Supporting Troubled Young People

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A practical guide to helping with mental health problems

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Chapter 1: What is mental illness and what is the extent of the problem?

Introduction

The spectrum of mental health problems covers a wide arc from 'normal', common, uncommon to complex and rare. This chapter will focus on how mental health problems are defined, how prevalent they are among young people, and will explore the link between child development and mental health problems commonly experienced by children and adolescents. The concept of 'normal' is highly problematic yet it is a term that regularly appears in textbooks and is used by professional staff to try to measure and quantify the individual experience of troubled young people.

Defining 'normal' is difficult due to the number of variables affecting a child or adolescent's behaviour or mood. Class, ethnicity, gender, language, culture, sexuality, religion and age are some of the factors that militate against generalising across populations. Within each factor there are sub-variables and distinctions, so for example it is problematic to make general assumptions about the age of adolescent transition and what is 'normal' behaviour at this time in a multicultural, ethnically rich and diverse society.

It is important to recognise that just because something is statistically common does not mean it is easier to manage; for an individual young person, their parents/carers, friends or teachers it can be part of complex and very difficult circumstances. It is not easy to distinguish between different levels of meaning and symptom severity as we shall see later on, but the available evidence will be evaluated to help you feel better able to understand what might be happening in certain situations you are likely to encounter and how you can use knowledge and skills to make a positive difference. The task is not helped by a variety of terms used by doctors, psychiatrists and psychologists in general or specialist contexts to describe often the same thing. Thus we find the terms *mental illness*, *mental health problem* and *mental disorder* used interchangeably. Their use with children and young people and/or their parents/carers is also problematic because of the impact such language might have and where other explanations for odd behaviour or changes in mood have previously been offered.

Workers themselves may be very hesitant to use essentially medical language and descriptions when assessing children and young people. The word *mental* can trigger a variety of associations and responses often conditioned by individual, family and societal attitudes. Media representations of mental illness can reinforce or sometimes challenge stereotypes. Plus, research demonstrates that there is still considerable stigma attached to the label *mental illness/disorder* or *problem* with children themselves

reflecting adult prejudice, ignorance and rank fear (Walker, 2011a). Staff and parents are not immune to such beliefs and influences but it is important that you keep an open mind and do not quickly leap to wrongly diagnose or equally deny that a child may be developing mental health problems.

The task of gathering information about possible causative factors of child mental health problems is complicated by the fact that it is adult carers, worried about children, not the children themselves, that usually present asking for help. Children may not agree with parental interpretations of events and indeed may not even accept that there is a problem at all.

Prevalence and problems

Recent evidence indicates that 10 per cent of children up to the age of 18 years in Britain have a diagnosable mental health disorder (The Guardian, 2018). Higher rates exist among those living in inner city environments. One in five children and adolescents have a mental health problem which, although less serious, still requires professional support. Mental health problems include depression, anxiety, self-harm and disturbed behavior, and 70 per cent of children and young people who experience a mental health problem have not had any help. Behaviour resulting from mental illness can be misunderstood as 'naughty' or 'lazy'. It has been further estimated that child and adolescent mental health services are only reaching a minority of the population in their catchment areas requiring help (Children's Commissioner, 2018).

This indicates that a large number of children and young people are not receiving the necessary support and help to relieve their suffering. Research shows for example that one in 17 adolescents have harmed themselves – representing 200,000 11 to 15 year olds. At the other end of the age spectrum, there are increasing numbers of children under seven years of age being excluded from school due to uncontrollable behavioural problems. In any average primary school there will be 20 children with mental health problems. In an average comprehensive/technical college there will be 100 students with mental health problems (Rodway et al, 2016).

The number of girls self-harming between the ages of 13 and 17 has risen by 70 per cent from 2014 to 2017 (Morgan et al, 2017). Data from the Office for National Statistics (2017) shows that in 2015 there were 168 males aged 10 to 19 and 63 females in the same age group who took their own lives. The total figure of 231 is the highest it has been since 2001 when 240 youngsters committed suicide. The increased rate of suicide over the last 28 years in children and adolescents is a cause of increasing concern and a stark indicator of the mental health of young people. The Children's Commissioner said that only between a quarter and a fifth of children with mental health conditions

received help in 2016 and it bears repeating the revelation from the Care Quality Commission in 2017 that there was an 18-month waiting time for access to treatment (Care Quality Commission, 2018). In 2017, the President of the Family Division of the High Court condemned the *'disgraceful and utterly shaming lack of proper provision in this country'* for young people struggling with mental illness (The Guardian, 2017a).

Common mental health problems in young people

Depression

Depression is one of the most common child and adolescent mental health problems. In order to understand the nature of the low mood a child or adolescent may be experiencing, the following guidance can help in measuring in some way the intensity of the depression and help you organise an appropriate response. An initial assessment should ascertain whether at least one of the following symptoms is present on most days, most of the time or for at least the last two weeks: persistent sadness or low (irritable) mood, loss of interests and/or pleasure and fatigue or low energy. If any of these are present, you should find out about associated symptoms that may be experienced, such as those below. Then ask about any past history of depression, family history, associated disability and availability of social support.

- Poor or increased sleep.
- Poor concentration or indecisiveness.
- Low self-confidence.
- Poor or increased appetite.
- Suicidal thoughts or acts.
- Agitation or slowing of movements.
- Guilt or self-blame.

