person in assessment. Typically, such referrals are brokered by a school counsellor.

Family interviewing attends to both content (the history provided) and process (observation and assessment of the interaction between family members). The emphasis can shift according to the nature of the presenting problem. When a problem seems to be reactive to circumstances within the family such as conflict, the interviewer will be interested in the role of the family in the genesis and maintenance of the problem. When a problem seems to be "hardwired", such as autism spectrum disorder or intellectual disability, the focus shifts to psychoeducation and the capacity for the family to adapt to the situation. A task of the family assessment is to identify strengths or competencies in the family. This can be probed by asking how the family have responded to other challenges. Disorders or problems of other family members can be identified. This is relevant, because if a young person has a mental health problem there is a reasonable likelihood a parent or sibling may also be affected by mental illness. Sometimes it becomes clear the referred person, or "identified patient", is not the most unwell member of the family system. Family interviewing affords the clinician the opportunity to observe parenting style in real time. Aspects include how well the parents have prepared the child for the appointment (including bring age-appropriate activities for younger children), and

how they respond to the child's affect and behaviour. Finally, the interview is an opportunity to engage family (particularly parents) in the treatment process.

The clinician starts by assuming the family cares about the child and has areas of competency in promoting child wellbeing. Even very disadvantaged and seemingly chaotic families may possess good fundamental child rearing skills. However, sometimes the assessment reveals significant deficits in caregiving (neglect) or harmful practices (abuse). Procedures and approaches for interviewing a family are not as well standardized as the psychiatric interview of the individual, nevertheless there are some common elements. The techniques have been derived from the family therapy movement (see treatment modalities below) that comprises many different schools. Each school has its own identifying characteristic or signature, but most schools of family therapy have more in common than they have differences. Opinions vary over whether all family members should be invited to the first appointment. Our default option is to invite all family members living in the same household, and any non-custodial parent who lives elsewhere. Parents may not wish to bring preschool aged children out of concern that they will be disruptive. They are reassured that the service likes and will accommodate young children at appointments. A specific circumstance where involvement of all family members is contraindicated is when there is documented or suspected abuse of one individual by another. Participation of the perpetrator may even be legally precluded through a Domestic or Apprehended Violence Order. Sometimes estranged parents are so conflicted it is better to see them separately.

The content of the family interview attends to, as a minimum, five key areas; family demographics, clinical symptomatology of the child, individual parent history, parent relationship history, and the history of family as a unit (Josephson, 2007) . The story of the family will typically link to the story of extended family who are not present at the interview. One technique for gathering and displaying complex family information is to draw a genogram (usually on a whiteboard) to which can be added salient information such as health and psychiatric status, personal characteristics, key dates, previous relationships, and the closeness or distance of existing relationships (Figure 25.1).

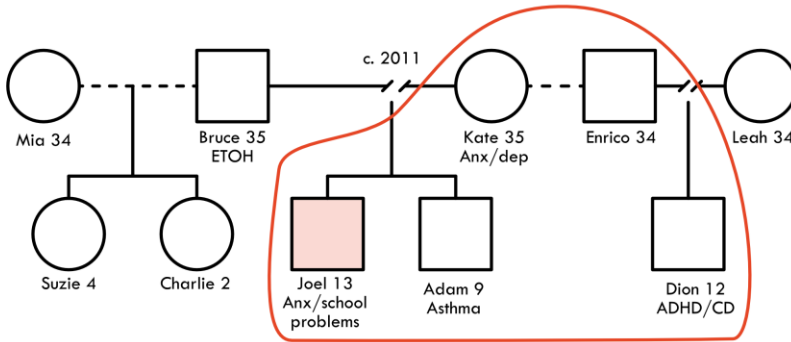

Figure 25.1. Example of a genogram. The genogram encompasses two generations. Joel, the referred patient, lives with his mother Kate, her new de facto partner Enrico, a younger brother, and Enrico's son from a previous relationship. Kate divorced Joel's father in 2011. Bruce has repartnered in a defacto relationship with Mia and they have two young daughters. Enrico is separated but not divorced from his first wife Leah. Various health problems are annotated.

Concurrently the clinician is attending to family processes, which can be grouped into the following four domains; structure, communication, family beliefs and family regulation of child development (Josephson, 2007). Specific examples are provided in Table 25.3. Below is a transcript of the first few minutes of a family interview. Adam (11 years of age) has been referred to a child and adolescent mental health clinic because of anxieties that have escalated since a change in family circumstances. There is a younger sibling with an intellectual disability. In this case, two clinicians have been assigned to the first assessment. Examine the transcript with reference to the process domains described in the box on the following page.

Clinician 1: Hello and welcome to the service. I am Philip, a child and adolescent psychiatrist.
Clinician 2: And I am Michael, a social worker.
Clinician 1: Would you like to introduce yourselves, maybe say a little about yourselves?
Mother: I am Anthea. I'm….34. Uh, I work part time, 3 days a week. As a research assistant.
Father: I'm Stewart….. I'm 32. I have a nursing background and I work as a pharmaceutical rep.
Child 1: I'm Adam
Mother: And this is our second son Bryce, he is 4 years old.
Clinician 1: Adam, what sort of things are you in to?
Child 1: I play soccer. Dad is….was….our coach. I like [insert a current popular computer game].
Clinician 1: And Adam, what is Bryce in to?
Child 2: Need a…need a….need a wee.
(Pause to see if anyone responds. No-one does)
Child 1: He, he likes it when we build a cubby house under the dining table
Clinician 1: And where does Bryce go when Mum is working?
Child 1: He….
Mother: Bryce goes to a preschool. A special preschool.
Father: Anthea needs time out. Bryce can be….
Mother: Hard going. Not that you….
Father: Say it
Mother: Well since you took the promotion…on the road a lot…both the boys….I don't know
Clinician 2: It sounds like there may have been some important changes for the family recently
Child 2: Need a…need a….need a wee.
(Pause to see if anyone responds. No-one does)
Clinician 2: So I wonder what you hoped would come from meeting with us today?
Mother: Adam has…a lot of worries. At night he thinks people might break into the house. Has to check, or actually get us to check, that doors and windows are locked. He gets bad dreams, can't sleep. Comes into our bed…
Father: Because you let him….
Mother: When Stewart is away. If Stewart is home he takes Adam back to his own room
Clinician 1: You have different um, attitudes, rules about kids co-sleeping…..
Mother: And Adam gets very upset if Stewart doesn't phone in on the nights he is away from home…
Father: That was once…
Adam: I thought…I thought…
Mother: That Daddy had been in an accident
Clinician 1: Do Adam's worries spill over to other places….like school?
Mother: Adam likes school
Father: No, there he is just a normal kid…
Clinician 2: So I am curious. Stewart you took on a new work role recently…
Father: Two months ago
Clinician 2: Which has led to some changes in how things run in the family
Father: I guess
Clinician 2: I wonder what sort of conversation you both had [gestures to parents] about how things would work when Stewart took the new job
Mother: [looks away]
Father: …we didn't
Child 2: Need a…need a….need a wee.

