Chapter

1

Introduction

At least 12–17% of the world's population of children suffer from mental health problems. Four fifths of these children live in developing countries.

SCENARIO IN DEVELOPED COUNTRIES

In the developed world, the situation is also unsatisfactory. Certain social factors such as employment of both parents (where no substitute care is available); fragmentation of families; Nuclearization and its breakup due to high divorce rate; alienation in impersonal urban settings; sexual abuse; severe accidents and intoxication contribute to mental health problems in children. Even the improvement of life saving technology may be increasing the number of survivors with severe brain damage.

SCENARIO IN DEVELOPING COUNTRIES

Despite the fact that children under 15 years of age constitute 40–50% of the population of the developing countries, a majority have little or no access to qualified help. A large number of mental health problems are due to childhood infectious diseases, trauma, malnutrition, lack of resources, lack of awareness and cultural obstacles. The persons dealing with children (i.e. pediatricians and teachers) are on the whole insufficiently trained in methods of diagnosis, treatment, rehabilitation and prevention.

PROBLEM AREAS IN CHILD PSYCHIATRY

I. Evolution of Concept of Psychiatric Disorder

Kanner (1960) had remarked that there is no absolute criterion for normalcy of any of the common forms of behaviour problems in children. Difficulty in defining the concept of psychiatric disorders in children has also been created by the profusion of terms used to designate children suffering from psychiatric disorders e.g. *problem children,* emotionally disturbed children; emotionally handicapped children; children with behavioural disturbances. The pathological significance of habits as thumb sucking, nail biting, casual masturbation, enuresis etc. is infact, decided by annoyance threshold of the parents and psychiatric referral in a number of causes may not be the severity or duration of the habits but of the circumstances in the child environment.

Only very rarely single behaviour items could be taken as sufficient evidence of psychiatric disorders. The psychiatric disorders in a child may represent social deviance or developmental lag instead of a disorder in itself.

II. Classification

There is no separate accepted standardized and uniform international classification of childhood psychiatric disorders. An ongoing effort is being made to develop and test a multiaxial classification system for child mental health care. This system shall allow the recording of relevant information about the psychiatric status, intellectual level and biological and psychosocial factors influencing mental functioning, useful not only for psychiatrists and psychologists but also for general health workers.

III. Epidemiology

A four country study done in primary health care settings in the Sudan, Columbia, India and the Philippines gave a prevalence rate of 12 to 29% (21% in India for child psychiatric disorders). whereas other surveys reported prevalence rates ranging from 12.5 to 16.5% for children and 20% for adolescents. The magnitude of drug dependence varies enormously from country-to-country e.g. 1% in Kenya to 43% in Columbia. Studies from West on the prevalence of childhood psychiatric disorders in general populations conservatively estimate rate of disorders between 7% and 20%. A multi-centre study in Southeast Asia found that 10–15% children presenting with somatic symptoms had functional complaints. Mental retardation is art of child psychiatric case load in developing countries. Prevalence rate of mental retardation (Intellectual disability) in children is 2–3%. The prevalence rate in India is reported to be over 3% in 6–10 years old.

The research in epidemiology is characterized by many lacunae. Some of which are : lack of definition of psychiatric disorder, no mention of classification and diagnostic tools used, marked differences in populations studied, differences in mental health workers conducting studies and projection of clinic based research data into general population. Many children seen at clinics do not have psychiatric problems, reflecting parental anxieties and differing perceptions of abnormality. Many children having overt diagnosable psychiatric disorders even corning to hospitals for some other health problems are not referred to child guidance clinics for psychiatric disorders. The trend is quite different in Western Countries where children with psychiatric disorders are easily identified either by the teachers for parents whereas in Southeast Asian countries, the children with psychiatric disorders are identified mainly by the health care professionals. In developing countries, more care and attention is given to male children, thus leading to biases in epidemiological research. Certain diagnostic categories (e.g. hysteria eating disorders etc. are either less common in developing countries or they are not easily recognized e.g. school related problems, conduct disorders). There is need to acquaint and train the general practitioners and pediatricians to recognize and refer the children having psychiatric disorders.

