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Child and Adolescent Mental Health

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ABSTRACT

Mental Disorders make up most of the disease proportion in young people throughout cultures. Yet, mental health needs of adolescents and children are neglected, and especially those belonging to lower and middle socioeconomic status families. Most mental disorders are diagnosed later in life but the onset is often in youth itself. In this paper, we aim to discuss such disorders with risk and protective factors associated with them, along with a focus on early detection and treatment-basedinterventions. Wealso found a special need for public health systems to build in capacity, relating to the promotion and prevention of such disorders in the youth. This as we discuss, can be done by making available low-cost and universally found resources to children and adolescents while also empowering them in the process. We conclude that action is imperative to reduce the burden of mental health problems which is a looming threat to our future generations so that we can allow for holistic development of children worldwide.

INTRODUCTION

Childhood and adolescents are accompanied by turbulence, upheaval and chaos. During these times children and adolescents face numerous changes in their life. Their development and adaption to physical and mental changes is a continuous process. Along with the adjustment to these changes, they face other challenges such as issues in families, peer pressure, diseases, injuries, violence, etc. While they are combating adversary and adapting to changes surrounding them, it is important to keep their psychological well-being in check. Mental health is considered as a salient part of overall health. We also need to understand the danger they are put in, exposure to certain risk factors can result in mental health issues. We must understand how to protect them from such issues and prevent the rise of mental disorders.

Psychiatric association (2013) defined mental disorder in terms of a reflection that marks maladaptive processes in an individual's psychological, developmental or physiological activity that underlies mental functioning. This syndrome is the result of disruption of a person's thought regulation of emotions or behavior. Psychological disorder, according to Barlow and Durand (2015), is a disintegration of the manner in which an individual thinks, behaves and regulates emotions which then leads to marked impairment, distress or culturally deviant responses.

Mental disorder is characterized by 4 D's- Distress, Deviance, Dysfunction and Danger (Comer, 2013). Personal distress if often experienced by individuals with mental disorders. It is marked by sadness, worry, suffering and/or agony. Deviance is another characteristic feature of mental disorder. Individuals showcase patterns that violate cultural norms (Kring, Johnson, Davison and Neale, 2012). Mental disorders also interfere with the routine functioning of an individual. Individuals with mental disorders are also considered to be dangerous to themselves and to others.

THEORETICAL PERSPECTIVES ON MENTAL DISORDERS

In order to have a better understanding of mental health among children and adolescents, it is imperative to throw some light on the different perspectives on mental disorders which will help us in apprehending the various causes behind this illness. Therefore, this section will discuss the different approaches/viewpoints of mental disorders.

HISTORICAL/EARLY PERSPECTIVES

The exploration of causes behind the mental disorders has been carried out since thousands of years (Barlow and Durand, 2015). The historical hunt for reasons behind mental disorders comprises of various viewpoints and perspectives:

EARLY DEMONOLOGY

In prehistoric societies, behaviors that were not in control of an individual were considered to be supernatural (Kring, Johnson, Davison and Neale, 2012). Early writing by Chinese, Egyptians, Hebrews and Greeks believed that individuals showcasing uncontrollable behavior were possessed either by a Demon or God. The symptoms followed by the possession decided whether the possessor was an evil spirit (Demon) or a good spirit (God) (Butcher, Mineka and Hooley, 2013). While exorcism was a common technique used as a treatment against possession, evidence shows that another famous technique used was called *trephination*, wherein, a hole was cut into the skull of the possessed person in order to release the spirit (Comer,2013; Kearney & Trull, 2011).

GREEK AND ROMAN PERSPECTIVES

One of the famous concepts of mental disorders was provided by the Greek physician, Hippocrates (460-377 B.C.). Denying the explanation of mental disorders by supernatural forces, he introduced the Humors- chemicals inside the body of individuals that affect mental and physical functions (Comer, 2013). He was of the belief that the maintaining a state of balance in the 4 Humors-blood, yellow bile, black bile and phlegm- is necessary for mental health. Mental disorders were the result of imbalance of humor(s) (Kring, Johnson, Davison and Neale, 2012).

MIDDLE AGES/ RETURN OF DEMONOLOGY

The increasing power of clergy in Europe led to the rejection of scientific investigation. Beliefs in supernatural forces came back into force once again. While the outbreak of war, plagues and famines was happening in Europe, emergence of *mass madness* marked symptoms of delusions and hallucinations. Belief in witchcraft and possession by a wolf spider and other animals was a common occurrence. Exorcism was often usedas an answer for the treatment (Comer, 2013; Kring, Johnson, Davison & Neale, 2012).

