The mental health of boys

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The trouble with boys is that they tend to be more restless than girls. This is partly biological, but is exaggerated by cultural assumptions about masculinity. In primary school years, mental health services see more boys than girls. The several diagnoses they attract – especially conduct and hyperactive disorders – often overlap, and clinical responses often fail to manage the complexity of the child's place in family and school. In the teenage years, even though girls more often get depressed or harm themselves, male adolescents are at greater risk of suicide.

BOYS' PROBLEMS START EARLY

Boys are in trouble. Even before birth there is a significantly greater mortality of male fetuses over female ones. Almost anything that can go wrong *in utero* is more likely to affect the male (spina bifida is a rare exception). Although many more males than females are conceived (around 130:100), by the time the pregnancy is over the ratio at birth is 106:100.

Throughout life, including childhood, mortality from all causes in males exceeds that in females. Neonatal paediatricians know that premature girls tend to do better than boys born equally early. Less well known is the fact that a pregnant woman under severe stress is more likely to lose a male than a female fetus. The male is the weaker sex.

Alongside being male, maternal physical and mental illness, drug abuse, alcohol and smoking during pregnancy and severe neonatal anoxic distress all make hyperactivity or attention deficit[1] and conduct disorders[2] more likely. These conditions dominate child mental health clinics, together with boys on the autistic spectrum (ASD), who outnumber girls by four to one.

MORE BOYS ON THE AUTISTIC SPECTRUM

As the term suggests, ASD is a continuum. The tendency of boys to be engrossed by 'anorak' and relatively impersonal interests is probably related to brain differences between the sexes.[3] Note, however, that the aloofness of a child or young person with autistic features is not a sign of diminished emotion. It is an involuntary attempt to reduce potentially overwhelming anxiety, particularly in demanding social situations such as a meeting with a doctor. In general, males are more frequently inarticulate (alexithymic) about their emotional states.

BOYS NEED MORE ATTENTIVE CARE

Developmental differences between boys and girls are apparent from very early on. Boys are, on average, less mature physiologically and are more emotional and demanding infants. They have heavier brains and bulkier muscles, but tend to be less mature than girls. This is not always evident to parents and other caregivers.

Most people think that males are stronger than females, but this is true only in terms of muscle power. Biology and culture collide at this point, giving us relatively immature and emotional infant boys perceived as little men who will soon be able to look after themselves.[4] Two consequences of this cultural blind spot are that:

- infant boys may receive less attentive care when they need as much – if not more – than girls
- adolescent and adult males are less likely to ask for help when distressed, the most tragic evidence for which is greater suicide rates in adolescents and in men of all ages.

POSTNATAL DEPRESSION AND POOR SELF-REGULATION IN BOYS

A prominent example of male vulnerability is that a boy reacts earlier and more visibly to a depressed mother. Although it affects one in ten new mothers, postnatal depression is easily missed. The mother is tired and ashamed of not feeling more attached to the baby. She is less attuned to the infant's cues than a more contented parent, which has consequences for later development.

Some of these children – especially boys – become hyperactive and inattentive, which is still evident years after the mother's mood has recovered.[5]

Attention deficit/hyperactivity disorder (ADHD), twice as common in boys, can best be understood as a disorder of self-regulation. Besides temperamental and biological factors, poor self-regulation is caused by persistent mismatches between parental care and early childhood demands.

Studies on conduct and hyperactive disorders show that very many boys with one diagnosis also have the other, yet treatments may still be offered separately. Parents of hyperactive children may be aware that their attachment to the child was not secure[6] and a diagnosis that implies genetic causation sometimes reduces their feelings of guilt.

MEDICAL AND PSYCHOLOGICAL INTERVENTIONS

Medication is attractive to doctors because it is not a labour-intensive treatment. There is enormous variation between countries (and between doctors in any one country) in prescribing stimulants for inattentive and hyperactive children. Some clearly benefit, but the prescriber should be a specialist, and medication – which has unwanted effects, particularly on growth and sleep – is not sufficient on its own. Psychological therapeutic interventions with child and parents are necessary in every case.