IV. Aetiology

Evidence of the relative role played by organic as opposed to environmental factors is insufficient except in the case of mental retardation. The role of malnutrition, anaemia, infections, infestations and perinatal accidents in producing cognitive maldevelopment, especially in developing countries need more exploration. The influence of age, sex, urban or rural setting and culture also need research. Family factors and child rearing practices e.g. nuclearization, marital conflict, separation, divorce, bereavement, parental attitudes, facilitatory and maladaptive mechanisms, family belief system, controls and disciplinary practices and varieties of carer-child interactions also need research. School related problems, though easy to recognize, have been poorly studied. Attention is also needed to study the high risk children, child abuse, deliberate neglect, girl child, abandonments, street or beggar children, adoption etc.

V. Diagnosis and Differential Diagnosis

There is need to develop standardized population and age-based assessment tools. Sophisticated scans, serological and biochemical tests are yet not available in a majority of developing countries, thus making the diagnosis of many psychiatric disorders as provisional and the appropriate preventive interventions (e.g. metabolic cause of mental retardation, vitamin deficiencies) can not be made. There is marked differences in the differential diagnosis of a childhood psychiatric disorder e.g, in a child with a psychiatric disorder, it is difficult to rule out even mental retardation because the facility for psychodiagnostics is not available in many mental health clinics.

VI. Management

Research in the management strategies of psychiatric disorder in adults can not be uniformally applied to manage psychiatric problems in children. This is reflected by the research in psychopharmacology. Most of the drugs available to treat various psychiatric disorders have not been uniformly studied and tested in children. This is also complicated by the uneven research e.g. stimulants used in the treatment of attention deficit hyperkinetic disorders have been well researched in comparison to other group of drugs e.g. newer antidepressants. The efficacy of many management techniques e.g. psychotherapy, behavior therapy, marital and family therapy, and somatic therapies have not undergone many double blind trials in the treatment of childhood psychiatric disorders.

VII. Prevention

Preventive methods are most useful in the early age-group and these can even now be applied at foetal and infant level. Many childhood disorders e.g. mental retardation, conduct disorders are preventable but not curable. A rupee on prevention can save a crane on rehabilitation. A significant amount of meagre health resources available in developing countries is being consumed by the rehabilitation services. Many known and avoidable hazards to the psychosocial development of children in developing countries remain largely unchallenged. Many important aetiological factors e.g. malnutrition, infectious diseases, and perinatal diseases can be largely prevented by adequate nutrition, immunization and better perinatal care.

VIII. Research

Research in childhood psychiatric disorders is needed in the areas of classification, epidemiology, aetiology, diagnosis, management strategies, rehabilitation, preven-tion, public awareness and attitude. Though children (under 15) constitute a majority (upto 50%) in developing countries, they do not get even one percent of the health resources. Though four-fifths of the children with mental health problems live in the developing countries, but they have little or no access to qualified help. This is further complicated by the brain drain to the developed countries. International Organizations (e.g. UNICEF, WHO, FAO, UNDP etc.) should help in providing the resources and manpower. Among the specific topics, priority is recommended for research leading to improvement of mental health assessment procedures, research on services and their evaluation, and research to develop indicators of child mental health and of the effectiveness of health promoting interventions; and also studies on the impact of schooling.

IX. Training

Techniques adopted from other settings should be adapted to allow for differences in reporting due to situational, cultural and semantic factors. There is need to develop curriculum for brief training courses for primary health workers, nurses etc. to recognize and deal with mental disorders in children. A training programme for teachers to enable them to identify and refer the children with psychiatric disorders is also required The training of teachers has been found effective in India The developing countries also need a special training curricula in child psychiatry even for psychiatrists, as the exposure to all childhood psychiatric disorders at undergraduate and postgraduate training is insufficient.

