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Child and Adolescent Mental health Research in India :An Overview

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Abstract

The area of child and adolescent mental health has not only been given a low priority in India but had also to face several vicissitudes. From the very early fifties to the mid-sixties it enjoyed a period of growth and development. Thereafter, the area became dormant till 1979 when there was a visible resurgence. The prevalence of emotional problems among children is estimated to be around 66/1000 of child population. Research evidence indicates a lack of perception by the society of emotional disorders among children as conditions requiring clinical intervention. Evolving socio-culturally relevant theoretical framework for generating research hypotheses; research on the personality development, socialisation process, stress tolerance and coping styles of children from disadvantaged groups; the felt needs of the community; the profile of those currently seeking clinical assistance along with strategies for the development of required man-power to work in this area are the challenges that face India as well as many other developing countries.

Key words -

Child Psychopathology,
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In the health sector, development of strategies for the delivery of health care; programmes to develop the required manpower potential and encouragement to carry out relevant and meaningful research are to a large extent a post-independence phenomenon in India. The minimal and meagre inputs made in the field of health were, of necessity used to solve pressing problems like malnutrition, communicable diseases, sanitation and the supply of pure drinking water. In such a situation mental health area did not receive a high priority and within it the problem of child mental health took a back seat. It must however be mentioned that maternal and child health did receive a very high priority but the emphasis had not been on the emotional and social development of the child or its mental health problems but on graver issues like reducing effects of malnutrition and the rate of infant mortality.

The point of concern with regard to child mental health is not the priority that has been denied to it but the vicissitudes borne by the area. Some obvious opportunities were left unattended while some other slipped through without giving tangible results.

The Enviable Past (1950-65)

Developments in the field of mental health started occurring around the year 1950. The country had about 20 psychiatrists at that time. The other members of the mental health team were more or less non-existent though academic psychologists, with a psychoanalytical orientation, working in the universities did show some interest in the area of mental health.

The establishment, in 1954, of the All India Institute of Mental Health at Bangalore brought about dramatic changes. Formal and regular training progammes were initiated and manpower was generated in the areas of psychiatry, clinical psychology and psychiatric nursing. During this phase, child psychiatry with emphasis on theoretical as well as practical training, formed an integral and important part of the curriculum. A reference to the curriculum that existed for training of clinical psychologists at this phase of time shows that they had extensive training and later an examination in child psychiatry before they could qualify.

Around 1960, there was considerable interest in pursing research problems in the area of child psychiatry, child psychology and adolescent mental health problems. The Indian Council of Medical Research (ICMR) had funded 5 research projects which dealt with the study of the relationship of child rearing practices and behaviour problems; the etiological significance of parental functioning in behaviour disturbances; the incidence and causes of personal and emotional problems among pre-primary, primary and secondary school children; the study of child personality and fifthly an investigation into the psychological factors related to adolescent adjustment [1]. Around this time, a valuable book [2] entitled "Indian Children on a Psychiatrist's Play Ground" was also published by the ICMR. This book contained a detailed analysis of the 208 child cases seen by the author, Dr. Erna Hoch, during the period 1956 to 1961. The author dealt with cases of mental retardation, postencephalitic states, epilepsy, neurosis, infantile psychosis, psychophysical conditions, adolescent problems and juvenile delinquency. The socio-demographic characteristics and the related psycho-social factors, numbering 22 in all, were studied for the cases in each of the groups mentioned above. It is unfortunate that this book, which was sold for a very nominal price of Rs.12.25 ps. received very sparse attention.

A quarterly journal of Child Psychiatry was also launched in the the sixties. The establishment of child guidance clinics, which had started in the early forties was progressing slowly but steadily. This development was comparatively more intense in and around Bombay where under the leadership of Dr. Marfatia and Dr. Masani the movements gathered momentum. All these augured well for the area of child mental health.