RENAISSANCE

With the end of the Middle Ages began the Renaissance period. The belief in supernatural forces declined rapidly followed by an increased focus on functions of body and medical treatments. Paracelsus (1490–1541), while criticizing supernatural beliefs, introduced mental causes of abnormal behavior (Kearney & Trull, 2011; Butcher, Mineka & Hooley, 2013). Similar views were presented by Johann Weyer (1515–1588), who stated that just like our body, our mind was also vulnerable to sickness (Comer, 2013). With the evident of 16th century, growth of asylums was also in full force. It was meant to care for the mentally ill patients. Hospitals and monasteries were turned into asylums due to shortage of places for the mentally ill (Comer, 2013; Butcher, Mineka & Hooley, 2013). Reform moment was marked by major changes in the approaches to treat mental disorder. Two famous personality who were the part of this moment were *Philippe Pinel and William Tuke (*Kearney & Trull, 2011; Butcher, Mineka & Hooley, 2013).

THE MODERN ERA

With the onset of Renaissance period, the focus departed from supernatural explanations to more scientific explanations of mental disorders. The contemporary viewpoints of mental disorders are discussed below:

BIOLOGICAL MODEL

This model believes that physiology, like brain function, play a role in certain mental states as well as emotional and behavioral responses. The focus of the biological model is particularly on genetic factors, neurotransmitters and brain function in regard to mental disorders. Emil Kraepelin (1856-1926) played a prominent role in the introduction of this approach. Evidences have shown that biological factors play a comprehensible role in disorders such as anxiety, schizophrenia, depression as well as in disorders which are evident since childhood like mental retardation and autism (Butcher, Mineka & Hooley, 2013).

PSYCHODYNAMIC MODEL

Sigmund Freud (1856–1939) introduced and dominated this model of mental disorder. This view was based upon the dynamics of unconscious motives within the person (Butcher, Mineka & Hooley, 2013). He was of the belief that the adult personality is the result of our experiences that we come across in our childhood. He described the 3 structure of the unconscious mind- id, ego and superego. Balance among these forces is necessary to maintain harmony. When our ego faces with too much pressure, either by id or by superego, it experiences anxiety. In order to reduce the anxiety, people use defense mechanisms (Kearney & Trull, 2011).

THE COGNITIVE-BEHAVIORAL MODEL

Behavioral theory came into existence as a reaction to psychodynamic theory. Behaviorists rejected the unconscious mind. Their focus was only on observable phenomenon. They believed that each and every behavior can be learned. Ivan Pavlov (1849-1936), John B. Watson (1878–1958) and B.F. Skinner (1904–1990) majorly contributed towards this theory (Barlow & Durand, 2015). Behavioral model states that the inability to learn adaptive behaviors or ineffective learning of responses leads to maladaptive behaviors (Butcher, Mineka & Hooley, 2013).

Cognitive model is particularly concerned with mental processes like memory, attention, perception, etc. Schema is a cognitive framework through which we interpret knowledge about the world. Psychopathology is the result of these schemas becoming distorted or if we develop maladaptive schemas (Butcher, Mineka & Hooley, 2013).

All these models, together, have majorly contributed towards understanding of mental disorders.

PREVALENCE

Several studies have been conducted to figure out the prevalence of mental disorders among children and adolescents in India as well as in other countries. Erskine, Baxter, Patton, Moffitt, Patel, Whiteford, and Scott (2017) carried out a global study to estimate the prevalence of mental disorders in children and adolescents within the age range of 5-17 years. The mean global prevalence of mental disorder was 6.7%. Autism Spectrum Disorder was the highest with 16.1% of prevalence followed by Depression 6.2%, Attention-Deficit/Hyperactivity Disorder 5.5%, Conduct Disorder 5%, Eating Disorder 4.4% and anxiety being the lowest with 3.2% of prevalence. Dalsgaard (2019) found that by the age of 18 years, in Denmark, 15.01% of children as well as adolescents were diagnosed with mental disorders. Total prevalence of mental disorders was found to be 13.1% among children (14%) and adolescents (12.1%) in Lithuania (Lesinskiene, Girdzijauskiene, Gintiliene, Butkiene, Puras, Goodman, & Heiervang, 2018). Diagnosable mental health problems prevail among 10% of children and early adolescents (5-15 years). 20 million adolescents are suffering from some mental health problem and 90% children exists with mental health issues who are not receiving any treatment (Shastri, 2009). In an epidemiological study by Srinath, Girimaji, Gururaj, Seshadri, Subbakrishna, Bhola & Kumar (2005), prevalence of mental disorder was examined in children and adolescents of Bangalore.The result reported 12.5 of prevalence was establish among children aged between 0-16 years.

