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.