The Eclipse (1965-80)

It is not possible to clearly state when the change started occurring but the area of child mental health started losing ground after the mid sixties. The earlier emphasis on child psychiatry during the training period got considerably diluted bordering on the non-existent. The pioneers who provided the initial thrust for research in the area of child mental health retired from active academic life or migrated abroad. Centres which were being nurtured by Mr. Khatri at Ahmedabad, Prof. Menon at Baroda, Prof. Masani at Bombay and Mr. Bhatia at Delhi all lost their initiative. A second generation of scientists interested in this area did not emerge immediately thereafter.

In 1974, Wig & Akhtar [3] while reviewing the psychiatric research done in India over a period of 25 years since independence pointed out that "Child psychiatry has been largely a neglected field in India. One or two prevalence surveys have been reported in school children but not with a very satisfactory design. In the last 5 years some interesting case reports have also come up. A couple of books dealing with theoretical aspects are also available, but the focus of attention has been on symptoms or specific disorders like bed wetting, speech problems etc. Research in mental retardation field in equally unsatisfactory....". This review is of importance from yet another angle. After having reviewed the research area, when they discussed the lacunae the authors emphasised that in India there is a sad dearth of laboratory research, lack of studies on the natural history of various mental illnesses, absence of research in the area of psychotherapy and in assessing the efficacy of undergraduate psychiatric education. In spite of their earlier evaluation that child psychiatry research is neglected the reviewers did not recommend that this needs further attention As a further step the authors contacted 20 "eminent Indian psychiatrists" to seek their views on areas which need to be given research priority in the future. On the basis of the 37 responses received they could identify 10 areas. It is to be noted (with regret?) that not a single "eminent Indian psychiatrist" from among the 20 worthies contacted thought of the area of child mental health to be an important area. Interestingly "Labour problems and industrial lock out" did receive a mention. The internationally mentioned "Cinderella syndrome" with respect to the area of child mental health was in bloom.

The Turning Point

In 1979 the ICMR adopted a task force approach in the area of mental health research and set up five task force groups and two working groups to cover different areas of research. One such group was a "Task force on psychological problems of children" to identify the priority areas of research in this field and to make suitable recommendation as to the future course of action to be taken. In his introductory remarks [1] the convener of this group pointed out that "research in the field was still at the 'case report' stage. Very little information was available regarding development norms, patterns of psychopathology and phenomenology and on the prevalence of disorders on the community. It was still not clear what was normal and abnormal and no standardised tools were available to measure what was known".

In its deliberations, the task force faced difficulties in coming to an understanding of the concept of adolescence in India. Opinion was divided whether in the Indian set-up there are special features relating to adolescence. Adolescence in India was looked upon by some as a protracted period unlike what it is in the west. An adolescent in India often continued to grow in a family fold without assuming much of individual responsibility. This encouraged dependency feelings which could lead to psychiatric problems when stressful situations occurred.

The task-force recommended that the following 5 projects in the order of priority, be given immediate attention.

-multicentered study on the pattern of childhood and adolescent psychiatric disorders attending psychiatric clinics.
-study of normal psychosocial development, including the development of an interview schedule for studies on child-rearing practices.

-study of patterns and prevalence of learning disorders among school children.
-patterns of childhood and adolescent disorders in the community.
-patterns of psychiatric disturbance among adolescent criminals/offenders.

There can be differing views regarding the recommendations of the task force or about the priorities it has laid down but these clear guidelines provided a fresh impetus for the rejuvenation of research in this area. The years since then have seen the completion of the first of the 5 projects.

