Health Care Analysis, Vol. 12, No. 4, December 2004 (© 2004)

Capacity and Competence in Child and Adolescent Psychiatry

Jacinta O. A. Tan[1,3] and Jorg. M. Fegert[2]

Capacity and competence in the field of child and adolescent psychiatry are complex issues, because of the many different influences that are involved in how children and adolescents make treatment decisions within the setting of mental health. This article will examine some of the influences which must be considered, namely: developmental aspects, the paradoxical relationship between the need for autonomy and participation and the capacity of children, family psychiatry, and the duty of care towards children and adolescents. The legal frameworks relevant to consideration of consent and competence will be briefly considered, as well as some studies of children's consent, participation and competence. A case vignette will be used as a focus to consider the complexity of the issue of competence in child and adolescent psychiatry, in the particular mental disorder of anorexia nervosa.

KEY WORDS: capacity; competence; child psychiatry; ethics.

INTRODUCTION

In dealing with questions of capacity in treatment decisions, it is not easy to choose a representative example for the practice in child and adolescent psychiatry and psychotherapy. Child psychiatrists deal with the developmental aspects

[1]The Oxford Centre for Ethics and Communication in Health Care Practice (The ETHOX Centre), Division of Medicine, University of Oxford, Old Road Campus, Old Road, Headington, Oxford OX3 7LF, United Kingdom.
[2]Universitätsklinikum Ulm, Klinik für Kinder- und Jugendpsychiatrie/Psychotherapie, Steinhovelstrasse 5, 89075 Ulm, Germany.
[3]Correspondence should be directed to Jacinta O.A. Tan, The Oxford Centre for Ethics and Communication in Health Care Practice (The ETHOX Centre), Division of Medicine, University of Oxford, Old Road Campus, Old Road, Headington, Oxford OX3 7LF, United Kingdom; e-mail: jacinta.tan@ethox.ox.ac.uk.

1065-3058/04/1200-0285/1 © 2004 Springer Science+Business Media, Inc.

of psychopathology from infant parent child interaction problems, developmental problems of preschoolers, conduct disorders, ADHD, oppositional behaviour mostly in school aged boys, and also the well known adult psychopathology arising in puberty and adolescence. These early onset forms of adult psychopathology often are more severe and have a poorer outcome, for example in early onset or very early onset schizophrenia. The first characteristic of child psychiatric decisions on capacity issues therefore has to do with the developmental aspect. Child psychiatrists have to define the developmental stage of a patient because reasoning on treatment issues and concepts of illness is age dependent, with preoperational processing in preschoolers, operational in primary school age and adult-like formal thinking developing from the age of about twelve years (e.g. Piaget, 1986; Peterson and Siegal, 1999; Perrin et al., 1991).

There is often a paradoxical relationship between the need for autonomy and participation and the capacity of children. This means that well protected children raised in an atmosphere of warmth and understanding often are able at a very early stage of their development to take part in treatment decisions, but these are often the children who have parents that can represent both their views and their best interests, which renders the issues of children's ability to make independent treatment decisions less crucial or problematic. In the context of neglect, child abuse and child sexual abuse, child psychiatrists frequently see children who have an extreme lack of autonomy and skills, but who would need to make important and serious decisions on their own because there is no one in their family who can protect their best interests or represent their views, and family members may attempt to influence their children's decisions for their own ends. In these cases, legal representatives of the child's interests like guardians ad litem or solicitors may be needed to represent the child's will. In other words, questions of capacity in treatment decisions in child and adolescent psychiatry often become crucial when there is conflict between the child's and the parent's interests.

Child and adolescent psychiatry always operates in the context of some sort of family psychiatry. This family aspect and the developmental aspect are the two main differences between the approach in adult psychiatry or even geriatric psychiatry and child and adolescent psychiatry.