Table 25.3. Family processes (adapted from AACAP, 2007).

Domain	Example
Structure	
Adaptability	The family's behaviour as a group in response to the unfamiliar experience of the clinic visit. Do they for example bring toys or activities with them to engage younger family members?
Cohesion (connectedness v separateness)	On a continuum from close to the point of intrusiveness through to distanced to the point of disengagement. An intrusive family member may persistently answer questions on behalf of others, while a disengaged family member may be ignorant of important information relevant to other family members
Boundaries	A loose intergenerational boundary may occur when a parent shares intimate information about the relationship between the parents with a child
Communication	
Clarity	People may express clearly what they think and feel or alternatively the content may be disguised or suppressed
Emotional expression	On a continuum from exaggerated expression of emotion through to constricted or suppressed emotion.
Problem solving	How the family go about arrangements for future appointments if another child in the family has a conflicting commitment
Family beliefs	Shared and non-shared beliefs about matters such as the respective roles of mothers and fathers, and at what age children may be expected to leave home or to pay rent
Family regulation of child development	
Responsiveness	How attentive older family members are to the needs of the younger family members
Consistent	Children cope naturally with different rules and expectations according to the environment and context. Difficulties arise when parents are internally inconsistent (for example ignoring behaviour sometimes and punishing it harshly at others) or when parents undermine each other's strategies.
Degree of regulation	How the parents respond if a child becomes, for example ,giggly and overexcited

Interviewing an Adolescent

Adolescence is characterised by rapid change in several developmental domains. Sometimes described as an "in-between" age, interviewing an adolescent requires accommodating their evolving autonomy while still appreciating the limitations in their decision-making abilities. Adolescents vary as to what they will discuss with a professional and working with them effectively necessitates flexibility of style and particular attention to interpersonal communication skills.

In the mental health setting, the adolescent is always evaluated in the context of the family, school, community, and culture (King, 1997). While collateral information from other sources is expected for a comprehensive assessment, meeting with the adolescent on their own is an important part of the evaluation. There is no fixed order or manner of conducting the adolescent interview, though some general considerations can guide the process.

The interview comprises history taking and mental status examination (see Chapter 5). History is obtained about significant areas of the adolescent's life and functioning, past and present, including factors leading to the referral, presenting problem, relevant life circumstances and psychological factors. The mental status examination involves observing and recording the adolescent's appearance, behaviour, communication, emotions and thought processes during the interview. The clinician will attend concurrently to the content of the history and to the mental state features (King, 1997). A few features distinguish the mental state examination of an adolescent with that of an adult. The clinician will be on the lookout for dysmorphic features that could signal a neurodevelopmental disorder. Pubertal stage relative to age is important, as precocious puberty is a risk factor for psychosocial problems in girls, and delayed puberty is a risk factor for boys. Observation of behaviour and attitude should include the interaction between the adolescent and parents. Interpretation of phenomenology is also important. A surprisingly high proportion of otherwise normally developing adolescents report hallucinations and ideas of reference. A degree of mood instability is also to be expected. More information about cognitive function will usually be gained from examining school reports than from conducting a Mini Mental State Examination.

For many adolescents, meeting someone new and talking about potentially difficult issues is anxiety provoking and threatening. Taking time to establish rapport and put the young person at ease from the outset of the interview is a critical initial step. Orienting the adolescent by introducing yourself, explaining your role and the purpose of the interview, is a good starting point. Rather than beginning with discussion of the presenting problem, establishing the young person in context first (e.g., where they live, go to school, who they live with etc.), as well as their interests

and hobbies, can foster rapport and trust and encourage disclosure. During the introduction, the clinician should also explain the concept and limitations of confidentiality.

Employing an approach that progresses from less threatening subjects to more difficult topics is recommended. Inquiring about the adolescent's understanding of why they have come to see you can segue into discussion of the presenting problem, and can also provide an opportunity to address misapprehensions or to relay to the adolescent your understanding of the reasons for referral. Listening to what the adolescent is telling you, showing interest and trying to understand their perspective can further consolidate rapport. The clinician should be discreet about note taking. When discussing sensitive topics, it is better to give your full attention to the adolescent and leave documentation for later.

Topics such as sex, family, peer group and drug use are common components to history taking with adolescents. A widely used approach to assess the major areas of adolescent functioning is the HEEADSSS interview, developed at the Children's Hospital of Los Angeles. This focuses on assessment of the **H**ome, **E**ducation and employment, **E**ating, peer-related **A**ctivities, **D**rugs, **S**exuality (activity, orientation, and sexual abuse), **S**uicide/depression, and **S**afety from injury and violence. These areas are explored using a developmentally oriented approach. A 12-year-old pre-pubertal female, for example, would not be asked the same questions in the same manner as would an 18-year old fully mature female.