Around the same time, while reviewing the research done in the country in the area of "developmental processes", Anandalakshmi [4] pointed out that the trend seen in the research studies in this area "By and large, is a a-theoretical one and the variables taken up for study are test-related, not theory-related. Studies have been undertaken partly at least, because psychological tests were available. The tendency, on the whole has been to use samples of literate persons, especially school and college students...it is hard to avoid the conclusion that in some instances, the samples were chosen for convenience of test administration rather than for theoretical reasons". She further criticised existing research in India as one where "theoriticaly unrelated constructs have often been arbitrarily selected as dependent or independent variables". This review covered several studies that have been carried out in the country to study developmental norms; socialisation processes; various aspects of cognitive development; personality and affect related variables in development, including the issues of self-concept, conformity, anxiety and adjustment. In yet another review, evaluating the research done in the area of emotional problems of children Prabhu [5] pointed out that "most of the studies in this area confined to the analysis of clinic data while few deal with monosymptomatic disorders like enuresis, abdominal pain etc."

It is rather difficult to concur with the remarks [1], mentioned earlier, of the Convenor of the ICMR task force that research in the area of child mental health is in the "case report" stage. The evaluation by Anandalakshmi [4] and Prabhu [5] seems to reflect the situation better though from all the foregoing accounts one comes to the conclusion that meaningful, relevant and theory based research is yet to emerge in this area. One may well accept the prioritisation of the research areas made by the ICMR task force, but from the point of view of methodology the suggestions made by Anandalakshmi [4] are worth noting. She pointed our that research in this area should be responsive to new social needs and advocated the method of observation of young children in the naturalistic and controlled conditions along with the use of ethological methods. She points out the danger in adhering to adaptations of vintage western psychological tests which are unsuitable and invalid in the Indian set up. Her emphasis is towards the study of children in the younger age groups-in infancy and pre-school years-an area that has been totally neglected in this country. This would obviously bring about the need for longitudinal studies as against the cross-sectional studies that are carried out at present.

The Magnitude

A number of community studies have been carried out in this country to study the prevalence of mental illness but almost all of them have concentrated on estimating the prevalence of psychiatric problems in the adult population. Psychopathology in children has been identified only when it is very severe and was brought to the notice of the investigators during the course of their efforts to identify cases in the adult population.

The study carried out in India by Verghese et al [6] did take into account the child population also. This Vellore study found the prevalence of psychiatric disturbance to be 66.2/1000 among adults and 66.8/1000 among children. Those who were below 12 years of age were taken as children for the purposes of this study. The prevalence of mental retardation was 17.6/1000 in this study. If one excludes them one would find the prevalence of childhood emotional problems to be around 49.2/1000 in the population studied. The investigators found enuresis, behaviour disturbances and sleep walking to be the three most commonly reported difficulties.

In a country where the child population is nearly 360 million if one projects the figures of the Vellore study, excluding mental retardation, one should be thinking in terms of nearly 20 million children with emotional problems. One is aware of the inherent dangers of projecting the figures from very small surveys and arriving at such "guesstimations". Yet, they are in the main the gross indicators for planning the pattern and extent of services in the future.

In the Minds of People

One of the very common remarks heard in the Indian setting concerns the heavy attendance of cases of mental retardation at the Child Guidance Clinics. Clients with behaviour disorders tend to be fewer. It is difficult to specify the reasons for such a phenomena. A study by Malhotra et al [7] does clarify a part of this enigma. Using vignettes, like the ones used by Shirely Star in the NORC studies, the authors tried to study the manner in which behaviour disorder of childhood was perceived by the general public. The case history vignette used by them was considered "abnormal" by 98 percent of the Indian psychiatrists who constituted the group of specialists. Of these 51.4 percent diagnosed the client in the vignette as one with behaviour disorder of childhood. On the other hand when the same vignette was read out to the general population only 10 percent of the respondents considered the behaviour as abnormal. It was obvious that the general public most frequently does not perceive behaviour disorder of childhood as deviant, although the psychiatrists may consider it as a definite diagnostic entity. The population studied felt that interpersonal and emotional reasons had given rise to such behaviour but only 8.5 percent of the respondents thought that it is necessary to take the child to a mental health agency. Most of the respondents felt that psychological, behavioural and social manipulation, without the assistance of a specialist, would probably make the child improve.