There is another important difference between child and adolescent psychiatry and other areas of psychiatry in the field of education. Whereas doctors in adult psychiatry have to learn to restrain their impulses to patronise their patients with education and instruction, in child and adolescent psychiatric treatment every child has the right to have his or her educational needs met. Capacity and competency issues in child and adolescent psychiatry always require educating children and young people by providing appropriately simplified information that is both general and specific to their disorder. Training and teaching can also improve children's capacity to make their own treatment decisions.

GENDER

All over the world, child psychiatric in- and out-patients under the age of puberty are predominantly male. Boys with disruptive behaviour disorders can cause a lot of trouble especially in the primary school setting and are referred more often than children who suffer from emotional problems, obsessive-compulsive disorders or depression and anxiety problems, which may remain undetected or given insufficient treatment.

Many of the children with disruptive behaviour disorders are not fully aware of their problems and have difficulty acknowledging a problem. This means that teachers and parents often describe a problem, but the patients do not have a sense of their own psychological difficulties, or externalise their problems by interpreting their own negative behaviours solely as a reaction to a hostile environment. These children, by failing to seek to address their problematic behaviours, are often rejected by their peers and have problems in their academic careers, often going on to have longer term behavioural and emotional problems. Difficulties in, and the influence of, schools and the peer group are two other very important elements that the child psychiatrist has to take in consideration.

DUTY OF CARE AND PROTECTION

Child and adolescent psychiatrists have a duty and responsibility towards their young patients which is greater than those treating adult patients. This is because of the legal minority and vulnerable status of their patient group, and the paramount importance of protecting the interests of children and young people, which is reflected in many European family justice systems (Salgo, 1997) or general legislation concerning child such as the Children Act 1989 in the United Kingdom (Murch and Thorpe, 1997). In many different legal contexts in Europe, for example in German civil law, there is a reflection of developmental aspects with regard to the ability of children to express their own will and a need for legal representation by adults (Zenz, 1997).

A further complexity is the importance of the involvement of parents in treatment decisions, where psychiatrists have to balance the need for individual care of the patient, with any family needs for psychiatric intervention or support; and also young people's views and choices against their parents' views and need to be involved and informed in their children's treatment. Parents are crucial to psychiatric treatment in the light of their important role both in caring for and supporting their children in practical ways, and their bearing parental responsibility for their children (Rothärmel et al., 1999; Kaufmann et al., 1998, 1982; Weithorn and Campbell, 1982).

At the same time, it is increasingly recognised that children themselves have a need and a right to some degree of self-determination as well as participation in their own treatment, and declarations such as the United Nations Convention of the Rights of the Child are an illustration of this.

Allowing children and young people to make major treatment decisions which can result in significant harm, either immediate or future, or threat to life, is therefore a difficult issue, and competence becomes an important consideration in the debate (Alderson and Montgomery, 1996; Billick et al., 1998, 2001; Casimir and Billick, 1994; Degner and Sloan, 1992; de Winter et al., 1999; Kaser-Boyd et al., 1985).

COMPETENCE AND CONSENT IN CHILDREN AND ADOLESCENTS—EMPIRICAL STUDIES

Relatively little empirical work has been done in the area of competence and consent in children and adolescents, either in general or in the field of psychiatry (Tan and Jones, 2001). This is an area which does deserve more attention and concern, as Paul and colleagues showed that a high proportion of children and adolescents attending an outpatient psychiatric clinic had not consented to attend (Paul et al., 2000). Most research studies of children's consent have focussed on an understanding-based approach to competence, assuming that possessing sufficient understanding and reasoning is equivalent to competence. Using these criteria and hypothetical vignette studies in which children are not making decisions for themselves, it has been found that children appear to have sufficient understanding to make treatment decisions by the age of 9 years with appropriately simplified information, and by the age of 14 years with adult-level information (Billick et al., 1998; Weithorn and Campbell, 1982). However, a qualitative study which examined children's and adolescents' consent while participating in an actual research project, showed that the quality of their consent was poor, with a high rate of misunderstandings as well as susceptibility to external influence even amongst older adolescents (Ondrusek et al., 1998). Clearly, there is a need to examine more carefully what factors are important in children's consent, rather than simply adopting an understanding-based model which has been developed for adult patients.

