Chapter 6

Mental Disability

By the end of this chapter the PHC physician should be able to:

- Recognize the definition of mental disability and its classification.
- Recognize and describe causes and risk factors of mental disability.
- Recognize important preventive measures of mental disability.
- Recognize and describe normal psychological development.
- Make a provisional diagnosis of the mental disability according to the categories outlined.
- Describe essential management procedures and care for the most important health problems.
- To identify appropriate referral needs not fulfilled at the primary care level including medical, social and psychological.
- Provide parents with proper guidance and support in dealing with the condition.

Section 1

Introduction to Mental Disability

All psychological disorders in children have both a physical and psychological component. For many disorders-such as asthma, eczema, and ulcerative colitis, the emotional factor plays important role in the course of the disease.

Stress precipitates symptoms in people of all ages. Headaches, leg aches, stomachaches, and vomiting are common symptoms of stress in children. The sort of stress that causes such symptoms may be problems at home such as parental discord, inconsistent parental behavior, rivalry with siblings, or unrealistic expectations by parents—or problems at school or with friends. The loss of a parent or a move to a new home can be an acute stress.

Minor behavior disturbance involving enuresis (urinating), soiling (defecating), or sleep disorders are common. Similarly, habit spasms (tics) involving repetitive involuntary movements, usually of the head and neck, are extremely common.

Most children who exhibit such behaviors should not be considered psychologically abnormal if they receive the appropriate management in the right time

Serious childhood psychological and mental disorders are relatively uncommon, early detection and intervention make huge difference in improving the quality of life of these children.

Although widely prevalent, child abuse often is overlooked by family, friends, and health professionals. Prejudice, anxiety, and shame—not lack of information—seem to be the major reasons for the failure to recognize these private acts of violence—a form of tacit denial that leads to their perpetuation.

Child abuse can have serious future consequences for its victims. Early detection of child abuse including identification of the risk factors and ending the silence around its prevalence can save the children from the permanent damage that may result from the exposure to the insult or lack of proper intervention in the proper time.

Normal psychological development of the child

Age	Cognitive /social	Behavioral	Motor	Speech
1st week	Normal cry		Normal Sucking	
8-12 weeks	Smile, recognize breast and bottle, and anticipate being lifted.	Communicate hungers fears and discomfort	Lift head and chest when lying on his stomach	Cooing and gurgle sounds
9-12 months	Follow hidden objects	Shy with strangers, imitates gestures	Sitting without assistance, crawls on belly	Says dad and mama, imitates words
18-24 months	Recognize, names of familiar people, follow simple instructions	Enthusiastic about company with others, Say No	Walk alone	Single words (18 months) simple phrase (2 years)
2- 3 years	Matches objects with pictures, sort objects by colors shapes, complete puzzle of 3-4pieces	Express affection openly, express wide range of emotions, shows affection for play mates	Pedal tricycle, holds a pencil in writing position	Identifies all common objects, says names and ages, pronouns, I, You, --
4-5 years	Names and colors, concept of time, knows every day things (Money, food)	Wants to please friends, aware of sexuality	Hops, swings, Uses folk, brush his teeth.	Speaks sentences more than 5 words, uses future tense

Normal psychological development of school age child (6-12)

Cognitive / social

- Metalinguastic understood
- Concrete – Children begin to think logically, understand conservation of matter (frozen milk same amount as melted)
- Hierarchical classification – arrange cars by type
- Reversibility- play games backwards
- Decent ration – worry about details, obsessive
- Spatial operation – likes models for direction
- Child focus on social cues to recognize gender
- Gender remains constant regardless of clothing or behavior
- Child accepts respect for rules; negotiate with peers Concept of reciprocity
- Child argues about punishment.
- Boys develop more motor skills

Landmarks to be observed & common problems during the first five years

Landmarks to be observed during the first year

- Attachment (Eye contact, smiling, response to familiar faces
- Special interest in special figures
- The onset of the language development (the first meaningful word)
- Fears (related to unexpected change in the surroundings)
- Review the motor development)

Landmarks during the second year

- More attachment skills
- More reactivity because of more motor development
- First NO, which means the start of perceiving him/herself as an independent ego
- Anger tantrum
- Imitation of gestures
- Toilet training
- Fears of sudden changes and strangers start to decrease by the end of the 2nd year but the beginning of developing specific phobias start by this year (like phobias from animals)
- The cognitive development during this stage is mainly sensory motor which means the child learn to use the sense (like taste) and the patter of motions become more purposeful.