The perception and thinking of the people does not seem to share the mental health profession's values and they do not seem to recognise the need for intervention by external agencies. The relative absence of behavioural disorder of childhood in the clinics may thus be a reflection of the inability in the general population to recognise deviancy among children. These conditions have not yet attained a high priority in the "felt needs" of the Indian population.

Yet another reason for this low rate of help seeking behaviour may be due to the comparative stability of the Indian family. Despite the fact that Indian society is going through rapid socio-cultural changes, the family as an institution has not shown much disintegration. It is known that spread of children's services becomes an unavoidable necessity when family life is subjected to high stresses and strains. The Indian population seems to perceive that the problems of children can be handled effectively in the family constellation itself.

The High Spots

If one takes stock of the developments that have occurred in the area of child mental health there are some bright spots as well. Four such specific strands deserve mention.

Khatri [8] put forth a theoretical postulation regarding the personality and mental health of Indians (Hindus) in the context of their changing family organisation. Discussing the rationale for Hindu basic personality structure Khatri points out that "child rearing environment in general and child rearing practices in particular provide basic framework for certain dispositions, unconscious assumptions, basic expectancy sets, broad attitudes of relating to persons in general and to certain role occupants in particular." He argues that the early experiences of Indian children in family living provide a scaffolding for positive mental health and /or a vulnerability to mental disturbances. Having made his assumptions explicit he evaluates the differential manner of bringing up the male and the female child in the traditional Hindu family.

Those brought up in a traditional Hindu family-irrespective of their sex-show a personality characterised by dependency; a firm sense of identity with a clear conception of the roles to be occupied; a sense of security; a tendency for conformity and anxiety over nonconfirmity and an unique interpersonal orientation with a deferential submissiveness to people in superordinate positions and a tendency to dominate people in subordinate positions. This is further accompanied by a hierarchical conception of human beings with a concomitant rejection of democratic values along with a need to placate authority figures and an inability and dread for being alone. Aview that life is governed by destiny and hence the futility of human strivings is seen coupled with a low drive for achievement, lack of initiative and poor creativity.

Khatri [8] is sensitive to point out that though the above characteristics are shared by those belonging to both the sexes, females tend to have a predominantly negative self-image and a circumscribed extension of the self limited to the husband, children, and in-laws. They also seem to have a predominately negative attitude to family members in superordinate positions and in general are more vulnerable to emotional disturbances than the males who according to Khatri are characterised by a positive, although vacillating self-image but with a positive attitude to people in superordinate positions. The extension of their self goes beyond the nuclear family to include other joint family figures.

In this theoretical postulation Khatri argues that considerable social change is occurring in the Hindu society because of exposure to western education and ideology; the development of industry leading to urbanisation and migration; the introduction of democratic modes of functioning, the increased educational possibilities for boys as well as girls; the rigorous campaign for family planning and the widespread use of the mass media. These have brought about radical changes leading to the family being smaller in size, less tyrannical relationships between family elders and youngsters, more equalitarian treatment of women and freer relationships between sexes with autonomy in mate selection.

The author concludes that his postulations are hunches and broad hypotheses based on impressionistic and clinical evidence. He suggests that those interested in empirical research should work out operationally defined conceptual schemata from the above and state in definite terms hypotheses that can be tested.

Clearly formulated theoretical postulations about personality development and its impact on mental health in the context of the Indian family, child-rearing and the changes to which these are being subjected to have been scanty in this country. The Indian scientist is still enamored by the theories generated in the developed and advanced western socio-cultural settings which have little resemblance to the socio-cultural realities of the Indian set up. It is 15 years since Khatri [8] put forth his view point. Khatri himself has left the country. His postulations seem to require greater amount of attention than has been hitherto given to it. Posterity may view this shortcoming as yet another instance of missed opportunity by the contemporary scientists, in the field of child mental health in India. Evolving socio-culturally relevant theories is an essential prerequisite for meaningful research. Khatri's effort is one such and there is hardly any doubt that more such efforts are needed. Further work [9] along similar lines has taken place in the Ahmedabad conference.