If the young person has four or fewer of the above symptoms, no past or family history and some social support available, then it may not be serious. If these symptoms are intermittent, or of less than two weeks in duration, the young person is not actively suicidal and has little associated disability, then your intervention can rely on providing general advice and 'watchful waiting'.

If the young person has five or more of the above symptoms together with a past history or family history of depression and a low level of social support, then the depression is more serious. Combined with suicidal thoughts and associated social disability, more active help will be required in primary care and the GP should be contacted to arrange an appointment. Together with the GP, you may decide after the first appointment that a referral to a mental health professional at Tier 2 CAMHS is necessary if the young person is not coping, neglecting themselves, their relatives are more concerned or there is a recurrent episode of depression within one year of the first. If the following factors are present then an urgent referral to a child psychiatrist is needed.

- Active suicidal ideas or plans.
- Psychotic symptoms.
- Severe agitation accompanying severe (seven or more) symptoms.
- Severe self-neglect.

Suicide

Suicide warrants particular attention for obvious reasons. It is worth considering the commonly accepted definition as well as other related terms such as *parasuicide* and *deliberate self-harm* to appreciate the differences between these terms and how they can get confused. Suicide refers to death that directly or indirectly result from an act that the dead person believed would result in this end. The definition of deliberate self-harm includes non-fatal or attempted suicide, but also life-threatening behaviours such as self-poisoning in which the young person does not intend to take their life as well as habitual cutting, piercing and head banging. Parasuicide is defined as serious but unsuccessful attempts to kill oneself such as any deliberate act with non-fatal outcome that appears to cause or actually causes self-harm, or would have done so without intervention from others.

Recent evidence confirms for example that suicide is of particular concern in marginalised and victimised adolescent groups including gay, lesbian and bisexual youth. Research such as that by Bhui and McKenzie (2008) suggests that despite the rhetoric of anti-discriminatory policies and professional statements of equality, heterosexist and homophobic attitudes continue to be displayed by some psychologists and social workers. This can further reinforce feelings of rejection, confusion and despair in troubled young people. Other evidence warns against a narrow definition of

sexual-minority adolescents that pathologises their behaviour or wrongly assumes a higher risk of self-harming behaviour (Walker, 2016).

Adolescents at risk of suicide can feel that they can resolve their internal states of despair and angst by splitting away from their body. Thus, by killing their physical body, they believe they can liberate their psychic self from the emotional pain and suffering. Adolescents at risk of psychosis are often suicidal, but suicide is not the outcome in many cases. Working with adolescents who are suicidal means being exposed to intense and extreme emotions such as anxiety, guilt, responsibility and fear. It is highly problematic to work with because it is immune to predictability and because there are multiple aspects to suicidality.

Anxiety

Fears and anxieties are normal developmental challenges facing the maturing young person. The relative intensity, frequency and duration of the behaviour associated with anxiety needs to be evaluated, and their role in the course of normal development considered against the frequency of the same behaviours among non-troubled children from the same class, culture and ethnic background. There are three main anxiety problems experienced by children and adolescents:

Generalised anxiety disorder

This is usually characterised by unrealistic and excessive anxiety and worry that do not seem to be linked to a specific situation or external stress. Children like this tend to worry about future events such as family activities, health issues and exams or just what is going to happen in the next hour or day. A young person in a chronic state of being on edge constantly can be understood as being in a state of anxious apprehension.

Obsessive compulsive disorder

This involves recurrent obsessions or compulsions that are time-consuming, cause distress and lead to problems in everyday functioning. Intrusive thoughts or images are also characteristic and perceived as senseless and inappropriate. Common themes are contamination, dirt, violence, harm or religious concepts. Washing rituals are particularly common.

Separation anxiety disorder

This is related to children usually and focuses on distress caused from and about being separated from those with whom the child is attached. It usually features children

refusing to sleep away from home, staying excessively close to a parent at home, and particularly problems around the time of starting school. Children are often fearful of some unspecific harm befalling their important attachment figures. School phobia is a variation of this problem and occurs when an anxious child can be comfortable in any setting other than school.

Autism

Autism has probably been around for a lot longer than the first recorded diagnosis and definition in the early 1940s. Like many problems before and since, it can be evidenced in children and young people in hindsight but until the 1940s there were different explanations for those showing the characteristics we nowadays associate with autism. The cause of the problem is still the subject of constant research and much controversy (Doherty et al, 2016) but there are associations with physical disorders (ie rubella) suggesting organic pathology as one important factor. A brief definition of autism is: *'abnormal development of language and social relationships with ritualistic and obsessional behaviours'* (Walker, 2011a, p 76). Key characteristics of a child or young person with autism are:

- failure to comprehend others; feelings, lack of interest in imitative or social play, and inability to seek friendships or comfort from others;

- impairments in verbal and non-verbal communication and avoidance of eye contact;

- resistance to change and limited interests.

Assessing autism accurately is notoriously difficult, especially in pre-school-age children when normal lack of socialisation and ranges in verbal communication vary widely. It is only when children attend school that those with autism tend to be identified because of the different way they behave and relate to others. It is also difficult to be certain about the prevalence of autism in the population. This is due to the complex classification systems used by health and psychiatric professionals and the way contemporary research has identified a variety of different conditions along the autistic spectrum of behaviour (Doherty et al, 2016). What is certain is that as diagnosis and assessment skills improve in health and social care staff, more children and young people are being identified and diagnosed with autism. Current estimates suggest a prevalence rate in the general population of between 7 and 17 per 10,000 children (National Austistic Society, nd).