A STUDY OF CHILD PSYCHIATRIC INPATIENTS' RIGHTS OF PARTICIPATION IN TREATMENT

In a study on child psychiatric inpatients rights of participation in treatment decisions and their overall information about their treatment (funded by the Volkswagen foundation, Fegert, 2003; Dippold et al., 2003; Wiethoff et al., 2003) we conducted interviews in 296 consecutive cases from West and East Germany in the age group between 7 and 17 years. In this sample we studied an instrument

developed in former qualitative interviews with a scale on children's participation with a fair internal consistency (Cronbach's alpha .87). Participation in treatment decisions at the beginning had a significant impact on motivation in the first and fifth week of treatment and on the perceived results of the treatment (Beta coefficient 518***, 245**, 183*). In the group of adolescent patients (14–17 years $n = 161$) patients with anorexia nervosa and very handicapped patients with schizophrenic and borderline personality disorders are those who significantly perceived treatment decisions as parental or medical decisions made from outside as against their will. Nevertheless, most of the girls with eating disorders in this sample did not want to have more freedom of choice, more autonomy or more influence in treatment decisions because they knew that their own choices would be wrong for themselves.

EPIDEMIOLOGY AND PSYCHOPATHOLOGY OF ANOREXIA NERVOSA

Anorexia nervosa is predominantly a female disorder, being 8–40 times more common in females than in males (American Psychiatric Association, 1994; Steinhausen, 2002a). The frequency of eating disorders seams to increase among twins, but Pawluck and Gorey (1998) found no increased risk over time of anorexia nervosa among teenagers in a cumulative review of twelve incidence studies covering 40 years.

ICD-10 and DSM-IV classification systems define anorexia nervosa by some main criteria like weight loss, body image distortion, amenorrhoea (in girls) and weight phobia. There are two different forms of the disorder: a restrictive type (patients only starving) and a binge eating/purging type (American Psychiatric Association, 1994).

The most striking psychopathological feature of anorexia nervosa is the fear of fatness. Because a feature of the disorder is a preoccupation with weight and shape as well as methods to lose weight, these girls often know everything about nutrition. They do not usually need more or better information on nutrition in order to have capacity to make treatment decisions. The distorted self-perception, a disturbance in body image plays an important role in the reasoning of these girls.

Despite being one of the main favourable prognostic factors in anorexia nervosa (Fairburn and Harrison, 2003) behaviour therapy of eating disorders often includes some sort of coercion. Even if negative reinforcers like bed rest, seclusion and tube feeding are no longer components of in many places, standard inpatient programmes and treatment algorithms, espoused by the professionals societies using so-called positive reinforcers, are often only the counterpart of what was formerly deprivation in early treatment stages (Steinhausen, 2002b:562): "Most operant programmes claim to be based mainly on positive reinforcers such as access to recreational activities, visiting privileges or freedom of movement within

or outside the hospital. Critics have objected that these privileges are also negative reinforcers because they imply relief from the prior situation of being deprived from these opportunities."

OUTCOME IN ANOREXIA NERVOSA

Most of the studies suggest that outcome in respect to restored weight is somewhat better in younger patients than in adults. This raises the question whether the involvement with, and support of, the patients by the family, and the greater ability and willingness of professionals to utilise various forms of coercion in legal minors in the specific conflict about treatment decisions, might play a role in the better outcome in comparison to adults who have to rely on their own treatment decisions and their capacity to do so, and who might therefore be left to refuse treatment when it is not in their best interests, competence or perhaps their underlying wish to do so (Rastam et al., 2003; Schulze et al., 2002; Steinhausen 2002b; Strober et al., 1997; Sullivan et al., 1998).