X. Services and Further Suggestions

Child psychiatry is now a recognized speciality within developing countries. There is a wide variation in the degree to which services have developed in individual countries but in general, child psychiatric facilities are more closely linked to adult psychiatric facilities than in the West. Services are also mainly urban based. There are few qualified child psychiatrists and they are usually based at academic centres. The majority of children with problems are seen by general psychiatrists or clinical psychologists. A significant proportion of the population does not have access to facilities either because it is predominantly rural or because the state run specialized services are too expensive.

There is need to utilize fully available resources, health services and manpower. The child mental health services can be integrated into the available health system and the available health care workers should be trained to recognize and refer the children with mental health problems to tertiary care centres mainly for intervention and guidance. The psychiatrist should assist in clinical services, research, teaching and train-ing. There is need to adapt child mental health services to the *triad of child, family* (or society) and *school* and evolve a professional team to deal with the mental health problems. It shall include psychiatrists, pediatricians, psychologists, nurses, social workers, teachers and parents and at times, health planners. These objectives will further help in

providing information about mental health needs, to develop a method for assessing child mental health problems and programmes, to raise awareness about mental health problems and possibilities for their solution within the countries concerned and to make recommendations for further action by WHO in the field of child mental health.

THE FUTURE

The child psychiatry in developing countries is now an established field. The rapid socio-cultural and political changes affecting the life styles of children and their families have increased its need. Child psychiatry can also contribute to changes in social policy about children. The diverse role of child psychiatrists demands training which equips clinicians for the ever-increasing demands of the society. The ultimate aim is to develop a healthy child because the child is the barometer of family and society's health and he is the father of the father.

Chapter

2

Normal Child Development

WHAT DETERMINES CHILD'S BEHAVIOUR

(A) Factors before conception (Preconceptional factors) i.e. age of parents, intensity of their desire for a child etc.

(B) Factors during pregnancy (Prenatal factors) i.e. maternal disease, psychological stress, preterm delivery etc.

(C) Factors after birth (Postnatal factors)

  (a) Establishment of a bond between parents and a child.

  (b) Parents and the home i.e. love for the child, fear of spoiling, overprotection, favouritism as well as rejection, parental habits etc.

  (c) Disturbed family e.g. inadequate family, antisocial family, disruption of family.

  (d) Attitude of other significant persons e.g. teacher, friends and siblings.

FACTORS BEFORE CONCEPTION

Behaviour problems have their origin before birth and often before conception. If one finds a child who is rejected and unloved by his parents, one always find that such mother or father had an unhappy childhood. Rejection, unhappiness and lack of love in a child's life may well affect the next generation.

Other factors are:

(1) **Age of parents:** Very young parents are too immature to look after the child, whereas aged parents cannot do it properly because of decreasing potentialities.

(2) **The intensity of their desire for a child** or for a child of a particular sex e.g. if the first four or five children in the family were girls and parents had a special desire to have a boy, one can imagine that if the next child to be born is another girl, she may be at least partly rejected and that if the child is a boy, he may get overprotection and favouritism with undesirable effects on his developing personality.

(3) **Duration** of **married life:** If a child is born after a long married life e.g. 10 years or more, the over-anxiety and overprotection are tremendous.

(4) **Forced marriage:** Will affect the life of the children as the parents are not really a match for each other and domestic conflict may result.

(5) **An illegitimate child:** Will suffer if placed in an institution.

CHILDREN LEARN WHAT THEY LIVE

If children live with criticism,
They learn to condemn.
If children live with hostility,
They learn to fight.
If children live with ridicule,
They learn to be shy.
If children live with shame,
They learn to feel guilty.
If children live with tolerance,
They learn to be patient.
If children live with encouragement,
They learn confidence.
If children live with praise,
They learn to appreciate.
If children live with fairness,
They learn justice.
If children live with security,
They learn to have faith.
If children live with approval,
They learn to like themselves.
If children live with acceptance and friendship,
They learn to find love in the world.