Autism begins at birth but tends to be unrecognised until the child is two to three years old. There is usually a delay between parent concerns and diagnosis. This can be explained by the general lack of knowledge around child development but especially

among primary health care staff who are untrained or cautious about offering an opinion. By the age of three however, both parents and health care staff usually concur that autism could be the cause of the language delay and lack of peer relationships. In addition, other people such as friends, neighbours or nursery staff are reporting the pronounced lack of sociability, inability to empathise or capacity to reflect on social situations. This then quickly leads to social isolation in play groups or nurseries, reinforcing the characteristic preference of an autistic child for solitary repetitive play.

Autism is found 75 per cent more often in boys than girls and half of all autistic individuals never speak (National Autistic Society, nd). Those that can show unusual use of language in their intonation, stress placed on various words and often speak in a monotone. A significant proportion of autistic children have behavioural and emotional problems expressed in hyperactivity, short attention span, aggression, self-harm and anxiety/depression. Autistic features are often present where there is a generalised learning disability.

Repetitive behaviour is a major symptom of autism but there are a variety of motivations that contribute to the behaviour's occurrence – anxiety, self-soothing, self-stimulation and some more desultory states where the child may be deeply bored but not know it; or, may not know how to seek out and shift to another more interesting activity. Where the activity has built up to a frenzy, the child may need to be distracted with a fairly exciting alternative. The importance of enlisting parents as co-therapists in behavioural treatments is crucial. Helping them learn problem-solving skills is important in their ongoing management of current and future behavioural problems.

Asperger's syndrome

A precise diagnosis and definition is difficult to obtain because there is still confusion between autism and Asperger's in medical and health literature. A child with Asperger's is likely to have better cognitive and communication skills but still experience poor social interaction and stereotyped interests. It is estimated that the prevalence rates for Asperger's are higher than for autism but there is little robust evidence in this area. This is partly explained by the relatively high levels of intelligence found in such children, which can serve to mask other difficulties especially during adolescence. Asperger's is more prevalent in boys and can be characterised by a notable physical clumsiness with a very characteristic monotonous speech pattern and inflection. Anxiety, depression and low self-esteem are particularly found in adolescence. As yet, there is no definitive treatment or support but your role would include:

- assessment needs to highlight the strengths of the child;

- parent education and support to help them understand and cope;
- early identification required to intervene with social and language skills.

Drug, alcohol and substance misuse

Young people in the UK are more likely to drink alcohol excessively and get involved in drug use much more than their counterparts in mainland Europe. Workers should consider whether the drug and alcohol misuse is a cause of mental health problems or a consequence. Alcohol and drug abuse are factors associated with anti-social behaviour, criminal activity and poor educational attainment. The interim period between adolescence and adulthood is the highest-risk period for problematic drug use. This is especially so for those individuals described as externalised (the under-parented) and the internalised (the over-parented).

These young people grow up in family units of two extremes. The externalised family tend to be permissive and exert little control over the development of the young person, model poor behaviour around high consumption and exert little influence on the peer groups that their children subscribe too. The internalised group tend to be abstinent, fretful parents who over-protect their offspring from risk and responsibility, censure peer contact and thus disconnect their children from the socialisation process.

Self-harm

Self-harm among young people is a major public health issue in the UK. It affects at least one in 15 young people and some evidence suggests that rates of self-harm in the UK are higher than anywhere else in Europe (Walker, 2012a). Self-harm blights the lives of young people and seriously affects their relationships with families and friends. It presents a major challenge to all those in services and organisations that work with young people, from schools through to hospital accident and emergency departments. Levels of self-harm are one indicator of the mental health and mental well-being of young people in our society in general. Due to the increased prevalence data emerging from the latest research, please refer to Chapter 6 for more guidance on this particular problem.

Eating disorders

Assessment of young people with eating disorders should be comprehensive and include physical, psychological and social needs, and a comprehensive assessment of risk to self. The level of risk to the young person's mental and physical health should be monitored as treatment progresses because it may increase – for example, following

weight change or at times of transition between services in cases of anorexia nervosa (NICE, 2017). For people with eating disorders presenting in primary care, GPs should take responsibility for the initial assessment and the initial co-ordination of care. This includes the determination of the need for emergency medical or mental health assessment.

Young people and, where appropriate, carers, should be provided with education and information on the nature, course and treatment of eating disorders. In addition to the provision of information, family and carers may be informed of self-help groups and support groups, and offered the opportunity to participate in such groups where they exist. Social workers should acknowledge that many people with eating disorders are ambivalent about treatment and recognise the consequent demands and challenges this presents. Young people with eating disorders should be assessed and receive treatment at the earliest opportunity. Early treatment is particularly important for those with or at risk of severe emaciation and they should be prioritised for treatment.

Anorexia nervosa

Most people with anorexia nervosa should be managed in the community with psychological treatment provided by a service that is competent in giving that treatment and assessing the physical risk of people with eating disorders. Young people with anorexia nervosa requiring in-patient treatment should be admitted to a setting that can provide the skilled implementation of re-feeding with careful physical monitoring (particularly in the first few days of re-feeding) in combination with psycho-social interventions. Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.

Feeding against the will of the patient

This should be an intervention of last resort in the care and management of anorexia nervosa. Feeding against the will of the patient is a highly specialised procedure requiring expertise in the care and management of those with severe eating disorders and the physical complications associated with it. This should only be done in the context of the Mental Health Act 1983 or Children Act 1989. When making the decision to feed against the will of the patient, the legal basis for any such action must be clear.