CO-MORBIDITY IN ANOREXIA NERVOSA

One-fifth of anorexia nervosa patients suffer from affective disorders, one-quarter from anxiety disorders and one in eight from obsessive-compulsive disorders (Anderluh et al., 2003; Serpell et al., 2002; Jarry and Vaccarino, 1996). Other comorbidities like substance abuse or posttraumatic stress disorders are less common (O'Brien and Vincent, 2003; Lating et al., 2002). Depression and anxiety (Fornari et al., 1992; Godart et al., 2000; Godart et al., 2002; Wittchen et al., 1998) disorders might play an especially important role in the question of capacity. This means that the impact of comorbidity has to be considered as well as the main disorder itself in capacity issues.

RELATING CASE C TO ISSUES OF CAPACITY AND COMPETENCE IN CHILD AND ADOLESCENT PSYCHIATRY

At face value, an adolescent girl with anorexia nervosa is not a prototypical child psychiatric case. Most of these girls are doing quite well in school, and they represent a small and specific subgroup in the large sample of child psychiatric patients. However, the case of an adolescent with eating disorders (case C; "Cases," 2004) highlights many of the particular difficulties that can arise in different areas of child and adolescent psychiatry.

One particular area illustrated in this vignette is the problem of 'perfect' knowledge and the difference between this and the ability to express true wishes.

Because adolescents with eating disorders typically have a good knowledge of the specific eating disorder, most parents and the doctors often confront difficult treatment decisions when patients who are legal minors refuse treatment. There is then a conflict between parental responsibility and medical duty of care to a young vulnerable person, and the need to respect treatment decisions as well as the opinions of an older child and adolescent who appears to understand the risks involved.

In child and adolescent psychiatry, there is often a discrepancy between the declared will of the patient and the covert or underlying wish of the patient, often communicated non-verbally, to be overridden and kept safe and within boundaries. This discrepancy between expressed and covert views also reflects the need in child and adolescent psychiatry to manage psychiatric disorder effectively while at the same time promoting the progressive development of autonomy which should be occurring during this period. In the vignette, views are expressed by Natalie at 13 and 15 years of age, that she needs and is willing to be guided by her parents, and that parental views are important as well as the child's views, which is protective to the young person in terms of securing their best interests. Natalie, aged 15 years, further makes the suggestion that serious consideration should be given to the situation when the views of the adolescent and his or her parents conflict.

This emphasis on the role of parents in treatment decisions underscores the need of many emotionally distressed, behaviourally disturbed or disordered children, to be managed with empathic but firm, consistent and secure boundaries by parents and professionals. This not only prevents them from coming to physical harm but also addresses the emotional security of the child and allows him or her to learn to exert self-control. In such cases, structure and even coercion in containing children and adolescents who feel out of control of themselves, can be experienced by the patients as positive and caring acts (Fegert et al., 2001; Cascardi and Poythress, 1997; Hoge et al., 1993; Roth and Roth, 1984; Tates and Meeuwesen, 2000; Bastien and Adelman, 1984).

The discussion above highlights the difficulty of the current conception of capacity, which is chiefly based on intellectual criteria of reasoning (Grisso and Appelbaum, 1998), as applied to children and adolescents. In children and adolescents, discrepancy occurs between the intellectual development of sufficient understanding required for treatment decisions, which has been shown to be attained at a simplified level before the second decade of life, and the emotional and psychological maturity required to independently make and take responsibility for major or complex treatment decisions that have serious implications for future health and wellbeing, which may take many more years and much more life experience to achieve. This may particularly be so in children and adolescents suffering from mental health problems or caught up in family problems, who may be impaired in their emotional and social functioning and development without necessarily being correspondingly impaired in their intellectual functioning.

CONCLUSION

Child and adolescent psychiatry faces particular problems when considering the issues raised by capacity and competence to make treatment decisions.

Children and adolescents are developing individuals, with development also being affected by psychopathology, often in different ways for different aspects of development. Family and systemic issues are also important, with parental support being crucial to promote and optimise children's competence to make or participate in treatment decisions. There is a sad paradox that children who are at most need to be able to make their own treatment decisions because of the failings of their families, are often the least able to do so. Education and gender are important issues in competence, as well as the gap between intellectual understanding and reasoning, attained to a sufficient level for treatment decisions at a young age, and other factors relevant to treatment decisions such as maturity and the ability to express true wishes for the self.