Ask open-ended questions where possible and avoid making assumptions. When inquiring about the adolescent's home environment, for example, starting with "Tell me about your mum and dad," immediately assumes that the patient lives with two parents and that the parents are of different genders. Compare this to "*Where do you live?"* or "*Tell me about your living situation,"* followed by "*Who lives with you?*" This allows the adolescent to describe what is most important in his or her home setting. Further questions may then explore areas such as what relationships are like at home and whether there have been any recent changes, e.g., moving, running away, divorce etc. (Klein et al., 2014).

Similar exploration of school, peers, interest, eating and exercise habits can follow. Is the young person attending school? What subjects do they enjoy? What goals do they have for when he or she finishes school? What does the adolescent do to have fun and with whom? Do they play any sports? Does their weight or body shape cause them any stress? Remember to search for the adolescent's strengths as focusing on risk factors alone can induce shame and deter engagement.

The HEEADSSS interview

1. **Home Environment:** This section explores the adolescent's living situation, family dynamics, relationships with family members, and any potential sources of stress or conflict at home.
2. **Education and Employment:** Here, the interviewer assesses the adolescent's school or work situation, including performance, satisfaction, and any challenges or concerns related to education or employment.
3. **Eating:** This part focuses on the adolescent's eating habits, attitudes toward food and body image, as well as any potential issues related to eating disorders or nutritional concerns.
4. **Activities:** The interviewer explores the adolescent's extracurricular activities, hobbies, interests, and social life, including friendships and peer relationships.
5. **Drugs:** This section addresses the adolescent's history of substance use, including alcohol, tobacco, and other drugs. It assesses frequency, quantity, patterns of use, and any associated problems or consequences.
6. **Sexuality:** Here, the interviewer explores the adolescent's sexual behaviours, sexual orientation, reproductive health, contraceptive use, and any concerns or questions related to sexuality.
7. **Suicide and Depression:** This part focuses on the adolescent's emotional well-being, including symptoms of depression, anxiety, stress, and thoughts or behaviours related to self-harm or suicide.
8. **Safety:** The last section addresses safety issues, including risk-taking behaviours, exposure to violence or abuse, use of protective equipment (e.g., seat belts), and any concerns related to personal safety.

Some areas, like drugs and sexuality, can be sensitive. These topics can be approached obliquely: "*We talked about what you and your friends do to have fun. Do any of your friends get drunk or high?*" Young adolescents who may be somewhat reticent about discussing their own drug or alcohol use are often more willing to talk about such behaviour by their friends. This might be followed by: "*Tell me about a time that you felt pressured by friends to use drugs or alcohol, if any.*" This may enable a more specific discussion of the circumstances and types of substances tried (Klein et al., 2014). Older adolescents can often be asked about drugs more directly, such as "*What types of drugs or alcohol have you tried?*"

Before proceeding with questions about the adolescent's sexual history, seeking the young person's permission can help maintain rapport, such as: "*Do you mind if I ask you a few more personal questions in order to work out how I can best help?*" Inquiring into current relationships is a good starting point, including whether the

adolescent is sexually active. For example: "*Are you going out with anyone right now?*" followed by: "*Can you tell me about that relationship?*" can lead into: "*As you know, many young people your age are sexually active. By that I mean that they have had sexual intercourse. There are also many young people who have chosen not to have sex. How have you handled this part of your relationship with Josh or with other people you have gone out with?*" (Klein et al., 2014). It is important to ask such questions sensitively, but also matter-of-factly. Oblique questioning about sex may convey to the adolescent a level of discomfort in asking the questions, which can further add to theirs.

Other areas to cover include suicidality and abuse. Has the adolescent had any prior suicide attempts? Does the adolescent have any current suicidal ideation? It is critical to ask about sexual or physical abuse in adolescents who are reporting significant problems in the areas such as family dysfunction, decline in school grades, lack of friends, substance abuse, early-onset of sexual activity, history of suicide attempts or runaway behaviour.

In addition to major areas of psychosocial functioning, inquiry should be made about the presence of specific psychiatric symptoms. Often information about psychopathological symptoms emerges during the course of the interview, whereby specific enquiry to determine the presence of a particular disorder is required (e.g., depression, anxiety, psychosis, conduct disorder, substance abuse disorder, etc.).

At the completion of the interview, the clinician should give the adolescent a brief summary of their understanding of the issues as well as a future plan and/or treatment options, where appropriate. Negotiate with the adolescent what information will be discussed with the parent(s) before inviting them into the assessment. The adolescent should also have time to ask final questions.

Internalising Disorders

Anxiety Disorders

These are similar to those in adults with the exception of separation anxiety (see Chapter 18), and are the most common conditions in primary school aged children. Clinical presentation takes many forms (see Table 25.4). Associated somatic complaints (e.g., headaches and abdominal pain, sleep disturbance and nightmares) are reasons for frequent visits to the GP. Anxiety, sometimes masquerading as a physical complaint, is a common reason for school refusal in primary school aged children. Anxiety may be complicated by the presence of other comorbid states like depression and poor impulse control (e.g., ADHD and oppositional behaviour). School performance, recreation and social life are often

impaired due to poor concentration and distractibility (which may be diagnosed incorrectly as ADHD).

Table 25.4. Types of anxiety-based disorders seen in children.

Disorder	Features
Generalised anxiety	Pervasive worries and fears
Social phobia	Timid and socially avoidant
Specific phobia	Unrealistic fears focused on a specific object (such as a dog) or situation (travelling in a lift)
Post traumatic stress	Recurrent thoughts about or reliving in play a stressful experience such as sexual abuse, a bush fire or exposure to violence in war-torn areas
Obsessive compulsive	Obsessive thoughts (such as contamination) and repetitive compulsive behaviours (such as handwashing)
Separation anxiety	Distress, agitation, restlessness and irritability upon threat of separation from a caregiver.