FACTORS DURING PREGNANCY

A variety of behaviour problems such as overactivity, defective concentration, ties and emotional lability have been found to correlate with the occurrence of toxemia (hypertension or high blood pressure with or without swelling over feet), excessive vomiting in pregnancy and birth asphyxia (delayed cry after birth). Psychological stress like financial burden, working mothers, etc. may predispose the newly born child to react in an undesirable way to subsequent adverse environment leading even to most severe behaviour problems including juvenile delinquency (inclination to antisocial acts). Similarly when a

mother has a difficult time during pregnancy or subsequently a troublesome delivery, one could imagine that her attitude to the child might be different from that of a mother who had a normal and uneventful pregnancy. The former might feel subconscious resentment against the child who caused her so much discomfort. Preterm deliveries (babies born before completing 9 months in mother's womb) have been found to be associated with behaviour problems at school age, especially with defective concentration (attention deficit disorders). These preterm babies had to stay in the hospital for a prolonged period and separation of the baby from mother during this period could be a factor.

FACTORS AFTER BIRTH

(a) The establishment of a bond between parents and child

It has been seen that newborn babies (like premature sick or with congenital defects) who are kept separate from the mother for some time have more psychosocial problems. Thus, even the newborn babies should be transferred to mother as early as possible so that mother can touch, fondle and love her. Breast feeding again increases the bond between mother and the child. The baby's responsiveness to the mother is also a vital factor in bonding. A baby who is difficult in his first few days, crying excessively and refusing to suck on the breast, not only causes his mother much anxiety at this time but later may be the objects of some degree of resentment. A mentally subnormal child is particularly liable to be unresponsive with resultant difficulties in establishing the bond. It bas been seen that mothers who have given birth to unduly drowsy or over active babies are more protective and dominant in their attitude to them in later years.

(b) The parents and the home

(1) **Love for the child:** It is of prime importance that parents should not only love their children but also show it and try to ensure that children learn to know it. Parents show love by the facial expression, tone of voice and understanding of his needs. Some parents have the mistaken idea that the love consists of giving the child everything that he wants and buying him expensive presents. We overheard one parent saying, "I can't understand it. I have given him everything that he wanted, everything that money can buy". But what such parents don't understand is that he wants something that money can not buy i.e. love. Lasting love is built-up by hundreds of kindness, hundreds of occasions when tolerance and understanding have been shown. The children are liable to show little love for parents if there has been constant criticism and bickering in the home, constant scolding and punishments etc.

(2) **The fear of spoiling:** The notion that a child is spoiled by being loved is wrong. A mother never harms her baby by giving him all the love that he demands. She could not hesitate to pick him up when he cries for company. It is a general feeling that responsive adults breed responsive babies and the rigid disciplinarians breed spoiled, unhappy children with no confidence in themselves or their parents.

