Presidential Address

SEARCHING FOR THE CHILD'S MIND

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Let me take the liberty of deviating a bit from the conventional style of Presidential Address by making it a narrative mix of my clinical experience and objective science of child psychiatry.

Ever since I started learning Psychiatry seriously, minds of children had a fascination for me: Why is Ajmal in 3rd standard so anxious about leaving his mother to the extent of refusing school? How is Aravind, who is good in everything, not able to acquire the skills of reading and writing? Why does Malu, who does not have any epileptic discharges in the brain, display convulsions? Why is the smart Dany in 5th standard not able to focus his attention and stay calm in the classroom? And why is the four-year-old Sachin always absorbed in his solitary play with the water sprinkling instrument and not at all paying attention even to his mother?

I got some answers from my teachers — Prof. VV Mohan Chandran gave beautiful descriptions of Kanner's syndrome, mimicked Gilles de la Tourette's syndrome for our benefit, and proved that Hyperkinetic syndrome could be managed by Arkamine even when Methylphenidate was not available. I got more questions and some answers when I had two-month training in NIMHANS where I was fortunate to get valuable exposure to pioneers like Prof. Sobha Srinath, Dr. Satish Chandra Girimaji, and Dr. Sekhar Seshadri. (Those days, the number of residents was less, and more time was available for discussing cases with teachers).

Soon after I started my career at Government Medical College, Kottayam in 1997, the slot in the Child Guidance Clinic (CGC) started by Prof. Praveenlal was remaining vacant as Dr. ND Mohan was transferred. I had come back to my home ground in Kottayam — My teachers in Pediatrics, like Prof. Sushama Bai, Prof. C Jayakumar, Prof. SS Pillai, and Prof. TU Sukumaran started sending their "difficult problems" — Ajmals, Aravinds, Malus, Sachins, and Danys — to the CGC. There was only one psychiatrist in CGC, and there was no luxury of having PGs around to work up the cases. Of course, Mr. Tomy Mathew, the Psychiatric Social Worker used to be there. Interested pediatricians like Dr. Darley Mammen used to come as observers. PGs in Pediatrics were posted there — So the responsibility was big on us. We had to prove to pediatricians that psychiatrists can help these difficult problems with or without medications.

Textbooks did not help much — but people did. I developed a habit of attending CMEs and workshops dedicated to child psychiatry. Dr. Philip John was a source of great inspiration and guidance in those days when we were struggling to sail the unchartered waters. Dr. Arun Kishore was another lighthouse.

We started off with these handicaps and limitations. The range of problems which came to us baffled us. To bring in some clarity, we categorized them into three groups — It was an attempt to chart the uncharted sea before we start sailing.

1. Children with MUPS (Medically Unexplained Physical Symptoms)
2. Children with PSP (Poor Scholastic Performance)

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3. Children with ABCD (Addictions, Behaviour & Conduct Disorders)

I would leave out PSP and ABCD from this discussion and am going to share some of the lessons learned from cases of MUPS.

The cases the pediatricians referred to us were mostly unexplained abdominal pains, neurologically unexplained convulsions and loss of consciousness, psychogenic coughs, and various sorts of "HCRs" (hysterical conversion reactions). Occasionally, we had children who were suspected to be feigning their symptoms. "? Munchausen's" "? Malingering" were not that uncommon causes of referral. Nosology of these cases baffled us, and the search for the conventional etiology of unconscious psychological causes led us nowhere. Initially, we were worried whether these problems were due to our inadequate training in child psychiatry — Later, we realized to our relief that these sorts of problems were there in every center. Nosology couldn't capture the uniqueness and complexity of these disorders — Whether one uses the term psychogenic vomiting or prefer to use the more glorified term Somatoform Autonomic Dysfunction doesn't make much of a difference in understanding or managing such problems. Just reminds us the quip by Bailey & Love: *"Common man calls it piles, aristocracy calls it hemorrhoids."* So also was the use of terms like "internalizing disorders" or "externalizing disorders" which had some currency in CGC settings those days. So, we decided to be humble and honest by labeling them as merely "*medically unexplained physical symptoms"* (MUPS) — Admitting our ignorance about the 'how' and 'why' of these challenging clinical situations. It is ironic that, later, MUPS turned out to be a casual diagnosis in Pediatrics and general medicine as a replacement for 'functional' (almost understood as imaginary conditions by non-psychiatrists) or HCR! We struggled and persisted with these difficult problems, and these young kids with MUPS taught us some valuable clinical lessons:

Lesson 1: They are very frequent in general practice and Pediatrics but continue to fall in the blind spot due to lack of training at graduate and postgraduate levels.

Lesson 2: The stressors, if at all to be searched for, are not the 'unconscious sexual ones', not the nuclear family, not single parenting, but conditions like Specific Learning Disorder.

Lesson 3: Multiple problems exist in the same child — e.g., ADHD, SLD, Language Disorders, Developmental Coordination Disorders, OCD, Tic Disorders, etc.