In addition to behavioural problems, encopresis, enuresis, tics and specific learning difficulties (such as dyslexia) are commoner in boys, who always lag behind girls (by around 10 per cent) in GCSE and A level results.

CONDUCT DISORDERS

Around one in 12 boys has a conduct disorder, twice as many as girls (Figure 1).[7] This is not just naughtiness. It means very bad behaviour, such as nasty or violent bullying, fire-setting, repeated stealing and running away. Calling this a psychiatric disorder is confusing.

Although there are temperamental and genetic factors, a major source of conduct disorders is developmental, arising out of the experiences the child has had in the early years of life, while the brain is still growing fast. Expectations of relationships – of morality – are 'wired in' to the child's view of the world. Hyperactivity and inattentiveness often occur together with conduct disorder and are associated with significant educational, health and social deficits, and social costs.

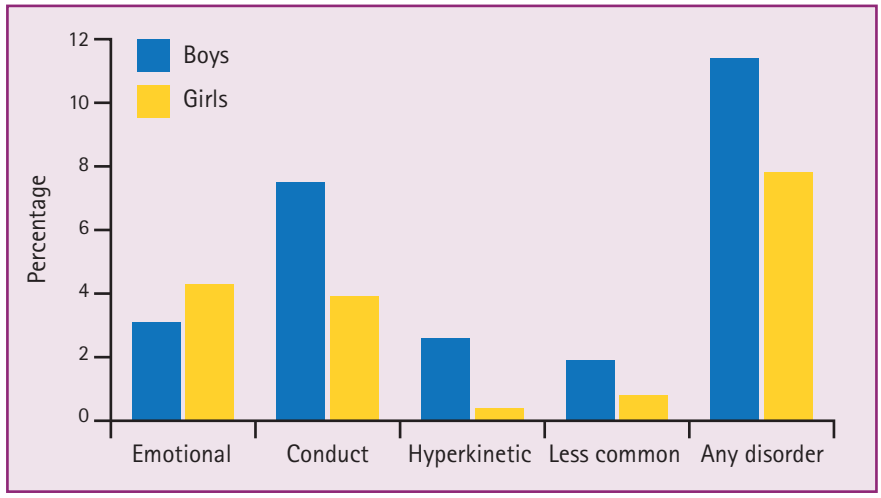

Figure 1. Prevalence of mental disorders in children aged 5–16 years[7]

ASK ABOUT THE BIRTH AND EARLY MONTHS

The most useful developmental questions to ask about any child are:

- How was the birth?
- What was the child like as an infant?

Most parents (especially mothers) will readily tell you how easy or difficult the baby was to care for, and to love. Anxious or depressed parents find it harder to look after their infants and toddlers. This is a commonly heard history of troubled children, and a source of parental guilt.

FIND OUT WHAT CHILDHOOD WAS LIKE FOR THE PARENTS

Even though we are inclined to feel indignant on behalf of children who seem beyond their parents' care or control, it is a poor strategy to blame parents. As doctors we can be quite judgemental, but when dealing with a child's emotional and behavioural problems it is better to be supportive, or at least sympathetic, to parental difficulties.

Rather than immediately trying to get parents to change (as if they could just do that), it is better to ask what they were like at the same age as their child with the problem.

A helpful framework for a family history is a three-generational genogram (Figure 2),[8] which you can draw as you enquire about the lives, illnesses, separations and deaths in earlier generations. This involves talking with fathers as well as mothers, and gives both a chance to make a link for themselves between past losses and traumas, and their struggles as parents now.

Such enquiries might make it easier for families to accept a referral to a parenting programme or a child and adolescent mental health clinic.

ISOLATED TEENAGE BOYS AT RISK

The most serious risk for males is suicide, the tip of an iceberg of masculine isolation. At all ages (and in almost all societies of the world), males kill themselves more frequently than females. This is so in spite of the fact that depression is more common among females. Suicide rates vary enormously according to social conditions, going down during wartime and up during economic depressions.