ACKNOWLEDGMENTS

The case vignette and the Study of Child Psychiatric Inpatients' Rights of Participation in Treatment were presented at the EPICC workshop on Child and Adolescent Psychiatry at Matera, Italy, 19 to 21 March 2003. The authors wish to thank Miss Natalie Smith and Mrs. Smith (not their real names) for their interest in the EPICC project, and for their kind consent for the use of Natalie's case vignette for the workshop and this article.

REFERENCES

Alderson, P. and Montgomery, J. (1996) *Health Care Choices. Making Decisions with Children.* London: Institute for Public Policy Research.

Anderluh, M.B., Tchanturia, K., Rabe-Hesketh, S., and Treasure, J. (2003) Childhood Obsessive Compulsive Personality Traits in Adult Women with Eating Disorders: Defining a Broader Eating Disorder Phenotype. *American Journal of Psychiatry* **160**(2), 242–247.

American Psychiatric Association (1994) *Diagnostic and Statistical Manual of Mental Disorders, 4 Edition*. Washington, DC.: American Psychiatric Association.

Bastien, R.T. and Adelman, H.S. (1984) Noncompulsory versus Legally Mandated Placement, Perceived Choice, and Response to Treatment among Adolescents. *Journal of Consulting and Clinical Psychology* **52**, 171–179.

Billick, S.B., Edwards, J.L., Burgert, W., Serlen, J.R., and Bruni, S.M. (1998) A Clinical Study of Competency in Child Psychiatric Inpatients. *Journal of the American Academy of Psychiatry and Law* **26**(4), 587–594.

Billick, S.B., Burgert, W., Friberg, G., Downer, A.V., and Bruni-Solhkhah, S. (2001) A Clinical Study of Competency to Consent to Treatment in Pediatrics. *Journal of the American Academy of Psychiatry and Law* **29**, 298–302.

Bulik, C.M., Sullivan, P.F., Fear, J.L., and Joyce, P.R. (1997) Eating Disorders and Antecedent Anxiety Disorders: A Controlled Study. *Acta Psychiatrica Scandinavica* **96**, 101–107.

Cascardi, M., and Poythress, N (1997) Correlates of Perceived Coercion during Psychiatric Hospital Admission. *International Journal of Law and Psychiatry* **20**, 445–458.

Cases (2004) *Health Care Analysis* **12**, 269–270.

Casimir, K.C., and Billick, S.B. (1994) Competency in Adolescent Inpatients. *Bulletin of the American Academy of Psychiatry and Law* **24**, 19–29.

Degner, L., and Sloan, J. (1992) Decision Making during Serious Illness: What Role do Patients Really Want to Play? *Journal of Clinical Epidemiology* **45**, 941–950.

De Winter, M., Baerveldt, C., and Kooistra, J. (1999) Enabling Children: Participation as a New Perspective on Child-health Promotion. *Child, Care, Health and Development* **25**, 15–25.

Dippold, I., Wiethoff, K., Rothärmel, S., Wolfslast, G., Konopka, L., Naumann, A., Keller, F., and Fegert, J.M. (2003), Dass Ich Verbessert werde mit Therapie"—Kenntnisse und Unkenntnisse Minderjähriger Patienten bei Behandlungsbeginn. In U. Lehmkuhl (Hg.) *Ethische Grundlagen in der Kinder- und Jugendpsychiatrie und Psychotherapie*. Göttingen: Vandenhoeck & Ruprecht.

Fairburn, C.G., and Harrison, P.J. (2003) Predictors of Mortality in Eating Disorders. *Archives of General Psychiatry* **60**(2), 179–83.

Fegert, J. M. (2003) Ethical and Legal Issues in Treatment of Schizophrenic Patients with Neuroleptics in Childhood and Youth. *Nervenheilkunde* 2/03, 75–79.