RISK FACTORS

Risk factors are related to increased chances in the presence of a disorder in an individual and they are also showcased before the onset of the disorder. It may not be necessary that a variable that puts an individual under risk at one stage of life will put the same individual at risk at another point of time. Risk factors can exist within the person as well as in a source surrounding the person from the outside, for instance, family or environment (Mrazek, &Haggerty, 1994).

Research evidences have shown several risk factors to be associated with mental disorders. Wille, Bettge, Ravens-Sieberer,and BELLA Study Group (2008) assesses the risk factors and their relationship with children and adolescent mental health. They found that several risk factors, such as Low Socio-economic status, family conflicts, presence of mental disorder in father, single parent, unwanted pregnancy, low social support, step-parent, parent with a chronic illness, unemployment, strain by the parents, psychiatric symptoms in parents, and many others were significantly related to mental disorders in univariate analysis. They further reported that as the number of risk factors increased, the percentage of children and adolescents showcasing mental health issues also increased. For instance, the percentage of mental illness among group with no risk factors was 13% which increased to by 3% among a group with 1 risk factor and the group with 6 or more risk factors showcased 55% of mental health issues in children and 67% health issues in adolescents.

Low achievements in education, low reproduction and sexual health, violence and substance abuse are strongly related with poor mental health (Patel, Flisher, Hetrick, &McGorry, 2007). Children and adolescents with parents having some serious physical illness has also emerged as a risk factor for psychosocial maladjustment among them (Barkmann, Romer, Watson, & Schulte-Markwort, 2007). Similar results were reported by Compas, Worsham, Epping-Jordan, Grant, Mireault, Howell, and Malcarne (1999). Highly depressed symptoms were found among adolescent's girls whose mothers were diagnosed with cancer. Anxiety and depressive symptoms were found among girls whose mother had cancer. These symptoms may have been the result of ruminative coping mechanism and added responsibility of the family (Grant & Compas, 1995). Research evidence also exists on family conflicts and poor mental health. Well-being of children with divorced parents was reported low in a meta-analysis by Amato and

Keith (1991). This meta-analysis was updated by Amato (2001) and was found that low academic achievement, conduct, psychological adjustment, self-concept and social relation in children are the result of divorced parents. Overt parent conflict was strongly associated with emotional and behavioral disturbances in children (Jenkins & Smith, 1991). Development of psychopathological symptoms, low academic achievement and cognitive performance is frequently common in children with alcoholic parents compared to non-alcoholic parents. This may also increase the risk of alcohol and drug problem among children in the future (Díaz et al., 2008). Low socio-economic factors have also been linked to poor mental health (Bradley & Corwyn, 2002). Links have been established between mental health and premature births. Gardner, Johnson, Yudkin, Bowler, Hockley, Mutchand Wariyar (2004) reported that infants born before 29 weeks showcased emotional, attention and peer problem in their teenage.

PROTECTIVE FACTORS

As opposed to risk factors, protective factors refer to the variables that help in preventing mental health disorders. While risk factors increase the probability of poor mental health, protective factors decrease the chances of development of mental health issues. US Department of Health and Human Services (2012) reported a list of protective factors in terms of variables within an individual, in the family and in the community. Factors within the individual included self-regulation, secure attachment, good communication skills, academic skills, ability to make friends and maintaining good relationships with them, high level of self-esteem, appropriate regulation of emotions, motivation towards achievement, etc. Factor in the family included dependable support from the caregivers, protection, resolution of conflicts, sufficient socioeconomic resources, language-based discipline, adequate rules and monitoring, balanced autonomy and relatedness with family, etc. Factors in the community involves high quality of care support by regulatory systems, healthy peer group, engagement with the school, teachers with positive expectations, management of classroom effectively, anti-bullying policies in school, safety of the children physically and psychologically, exploration opportunities at work or at school, etc.