Bulimia nervosa

As a possible first step, young people with bulimia nervosa should be encouraged to follow an evidence-based self-help programme. The course of treatment should be for 16 to 20 sessions over four to five months. Adolescents with bulimia nervosa may be

treated with CBT-BN, adapted as needed to suit their age, circumstances and level of development, and including the family as appropriate.

For all eating disorders

Family members, including siblings, should normally be included in the treatment of children and adolescents with eating disorders. Interventions may include sharing of information, advice on behavioural management, and facilitating communication. In children and adolescents with eating disorders, growth and development should be closely monitored. Where development is delayed or growth is stunted despite adequate nutrition, paediatric advice should be sought. Staff assessing children and adolescents with eating disorders should be alert to indicators of abuse (emotional, physical and sexual) and should remain so throughout treatment.

The right to confidentiality of children and adolescents with eating disorders should be respected. When working with children and adolescents with eating disorders, workers should familiarise themselves with national guidelines and their employers' policies in the area of confidentiality. In the absence of evidence to guide the management of atypical eating disorders (eating disorders not otherwise specified) other than binge eating disorder, it is recommended to follow the guidance on the treatment of the eating problem that most closely resembles the individual patient's eating disorder.

Schizophrenia

This is best understood as a collection of several disorders rather than one single mental health problem. It is nothing to do with 'split personality'. It is uncommon in early adolescence but prevalence increases with age and in males. The signs to watch out for are:

- psychotic state with delusions, hallucinations or thought disorders;
- significant reduction in social contact;
- deterioration in general and academic functioning;
- reduction in personal care and hygiene;
- lack of emotional affect in some young people;
- lack of energy or spontaneity;
- lack of enjoyment.

Risk factors include:

- family history;
- biochemical and brain disorder;
- substance misuse which triggers psychosis.

The treatment and management of schizophrenia has been divided into three phases: initiation of treatment at the first episode; acute phase; and promoting recovery. As a worker you might be involved at any or all of these phases.

The national guidelines makes good practice points and recommendations for psychological, pharmacological and service-level interventions in the three phases of care in both primary care and secondary mental health services.

The effects of schizophrenia on a young person's life experience and opportunities are considerable. Service users and carers need help and support to deal with their future and to cope with the changes the illness brings. Workers should work in partnership with service users and carers, offering help, treatment and care in an atmosphere of hope and optimism. For most young people experiencing a schizophrenic breakdown, the level of distress, anxiety and subjective confusion, especially during first episodes, leads to difficulty in accessing services. Service users and their relatives seeking help should be assessed and receive treatment at the earliest possible opportunity

The focus of your intervention and joint work is to help improve the experience and outcomes of care for people with schizophrenia. These outcomes include:

- the degree of symptomatic recovery;
- quality of life;
- degree of personal autonomy;
- ability and access to work;
- stability and quality of living accommodation;
- degree and quality of social integration;

- degree of financial independence;

- the experience and impact of side effects.

The assessment of health and social care needs for young people with schizophrenia should therefore be comprehensive, and address medical, social, psychological, educational, economic, physical and cultural issues.

Attention deficit hyperactivity disorder (ADHD)

ADHD is for some social workers and health professionals a controversial subject where it is believed by some that there is over-diagnosis and over-use of stimulant medication to control children's natural boisterous behaviour, or that the problem of ADHD is more widespread and under-diagnosed. Diagnosis of ADHD has multiplied in recent years as have concerns about the short and long-term side effects of drug treatment. Others accept that it is a real problem and a behavioural syndrome characterised by the core symptoms of hyperactivity, impulsivity and inattention. While these symptoms tend to cluster together, some children are predominantly hyperactive and impulsive, while others are principally inattentive. Not every young person with ADHD has all of the symptoms of hyperactivity, impulsivity and inattention. However, for a person to be diagnosed with ADHD, their symptoms should be associated with at least a moderate degree of psychological, social and/or educational impairment.

Moderate ADHD in children and young people is present when the symptoms of hyperactivity, impulsivity and/or inattention, or all three, occur together, and are associated with at least moderate impairment, which should be present in multiple settings (for example, home and school or a healthcare setting) and in multiple domains such as achievement in schoolwork or homework; dealing with physical risks and avoiding common hazards; and forming positive relationships with family and peers, where the level appropriate to the child's chronological and mental age has not been reached. Determining the severity of the disorder should be a matter for clinical judgement, taking into account the severity of impairment, pervasiveness, individual factors and familial and social context.

What are the causes of child and adolescent mental health problems?

Research into the causes of problems (Walker, 2011a) reveal very complex, often interrelated, causal factors in relation to young people's mental health. Two aspects of causation should not be confused:

• **Individual differences:** in the liability to develop difficulties, in the course of those difficulties and in the extent to which they recur.

• **Group differences:** for example, between the sexes (asking why a certain increase is greater among boys or girls) or between different ethnic groups.

It is important to look at the influence of the context and environment on an individual, at why a susceptibility to difficulty actually translates into, for example, a mental health problem or anti-social act. Risk factors are typically considered but are not always indicative so a young person with high numbers of risk factors may not develop mental health problems, whereas someone with low numbers does. The death of a parent or loss due to divorce/separation is associated with depression, but it is the *impaired parenting* that follows the loss that triggers the depression, not the loss itself.

Why has there been an increase in mental health problems among young people?