Anxiety is more likely to occur at times of transition (e.g. moving from pre- to primary school). Children who refuse to attend school may fear leaving home out of concern for a depressed mother but then become secondarily anxious because of missed education and social embarrassment. Over-anxious or distant parents and traumatic events (e.g., accident, death of a relative) can reinforce age-appropriate fears. Some children are temperamentally predisposed to react to stress by becoming anxious.

Effective *treatment* comprises CBT (see Chapter 33) combined with exposure to the feared situations (e.g., separation from parents), relaxation training and reinforcement of confident behaviour (Bernstein and Shaw, 1997). The cognitive aspect entails formulating positive thoughts to counter overly critical self-appraisal. A useful treatment for concurrent anxiety and depression in either parent is counselling aimed at reducing over-protection and inadvertent reinforcement of maladaptive behaviour. Return of the child to school is a priority and is eased by consulting with the class teacher and providing a rewarding, non-threatening and structured educational program. RCT evidence supports the use of specific serotonin reuptake inhibitor antidepressant medication, SSRIs, particularly when

combined with CBT. Prognosis is good with treatment, particularly if anxiety is detected early.

Mood Disorders

While depression (see Chapter 16) does occur in younger children, there is a marked upswing in incidence in the teenage years, especially among females. The onset of depression is typically gradual, making it difficult to pinpoint when the problem began. Instead of looking sad or unhappy, depressed young people often appear cranky, grouchy and irritable. Atypical presentations (e.g. sleeping or eating more than usual) are common, contrary to the more typical picture (sadness, insomnia and loss of weight) observed in adults. Comorbidity is frequent, particularly with disruptive disorders, drug and alcohol problems and anxiety.

Prior to seeking professional help for their depression some young people access self-help guidance via the internet. There is evidence that internet delivered psychological treatments can prevent the progression of depressive disorder in its prodromal or very early stages. About 20% of young people will try dietary supplements or herbal remedies, but there is a lack of quality clinical trial evidence to support the practice (Hazell, 2015). Mild symptoms of brief duration (a few weeks) may remit spontaneously. Therefore, it is reasonable to simply wait, or recommend self-help material that the young person will be able to access via the internet. Persistent mild or moderate symptoms (a few months) respond to psychological interventions such as CBT and interpersonal psychotherapy (IPT) (Hazell, 2011). Patients who do not respond to psychological treatment, or have severe symptoms, require pharmacotherapy. Among the antidepressant medications, only fluoxetine seems to be effective in inducing remission (Hazell, 2011) . Time to response can be lengthy. Time on treatment seems to be more important than dose for achieving that response. While new generation antidepressants are well tolerated, they may induce suicidal behaviour (in about 4% of young people, compared with 2% taking a placebo). The mechanism underlying this phenomenon is unclear. Symptoms of 'activation' may be an indicator of increased suicide risk and needs to be monitored closely. To prevent relapse or recurrence antidepressant treatment must continue for at least 6 months after remission has been achieved. A patient who has not responded to an adequate course of fluoxetine may be switched to a different class of antidepressant such as venlafaxine (usually in older teenagers). If this is also unsuccessful augmentation with a mood stabilizer or a second generation antipsychotic may be required.

Key points about depression in young people

- About one in ten adolescents will endure a major depressive episode (i.e., meet conventional diagnostic criteria).
- Only a small proportion will be diagnosed or receive treatment.
- Depressed young people have increased rates of suicide, academic or vocational impairment, interpersonal problems, and substance use.
- Episodes of depression eventually remit, but about 40% of affected children experience a relapse. Relapses are more likely among those who in previous episodes, have been depressed for a long time, had incomplete recovery despite treatment, continue to face environmental stressors (i.e., family conflict), or suffer comorbid psychiatric or other medical conditions.
- One third of affected children will attempt suicide,
- Three to four percent of affected children will complete suicide.
- Depression leads to more functional impairment than any other commonly occurring mental illness.

Typical features of mania seen in adults—grandiosity, pressured speech and excessive spending—are not easily identified in young people. Flight of ideas, poor judgement, hypersexuality (which may be falsely attributed to sexual abuse), aggressiveness and auditory hallucinations may occur. Further complicating the diagnosis of bipolar disorder is the ambiguous onset and offset of episodes. Diagnosis is not difficult when symptoms are classical. The usual age of onset is late adolescence or young adulthood, but many patients describe childhood difficulties. Reliability of diagnosis of bipolar disorder in preadolescents, when there may be an overlap with ADHD, is questionable.

Second generation antipsychotic medications are the treatment of choice for the management of acute mania (Hazell and Jairam, 2012). Bipolar depression is best treated with a combination of antidepressant medication and a second-generation antipsychotic (to prevent a manic switch). Prevention of relapse demands the application of the full range of specialist clinical skills including the maintenance of a therapeutic alliance, individual psychological support, motivational interventions, attention to physical wellbeing and lifestyle, education and support of family or carers, liaison with education providers and other key people in the young person's life, and the capacity to monitor and fine tune pharmacotherapy. On the basis of existing evidence there is slightly more support for second generation antipsychotic than there is for mood stabilizers for preventing relapse of bipolar disorder in children and adolescents, but there is a major knowledge gap in this area.

