The axiom “mad, bad or sad” has historically served as an informal aide memoir in assisting those new to psychiatry to conceptualise mental disorders. “Mad” refers to psychosis (including schizophrenia) and serious mood disturbance (particularly mania). “Sad” refers to depressive disorders and, through inference, anxiety disorders. “Bad” inevitably refers to antisocial personality disorder in adults and the equally unenviable label of conduct disorder in children and adolescents.

Unfortunately, a rigid holding to the “mad, bad or sad” paradigm does a disservice to youth with mental health difficulties. We will look at significant shortfalls in this paradigm and how to move forward to a more evidence-based (and probably humane) way of practice.

The three categories overlap more than is realised

One major problem with “mad, bad or sad” is the implied assertion that people with psychiatric disorders can be separated into those exclusive categories. This does not bear true in clinical practice. Numerous studies have demonstrated marked co-morbidity between psychosis, mood disorders, attention deficit/hyperactivity disorder (ADHD) and behavioural disorders in youth. A recent study of adult patients with schizophrenia in a (non-forensic) inpatient psychiatric unit, found a substantial proportion met diagnostic criteria for conduct disorder prior to age fifteen. Conversely, young offender populations demonstrate high levels of mental disorders. Even after excluding conduct disorder in over 1,829 young offenders (aged ten to eighteen), 60% of males and 67% of females met diagnostic criteria for one or more psychiatric disorders. Another study found the six-month prevalence of substance abuse disorders (50%), anxiety disorders (31%) and mood disorders (28%) in young detainees were much higher than community estimates.

Mental disorders emerge in adolescence and can be mistaken for “bad”

Increasingly research has shown that serious mental disorders (such as schizophrenia and bipolar disorder) often emerge for the first time between ages twelve and twenty-five. 14% of twelve to seventeen year-olds and 27% of eighteen to twenty-five year-olds experience mental health problems in any one year. Ironically, this age range is least likely to access General Practice and mental health services. Treatment delays are common and only one in four young people with mental health problems receives professional help. Even among young people with severe mental health problems, only half receive professional help and fewer receive optimal evidence-based care. The Australian Government has initiated “headspace”, a National Youth Mental Health Foundation (www.headspace.org.au), which may help improve access for this population. However, the need remains for all clinicians working with young people to be aware of the potential for undiagnosed mental disorders.

Intellectual disabilities and autism may be overlooked

Intellectual disability and autistic disorders do not fit into any of the categories of “mad”, “bad” or “sad”. Young offender populations demonstrate high levels of intellectual disability, even when educational disadvantage is accounted for. The hallmarks of autism include qualitative impairment in non-verbal behaviours (poor eye-to-eye
gaze, facial expression and social regulatory gestures) and failure to develop peer friendships, qualitative impairments in communication and restricted, repetitive and stereotyped patterns of behaviour and interests (DSM-IV-TR).

**Look beyond conduct disorder**

The co-morbidity of behavioural problems and psychiatric disorders should be conceptualised as the rule rather than the exception. “Mad, bad or sad” must rightly be renamed “mad and/or bad and/or sad” or, even better, scrapped completely. Under the “mad, bad or sad” paradigm, clinicians may readily diagnose conduct disorder in young people and then are tempted to look no further. The evidence-base encourages clinicians to look beyond behavioural problems and to ask, “What else is there?” Not, “its conduct disorder, we can’t help - case closed”.

**Don’t miss the obvious**

Once we look beyond conduct disorder, this allows us to acknowledge the presence of mental illness in young people. The next step is to treat the predominant mental disorder or symptom cluster. It is important not to be “put off” by co-morbid conduct and/or substance use disorder(s). In essence, “treat what you see”. The diagnosis need not be definitive. As medical practitioners, we are comfortable enough to diagnose acute appendicitis and institute management based on clinical symptoms and signs alone (and so we should be) – mental disorders should be no different.

**Medication may be needed**

Sustained psychotic symptoms warrant treatment with atypical antipsychotic medication. Even if illicit substances were involved, a diagnosis of first episode psychosis is preferable, placing emphasis on engagement by the treating team. The label “substance-induced psychosis” may result in the patient being blamed for their illness and treatment denied. For psychosis in youth, the first-line treatment of choice is risperidone, due to its evidence base in early psychosis and favourable metabolic profile compared to some other antipsychotics. “Start low and go slow” is a good mantra, unless the presentation is acute.

Symptoms and signs of mania deserve mood stabiliser treatment with either lithium or valproate. In a young female with mania who is at risk of unprotected sexual intercourse, quetiapine is an option (due to emerging evidence of its safety in pregnancy). Mild to moderate pervasive depression and/or anxiety should be managed by cognitive behavioural therapy. If there is an inadequate response, severe illness or poor engagement, antidepressant medication should be offered. Fluoxetine has the greatest efficacy and safety in youth depression. ADHD responds to either stimulants (methylphenidate or dexamphetamine) or atomoxetine. For severe behavioural disturbance (agression towards self and/or others) with autism, where non-pharmacological methods alone have been unsuccessful, risperidone has some evidence of efficacy.

**Longitudinal findings of mental illness trump cross-sectional findings of “normality”**

Mental disorders and symptoms in young people can fluctuate and appear significantly different at varied time points. Mental illness in youth often improves dramatically once they are on the right medication(s). The fact that a young person’s illness improves to the point of remission does not disprove the fact that they had, and continue to have, what may be a serious mental illness. For instance, let us take the fictitious case of Sam, a young person who heard voices and felt paranoid for six months. Dr X assessed Sam, diagnosed a first episode psychosis and commenced antipsychotic medication. Dr X saw Sam improve gradually over three months of treatment to the point of being symptom-free. Dr Y sees Sam one month later (after four months of treatment) and finds “no symptoms of psychosis”. Does Sam no longer have a psychotic illness? No, of course not – Sam has a psychotic illness that responded well to treatment.

“Mad, Bad or Sad” – Is There a Better Way?
We need to trust the diagnostic assessments of colleagues, particularly when they emerge from longitudinal assessments. Assessments showing a mental illness over time must trump any single cross-sectional finding of “not mentally ill”.

**Multidisciplinary specialist care is needed for severe mental illness**

For young people with a severe mental illness, adjunctive specialist psychiatric referral and ongoing care should be sought, especially if a risk of harm to self or others is present. For severe and complex cases, the involvement of a multidisciplinary mental health team is the ideal, although accessibility to services may be a struggle. Youths with severe mental illness are likely to benefit from outreach and proactive models, usually essential elements of a community-based mental health team.

**Important messages**

- Expect co-morbidity of behavioural problems and mental illness in young people.
- Mental disorders in youth can be mistaken for “bad” behaviour.
- Think about intellectual disability and autism.
- Look past conduct disorder.
- Treat the predominant psychiatric symptoms.
- Longitudinal findings trump cross-sectional ones.

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**Useful References**


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