Fegert, J. M., Späth, K., and Salgo, L. (Hg.) (2001) *Freiheitsentziehende Maßnahmen in Jugenhilfe und Kinder- und Jugendpsychiatrie*. Votum Verlag.

Fornari, V., Kaplan, M., and Sandberg, D.E. (1992) Depressive and Anxiety Disorders in Anorexia Nervosa and Bulimia Nervosa. *International Journal of Eating Disorders* **12**(1), 21–29.

Godart, N.T., Flament, M.F., Perdereau, F., and Jeammet, P. (2002) Comorbidity between Eating Disorders and Anxiety Disorders: A Review. *International Journal of Eating Disorders* **32**(3), 253–70.

Godart, N.T., Flament, M.F., Lecrubier, Y., and Jeammet, P. (2000) Anxiety Disorders in Anorexia Nervosa: Co-morbidity and Chronology of Appearance. *European Journal of Psychiatry* **15**, 38–45.

Grisso, T., and Appelbaum, P. S. (1998) *Assessing Competence to Consent to Treatment: A Guide for Physicians and Other Health Professionals*. Oxford: Oxford University Press.

Hoge, S., Lidz, C., Eisenberg, S., Gardner, W., Monahan, J., Mulvey, E., Roth, L., and Bennett, N. (1997) Perceptions of Coercion in the Admission of Voluntary and Involuntary Psychiatric Patients. *International Journal of Law and Psychiatry* **20**, 167–181.

Jarry, J.L., and Vaccarino, F.J. (1996) Eating Disorder and Obsessive-compulsive Disorder: Biochemical and Phenomenological Commonalities. *Journal of Psychiatry and Neurosciences* **21**(1), 36–48.

Kaser-Boyd, N., Adelman, H.S., and Taylor, L. (1985) Minors' Ability to Identify Risks and Benefits of Therapy. *Professional Psychology* **16**, 411–417.

Kaufmann, N.H., and Flekkoy, M.G. (1998) Participation Rights of the Child: Psychological and Legal Considerations. *Children's Legal Rights Journal* **18**, 15–29.

Lating, J.M., O'Reilly, M.A., and Anderson, K.P. (2002) Eating Disorders and Posttraumatic Stress: Phenomenological and Treatment Considerations using the Two-factor Model. *International Journal of Emergency Mental Health* **4**(2), 113–8.

Murch, M., and Thorpe, L.J. (1997) The Development of the Family Justice System in England and Wales: Past, Present and Future. In Salgo, L. (Ed.) *The Family Justice System. Past and Future, Experiences and Prospects*. (pp. 5–34). Collegium Budapest, Workshop Series No. 3, Budapest.

O'Brien, K.M., and Vincent, N.K. (2003) Psychiatric comorbidity in anorexia and bulimia nervosa: Nature, prevalence, and causal relationships. *Clinical Psychology Review* **23**(1), 57–74.

Ondrusek, N., Abramovitch, R., Pencharz, P., and Koren, G. (1998) Empirical Examination of the Ability of Children to Consent to Clinical Research. *Journal of Medical Ethics* **24**(3), 158–165.

Paul, M., Foreman, D. M., and Kent, L. (2000) Out-patient Clinic Attendance Consent from Children and Young People: Ethical Aspects and Practical Considerations. *Clinical Child Psychology and Psychiatry* **5**(2), 203–211.

Pawluck, D. E., and Gorey, K.M. (1998) Secular Trends in the Incidence of Anorexia Nervosa: Integrative Review of Population-based Studies. *International Journal of Eating Disorders* **23**, 347–352.

Peterson, C.G., and Siegal, M. (1999) Cognitive Development and the Competence to Consent to Medical and Psychotherapeutic Treatment. In C.G. Peterson and M. Siegal (Eds.), (pp. 257–281). *Cognitive Development and the Competence to Consent*.