Externalising Disorders

Attention Deficit Hyperactivity Disorder

Danny (see case example below) manifests many of the features typical of ADHD including motor overactivity, impulsivity, distractibility, and inattention. We can suspect inattention because of the poor handwriting and the avoidance of tasks that require mental effort. Danny's problems are apparent in more than one setting, which is essential for fulfilling the ADHD diagnosis. Were Danny younger (say 3 years old) his behaviours might be acceptable, but he is not regulating himself in the manner expected of a 9 year old. Danny was less than 12 years old when symptoms first became apparent, another requirement to fulfil diagnostic criteria. If it hasn't happened already, Danny will soon fall behind at school. His parents will show signs of parenting fatigue and to an outsider their parenting may seem ineffective or maladaptive. Danny may develop secondary problems such as oppositionality, anxiety or even depression. Danny has combined type ADHD, but it is possible for children to have just problems with concentration (inattentive subtype) or just problems with overactivity and impulsivity (hyperactive-impulsive subtype) Referrals for ADHD peak between 8 and 11 years of age. Boys are affected three times more than girls. Clinical features can manifest at preschool but a diagnosis made in children less than 4 years is unreliable.

Case example

Danny's parents dreaded taking him to the supermarket because his behaviour was not that which would be expected from a 9-year-old boy. He would excitedly run from aisle to aisle, shouting the names of the products on the shelves. If not watched carefully Danny would help himself to sweets and ice cream, even though he knew he was only allowed one treat. He would engage other shoppers in random conversation. Mostly they were amused, but sometimes he could be offensive. Danny's parents also dreaded parent teacher meetings. They were weary of hearing about his exuberant but dysregulated classroom behaviour, his tendency to talk when he should be listening, his fidgetiness, and the manner in which he seemed to disrupt the other children. His handwriting was immature and scrawling, and his spelling barely phonetic. At home Danny could be loving and fun, but his parents had learned that it was best to keep him busy with physical activity. A deal had been struck with school that Danny was exempt from homework, on the grounds that getting him to do it had become too traumatizing for the family.

Functional neuroimaging shows underactivity in the frontal lobes (associated with the organization of behaviour) and caudate (associated with regulating movement) and overactivity in the amygdala (associated with regulating emotion). Serial MRI studies show a delay relative to typically developing children in thickening across a range of cortical structures.

Assessment requires a careful history from parents and other sources such as teachers. Behaviour rating scales for parents and teachers help to quantify symptoms and allow comparisons with similar-aged children. Hearing, visual and neurological problems are excluded. IQ and reading assessment are indicated if intellectual impairment or learning disorders are suspected.

Management is multimodal (Health, 2009). Behavioural counselling helps the parents to increase the young person's behavioural compliance but ADHD symptoms respond less well. Techniques include praise and reward for appropriate behaviour, clear instructions (e.g. one specific request at a time) and consistency (e.g., both parents adhere to a simple set of rules). Classroom strategies include: presenting work in modules under 10 minutes to avoid overtaxing capacity to attend; interspersing classroom learning with brief periods of exercise; permitting movement provided it does not disrupt peers; using cues to alert students they have strayed from the task; seating them close to the teacher or students who concentrate well; and articulating expectations of behaviour.

CNS stimulants such as methylphenidate and dexamphetamine have a pivotal role in reducing symptoms where these interfere with learning, social interaction and family life. Stimulant medications increase the activity of dopamine and noradrenaline in neurons. The putative mechanism of action is better filtering of extraneous information (noise) coupled with a boost in focus on salient information (signal). Efficacy and safety are well established in the short term and, provided there is treatment adherence, is maintained long term. Common side-effects are loss of appetite, weight loss and sleeplessness.

In about a quarter to a third of cases ADHD persists into adulthood. By this time hyperactivity has usually resolved but inattention and impulsivity remain a problem. Remission may be attributable to compensatory neural mechanisms as much as it is to normalisation. Antisocial behaviour and substance misuse are the most consistently reported adult outcomes of childhood ADHD, but individuals are also at increased risk of mood and anxiety disorders. Secondary impairments impact on functioning in domains such as: education, occupation, relationships, parenting, and complex skills such as driving.

Oppositional Defiant Disorder

Oppositional Defiant Disorder (ODD) applies to children who lose their temper persistently, argue with adults, annoy people, blame others, are touchy, and have frequent or intense temper tantrums. This disrupts relationships with family and peers, and makes them 'difficult to manage' at school. ODD can be a response to an overly authoritarian or overly permissive family.

Defiance, often the presenting feature, can manifest in other conditions. Depressed adolescents may be angry and oppositional; anxious or obsessive children may be unco-operative when forced to confront feared situations or prevented from performing their rituals; psychotic young people can appear defiant. Disruptive Mood Dysregulation Disorder (DMDD) shares features in common with ODD, but is characterized by severe temper tantrums and chronic irritability. DMDD was only established as a diagnosis in 2013. Children currently meeting DMDD criteria may formerly have been diagnosed with ODD, or childhood onset bipolar disorder. First line treatment for ODD is parent behaviour management training.

Conduct Disorder

Young people with Conduct Disorder (CD) display behaviours such as bullying, initiating fights, truancy, cruelty or violence to people or animals, deception, and theft. CD is not diagnosed when behaviours are better explained by another condition such as schizophrenia, bipolar disorder or autism spectrum disorder. Depression, ADHD, substance abuse and learning problems are common co-morbidities. An isolated antisocial act does not warrant the diagnosis. An earlier onset has a worse prognosis. Most young people with CD will have shown symptoms of ODD earlier in development. ODD behaviours are always overt and easily observed, while CD behaviours can be covert and difficult to detect. This is relevant to treatment, because observable behaviours are more readily responsive to behaviour management strategies. Most aggression seen in association with CD is an excessive reaction to a situation, is associated with heightened arousal, and is sometimes referred to as 'hot' aggression. In contrast, some people with CD manifest 'cold', calculated aggression that is associated with normal or suppressed arousal. They show a striking lack of empathy, referred to as callous unemotional traits. The basis for the lack of empathy seems to be a deficit in emotion recognition. Individuals with callous unemotional traits do not direct their gaze to the eyes of picture faces expressing emotion, thus failing to receive salient information (Dadds et al., 2008). Aetiological factors for CD include the parent child interaction difficulties associated with ODD, but extend to biological and social factors. CD is heritable, affecting neurotransmitter systems such as the monoamine oxidase transporter gene. Perinatal hazards such as hypoxia and maternal smoking, alcohol and heroin use increase the risk of CD, as does exposure to environmental toxins

such as lead. Finally, CD tends to aggregate in communities where there is disadvantage.