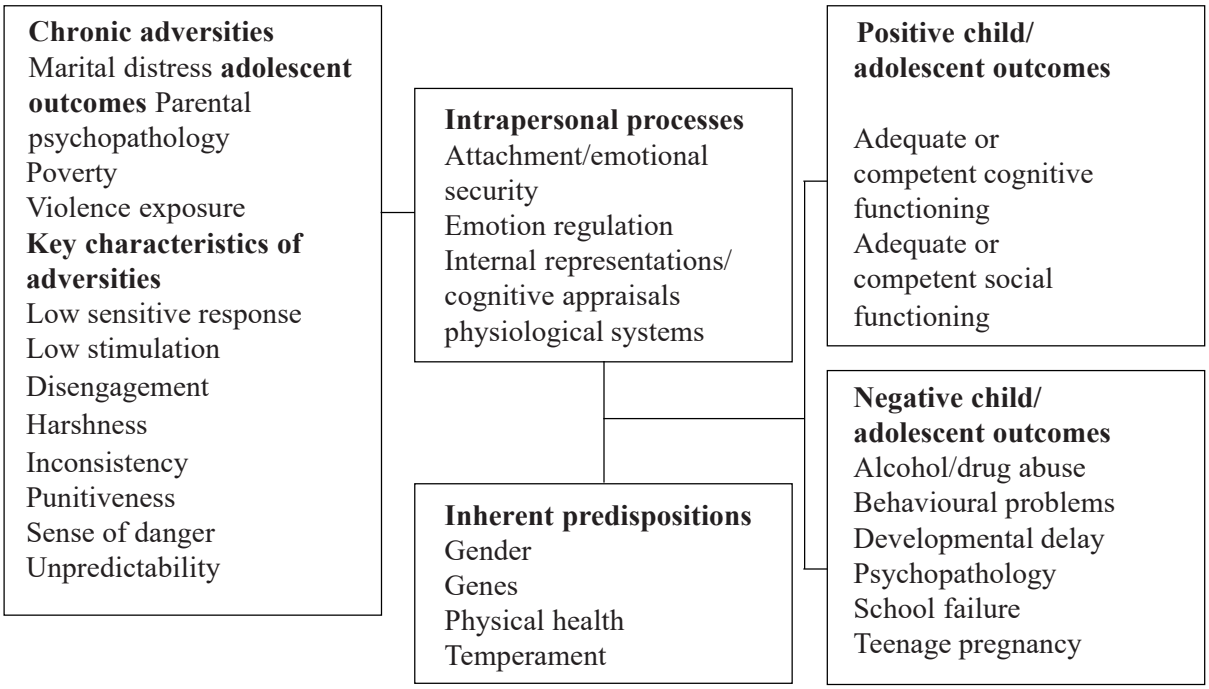

Fig. 2.1: Factors affecting behaviour

The baby can be spoilt if:

(i) The mother or grandmother never leaves him alone when he is not wanting attention.

(ii) After attaining the age of one year, a child is spoilt by **overprotection** (by never being allowed to do things for himself).

(iii) **Lack of discipline** because of fear of repressing him e.g. child is being allowed to wreck the furniture, walk on the table, draw on the wall and ride around the room on his tricycle.

(iv) **Deprivation of love,** affection and security.

(v) By letting him learn to get his own way by wailing or by **temper tantrums** (excessive anger).

(3) **Overprotection and anxiety:** The term signifies more than excessive protection of a child against danger. It includes:

(i) Failure to allow him to grow up and look after himself. The mother continues to feed him,

(ii) *Resriction of outdoor exercise* as he may catch cold or get his feet wet.

(iii) Preventing him playing with other children because they are rough. It convinces the child that he is incapable of looking after himself and his conduct remains immature. He remains utterly

dependent on his mother and so is late in learning various skills i.e. in feeding himself, attending the toilet and in dressing himself. He is insecure and does not play well with other children. He is apt to be bullied by other children. He runs to his mother for protection and is accident prone. Later on he fails to make friends. In his later life, he is unable to make any decision independently.

Table 2.1: Principle types of parental attitudes

	Attitude	*Characteristic Verbalization*	*Handling of the child*	*Reaction of the child*
1 .	Acceptance and affection	It's the child that makes the home interesting	Fondling, Play; Patience	Security; normal personality development
2.	Overt rejection	"I hate him" won't bother him"	"Neglect; harshness, avoidance of contact, severe punishment	Aggressiveness; delinquency; shallowness of affect
3.	Perfectionism	" I do not want him as he is" , I must make him over."	Disapproval; fault finding; coercion	Frustration lack of self-confidence, obsessiveness.
4.	Overprotection	"Of course, I like him; see how I sacrifice myself for him.	Spoiling; nagging over indulgence or hovering domination	Delay in maturation; emancipation; protracted dependence on mother spoiled child behaviour

Causes of overprotection

Overprotection is due to a variety of factors.

(i) When the parents have had a *long wait for the child* especially if on account of age or other reasons or it is not possible to have another.

(ii) When parents, determined to have a boy, achieve their ambition after having a succession of girls.

(iii) When there has been a succession of miscarriages or a difficult labour.

(iv) When the death of a sibling has occurred

(v) When a child arrives many years after a serious illness in hospital

(vi) When a child is *handicapped* e.g. mentally retarded etc.

(vii) When a child is adopted after a long period of sterility or when a previous child has died.