The Culture of Poverty

In a country with widespread poverty the most relevant topics for research are obviously those on the effects of poverty. Some amount of work done in this area by different scientists, is available. At the present juncture it needs to be put together so as to plan for the future. A review of these studies reveals some inter-related psychological effects associated with poverty. The first relates to cognitive, perceptual and linguistic aspects. Studies [10], [11] conducted have shown that disadvantages whether economic, social or ecological, adversely affect the cognitive developments of the individual. The results jointly indicate that though the deprived groups do not always perform poorly on intelligence tests their performance is poor on the whole variety of cognitive tasks like concept formation, comprehension of meaning, vocabulary and association of ideas.

Apart from general cognitive competence, reading ability and linguistic skills also suffer due to deprivation associated with poverty. Monotony and lack of sensory inputs that often go with poverty retards the individual's reading ability and childless brought up under poor environment develop "restricted" as against "elaborated" language codes. It is also observed that there is something like a cumulative deficiency phenomenon or what is called the "broomstick effect". In very early stages the performance of the poor is not very much different from that of the affluent but as the child advances in years the difference goes on getting more and more accentuated in favour of the more privileged children.

The second dimension of poverty relates to the motivation and personality of the poor, the root of which is traced to the general process of socialisation and the pattern of parental interactions with the children which produces what has been described as the "socialisation of apathy and under-achievement". Rath [12] has reported significantly low aspiration levels among poor tribal and scheduled caste children. Udai Pareek [13] has given a paradigm of the culture of poverty which produces a three fold motivational pattern characterised by low need for achievement, low need for extension and a high need for dependency. Sinha [10], [14] showed that the poor show high apathy, resignation, stagnant aspiration levels, and attitude of indifference with a characteristic absence of risk-taking. The distinct pattern of personality and motivation was dysfunctional in coping. It is also seen that the personal style of functioning and coping mechanisms learnt by the poor made them acquire certain set attitudes towards child-rearing; locus of control; gratification of needs; time

perceptive, ego identity and self- esteem which renders them less capable of meeting the demands of various life situations.

The above studies have far reaching consequences not only from the point of view of understanding child development and child mental health but also with regard to the development of intervention strategies. One of the conclusions brought out pointedly is that damage due to poverty, whether it is on the cognitive plane or personality domain, occurs early and corrective measures have, therefore to be taken in pre-school years. Delayed intervention is likely to produce only meagre results and earlier we apply compensatory intervention better the results are likely to be. This basic intervention should not aim at just remedial reading and overcoming linguistic deficiency but should aim at the generalised re-socialisation of individuals which includes the generating of a positive self-image, realistic self-evaluation, proper motivation and adequate coping. Left unattended, a large segment of child population of this country may be one that is at risk.

The introduction of the Integrated Child Development Services Scheme (ICDS) as a national programme is a welcome measure of early intervention. As laid down, [15] the second objective of this programme is "to lay the foundations for proper psychological, physical and social development of the child". In the light of the work that has already been cited it is high time that scientists in the field of socio-behavioural sciences make an effort to contribute to the maximum extent possible the scientific know-how to make this programme most effective. In a country where there are many resource constraints the type of programme like the ICDS seem to be the only possibility to prevent the poor cognitive, social and personality development in children coming from disadvantaged groups.

An approach similar to the above has been strongly advocated by the World Health Organisation by way of simple child mental health services programme to fit into the existing primary health care machinery without depending too much on specialist oriented services as in the western countries. The WHO emphasizes the better understanding of child mental health problems at the primary care level aiming mainly at prevention and, whereever necessary, by simple forms of treatment by the non-specialist along with the generated community support. India as a third world country, with the availability of limited financial resources, should find this beneficial and practical.