Parent training in behaviour management is the treatment of choice for primary school aged children with CD, but the intervention is less effective with teenagers. Cognitive and social problem solving groups are helpful for children 10-14 years with CD. Adolescents with CD typically require multimodal interventions including individual therapy, family work, community advocacy, diversionary activity (such as cultural groups, Police Boy's Club) and medication. Medication is prescribed for comorbid conditions such as ADHD. A prominent guideline recommends the second generation antipsychotic risperidone for severe aggression (National Institute for Health and Clinical Excellence, 2013). We do not endorse this practice, because of the problems of metabolic side effects, and our observation that benefits attenuate with time (the guidance is based on evidence from short term clinical trials). Clonidine has more enduring effects. Note that callous unemotional traits do not generally respond to pharmacotherapy.

Treatment Modalities

Treatment flows from formulation and can be categorised into biological, psychological and social components. Goals are collaboratively established to target problems or behaviours, and monitoring mechanisms are used. Informed consent is obtained from parents and adolescents over 15 years. It is desirable that younger children also assent to treatment. Because co-morbidity is common, a multi-modal approach is usually indicated.

Psychoeducation

Education for the parents and child about the nature of the condition, its longitudinal course and treatment is essential. Parents may be provided with written information prepared by professional organisations. An example would be parent's guide to depression and anxiety in young people developed by Beyond Blue. Mobile devices provide opportunities to deliver mental health information, treatment, and monitor function and symptoms. An example would be the Love, Talk, Read, Sing, Play mobile App developed to assist parents to engage in and enjoy the development of their preschool aged children. Psychoeducation sometimes extends to other adults engaged with the child. A school visit to meet relevant teaching and student support staff can help address uncertainties about the nature of a child's problem, the significance of symptoms, and the best way to address behaviours that occur in the school environment. It is always best that parents also participate in such school meetings.

Advocacy

Young people often lack shared decision-making in terms of their social environment and the expectations of them in terms of output, that is, the family they live with and the school they attend are often not of their own choosing. Some young people may view school refusal and running away from home as their only available option to modify the situation. Child and adolescent psychiatrists have roles in communicating, advocating for systems change and managing young people in out of home care. Advocacy extends to providing reports to enable children to gain access to additional educational funding and support, and parents to gain access to carer's allowance or other financial support. This is relevant because costing studies demonstrate that childhood mental illness places a considerable financial burden on families.

Parent Behaviour Management Training

Behaviour management refers to the actions or inactions taken to aid an individual (or group) to learn to act appropriately and pro-socially relative to the given context and their developmental stage. In essence, the overall goal of behavioural management for parents and carers is to help young people develop adaptive self-regulation skills. Self-regulation is the ability to recognise, direct and modulate one's own thoughts, feelings and behaviour. This is done by teaching parents and carers skills to help scaffold their young person's ability in an age-appropriate manner.

Behaviour management is essential in ensuring young people grow up to become functional and pro-social members of society. This means following the rules and expectations of society and managing their own emotions and behaviours adaptively. Throughout childhood and adolescence behavioural non-compliance is a normal aspect of development. For example, it is very normative for a two year old to throw a temper tantrum. However, if non-compliance and externalising behaviours continue and increase with age, this can lead to significant difficulties and poorer later life outcomes. Indeed, a temper tantrum in an adolescent is not only less acceptable; it is also likely to be much harder to manage and may result in significant risk to the teenager and others. Where non-compliance and acting out becomes severe, persistent and unmanageable across multiple settings, the young person is at increased risk for a number of negative life trajectories. These may include peer relationship problems, academic difficulties, increased mental health problems (including increased alcohol and drug use) and a criminal lifestyle.

Successful behaviour management approaches make use of regular routines, structure and expectations. They teach young people what to do (making the adaptive, desired behaviour explicit), as opposed to what they are not allowed

to do. For example, “Please keep your hands and feet to yourself” rather than “Do not punch or kick others”. This allows the parent or carer to positively reinforce desirable behaviour rather than having to set down consequences for poor behaviour. Similarly, feedback on the form of praise towards the young person should be specific rather than general. For example, “I appreciate that you made your bed this morning”, “I like the way you took your plate to the sink” rather than generic “Good girl” or “Good boy”. This helps the young person to know what it is they have done well and repeat the desired behaviour.

Reinforcement can be both interpersonal (such as attention, praise, and carer time) and/or tangible (such as toys, screen time). Reinforcement should be meaningful for the young person and where possible be associated with the desired behaviour. For example, “You may play on the computer after you finish your homework”. If possible, it is generally advisable to avoid using food or money as the primary reinforcer.

Types of reinforcement

Positive reinforcement. Adding something to increase the frequency of a behaviour. A teenage son will be more likely to empty the dishwasher if he is praised for doing it.

Negative reinforcement. Removing something to increase the frequency of a behaviour. Parents have nagged their son about emptying the dishwasher for weeks. One day he voluntarily empties the dishwasher and to his surprise the nagging stops. He is more likely to repeat the behaviour.

Punishment. Adding something aversive to decrease the frequency of a behaviour. A teenage son breaks curfew by more than an hour and is grounded from outings for a week. In this case the addition is the temporary restriction in freedom.

Extinction. Removing something to decrease the frequency of a behaviour. A four-year-old child makes frequent ‘curtain calls’ to the living room after bedtime. Her parents have typically made a fuss, engaged her in conversation and even made her hot milk drinks to ‘help her sleep’. Fun! Parents change their strategy, are cool, offer no drinks and walk the child to her bedroom without comment. The ‘curtain calls’ cease.