It is easy to criticize a mother for being overanxious but it is not so easy for a parents to avoid overanxiety particularly when there had been a long wait for the child or when he has been born prematurely or had some serious illness. One should be sympathetic and understanding with such mother particularly ,when the child is her first one, bearing in mind the fact that over anxiety springs from love.

(4) **Favouritism and rejection:** Both are very harmful to personality development of the child. They spring from the subconscious mind and are not deliberate or voluntary. It is obvious to every one else but the parents. Favouritism arises from a variety of causes more or less similar to that of overprotection e.g.

(i) If there has been a sequence of girls and finally a much wanted boy comes, he is likely to be treated as a favorite

(ii) The more intelligent child;

(iii) A child with more pleasing and affectionate personality;

(iv) Child with good looks etc.

The favoured child will have the problems as described with that of overprotected child. The unfavored child may feel resentful against the parents and shows little affection for them. A child may be neglected without being rejected as the parents are so much occupied with their work that they neglect their own children. Rejection may manifest excessive fears, shyness, aggressiveness, thumb sucking, bed wetting, depression, temper tantrum, lying, stealing etc. Nearly all these arise at subconscious level so that the child can not help them.

(5) **Parental habits:**

"Whatever you would have your children become, strive to exhibit in your own lives and conversation."

— ***Lydia H Sigourney***

" Train-up a child in the way he should go; when he is old, he will not depart from it."

— ***Jawaharlal Nehru***

Children are imitators and so the parents should set a good example to them. A child can learn good manners, good habits and kindness to others only if the parents are practising these in routine life. If parents show bad temper and irritability, use bad language, are unloving, dishonest and selfish, they must expect their children to be the same. If there is violence in the home e.g. due to the alcoholic father, the son may become aggressive and the daughter be withdrawn but to grow-up to become a violent neglectful mother.

When the child is older, he will be greatly influenced not only by his parents but also by his friends and his teachers. If the teachers arrive late for their class, are untidy, smokers, loose their temper and even hit children, children are liable to copy them.

(6) **Separation from the parents:** The effect of prolonged separation from the father depends on the reasons for his absence, the age and sex of the child and the length of separation. It is seen that boys separated from their father in the preschool period may be less aggressive, more dependent and enjoy less masculine games than others; they, may be shy in the presence of males, show somewhat feminine behaviour and later, have difficulty in establishing heterosexual relationship.

The personality of the children whose mothers go for work depend on the **type of work** (i.e. if she enjoys work then she will be able to maintain good mood).

Table 2.2: Undesirable conditions influencing the personality of a child

Rejection

It results in feelings of anxiety, insecurity, low self-esteem, negativism, hostility, attention seeking, loneliness, jealousy etc.

Overprotection

If child is overprotected in the childhood, the child will have submissiveness, lack of self-reliance, dependence in relations with others, low self-evaluation etc.

Overpermissiveness

Causes self-demanding attitude, inability to tolerate frustration, rebelliousness towards authority, attention seeking, irresponsibility, inconsiderateness, exploitativeness.

Perfectionism

Perfectionism with unrealistic demands result in lack of spontaneity, rigid conscience development, severe conflicts, tendency towards self-condemnation and guilt.

Faulty discipline

Lack of discipline causes aggressive and antisocial tendencies while harsh, overly severe discipline results in fear, hatred of parents, lack of initiative and lack of friendly feelings.

Contradictory demands or faulty interpersonal communications

It makes a child prone towards the tendency of confusions, unclear self-identity, self-devaluation etc.

Undesirable parental models

It results in the learning of faulty values, formulation of unrealistic goals and development of maladaptive coping patterns (not able to adapt against adverse situations in a normal manner).

Mother's temperament and husband's cooperation. Thus the daily separation of the child from the mother does not harm him provided that arrangements for his care are satisfactory and to his likings. He tends to be more self-assertive, independent and better able to look after himself. There is no evidence that school work has suffered from earlier separation but if a child is merely left alone all the day, bored, perhaps crying and denied normal stimulation he may certainly suffer in the future.