The Help Seekers

Yet another area which deserves mention is the multicentre studyof the patterns of child and adolescent psychiatric disorders recommended by the task force of the ICMR, and conducted at Bangalore, Delhi, Lucknow, and Waltair, This project studied a total of 1,835 cases and found that in clinic attendance psychosis (25%), hysterical neurosis (23%), conduct disorders and hyperkinetic syndrome (9% each), emotional disorders of childhood (5%), academic problems (4%), enuresis, stammering and stuttering (3% each) were the most commonly seen complaints. In the after-math of this study, which was carried out by 4 research teams with considerable amount of financial input by the ICMR, the earlier work by Hoch [2] attains special significance. Hoch studied 216 cases of which she analysed 208 single handedly without any financial assistance. In the multi-centre study the cases studied at the Delhi and the Lucknow centers were marginally more than the number of cases studied by Hoch. This is not a criticism of the multicentre study but is cited here only to highlight that the scientific community failed in 1961 to take note of a significant contribution of Dr. Hoch to the field of child mental health.

Probably this marked the beginning of the early signs of apathy towards child mental health. Remedial action had to come two decades later by way of the ICMR project.

One of the important aspects that has been brought out by the multicentre study is the impact of family pathology on the child in the Indian setting as well. Familial over involvement; mental disturbances in other members of the family, discordant intra-familial relationships, stresses or disturbances in school or family atmosphere, inadequate or inconsistent parental control and anomalous family situation were most important contributory factors to the child's mental health problems.

Manpower For The Third World

The last of the important trends is the development of an approach to identify potential mental health counsellors amongst school teachers. First attempted [17] in the later half of the seventies the approach aims to sensitize teachers to emotional problems of children by giving them brief courses on the causation, identification and referral regarding behaviour and emotional problems, poor school performance psychosomatic illness, speech disorders, epilepsy and psychosis among school children. The evaluation of information gained and of the counseling potential of the teacher participants is carried out by comparing their performance on specific parameters before and after the course. The teachers so trained showed significant gain in information. Their counscelling potential as rated by 4 independent rates also showed improvement. The whole programme highlights the rationale and methodology of one of the methods for detecting potential mental health workers who can identify fairly early children with emotional problems and can also function as counsellors.

In this approach the school teachers have been trained to function as mediators. The possibility of identifying other groups of workers who come in constant contact with children in different settings can be explored with a view to train them for taking up similar responsibilities. Probably therein lies the answer for generating the required man-power in the developing countries to look after child mental health service integrated with primary care programmes.

The Future

As one takes stock of what has happened during the last four decades, in the field of child mental health in India, one feels optimistic about the future. The number of child guidance clinics- both within the medical model and the psychosocial model-has been growing steadily. The Indian Council of Medical Research has not only played a cardinal role in developing a clear research policy but has also funded the research generously. A national programme like the ICDS has taken note of the importance of providing services for the betterment of emotional and psychological well being of the child. More than the advances made in the area of providing services and research, progress is made in the development of the required manpower. The child mental health area has become an increasingly sought after area of research by post-graduate scholars at the doctoral levels. The NIMHANS, for example, will be turning out one Ph.D. scholar every year with specilsation in the area of child mental health. This is important as the service and research area would not prosper unless there is qualified manpower to shoulder effective leadership roles. The future development of the area, however, is not

likely to be on the same lines in which it has become super-speciality in the western countries. The number of psychiatrists in the country being limited it is doubtful whether many would take exclusively to child psychiatry as a speciality except in a few advanced teaching centres. As the mental health services are likely to be integrated with the primary care services the pattern for the future will be of a generalist nature where effective and leadership role may have to be taken by non-medical and para-medical personnel. Irrespective of the exact shape it will take in the future one can optimistically feel that the area of the child mental health which had an eclipsed existence since the mid sixties has turned the corner and is now set to march ahead towards a brighter future.

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