Clinical topics in child and adolescent psychiatry

For Michael Carter

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Edited by Sarah Huline-Dickens

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Contributors

Catia Acosta Specialty Trainee in General Adult Psychiatry, Charing Cross Rotation, West London Mental Health Trust, London, UK

Gwen Adshead Forensic Psychiatrist and Consultant Forensic Psychotherapist, Broadmoor Hospital, Crowthorne, UK

Bisharda Angom, Child and Adolescent Psychiatrist, North Essex Partnership NHS Foundation Trust, Severalls Hospital, Colchester, UK

Elizabeth Barrett Consultant in Child and Adolescent Liaison Psychiatry, Temple Street Hospital, Dublin, Ireland

Christopher Bass Consultant in Liaison Psychiatry, John Radcliffe Hospital, Oxford, UK

Gerry Byrne Clinical Lead, Family Assessment and Safeguarding Service & Infant–Parent Perinatal Service, Oxford Health NHS Foundation Trust, UK

David Coghill Reader in Child and Adolescent Psychiatry, Division of Neuroscience, Medical Research Institute, University of Dundee, UK

Felicity de Zulueta, Former Emeritus Consultant Psychiatrist in Psychotherapy, South London and Maudsley NHS Foundation Trust, and Honorary Senior Lecturer in Traumatic Studies at King's College London, London, UK

Domenico Di Ceglie Consultant Child and Adolescent Psychiatrist and Director of Training, Development and Research, Gender Identity Development Service, Tavistock and Portman NHS Foundation Trust, London, and Honorary Senior Lecturer, Department of Clinical, Educational and Health Psychology, University College London, UK

Bernadka Dubicka Consultant Psychiatrist, The Junction Adolescent Unit, Lancashire Care Foundation Trust, and Honorary Senior Lecturer, University of Manchester, UK

Nicky Dummett Consultant Child and Adolescent Psychiatrist, East Leeds Child and Adolescent Mental Health Service, Leeds, UK

Rachel Elvins Consultant Child and Adolescent Psychiatrist, Salford Child and Adolescent Mental Health Service, Central Manchester University Hospitals NHS Foundation Trust , UK

Mary Eminson Retired Consultant Child and Adolescent Psychiatrist, Bolton NHS Foundation Trust, Bolton, UK

Victoria Fernandez Consultant Child and Adolescent Psychiatrist, South West London and St George's Mental Health NHS Trust, and Honorary Teaching Fellow in Child and Adolescent Psychiatry, Imperial College, London, UK

Olivia Fiertag Locum Consultant Child and Adolescent Psychiatrist, Barnet, Enfield and Haringey Mental Health NHS Trust, London, and Honorary Lecturer, Imperial College, London, UK

David Foreman Visiting Senior Lecturer, Department of Child and Adolescent Psychiatry, King's College London, London, UK, and Consultant in Child and Adolescent Psychiatry to the Isle of Man Government

Ian M. Goodyer Professor of Child and Adolescent Psychiatry, University of Cambridge, and Honorary Consultant Child and Adolescent Psychiatrist, Cambridgeshire and Peterborough NHS Foundation Trust, UK

Jonathan Green Professor of Child and Adolescent Psychiatry, University of Manchester, and Honorary Consultant Psychiatrist, Central Manchester University Hospitals NHS Foundation Trust, UK

Peter Hill Professor Emeritus in Child Mental Health, St George's, University of London, and Great Ormond Street Hospital for Children, London, now working in independent practice, Harley Street, London, UK

Chris Hollis Professor of Child and Adolescent Psychiatry, University of Nottingham and Institute of Mental Health, Queen's Medical Centre, Nottingham, UK

Patricia Howlin Professor of Developmental Disorders, University of Sydney, Australia, and Emeritus Professor of Clinical Child Psychology, King's College London, London, UK

Sarah Huline-Dickens Consultant Child and Adolescent Psychiatrist, Plymouth Community Healthcare and Honorary Clinical Senior Lecturer, Peninsula College of Medicine and Dentistry, UK

Sajid Humayun Lecturer in Criminology, School of Law, University of Greenwich, London, UK

Raphael G. Kelvin Consultant Child and Adolescent Psychiatrist, Cambridgeshire and Peterborough NHS Foundation Trust, and Associate Lecturer, University of Cambridge, UK

Roger Lakin Consultant Child and Adolescent Psychiatrist, East Leeds Child and Adolescent Mental Health Service, Leeds, UK

Paul McArdle Consultant Child and Adolescent Psychiatrist, Northumberland, Tyne and Wear NHS Foundation Trust, Newcastle upon Tyne, UK