Reinforcers also need to be age and capacity appropriate. For example, factors such as trauma or intellectual disability are likely to impact a young person's ability to manage their emotions. If this is the case, behaviour management may need to initially start with co-regulation techniques. This involves adult modelling of how to deal with difficult emotions alongside the young person, using attachment bonds to help the young person regulate their emotions. The adult may have to help the young person to first identify and then manage the difficult emotion. Similarly, parents or carers may need to scaffold the young person through successive approximations in order to get to the appropriate pro-social response. Typically, as the young person gets older, they should take a larger role in helping identify expectations and reinforcers. Some families may find it helpful to incorporate written or visual guides and achievement charts ("star charts") especially around routine expectations. These can be helpful guides for the young person and provide direct, often rewarding, feedback.

All behaviour management approaches take consistency and persistence. If the young person has a history of non-compliance or comes from a background where there has been previous inconsistency in behaviour management then it is highly likely there will be an initial increase in non-compliant behaviours when strategies are first implemented. Parents and carers should be warned about this when implementing behaviour management. Where reinforcement of adaptive behaviour alone is not successful, short amounts of time in or time out are often used as a consequence to manage maladaptive behaviours. Time out refers to a low intensity punishment in which the child is briefly isolated from others. As the child learns to manage themselves, they may choose to remove themselves to a safe and calming place as a way of coping while learning more advanced skills. General guidelines for time out are typically one minute per year of age (i.e., six minutes of sitting calmly for a six-year-old child). On occasions where the young person is placing either themselves or another at risk, restraint may be implemented. Ideally, seclusion or restraint should be used only as a last resort. This makes sense when one considers that the young person is being taught that they cannot manage themselves when these strategies are implemented.

There are a number of well researched and empirically supported programmes available to teach parents and carers behaviour management in the community. These include Triple P Parenting and Magic 1-2-3. There are also play-based parenting guides such as Parent Child Interactional Therapy (PCIT), which focus on the attachment relationship as a means of improving difficult behaviours. The aetiology of disruptive behaviour is multifaceted and should be considered in a full assessment. Areas of consideration include individual psychological and biological factors, family factors and environmental factors.

Individual factors as mentioned earlier include aspects such as temperament, trauma and developmental level. Even within families some young people require more limit setting while others are acutely aware of social roles and expectations. Trauma is well known to disrupt regulation capacity and therefore the young person may be more sensitive and require more scaffolding in relearning adaptive strategies. Likewise, certain developmental disabilities and syndromes are frequently associated with regulation difficulties which may amplify acting out behaviours (such as Foetal Alcohol Syndrome, Pervasive Developmental Disorders, Noonan Syndrome and Tuberous Sclerosis).

Relevant family factors include parental and carer health issues, both mental and physical. Issues such as parental history of abuse and neglect and of antisocial behaviour (parents who themselves have a history of non-compliance) should be considered as these may impact a parent or carer's own ability to self-regulate. Other relevant family factors include marital conflict (including domestic violence); stress (including work and financial pressures); the level of support the family has, such as extended family and community involvement; and environmental disruptions (such as moving house regularly).

At a broader level, factors such as cultural expectations, gender biases and the role of generational timing should be considered. For example, the influence and implication of social media on youth behaviour is a relatively new but increasingly pertinent factor to consider in regards to behaviour management.

When considering a young person's disruptive behaviour, it is important to try to understand the meaning of the behaviour. Developmentally, young people around certain ages are expected to push the boundaries (toddlers and teenagers particularly). Indeed, this is part of the natural individuation process. Most young people are not deliberately trying to do the wrong thing. It is unhelpful to label a young person as "bad". Instead, it is helpful to consider why the young person might be acting in the way they are and in what way the environment is reinforcing the current behaviours (either explicitly or inadvertently). Examining the aetiology above, acting out behaviours may be a bid to engage a parent or carer, a distraction from something else in the family system or the result of an underlying difficulty or recent trauma. Consider all members of the family and their role in perpetuating the acting out behaviour. For example, a sibling with a recent health diagnosis may be impacting the previous balance of allocated time and attention.

The following factors have been identified as being present in young people who have come from difficult backgrounds, or have faced a number of risk factors, but have managed to maintain adaptive self-regulation skills. Individual factors include high intelligence, easy temperament and alternate areas of competence (such

as a young person struggling at school but doing well at sport or music). Protective family factors include supportive relationships, strong extended family networks and a secure attachment to at least one adult within the family network. Social and environmental factors that are likely to aid a young person in developing adaptive self-regulation capacities include a supportive school environment that fosters responsibility taking, pro-social peers and a group with which the young person identifies. For example, this may include a religious group, an ethnic community group or a sports group. Finally, good role models able to provide examples of adaptive self-regulation across any setting (home or external) are also likely to be of benefit.

As with the aetiology factors that elucidate risk, different protective factors are stronger at different developmental stages. In children, family factors are paramount, whereas in adolescence individual, school and peer influences are more important. The task for professionals is to promote these protective factors in order to lessen the effects of risk factors, as well as to intervene where possible to reduce risk factors. As young people grow older, they tend to accumulate more risk factors and so stronger protective measures are needed. This highlights the importance of intervening early to prevent effects on development, and to address the problem behaviours before they are entrenched. Hence it is important to consider the degree of impairment of life functions in assessment, not just diagnostic symptoms.

Family Therapy

Family therapy is a form of psychological treatment that focuses on the interaction of family members as a means of understanding a symptom and effecting change. It is a problem oriented rather than diagnosis-oriented treatment. Family therapy has grown from the observation that emotional or behavioural problems in an individual often impinge on others with whom they live. Most family therapists do not view the family as necessarily dysfunctional, but rather see the family as a forum in which to solve a problem. The family therapist may work alone, but it is common for two people to work together as co-therapists. Sometimes the therapist may work with the assistance of a 'team'. The team consists of one or more co-therapists who do not participate actively in the session but who observe the interactions of family members with each other and with the therapist and may provide advice or feedback to the family through the therapist. Commonly the team will observe the session through a one way screen or on a video monitor.

