**Clinical and Forensic Psychology: Clinical Case Study**

Bertie was described as “always on the go”, he has problems controlling himself, aggressive outbursts, temper tantrums and he had difficulties at school. These symptoms are characteristic of ADHD. Most of ADHD symptoms (hyperactivity, impulsivity and inattention) are present in Bertie's life in more than one settings and situations, however, problems with attention are less obvious. Bertie's sleeping difficulties, nightmares, low mood, negative thinking and suicidal ideations could be also due to ADHD, but ADHD medications can cause some of these side effects.

However, the NICE guideline suggests that ADHD cannot be considered a categorical diagnosis, as many common coexisting conditions could be present, such as personality disorders, bipolar disorder, obsessive-compulsive disorder and substance misuse (NICE, 2015).

To diagnose someone with ADHD, different assessments by multidisciplinary teams are needed. Bertie has already gone through this assessment and he has been diagnosed with ADHD.

Bertie's mother's alcohol abuse and her mental/physical health problems during pregnancy could be risk factors for ADHD. Bertie's mother was violated by her partners, if it appeared during the prenatal period, it is a strong risk factor for ADHD (e.g. brain damage or prenatal stress).

A meta-analysis with a small number of studies involved found that maternal drinking is associated with alcohol syndrome disorders (FASD) and ADHD. The result suggests that exposed children are 2.33 times more likely to have ADHD than non-exposed children (Gronimus et al., 2009, pp. 28-35).

Relationship problems can also cause the development and the maintenance of ADHD. Bertie stayed with different family friends and relatives and he was accommodated with foster carers at age two. These changing abnormal family environments early in life may also heighten the risk of developing ADHD.

Carr (2012) noted that genetic hypothesis suggests a predisposition to hyperactivity is inherited by children who develop this condition. Twin studies show that ADHD is 80% heritable and 20% is due to environmental factors, however, it varies from case to case (Carr, 2012, p. 41). There is no information that anyone had ADHD in Bertie's family. Nevertheless, his mother has Bipolar Affective Disorder and children of bipolar parents may develop a different psychiatric disorder such as ADHD. Birmaher et al. (2011) compared 121 children ages 2-5 from 83 parents with bipolar disorder with 102 children of the same age from 65 demographically matched control parents with no history of bipolar disorder. They found that children who have bipolar parents have an eightfold increased lifetime prevalence  of ADHD relative to children of mentally healthy parents (Birmaher et al., 2011, pp. 321-330).

**Treatment**

Carr (2012) suggested that there are a number of theories that emphasise the importance of deficits in specific cognitive and behavioural processes that contribute to the clinical syndrome of ADHD. To compensate these deficits, training programmes have been developed, mainly within cognitive-behaviour tradition (Carr, 2012, pp. 44-46). Individuals with ADHD require structure regarding the personal organisation, social boundaries, and practical help to cope with everyday problems (Young and Bramhan, 2012, p.29).

ADHD is a complex problem, so multimodal treatment is needed. Bertie needs to learn ways to manage himself. CBT can change his thoughts and it can provide practical strategies for organisation, planning and time management.

As his problem is partially maintained by problematic relationships at school and in the family, self-instructional and social skills training could be beneficial. Also, he might need to continue attending an emotional regulation group to control his impulses.

Gradually he can build up social bonds, resilience and coping strategies. A healthy environment needs to be created that discourages self-medication. Looking from a holistic approach, healthy lifestyle − diet, regular-sleep, regular exercise and mindfulness − would be also useful.

Bertie tried various medications for ADHD, but they have had limited impact on his behaviour. Controlled trials show that 70% of children with ADHD respond to medications, but the effects of medication cease if psychological interventions have not been provided concurrently with medication (Carr, 2012, p.43). It means that Bertie might fall into that 30% of children, who did not get the right medication and/or appropriate therapy.

Together with psychotherapy, Bertie needs to be on medication. Stimulant therapy could be necessary (e.g. methylphenidate). Some medications lose their efficacy after a few years. So, if psycho-social interventions are not normalising Bertie's behaviour, he might need a different medication along with therapy, but it need to be considered that many medications have side effects.