Dasha Nicholls Honorary Senior Lecturer and Consultant Child and Adolescent Psychiatrist, Great Ormond Street Hospital, London, UK

Mary Robertson Emeritus Professor of Neuropsychiatry, University College London, UK, Honorary Professor, Department of Psychiatry and Mental Health, University of Cape Town, South Africa, and Visiting

Professor and Honorary Consultant, Atkinson Morley Wing, St George's Hospital Medical School, London, UK

Jaydip Sarkar Consultant, Department of General and Forensic Psychiatry, Institute of Mental Health, Singapore

Stephen Scott Professor of Child Health and Behaviour, Institute of Psychiatry, King's College London, London, UK

Eugenia Sinita Head of Research and Development & Consultant in Adult Psychiatry, Department of Research and Development, National Centre of Mental Health, Clinical Psychiatric Hospital, Chisinau, Republic of Moldova

Gregory Stores Emeritus Professor of Developmental Neuropsychiatry, Department of Psychiatry, University of Oxford, UK

Aaron K. Vallance Consultant Child and Adolescent Psychiatrist, Surrey and Borders Partnership NHS Trust, and Clinical Senior Lecturer, Faculty of Medicine, Imperial College London, UK

Paul Wilkinson Honorary Consultant in Child and Adolescent Psychiatry and Lecturer, University of Cambridge, UK

Alison Wood Consultant Child and Adolescent Psychiatrist, Fairfield Hospital, Bury, UK

Preface

Caught up in the drama and conflict of other people's lives, children are often to be found in Paula Rego's art in those sinister, paradoxical or unexpected ways familiar to child psychiatrists. Sometimes they are looking after parents, sometimes they are about to be abused or humiliated, and sometimes they are even performing their own abortions. Her image on the cover of this book features J. M. Barrie's character Peter Pan, or The Boy Who Wouldn't Grow Up. Though apparently playful and mischievous, Peter Pan is in flight, and his escape from parents and family is a means of coping with painful displacement, or something worse.

As described in the introduction to this book (Chapter 1), there has always been a hope that a study of troubled children would produce recorded information of *how mental illness began* (Evans *et al*, 2008: p. 456) (my italics). This aim is an important one, and one that often attracts child psychiatrists to the work in the first place. Unfortunately, for many clinicians it is so often forgotten in the business of endless restructuring of service provision and policy revision.

However much policy material is produced, the real function of most child psychiatrists is to assess and treat mental disorders in childhood and adolescence. This book is aimed at them, to help them keep up to date with clinical topics. The clinical topic can be seen to reflect the medical approach to a clinical problem and embody a certain habit of thought, often involving the application of clinical reasoning and diagnostic decision-making. Most chapters in this book concern discrete clinical disorders, although some are about an aspect of treatment, such as pharmacological management. All are central to the work of practising clinicians in the specialty, and many will be relevant to other doctors, psychologists, child and adolescent mental health professionals, social workers, teachers and students, and trainees in all of these fields.

The selection of topics has largely been guided by what has appeared in the journal *Advances of Psychiatric Treatment* in the form of educational articles published since 1994. These chapters therefore represent a scholarly trend of practice over the past two decades. Many of the chapter authors have made contributions to the specialty: maybe not always in the shape of new knowledge (although this is true for some), but in the conceptualisation of their topics for purposes of medical education and the development of good practice.

The following four contemporary themes – continuity into adult life, the integration of biological and social aetiology, the influence of neuroscience, and the increasing use of research and evidence – have been discernible from conference material, editorials and journal articles over the past few years. These themes have formed the axes for the revision of all of the chapters in this volume since the time of original publication and for the chapters that have been newly commissioned.

Continuity into adult life

The continuity of mental disorder from childhood into adult life has, of course, been recognised for a long time. In the case of schizophrenia, for example, in a series of 1054 individuals with dementia praecox, Kraepelin found that 57% met this diagnosis before the age of 25, with 3.5% aged 10 or under and a further 2.7% between 10 and 15 years old. Indeed, he reminds us that it was this 'predisposition of youth' that led Hecker to coin the term hebephrenia, which means insanity of youth (Kraepelin, 1919). We also have more information now on the long-term nature of many other neurodevelopmental disorders, such as autism spectrum disorder (ASD), attention-deficit hyperactivity disorder (ADHD) and Tourette syndrome, which are seen very widely in clinical practice. It is surely time to place continuity at the centre of service design and research. Within the paradigm of continuity throughout the lifespan, there have also been calls for some time for more attention to be paid to disorders of infants and young children (see below).