The UK has seen an increase in family disruption, in educational expectations and demand for scholastic credentials, in major decision-making (eg drugs, sex) and in prolongation of financial dependence on parents. Environmental factors could include greater cultural conflict, media images at odds with reality, toxins and pollutants, greater inequality and a decline in social cohesion and responsibility.

Here is a list of factors to bear in mind when trying to understand why a young person may be becoming mentally ill.

- Family dysfunction: separation, divorce.
- Racism, homophobia.
- Sexual, physical or psychological abuse.
- Economic stress: unemployment, poor housing, low income, poverty, debt.
- School stress: exam pressure, bullying, league tables, budget cuts, low staff morale.
- Access to drugs or alcohol.
- Cyberbullying, internet culture, violent video games, pornography.

- Genetic factors; biological and neurological issues.
- Parental mental illness.
- The pace of modern life.

It is useful to the discussion about definitions and distinctions to make a distinction between mental health problems and mental health disorders. Problems are defined as a disturbance of function in one area of relationships, mood or behaviour, or development of sufficient severity to require professional intervention. Mental health disorders are defined as either a severe problem, commonly persistent, or the co-occurrence of a number of problems, usually in the presence of a number of risk factors. This can be translated into some descriptions of the more common disorders of mental health found in children and adolescents.

- Emotional disorders (phobias, anxiety states, depression).
- Conduct disorders (stealing, defiance, fire-setting, aggression, anti-social behaviour).
- Hyperkinetic disorders (disturbance of activity and attention, ADHD).
- Developmental disorders (autism, speech delay, poor bladder control).
- Eating disorders (infant eating problems, anorexia nervosa, bulimia).
- Habit disorders (tics, sleeping problems, soiling).
- Somatic disorders (chronic fatigue syndrome).
- Psychotic disorders (schizophrenia, manic depression, drug-induced psychoses).

Schizophrenia represents one of the most serious, rare and controversial disorders classified by psychiatrists. Until relatively recently, child and adolescent psychiatrists had previously considered that the onset of schizophrenia only occurred in late adolescence. However, there is growing evidence that younger children are experiencing this most severe form of mental health problem without receiving adequate help and support. Part of the reason for this is the general reluctance to diagnose such a disorder because of fears about the potentially adverse consequences of the label, but there is also a history of uncertainty and lack of reliable classification instruments with which to apply a core definition across the variety of childhood developmental stages.

Table 1.1 Problem, disorder or illness?

Mental health problem	Common difficulties recognised as typically of brief duration and not requiring any formal professional intervention.
Mental health disorder	Abnormalities of emotions, behaviour or social relationships sufficiently marked or prolonged to cause suffering or risk to optimal development in the child, or distress or disturbance in the child or community.
Mental illness	A clinically recognisable set of symptoms or behaviour associated in most cases with considerable distress and substantial interference with personal functions.

Definitions and distinctions

The terms *mental health problem*, *mental health disorder* and *mental illness* are often used synonymously in both professional practice contexts and in the evidence-based literature. This can be confusing, particularly for non-specialists and service users and their families. Table 1.1 offers a guide to help clarify the differences between these terms and how to measure their use in particular situations:

Mental health problems can be distinguished by the term *disorder*, by the degree of seriousness and the length of time the condition lasts. The assumption is that most people will recognise these symptoms and understand they do not require specialist or intensive intervention. Note the idea of abnormality of emotions and the notion of them being sufficiently marked or prolonged. This parallel is useful in as much as it reveals how imprecise these definitions are and how open they are to interpretation. Who decides what is abnormal: the worker, parent or child? How is the notion of sufficiently marked or prolonged measured and against what standard? Mental illness takes us into the realm of medicine and the clinical guidelines and diagnostic criteria usually applied to the most serious difficulties and those that are statistically rare. At the other end of the scale, the terms *emotional well-being* or *emotional literacy* are becoming popular among the wider public and professionals even though it would be hard to find agreement about a definition of what these terms mean.

Different perceptions

The behaviour and emotional affect of children and young people diagnosed with symptoms of mental health difficulty can be considered in different ways within a variety of professional and public discourses. The dominant discourse is that of medicine and especially psychiatry, which continues to refine classifications of symptoms into universal descriptors. Yet behaviour and expressed emotions can be

interpreted widely, depending on the theoretical base of the professional involved and the specific cultural and historical context of their manifestation.

The term *mental illness* was constructed in the context of a debate among psychiatrists about the criteria for diagnosing specific mental health problems. Previously they had relied on a constellation of symptoms based on adult measures to distinguish children and adolescents whose condition was outside the normal experience. There are limitations in psychiatric diagnosis and by implication, the medical model it embodies. Not all children with symptoms of mental disorder show marked impairment, and conversely, some children have significant psycho-social impairment without reaching the clinical threshold for diagnosis.

If it is problematic to define mental *illness* or disorder, then it is equally difficult to define what is meant by mental *health* for children and young people. It can mean different things to families, children or professionals, and staff from different professional backgrounds might not share the same perception of what mental health is. A common set of characteristics that show mental health in childhood and adolescence is present includes:

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

Defined in this way, mental health is a rather ideal state, which depends upon the potential and experience of each individual, and is maintained or hindered by external circumstances and events. The Mental Health Foundation suggests that children who are mentally healthy will have the ability to:

- **develop** psychologically, emotionally, creatively, intellectually and physically;
- **initiate**, develop and sustain mutually satisfying personal relationships;

- **use** and enjoy solitude;
- **become** aware of others and empathise with them;
- **play** and learn;
- **develop** a sense of right and wrong;
- **resolve** (face) problems and setbacks and learn from them.