Piaget, J. (1986) *Judgement and Reasoning in the Child*. New York: Harcourt Brace and Co.
Perrin, E.C., Sayer, A.G., and Willett, J.B. (1991) Sticks and Stones may Break my Bones. . . Reasoning about Illness Causality and Body Functioning in Children who have a Chronic Illness. *Pediatrics* **88**, 608–619.
Rastam, M., Gillberg, C., and Wentz, E. (2003) Outcome of Teenage-onset Anorexia Nervosa in a Swedish Community-based Sample. *European Child and Adolescence Psychiatry* **12** (Suppl 1), I78–I90.
Rothärmel, S., Wolfslast, G., and Fegert, J.M. (1999) Informed Concent, ein Kinderfeindliches Konzept? *Medizinrecht* **7**, 293–298.
Roth, E.A., and Roth, L.H. (1984) Children's Understanding of Psychiatric Hospitalization. *American Journal of Psychiatry* **141**, 1066–1070.
Salgo, L. (Ed.) (1997) *The Family Justice System. Past and Future, Experiences and Prospects*. (153 p.). Collegium Budapest Workshop, Series No. 3, Budapest.
Schulze, U., Mehler-Wex, C., Remschmidt, H., Herpertz-Dahlmann, B., and Warnke, A. (2002) Children in the Drive for Thinness. How Early Anorexia Nervosa modifies Development. *MMW Fortschr Med.* **144**(38), 28–30.
Serpell, L., Livingstone, A., Neiderman, M., and Lask, B. (2002) Anorexia Nervosa: Obsessive-compulsive Disorder, Obsessive-compulsive Personality Disorder, or Neither? *Clinical Psychology Review* **22**(5), 647–669.
Steinhausen, H.C. (2002a) The Outcome of Anorexia Nervosa in the 20th Century. *American Journal of Psychiatry* **159**(8), 1284–1293.
Steinhausen, H.C. (2002b) Anorexia and Bulimia Nervosa. In M. Rutter and E. Taylor (Eds.), *Child and Adolescent Psychiatry*. Oxford: Blackwell Publishing.
Strober, M., Freeman, R., and Morrell, W. (1997) The Long Term Course of Severe Anorexia Nervosa in Adolescents: Survival Analysis of Recovery, Relapse and Outcome Predictors over 10–15 Years in a Prospective Study. *International Journal of Eating Disorders* **22**, 339–360.
Sullivan, P.F., Bulik, C.M., Fear, J., and Pickering, A. (1998) Outcome of Anorexia Nervosa: A Case-control-study. *American Journal of Psychiatry* **155**(7), 939–946.
Tan, J. O. A., and Jones, D. P. H. (2001) Children's Consent. *Current Opinion in Psychiatry* **14**, 303–307.
Tates, K., and Meeuwesen, L. (2000) 'Let Mum Have Her Say': Turntaking in Doctor-parent-child Communication. *Patient Education and Counseling* **40**, 151–162.
The Children Act 1989 (c.41)(1989). London: HMSO.
UN Convention on the Rights of the Child, United Nations (1989).
Weithorn, L.A., and Campbell, S.B. (1982) The Competency of Children and Adolescents to Make Informed Treatment Decisions. *Child Development* **53**(6), 1589–1598.
Wiethoff, K., Dippold, I., Rothärmel, S., Wolfslast, G., Konopka, L., Naumann, A., Keller, F., and Fegert, J.M. (2003) "Ich Dürfte Ja Nichts Sagen, Ich Musste Hier Rein"—Bedingungen und Folgen der Stationären Aufnahme aus der Sicht Minderjähriger Patienten. In U. Lehmkuhl (Hg.), *Ethische Grundlagen in der Kinder- und Jugendpsychiatrie und Psychotherapie*. Göttingen: Vandenhoeck and Ruprecht.
Wittchen, H.U., Nelson, C.B., and Lachner, G. (1998) Prevalence of Mental Disorders and Psychological Impairments in Adolescents and Young Adults. *Psychological Medicine* **28**, 109–126.
Zenz, G. (1997) The Chaos of Legal Representation: A Challenge for the Family Justice System. In *The Family Justice System*. Collegium Budapest, Workshop Series No. 3, 110–117.