Integration of biological and social aetiology

As more sophisticated techniques emerge for investigating gene–environment interactions, we understand that certain children with genetic susceptibilities may be more influenced by negative environments; children who are exposed to multiple family adversities are more likely to demonstrate disturbance; and stressful environments can affect all levels of the emotional system, including the hypothalamic–pituitary–adrenal axis, neurotransmitter systems and brain architecture (Jenkins, 2008).

In a paper on vulnerability to mental disorders, Goldberg (2009) discussed 'the interaction between our genetic constitution and social environments that either allow genes to manifest themselves in the phenotype, or suppress them altogether. It is now possible to describe the biology of secure attachment, and describe the physiological changes that accompany [it]'. Children who are raised in families in which a parent has a mental illness find themselves in a situation where the risks are both genetic and environmental. The many ways in which this might affect children are well described (e.g. see Stallard *et al*, 2004). Advances in

understanding are likely to occur in investigating the early developmental origins of mental disorder, and mechanisms of adaptation and resilience need to be better understood.

Findings from neuroscience

A consensus is emerging that developmental and biological disruptions in early life often lead to adult psychiatric disorder. This might happen through cumulative damage or as a result of an event occurring during a sensitive period. As well as the genetic and cellular events leading to brain formation, evidence is accumulating that the uterine and postnatal environments, together with early relations in life, can affect childhood brain development and behaviour (Leckman & March, 2011). Furthermore, it seems likely that not all children will be affected equally, so that susceptibility to these processes may be genetically determined and various areas of the brain may mature at different rates in different children. These findings, together with technological advances such as in brain imaging, give us a more sophisticated understanding of the relationship between genetics and the environment.

Research and evidence

Finally, it is important to acknowledge that there has been a growth in the academic aspect of our specialty. The conspicuous increase in the volume of literature about neurodevelopmental psychiatry over the past two decades in, for example, ASD, ADHD and Tourette syndrome, has been accompanied by an increase in publications about their treatment. Since 2005, there has been a proliferation of guidance from the National Institute for Health and Care Excellence (NICE), so that treatments can now be based on published work. At the time of writing there are specific NICE guidelines for children and adolescents who present with eating disorders, self-harm, post-traumatic stress disorder (PTSD), depressive disorder, obsessive–compulsive disorder (OCD), ADHD, autism, conduct disorder, psychosis and schizophrenia, and the list continues to grow. The Faculty of Child and Adolescent Psychiatry is the only faculty of the Royal College of Psychiatrists currently to insist on research training as a mandatory part of the higher training curriculum and this will be crucial to the development of the discipline.

An outline of this book

The three newly commissioned chapters for this volume serve to illustrate these themes particularly well. David Foreman, in marshalling a wealth of research evidence, describes the epidemiology of disorders of young children (aged 0–4 years) in terms of disorders across the rest of the

lifespan, and in so doing he not only creates a paradigm shift, but also draws attention to the paradox that this group is increasingly neglected by child psychiatry even though cost-effective treatments are available. Changes in service configuration, however, will be required.

Mary Robertson draws on her extensive career in research and treatment of Tourette syndrome to richly describe the familiar phenomenology of a disorder that straddles psychiatry and neurology, and also to provide us with new material on psychosocial impact, aggression and neuroscience.

The third new chapter, by Aaron Vallance & Victoria Fernandez, serves to summarise the central topic of anxiety: a common disorder whose impact is easily underestimated, especially when comorbid with other disorders. The chapter comprehensively describes the aetiological factors and reviews evidence-based treatment.

The remaining chapters have been revised or updated since their publication in *Advances in Psychiatric Treatment*. At a time when child abuse and neglect is a major public health problem, the chapter by Christopher Bass and colleagues provides clinicians with a review of fabricated illness (formerly known as Munchausen syndrome by proxy). This chapter emphasises the need for adult and child psychiatrists to work together and orders the clinical reasoning processes associated with such cases, in addition to informing us about new findings about the perpetrators.

Spanning the worlds of developmental psychopathology and neuroscience, with many implications for the continuity of disorders into adult life, the chapter by Jaydip Sarkar & Gwen Adshead exemplifies how there has been a transformation of approach to the topic of personality disorders. This chapter, strong in theoretical orientation, describes how disorganisation of the capacity for affect regulation has come to be understood as central to the origin of personality development and disorder. These cases form the bulk of work for child psychiatrists and become the future patients of adult psychiatry. It is time that those leading services recognised this and adapted interventions accordingly. Associated with this topic is the chapter by Felicity de Zulueta, who discusses the aetiology of complex PTSD in terms of attachment theory, and examines the similarities between complex PTSD and borderline personality disorder. This chapter is important for providing a more international perspective to the practice of the specialty.