The World Health Organization (2005) defines good mental health among children and adolescents as:

Able to achieve and maintain optimal psychological and social functioning and well-being. They have a sense of identity and self-worth, sound family and peer relationships, an ability to be productive and to learn, and a capacity to tackle developmental challenges and use cultural resources to maximise growth.

Workers practising in a holistic context will be attuned to the social dimension affecting children's mental health. They need to consider how they define the terms *mental disorder* and *mental health* and whether their practice aims to help children and young people 'adjust to the stress of everyday living' or challenge those stresses within a personal helping relationship.

These definitions and the subtle distinctions between mental illness and mental health are important in the sense that they set the context for how parents and professionals and others conceptualise difficulties experienced by children and young people. Examples later on in this text will illustrate how education, youth justice and social work staff can all offer quite different explanations for the same behaviour with significantly different outcomes to intervention. So it is very important to be as clear as you can be about what it is you are observing and what sources of knowledge are informing those perceptions. Acquiring a label of mental illness can not only be stigmatising in the short term but can have profound longer-term consequences for a young person in terms of relationships, employment, education and personal health or life insurance.

Activity 1.1 Case illustration

You are a teacher in a primary school and responsible for a class of 10 year olds. One child is persistently loud, interrupts you and is affecting other children. The child does not seem able to concentrate, and normal interventions to stop the behaviour

are failing. The child is a black boy from a single parent family living in poor housing conditions. You feel angry with this boy because he is distracting you and other children. He is removed from the class. In discussions with your head of year and the boy's parent you discover that his father recently died in an accident at work.

Commentary

With more information you have been able to place the child's behaviour in a wider context. The impact on this child and the rest of the family of the father's terminal illness and subsequent death has been disturbing and distressing, resulting in anxiety which prevents concentration and learning and is expressed in distracting behaviour within class. With new information, your feelings of irritation and anger have shifted to those of care, concern and guilt. Now you can work together with pastoral care, his mother and other colleagues to try to mitigate his impact on others, get him support to modify his behaviour and monitor him to see whether his behaviour becomes worse and more disturbed, requiring referral/consultation to CAMHS.

Recognition

Growing evidence for the difference in professional perceptions of mental health problems in young people is shown by a recent survey conducted among GPs (O'Brien et al, 2017). It revealed that they were only identifying 10 per cent of children attending GP surgeries who had some form of severe psychological or emotional problem. These findings are worrying because primary care is one of the most crucial gateways for children and young people to gain access to appropriate services and resources and for signposting to accessible and acceptable support in this area. Different professionals and parents will view a child's behaviour through a different lens resulting in a diversity of opinions and assumptions about what is wrong. This reflects the value and knowledge base of each person coming into contact with a child, influenced by cultural norms, stereotypes and expectations. For example, a teenager with a history of anti-social behaviour may be perceived by youth justice staff as displaying criminal tendencies, whereas a social worker may view the same child as suffering from neglect, social exclusion and inconsistent parenting. A CAMHS worker may diagnose underlying untreated depression at the root of the problem behaviour.

Up until relatively recently, the different theoretical approaches to understanding the origin of children's mental health problems existed in isolation from each other. When brought together they were more likely to lead to competitive discussion and rivalry than thoughtful reflection and critical analysis. The polarised nature versus nurture debate is largely in the past and the interrelationships between the factors associated with child developmental outcomes are now widely acknowledged to be complex. We

have moved far away from assuming that factors associated with risk are necessarily the direct cause of problems. Likewise, we no longer consider risk factors alone without also taking into account factors that promote resilience in children and young people. Simplistic statements that promote single causes of mental health problems in children, whether it be the role of diet, poverty, genes or other relevant associated factors, are misleading.

Is there a consensus emerging on the causes of CAMH problems?

- Individual differences are important: people react differently to similar stimuli that can be social, biochemical or environmental. Some of these individual differences may be genetically influenced.

- Nature versus nurture is a false dichotomy – too many factors intervene to alter possible or probable causal pathways. Our genes merely determine predispositions, not precise outcomes.

- We need to take far more seriously the associative connections that undoubtedly exist between mind and body, which seem to be stronger than many suppose.

- What children eat (nutrition) and young people's perceptions of and reactions to stress (cortisol and its aftermath) undoubtedly affect the biochemistry of their brains and bodies in fundamental ways. This is likely to affect behaviour patterns and control mechanisms (impulsivity).

- When identifying solutions, it is vital to differentiate between the predicament/environment of a particular individual and that of the group (age, area, socio-economic status, ethnicity).

- The origins of mental health issues in adults will invariably lie in past experiences.

- Socio-economic status can have a profound impact on individual behaviour, for a range of different reasons, and these must be assessed carefully.

- Mental health problems and disorders can be viewed as the outcome of impaired, delayed or otherwise inhibited normal healthy development; as a rational yet often dysfunctional reaction to a difficult or challenging context; and as a dysfunctional, more extreme manifestation of an otherwise normal and functional state of mind.

Child and adolescent development

Understanding the key elements of human growth and developing theoretical resources relevant to young people's mental health are critical when seeking to understand and then plan to assess and intervene appropriately in the lives of troubled young people. Summaries have been provided below. They have been simplified to aid clarity and comparison and should be seen as part of a wide spectrum of potential, rather than deterministic, interactive causative factors in the genesis of child and adolescent mental health problems. Some social psychologists criticise the emphasis in child development theories on normative concepts and suggest enhancing the judging, measuring approach towards one that embodies context, culture and competencies. The following summaries should be adapted to every individual situation encountered and always considered against the white, Eurocentric perceptions they embodied when first constructed.