**Possible Secondary Diagnosis**

According to Follan et al. (2011) ADHD can have a high degree of co-morbidity with Reactive Attachment Disorder (RAD). They found that from 30 children diagnosed with ADHD 53% had risk factors of RAD. They may have similar symptoms, however, clean disctinction can be made between children with ADHD and children with RAD (Follan et al., 2011, pp. 520-526). Most RAD risk factors are present in Bertie's situation. These are parental mental health problems, parents' substance abuse, disruptive care or substitute care. When Bertie was a child, perhaps his emotional and/or physical needs were not met. When his mother was unwell he stayed with various family friends and relatives and later he was accommodated with foster carers. Also, he was developmentally delayed. Therefore, as a secondary diagnosis RAD might be considered. He demonstrated many symptoms that can be associated with RAD. These are behavioural problems, including hyperactivity, aggression, emotional problems and lack of empathy.

Children who are separated from primary caregivers for extended periods of time during their first months of life did not have a working internal model for secure trusting relationships. They behave immorally and they are displaying affectionless psychopathy (Bowlby, 1944, cited in Carr, 2012, p.60). The absence of human connections can result in permanent problems, including the risk of becoming sociopaths and violent criminals who feel no remorse for their acts (Fonagy, Target, Steele and Steele, 1997 cited in Shi, 2014, p.10). Bertie can have attachment problems, which may explain his criminal and antisocial behaviour toward his foster parents and strangers.

Treatments for RAD are still under-researched; it is difficult to produce long-lasting clinical progress as the client's basic trust in others is reduced (Shi, 2014, pp.1-2).

**Prognosis**

## About a third of ADHD children with ADHD have a good prognosis, about a third moderate prognosis and a third have a poor prognosis (Faraone et al. 2006, cited in Carr, 2012, p. 41). For two third of cases the primary problems (inattention, impulsivity and hyperactivity) persist in late adolescence and adulthood. About one third develop significant antisocial problems, conduct disorders and substance abuse by adolescent (Carr, 2012, p. 41).

The Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool for assessing the risk of violence (Carr, 2012, p. 279). By analysing Bertie's case by HCR-20, it seems that most *historical issues are present on a medium scale*. For example, earlier violence and criminal record, relationship instability, alcohol misuse and history of a major mental health disorder (diagnosed with ADHD).

On the *clinical scale (present issues) most items are also rated medium*, such as violent ideation and/or intent, symptoms of major mental disorder, impulsivity and negative attitude. In addition, he has low mood, withdrawal, insomnia and nightmares.

There is a *medium risk of future problems,*  on the risk management scale, he may lack personal support (does not want to see parents and living alone), he might have problems with stress and coping (low mood, negative thoughts, etc.).

Bertie has a *medium risk of an escalation of mental health difficulties*. Substance use, negative thinking, lack of social support and externalisation of his behaviour can exacerbate his mental health. His medications had a limited impact on his behaviour.

In addition, white and black mixed ethnic groups are more likely than others to experience additional problems (due to bad housing, unemployment, stress and racism) that may affect their mental health (NHS, 2015).

Ameliorating factors are that on his entry to care he made a significant progress and he was described as "bright". Now, he presents charming and he has engaged well with mental health services. These are great ameliorating factors, as engagement and willingness to change can contribute to the effectiveness of a treatment.

The *risk of harm to others is medium*, because he was violent in several occasions. He hit her foster mother at the age seventeen. He has a criminal record for common assault and theft of a vehicle and driving without a licence, so he may represent a risk to others in society.

Bertie has a *high risk of offending*, as he has a history of assaults. Recently he was arrested after he seriously assaulted a stranger in a pub without an obvious reason. Other factors present and contributing to the risk of offending: self-medication with alcohol, negative thoughts, externalising behaviour as a self-protective mechanism to avoid adverse consequences and fail to show guilt, regret or remorse after behaving badly. There is only limited information about his offending history and he might be stereotyped. Yet, he might be sectioned (Mental Health Act 1983, section 136) in the future if he appears to be suffering from mental disorder.

There is a *medium risk of suicide* as he denies any current suicidal ideation, but there is evidence of the previous overdose. There are a number of vulnerabilities to suicidal thinking present in Bertie's life, such as a mental health problems, alcohol misuse, unemployment and social isolation. But there is no record of the history of family suicide; there is no evidence of genetic factors contributing to suicide risk. Childhood trauma can also affect vulnerability to suicidal thinking. Bertie might experienced traumatic experiences during childhood, however, there is no direct evidence of it. He stated that he cannot remember any details about his early history, but he might have repressed traumatic memories.

It can be concluded that Bertie's assessment indicates moderate prognosis as primary problems are still present. He developed antisocial problems and substance abuse by adulthood too, yet, he has a willingness to change.

**References**

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