Although child psychiatry developed to deal with antisocial behaviour in troubled or maladjusted children, as described in Chapter 1, there has since been much debate about whether these children should still be centrally the business of the specialty. The chapter on antisocial behaviour in childhood by Sajid Humayun & Stephen Scott summarises new information about treatment studies and includes children with so-called callous-unemotional traits, who appear to be an aetiologically distinct group with low empathy and high fearlessness. The evidence is presented that there may be higher genetic heritability for these traits than for ordinary conduct disorder and that there may also be a different pattern of neurocognitive deficits.

Several chapters reflect the growing evidence base and increasingly widespread practice of using psychopharmacological treatment in children and adolescents. In a pair of chapters, David Coghill & Eugenia Sinita survey the psychopharmacological treatments of the major disorders seen in child and adolescent mental health services (CAMHS), with particular emphasis on one on evidence-based practice and ensuring safety in the use of medications for ADHD. Rachel Elvins & Jonathan Green focus on the pharmacological management of core symptoms and comorbidity in ASD. With increasing recognition of this disorder and accumulation of empirical evidence, this is likely to be an area of developing demand for services from child psychiatrists. The chapter by Bernadka Dubicka and colleagues summarises the significance of the data on the treatment of mood disorders, and investigates the matter of suicidality, which is a term variously defined, and its relation to the use of antidepressants in young people. As one would expect, the answers are not simple.

The chapter by Nicky Dummett & Roger Lakin provides some very practical strategies for clinicians in the application of cognitive–behavioural therapy (CBT), but accompanied by rigorous formulation of the child's presenting problems. Refreshingly, these authors make connections between the worlds of CBT and other therapeutic approaches and draw attention to the importance of continuing to conceptualise problems systemically. Mary Eminson's lucid descriptions of the practice of paediatric liaison in her two articles of 2001 have been updated into two chapters jointly written with Olivia Fiertag. The first reminds us of the clinical presentations of the somatising disorders and the second deals with management and outcomes. These chapters remind us of the important role that child psychiatry has within paediatrics.

Patricia Howlin also focuses on psychological management by taking an overview of what counts as effective interventions for children and young people with ASD. Although not a clinical topic, and therefore not in the style of the other contributions, this chapter reviews the recent evidence base for psychosocial treatments of ASD. Child psychiatrists are increasingly confronted with children with these complex disorders, which are far more widespread than previously recognised, and the despair these children can cause their families. Howlin concludes that many psychosocial interventions have yet to be shown to be definitively helpful in these conditions and emphasises the problem of lack of services for individuals with ASD after they graduate from CAMHS.

Continuing the neurodevelopmental thread, and crystallising all the themes of the book, Peter Hill provides us with a masterclass and comprehensive revision of the topic of ADHD. This chapter is dedicated to the memory of his late coauthor, Mary Cameron, who wrote the original version with him in 1996. Chris Hollis, in his chapter on adolescent schizophrenia, summarises new research as well as the core features, course and outcome of this disorder, and investigates its neurobiology as

well as continuity into adult life. He concludes, in conformity with other conclusions in this book, that adult-based diagnostic criteria have validity in adolescents. Sadly, however, the disorder has a poorer outcome when first occurring in youth.

Other chapters give the clinician updated guidance by experts on the assessment and treatment of sleep disorders (Gregory Stores), self-harm (Alison Wood) and substance misuse (Paul McArdle & Bisharda Angom), including the use of more contemporary substances in the modern age. The fields of both eating disorders, written about here by Dasha Nicholls and Elizabeth Barrett, and gender dysphoria, by Domenico di Cegli, have been under some recent transformation. Research activity on the range of eating problems in younger children has advanced considerably, as has the trend for increasingly individualised treatments. As for the fascinating and complex world of gender identity and dysphoria, di Cegli's chapter reminds us that nowhere is psychiatry or its patients free from harmful cultural, social and often religious attitudes. In the case of these problems, their social and legal recognition in recent years in the UK at least has transformed the experience of those of transgender, who are now protected by equality legislation. This then is an area of optimistic and progressive social change.

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Sarah Huline-Dickens
BSc MA MSc BMBCh MRCPsych FAcadMed
Consultant Child and Adolescent Psychiatrist
Honorary Clinical Senior Lecturer