Freud's psychosexual stages of development

Year 1: The oral stage during which the infant obtains its principle source of comfort from sucking the breast milk of the mother, and the gratification from the nutrition.

Years 2–3: The anal stage when the anus and defecation are the major sources of sensual pleasure. The child is preoccupied with body control with parental/carer encouragement. Obsessional behaviour and over-control later in childhood could indicate a problematic stage development.

Years 4–5: The phallic stage, with the vagina and penis the focus of attention, is the characteristic of this psychosexual stage. In boys the Oedipus complex and in girls the Electra complex are generated in desires to have a sexual relationship with the opposite-sex parent. The root of anxieties and neuroses can be found here if transition to the next stage is impeded.

Years 6–11: The latency stage, which is characterised by calm after the storm of the powerful emotions preceding it.

Years 12–18: The genital stage whereby the individual becomes interested in opposite-sex partners as a substitute for the opposite-sex parent, and as a way of resolving the tensions inherent in Oedipal and Electra complexes.

Bowlby's attachment theory

The following scheme represents the process of healthy attachment formation. Mental health problems may develop if an interruption occurs in this process, if care is inconsistent, or if there is prolonged separation from the child's main carer.

Months 0–2: This stage is characterised by pre-attachment undiscriminating social responsiveness. The baby is interested in voices and faces and enjoys social interaction.

Months: 3–6: The infant begins to develop discriminating social responses and experiments with attachments to different people. Familiar people elicit more response than strangers.

Months 7–36: Attachment to the main carer is prominent with the child showing separation anxiety when the carer is absent. The child actively initiates responses from the carer.

Years 3–18: The main carer's absences become longer, but the child develops a reciprocal attachment relationship. The child and developing young person begins to understand the carer's needs from a secure emotional base.

Erikson's psycho-social stages of development

Five of Eriksen's eight stages of development will be considered.

Year 1: The infant requires consistent and stable care in order to develop feelings of security. He/she begins to trust the environment but can also develop suspicion and insecurity. Deprivation at this stage can lead to emotional detachment throughout life and difficulties forming relationships.

Years 2–3: The child begins to explore and seeks some independence from parents/carers. A sense of autonomy develops but improved self-esteem can combine with feelings of shame and self-doubt. Failure to integrate this stage may lead to difficulties in social integration.

Years 4–5: The child needs to explore the wider environment and plan new activities. Begins to initiate activities but fears punishment and guilt as a consequence. Successful integration results in a confident person, but problems can produce deep insecurities.

Years 6–11: The older child begins to acquire knowledge and skills to adapt to their surroundings. Develops a sense of achievement but marred by possible feelings of inferiority and failure if efforts are denigrated.

Years 12–18: The individual enters stage of personal and vocational identity formation. Self-perception heightened, but there is potential for conflict, confusion and strong emotions.

Paget's stages of cognitive development

Years 0–1.5: The sensory-motor stage is characterised by infants exploring their physicality and modifying their reflexes until they can experiment with objects and build a mental picture of things around them.

Years 1.5–7: The pre-operational stage when the child acquires language, makes pictures and participates in imaginative play. The child tends to be self-centred and fixed in her/his thinking, believing they are responsible for external events.

Years 7–12: The concrete operations stage when a child can understand and apply more abstract tasks such as sorting or measuring. This stage is characterised by less egocentric thinking and more relational thinking – differentiation between things. The complexity of the external world is beginning to be appreciated.

Years 12–18: The stage of formal operations characterised by the use of rules and problem-solving skills. The child moves into adolescence with increasing capacity to think abstractly and reflect on tasks in a deductive, logical way.

Personality development

A more recent view of personality development lists five factors that combine elements of the older more classic ways of understanding a child or adolescent together with notions of peer acceptability and adult perceptions.

- **Extroversion:** includes traits such as extroverted/introverted, talkative/quiet, bold/timid.

- **Agreeableness:** based on characteristics such as agreeable/disagreeable, kind/unkind, selfish/unselfish.

• **Conscientiousness:** reflects traits such as organised/disorganised, hardworking/lazy, reliable/unreliable, thorough/careless, practical/impractical.

• **Neuroticism:** based on traits such as stable/unstable, calm/angry, relaxed/tense, unemotional/emotional.

• **Openness to experience:** includes the concept of intelligence, together with level of sophistication, creativity, curiosity and cognitive style in problem-solving situations.

Sociological perspectives

In addition to the classic means of understanding child and adolescent development outlined above, there are other, less prominent but as important resources for workers to draw upon to help inform practice in this area. Sociology may be suffering from less emphasis in government policy and occupational standards guidance but it still offers a valuable conceptual tool to enable a rounded, holistic process of assessment and intervention with troubled children. Sociological explanations for child and adolescent mental health problems can be located in a *macro* understanding of the way childhood itself is considered and constructed by adults.

• Childhood is a social construction. It is neither a natural nor a universal feature of human groups but appears as a specific structural and cultural component of many societies.

• Childhood is a variable of social analysis. Comparative and cross-cultural analysis reveals a variety of childhoods rather than a single or universal phenomenon.

• Children's social relationships and cultures require study in their own right, independent of the perspective and concern of adults.