Lesson 4: The families of these children need assessment, and parent training with an emphasis on behavioral principles hold the key to effective management.

Lesson 5: Liaison with pediatricians is a bidirectional learning experience which pays a rich dividend for both the professionals. Psychiatrist-Pediatrician liaison provides the answer for issues of stigma and manpower resource limitations.

These children forced us to develop an algorithm for assessing MUPS. Let me briefly discuss it.

Level 1 — Rule out common medical disorders with the concurrence of two pediatricians (sometimes a pediatrician-neurologist combo). Explanation to parents in a joint session and reassuring the parents that medical causes will not be ignored down the lane are very important. Very importantly, document everything. Psychiatrists often face the difficult task of managing the concerns of a worried parent with his Googled medical knowledge on one side and sometimes an anankastic pediatrician who wants to rule out every medical condition in Nelson or Harrisons on the other side. We may need to remind him/her that common conditions are common and rare conditions are rare. *"Hoof beets are more likely to be horses' than zebras'".*

Level 2 — Consider psychological stressors contributing to the exacerbation of the medical problem. What is focused is a visible stressor like a change of school, bullying by peers, the nearly impossible unrealistic demand by a parent on a child for academic performance, or rarely a situation of child abuse, rather than the vague and ill-founded

ones like nuclear family or globalization. At this level, the temperament of the child is also briefly evaluated. (As psychiatrists, we all know that it is the personality traits and not merely the nature or severity of stress which are more important determinants of a person's stress response. We need to repeatedly remind ourselves that this is more true in children. The sum of temperament and level of development are the denominators, and stressors are only the numerators.) Eliciting the nature or severity of these stressors and demonstrating the temporal correlation of symptom exacerbation or relief with a psychologically, temperamentally, and developmentally meaningful stressor not only strengthen the level of confidence of our diagnosis but also is very educative for the pediatricians. Along with us, the pediatrician learns that a medically trained person is the best-trained professional who can deal with possible stress-related conditions. They gain the confidence that they can help these children better than just sending them away for further medical investigation or referring to another specialist or referring them for counseling to non-professionals. A joint sitting explaining how the mind (stressors) influences the body (organs) through biological pathways is very reassuring to the child and the parents. Simple explanations by using a line diagram (using paper and pen or a tabletop whiteboard) are very helpful. We have found that this step has good effects beyond treating the individual child — This effectively conveys to the parents as well as the pediatricians that psychiatrists do consider psychological factors and we are psychologically minded. (Many pediatricians are afraid to refer the child to a psychiatrist and prefer a psychologist, with a fear or belief that the psychiatrist would be only looking for a mental disorder and might ignore more soft problems like stress-related ones. In a CME program for pediatricians, a gastroenterologist from a reputed institution wound up her presentation of Functional Bowel Disorders in children with the slide "Don't refer to a psychiatrist — Refer to a psychologist or counselor!")

Level 3 — Consider Anxiety Disorders, OCD and Depression. The points to be emphasized here are the differing or atypical clinical presentations in pediatric age group (e.g., irritability being more evident than sadness in depressed children), the developmental influence on the presentation (depression in a six-year-old will be much different from the depression in a teenager), the subsyndromal nature of the symptoms, significant overlap between these conditions, and how the temperament modifies the clinical presentation. A psychiatrist may have to shift the gears and change to the 'child mode' to capture these subtle but complex clinical situations which could otherwise be elusive. In many children, factors from both Level 2 (psychosomatic-temperamental factors) and Level 3 (mood and anxiety disorders) may be important.

Level 4 — Consider neurodevelopmental disorders. Neurodevelopmental disorders (NDD) may be very invisible especially when they are subsyndromal. Level of intelligence, features of ADHD, and features of SLD should be looked for in every case of MUPS. This is perhaps the most important new lesson these children taught us. These conditions are very likely to be missed especially when they are subsyndromal — One is unlikely to miss Down's syndrome, but borderline levels of intellectual function in a child without physical stigmata are very likely to be missed. One is less likely to miss the very disruptive and severe ADHD-combined type, but very likely to miss the less severe ones not fulfilling the full DSM criteria — especially the inattentive subtype. SLD is perhaps the most frequently missed condition in children who present with MUPS. The reason is obvious — widespread lack of awareness even among teachers about this condition. What is in common for these NDD is that they put tremendous emotional pressure on the children — These problems, especially when they go undetected, impair the child's scholastic performance very significantly. The inability to perform academically due to the unidentified and unintervened ADHD or SLD plus the unrealistic expectations and pressures by the insensitive educational system is the fertile ground in which MUPS emerge. Though we are yet to prove this hypothesis by a well-conducted study,

the statistics available in our CGC is that nearly 70% of children referred for evaluation of MUPS have one or more of NDD hitherto undetected. (It is sad that in the majority of these cases, the parents have mentioned to their pediatricians or general practitioners that "my child is not studying well" as a subsidiary complaint. The usual responses from doctors include suggestions or opinions like "Get an IQ done", "It might be the CBSE syllabus and the English medium that's burdening him — Change the school, and he will be alright", or a very casual reassurance "Everything will be alright as he grows up" or a snub that everything is the mother's anxiety).