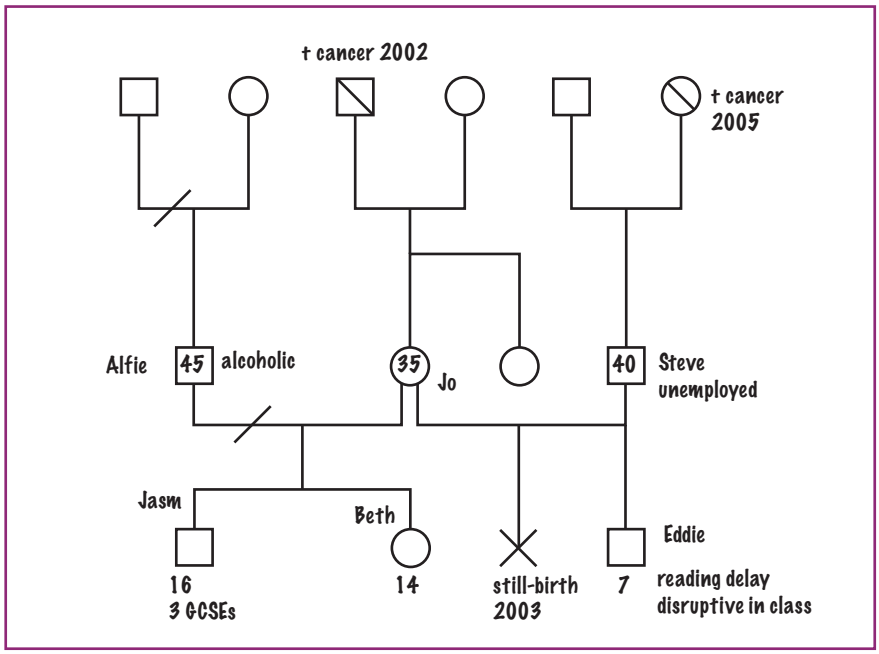

Figure 2. Fictional genogram of Eddie, age 7 years, referred for school problems

In the surgery or clinic, the danger signs for suicide are hopelessness, hostility, self-loathing and social isolation.[9] Few teenagers or young men will volunteer suicidal thoughts, yet it will not make matters worse – and may save a life – to ask directly 'have you been thinking of harming or even killing yourself?' The problem arises if the answer is 'yes', because help is urgently required, and not always easily found. All doctors working with young people should know in advance what local resources there are for urgent mental health assessment for under-18s.

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REFERENCES

1 Mick E, Biederman J, Faraone S, *et al.* Case-control study of attention-deficit hyperactivity disorder and maternal smoking, alcohol use, and drug use during pregnancy. *J Am Acad Child Adolesc Psychiat* 2002;41:378–85.

2 Wakschlag L, Lahey B, Loeber R, *et al.* Maternal smoking during pregnancy and the risk of conduct disorder in boys. *Arch Gen Psychiat* 1997;54:670–6.

3 Baron-Cohen S, Knickmeyer R, Belmonte M. Sex differences in the brain: implications for explaining autism. *Science* 2005;310:819–23.

4 Kraemer S. The fragile male. *BMJ* 2000;321:1609–12.

5 Morrell J, Murray L. Parenting and the development of conduct disorder and hyperactive symptoms in childhood: a prospective longitudinal study from 2 months to 8 years. *J Child Psychol Psychiat* 2002;43:1–20.

6 Clarke L, Ungerer J, Chahoud K. Attachment deficit hyperactivity disorder is associated with attachment insecurity. *Clin Child Psychol Psychiat* 2002;7:179–98.

7 Green H, McGinnity A, Meltzer H, *et al.* *Mental health of children and young people in Great Britain, 2004: Summary report.* London: Office for National Statistics, 2005.

8 McDaniel S, Campbell T, Hepworth J, Lorenz A, eds. *Family-oriented primary care: a manual for medical providers,* 2nd edn. New York: Springer Verlag, 2004.

9 Rutter P, Behrendt A. Adolescent suicide risk: four psychosocial factors. *Adolescence* 2004;39:295–302.