• Children are and must be seen as active in the construction and determination of their own lives, the lives of those around them and of the societies in which they live.

An examination of the experience of childhood around the world today shows how greatly varied it is, and how it has changed throughout history. Contemporary children in some countries are working from the ages of eight and independent from the age of 14, whereas in other countries some do not leave home or begin work until they are 21. The developmental norms above show how adults construct childhood and therefore how to measure children's progress and detect mental health problems. They are however set down as solid absolutes and are based on notions of adults' fears

about risk and lack of confidence in children, and are rooted in adults' own childhood experiences. These theories have had positive effects but they have also restricted the field of vision required to fully engage with and understand children and adolescents.

Activity 1.2

- Together with a friend or colleague, each write down three lists of your own characteristics at age 14 as you felt them, as your parents saw you, and as your class teacher perceived you.
- Note the similarities and differences, and think about and discuss together what concepts informed those differences.

Commentary

Early childhood studies are beginning to challenge the orthodoxy in child development theories so that children are seen as accomplishing, living, competent persons rather than not yet quite fully formed people who are learning to become adults. The idea that the stages have to be accomplished sequentially ignores the different pace at which different children change according to external and other influences. Adults simply need to reflect on themselves to see that adults of the same developmental age can be at very different stages of emotional maturity, skill and capacity. Workers therefore need to use concepts of development and definitions of child and adolescent mental health problems cautiously and sceptically. An appreciation of how these concepts are constructed reflecting historical and cultural dominant values, and how they reinforce the power relationships between adults and children, is required. The central processes apart from physical changes are the critical process of development of self, the search for identity and the development of relationships and the changing nature of relationships.

How can critical/reflective practice be developed?

Supervision or professional consultation in the area of child and adolescent mental health is a crucial component of reflective practice. A manager with the skills to offer case consultation combined with management supervision is ideal but probably a rarity. Workers involved with families or in situations where child mental health problems are an issue require quality consultation separate from the administrative and managerial aspects of their work. A senior colleague or other professional might be the best resource as long as they can help the worker disentangle their own feelings from those being generated during intense work. Simple concepts such as transference and projection used in a pragmatic way can go a long way towards increasing effectiveness and clarity in confusing and worrying situations.

A child's behaviour could be assessed as genetic predisposition by a physician, a specific disease requiring treatment by a psychiatrist, cognitive distortions by a psychologist, repressed unconscious desires by a child psychotherapist, or a consequence of environmental disadvantage by a social worker. It is therefore important to acquire knowledge and understanding of these potentially competing narrative understandings and theoretical paradigms. The challenge is to reflect on them with a sceptical, uncertain and inquisitive stance, in order to open new possibilities with colleagues and generate a range of resources to apply to the situation they are seeking to help. Taking a community-oriented, psycho-social perspective enables staff to place a child and young person's behaviour in context, which can synthesise and evaluate all the potential explanations offered by other professionals.

Summary of key points

- As well as understanding why some children develop mental health problems, it is crucially important to learn more about those who in similar circumstances do not. Research is required to analyse the nature of these resilient children to understand whether coping strategies or skills can be transferred to others. Positive factors such as reduced social isolation, good schooling and supportive adults outside the family appear to help

- Mental health problems can be distinguished by the term *disorder*, by the degree of seriousness and the length of time the condition lasts. The assumption is that most people will recognise these symptoms and understand they do not require specialist or intensive intervention.

- Research has revealed that GPs were only identifying 2 per cent of the 23 per cent of children attending surgeries who had some form of severe psychological or emotional problem (Freer, 2016). These findings are worrying because primary care is one of the most crucial gateways for troubled children and young people to gain access to appropriate services and resources and for signposting to accessible and acceptable support in this area

- Understanding the key elements of human growth and development theoretical resources relevant to CAMHS are critical to social workers seeking to assess and intervene appropriately in the lives of troubled young people. Some social psychologists criticise the emphasis in child development theories on normative concepts and suggest enhancing the judging, measuring approach towards one that embodies context, culture and competencies.
- Linking child development with attachment theory can provide a sound theoretical knowledge base with which to assess a variety of situations you may encounter. An

additional refinement would be to integrate systemic theory with attachment theory to enable a synthesis of the individual with the family context.

- Early childhood studies are beginning to challenge the orthodoxy in child development theories so that children are seen as accomplishing, living, competent persons rather than not yet quite fully formed people who are learning to become adults. The idea that the stages have to be accomplished sequentially ignores the different pace at which different children change according to external and other influences.

Further reading

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Dendy, C (2006) ***Teenagers with ADD and ADHD: A Guide for Parents and Professionals***. Bethesda, MD: Woodbine House.

Fonagy, P, Cottrell, D, Phillips, J, Bevington, D, Glaser, D and Allison, E (2016) ***What Works for Whom? A Critical Review of Treatments for Children and Adolescents***. London: Guilford Press.

Prior, V and Glaser, D (2006) ***Understanding Attachment and Attachment Disorders: Theory, Evidence, and Practice***. London: Jessica Kingsley.

Walker, S (2011) ***The Social Worker's Guide to Child and Adolescent Mental Health***. London: Jessica Kingsley.

World Health Organization (2005) ***Child and Adolescent Mental Health Policies and Plans***. Geneva: WHO.

Internet resources

- NSPCC: **www.nspcc.org.uk/**
- PAPYRUS – Prevention of Young Suicide: **www.papyrus-uk.org**
- Young People in Care: **www.becomecharity.org.uk**