Level 5 — Consider the 'Primary' MUPS. Classical conversion disorders and dissociative disorders are becoming rare. But, as psychiatrists, we (1) should not be totally losing the sensitivity, skills and expertise to understand the unconscious nature of symptom production, (2) should not disregard the reinforcements from the family and the school environment, and (3) should not forget to manage these problems with non-pharmacological interventions. There may be some situations where the clinician does not have an option but to use the other categories in somatoform disorders. I am a bit reluctant to use this category of diagnoses because they do not convey much — either regarding the etiology or regarding the management. Of course, one can give a bit stretched out explanations like augmentation and amplification of sensory stimuli and the distorted cognitive interpretations, but how much these hypothetical explanations can convince a practising pediatrician or a concerned parent is doubtful. My choice is to leave it open as MUPS — "*Watchful Expectancy and Masterly Inactivity*" (WEMI) could be a golden rule not only for surgeons but also for psychiatrists dealing with MUPS. But, if the policy of WEMI has to work out, the trust of the parents, healthy liaison with the Pediatrician, and willingness of all concerned parties to abide by behavioral principles are the basic requisites.

Level 6 -—The diagnoses of factitious disorder and malingering should not be made except in very compelling situations. There is any number of instances where clinicians have burned not only their fingers but the whole body! The psychiatrist may sometimes have to take extra pains to convince our fellow professionals that Lord Baron Munchhausen or His Lordship's proxy is very rare in the clinical scenario. We may also have to do some extra work to dispel the prejudice that the smart young fellow is out to deceive you with his tricks.

This sequential approach was developed to capture the complexity of MUPS. It has helped us to capture diagnoses at different levels. We have found this algorithm very useful in consultation-liaison settings. A model which we can sell to medically trained professionals like GPs, physicians, and pediatricians with relative ease. In short, it helps the medical profession "*to make sense out of non-sense*" (Title of the article in Indian Journal of Psychiatry authored by me along with Prof Roy AK).

The issue of co-morbidity, "*the basketful of diagnoses*", which is frequently encountered in PSP, is a reality also in children with MUPS. The same child may have temperamental difficulties, NDDs at syndromal or subsyndromal levels, and mood-anxiety-OC symptoms at syndromal or subsyndromal levels. This algorithm is good for picking up these multiple problems. Another advantage of this approach is its comprehensiveness — One of the allegations made against psychiatric diagnoses is our tendency to put everything into a disease model. This algorithm is a good defense against this accusation of medicalizing a child's distress. The medical, neurodevelopmental, psychological, temperamental, behavioral, and contextual factors are all given their respective due. We, being trained in Psychiatry, may have a difference of opinion regarding the relative importance of these factors or the order in which these levels are placed. But the experience of our team is that this is a more acceptable model in liaison settings.

Based on this algorithm, the psychiatrist develops a diagnostic formulation which is beyond medical labeling. A comprehensive assessment which is truly

bio-psycho-social, which captures the comorbidities, including the subsyndromal ones, forms the basis of management. This understanding of the child's problem is explained to the parents in a language comprehensible to them, and the treatment is planned. Behavioral and pharmacological interventions may be needed in most cases — the choice and priority are clinical decisions. The bottom line is the effective communication and participation of parents in decision-making — Parents should be co-therapists in the management of MUPS.

I was trying to exemplify the case of MUPS to drive home the point that it is possible to bring in clarity to the assessment of childhood psychiatric disorders without missing its complexity. The same is true with the multi-step which we have developed for the assessment of PSP or ABCD. There is a need to further refine it and disseminate it, first in our own settings — a psychiatrist version and another one version for GPs and pediatricians.

THE WAY FORWARD

Considering the increasing importance of child and adolescent mental health, our responsibility to assume leadership in this area and fill in the huge knowledge-skill gaps existing in this area, I, as the President of this august scientific society, feel that IPS Kerala has a big responsibility to take it up as a priority area. I have some dreams about what we can do concretely in this area in the near future. I wish and hope that in the coming year, the IPS Kerala can take some practical steps like

1. Preparing and publishing the assessment algorithms for children with PSP, MUPS, and ABCD in CLP settings,
2. Developing standard modules for training GPs and pediatricians in the assessment of these conditions in primary care settings,
3. Developing standard modules for training school teachers and school counselors on PSP and ABCD,
4. Conducting focused workshops for teachers on PSP and ABCD and efforts to include these in the teacher training curriculum, and
5. Encouraging research by young psychiatrists in child and adolescent psychiatry.

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