Positive relationship between a parent and an adolescent was linked to less deterioration in overall functioning in adolescents when their parents were going through divorce or were facing some interpersonal conflict (Forehand, Wierson, Thomas, Armistead, Kempton, & Neighbors, 1991). For optimal psychological functioning of physically abused children, support from peer group and family is important (Ezzell, Swenson & Brondino, 2000). Lower prevalence of poor mental health is linked to resources such as high social support, appropriate family climate, and personality features (Wille, Bettge, Ravens-Sieberer,and BELLA Study Group, 2008). Low anxiety and depressive symptoms in children who faced certain adversity was linked to resilience factors such as high self-esteem, high tolerance for distress, low aggression and low suppression of expression (Fritz, de Graaff, Caisley, van Harmelen & Wilkinson, 2018). Lower mental health issues in children and adolescents are reported if the social network is wide and of good quality (McPherson, Kerr, McGee, Morgan, Cheater, McLean & Egan, 2014).

INTERVENTION

Onset of many mental health related disorders occur during early childhood to late adolescence. If not intervened, mental health issuescan be carried to later life creating more disturbances and problems for an individual. Various researches have come across to provide evidences for intervention and prevention of these disorders. Earlier, the basic response to crisis was intervention to brace family and children. The main focus was on juvenile crime reduction and/or youth character development. With the increase in the youth problems, various interventions and treatment plans were developed to deal with these broad ranges of problems. Positive alteration in youth behavior (interpersonal skills, relationship with peers and family, cognitive capability, self-efficacy, etc) was shown with the implementation of 19 effective programs and problem behaviors improved with the implementation of 24 programs (Catalano, Berglund, Ryan, Lonczak & Hawkins, 2004). School that focuses on mental health instead of focusing on mental illness prevention effectively promotes child and youth mental health (O'Mara & Lind, 2013). Nurture groups in school have shown positive influence in children on their emotional and social well-being (Cheney, Schlösser, Nash, & Glover, 2014). Interaction-based intervention in schools for children and adolescents has a positive impact on their mental health. It not only decreases the symptom of mental disorders but also encourages emotional well-being (García-Carrión, Villarejo-Carballido & Villardón-Gallego, 2019). Positive parenting programs have shown children to be less disruptive and more cooperative (Sanders, 2002).

Young individuals who received multi-systematic therapy at home showed improved functioning by externalizing symptoms and attending school frequently (Shepperd, Doll, Gowers, James, Fazel, Fitzpatrick & Pollock, 2009). Young and Faristad (2015) carried out a study to assess family-based intervention for mood disorder among children. They found that family psychoeducation along with skill building was likely found to be effective for children with Childhood Spectrum Mood Disorder. They also found cognitive behavior therapy to be successful for

Childhood Depressive Spectrum Disorder. Family-based therapy for children with mood disorders was found to be very efficient. Evidence has shown that community-based mental health intervention is useful and effective for adolescents. When it is believed that the psychological problem that an adolescent is facing is due to the individual, environment, parent and family interaction, community-based intervention is then carried out (Manjula, 2015). A meta-analytic review was performed on 177 studies which reported that implementation of mental health program not only reduced problems but also increased competencies (Durlak & Wells, 1997). A systematic review found that computerized cognitive behavior therapy treatment yielded high satisfaction along with being cost effective (Musiat& Tarrier, 2014). Similarly, another internet-based treatment for children and adolescent suffering from anxiety and depression has proved to be effective. These interventions build on cognitive behavior therapy (Calear & Christensen, 2010). Exercise in children and young people has proven to have short-term effect on their self-esteem (Ekeland, Heian, Hagen, Abbott & Nordheim, 2005). A systematic review states that physical activity improves social and emotional wellbeing in children and adolescents, though the risk bias was high in the study (Lubans, Plotnikoff & Lubans, 2012). 41 studies wereanalyzed to review the effect of cognitive behavior therapy for children with anxiety disorders. The result proved to be an effective treatment among children and adolescent (James, James, Cowdrey, Soler & Choke, 2013).

CONCLUSION

Understanding the mental health issues of children and adolescents is extremely important. Onset of many mental disorders takes place in early childhood and adolescence. If these problems are not acknowledged and intervened at an early stage, the issues are carried out to later stages of life and hinders with daily functioning of an individual. Various risk and protective factors have been recognized that exists within the individual as well as in the family or society that may alter mental health. Along with these factors, intervention techniques that have proved to be useful to improve mental health have also been pointed out.

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