Family therapy is informed by systems theory, which in turn is derived from the basic biological and physical sciences and is concerned with describing and predicting the behaviour of complex systems on the basis of the interaction of the parts. The important principles underpinning systems theory are:

1. The notion of homeostasis, or a dynamic steady state, which is sustained by monitoring shifts of parts of the system away from the balance, and the correction of these shifts (negative feedback).
2. The notion that the steady state of a system or organism may shift abruptly from time to time through a process of 'deviation amplification' or positive feedback. This shift in steady state is conceptualised as essential for the adaptation of the system or organism.

While there are many different schools of family therapy, they share some common techniques:

1. Reframing is restating a problem or behaviour in a different (usually more positive) way. An example would be reframing a child's disruptive behaviour in the context of marital discord as a caring and concerning activity designed to distract the parents from their conflict with one another.
2. Circular questioning is a technique used to elicit differences in relationships the family have experienced before and after a problem began, or has resolved. An example would be asking what a younger sibling has noticed about his parents' interaction with each other since a teenage sister re-emerged after months of isolating herself in her bedroom.
3. Metaphor is employed by many therapists as a means of illustrating a problem, or assisting the family to distance themselves from a problem so they can look at it more objectively. An example would be to liken the arguments between a mother and daughter over the issue of responsibility versus freedom to a strange tennis match in which the object seems to be to hit the ball as far out of court as possible.
4. Paradox is a technique that stimulates the family to resolve a problem through the mechanism of deviation amplification. Instead of offering strategies that might reduce the intensity of the problem, the therapist suggests a counter strategy that intensifies difficulties in the short term. Rather than ban internet access, parents of a teenager may encourage increased usage, while at the same time demonstrating intense interest in the content that has been accessed.

A specific application of family therapy is in the treatment of anorexia nervosa in younger people. Family Based Treatment is recommended as first-line treatment for people with anorexia who are aged less than 19 years, have had a duration of treatment of less than three years, and are not in need of emergency refeeding (Hay et al., 2014). Family Based treatment encourages parents to engage

in restoring the weight of their child to a healthy level, while at the same time re-engaging with the child emotionally.

Therapy with the Child

Psychological treatments developed for the treatment of adults have been adapted for application in older children and youth. Modalities include cognitive-behaviour therapy (CBT), interpersonal psychotherapy (IPT) dialectical behaviour therapy (DBT) and mindfulness based therapy (MBT). Play therapy directed to younger children may be psychodynamically informed, or structured as in CBT; for example, a doll may be used to provide exposure play therapy for an upcoming insertion of an intravenous canula. Art therapy may be used in a psychodynamically-informed fashion for the young person to express intra-psychic conflict, and is particularly useful in cases where that would not be possible verbally. Group approaches are effective in treating anxiety and depression in teenagers and have been successfully delivered in schools. Group therapy has also been successfully delivered in schools directed to young children with evolving conduct problems. Socially awkward children can be helped by group-based social skills programs such as the Secret Agent Society.

Medication

Few medicines are approved by regulatory bodies for the treatment of psychiatric illness in children and adolescents (see Table 25.5), therefore most prescribing is “off-label”. The most common classes of medication prescribed for children are the antidepressants, and medications for the treatment of ADHD. Less commonly prescribed are antipsychotic medications and anxiolytics.

Children are not just undersized adults. They metabolise and eliminate drugs more quickly than adults leading to shorter drug half-lives. As a consequence they typically require higher weight-adjusted doses and more frequent dosing than adults. Children with neurodevelopmental disorders are vulnerable to the side effects of psychotropic medication, and may have idiosyncratic reactions. Noradrenergic pathways develop more slowly than serotonergic pathways, rendering noradrenergic specific drugs less effective. This is thought to account for the lack of effectiveness of tricyclic drugs for depression in young people. About one in five medicated children are receiving more than one psychotropic drug. Some drug combinations are supported by clinical trial evidence. An example is the combination of a stimulant medication and clonidine for children who are both hyperactive and aggressive (Hazell and Stuart, 2003). Much polypharmacy however is a reflection of desperation and a lack of planning and should be avoided since it increases the chances of drug interactions and reduces adherence. Prescribing is done

cautiously and by well-informed clinicians, for example SSRI prescription in adolescents is accompanied by information about the increased risk of suicidal ideations. Not only should assessment information come from multiple sources, but so should information to help evaluate treatment effectiveness and tolerability. Symptom or behaviour checklists can be of help in this regard. Growth parameters, pulse rate and blood pressure should be measured regularly in all children receiving psychotropic drugs, and a screen for common side effects should be undertaken at each review. Specific precautions against metabolic side effects must be taken when prescribing second generation antipsychotic drugs.

Table 25.5. Psychotropic medications approved by the Australian Therapeutic Goods Administration for use in children.

Medication	Indication
Methyphenidate (short and long acting)	Attention-Deficit/Hyperactivity Disorder
Dexamphetamine (short and long acting)	Attention-Deficit/Hyperactivity Disorder
Atomoxetine	Attention-Deficit/Hyperactivity Disorder
Guanfacine extended release	Attention-Deficit/Hyperactivity Disorder
Risperidone	Conduct disorder, other disruptive disorders in patients with subaverage intellect, intellectual disability intellectual disability, and prominent destructive behaviour Behavioural disorders associated with autism
Quetiapine	10-17 years: monotherapy in acute mania associated with bipolar I disorder; 13-17 years: schizophrenia treatment
Fluvoxamine	Obsessive Compulsive Disorder

Further Reading

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