Common problems during the first two years
• Delay in development (Motor, emotional, behavioral, and cognitive)
• Involuntary movement & seizures
• Feeding problems (failure to thrive)

Landmarks during the third – fifth years

- Development of the fine purposeful movement (review motor development)
- Development of the fine discrimination (by the age 5 the child is able to fully recognize pictures and draw it.
- Sex differences in attitude
- Gender identity
- Identification with other figures (parents, teachers, etc.
- Imaginary thinking & fears
- Attachment to an object like a toy or similar thing

Common problems
• Tics, thumb sucking
• Sleeping problems
• Involuntary movement
• Absence & seizures
• Delayed development (manifested by behavioral problems)
• Eating problems
• Autistic behavior

Situations dangerous for children mental health

• **Malnutrition:** Malnourished child is particularly prone to chronic infection which itself may result in long term neurological and mental health impairment

• **Poverty:** Poverty deprives children from the essential elements of development, poor families are disadvantaged because of the lack of supportive environment and the lack of accessible services or space required for normal and health development.

• **Migration:** Refugee children are among the most vulnerable groups to emotional problems.

• **Environmental hazards:** Lead poisoning result from lead water pipes and lead base paint, insecticide in the rural areas also proved to affect the mental state and ability of the children

• **School factors:** Bullying and physical punishment at school inhibit healthy psychological development

General psychiatric assessment of children

Set routine for psychiatric examination of children is quite difficult or impossible. It depends on the age, language, social and motor skills

General appearance:

Size, level of nourishment, general hygiene, any abnormalities of facial, head, body build or limbs, bruises, cut, burns, mode of dress and its appropriateness to the weather.

Self – regulation:

- **Digestive system:**
  Eating habits, vomiting, abdominal pain, chronic diarrhea, faecal soiling, and pica.

- **Urinary system:**
  Bedwetting, wetting by day, over-frequent or painful micturation.

- **Sleep:**
  Problems of going to bed, nightmares, night terrors, excessive sleepiness, interrupted sleep.

- **Motor System:**
  Restlessness, overactive, under activity, tics or other involuntary movements, motor weakness, abnormal gait.

- **Neurotic habits:**
  Nail biting, thumb sucking, nose picking, head banging,

- **Speech:**
  Over talkative, mutism, articulation, faulty speech, stuttering, vocabulary.

- **Temperamental traits:**
Each child is born with specific temperamental pattern of behavior response. These traits can be discerned throughout the child's life span. There are two main Categories:

Easy children
- Regular in biological functions
- Positive approach to new stimuli
- High adaptability to change

Difficult children
- Irregularities in biological functions
- Negative withdrawal responses to new stimuli
- Non or slow adaptability

- **Behavior:** Fearfulness, reactive, irritable, tearfulness temper tantrum.

- **School:** attitude to school, behavior at school, progress and social adjustment at school is quit significant from the mental health point of view

- **Episodic disorders:** Convulsions, fainting, breath holding attacks.

- **Signs of physical abuse.**

Formulation:

- **Formulation grid**

	Constitutional	Temperamental	Physical	Environmental
Predisposing				
Precipitating				
Perpetuating				
Protective				

* The grid above may be used to help in the process of developing formulation of the case, it is not just to list the causative or contributing factors but the interaction and interplay between each of them is crucial to have a successful treatment plan It may be used also to update the information during the treatment process.

Child psychological disorders are usually the results of combination of different factors in the child and in his environment including the family. Strengthens as well as weakness should be included in our formulation of the case

- Constitutional Factors Like: genetic factors, chromosomal abnormalities, intrauterine disease
- Temperamental Factors: As mentioned above the pattern of reaction and behavior of the child
- Physical: Physical damage of the brain, Physical signs of abuse
- Environmental: family status and environment

Section 2

Mental Retardation and Associated Disorders

Mental retardation is characterized by incomplete or insufficient general development of mental capacity, causing a delay in the normal development of motor, language, and social skills. Behavioral abnormalities and impaired emotional control are also common. Before birth, chromosomal and developmental diseases, genetic and other metabolic disorders, and intrauterine infections or toxicity are possible causes. In the postnatal period, asphyxia, hemolytic disease, nutritional deficits, infections such as meningitis and encephalitis, trauma, and toxins are the most frequent causes of mental retardation.

Mentally retarded people are those develop at low average rate and experience difficulties in learning and social adjustment (it means sub average general intellectual functioning concurrent with maladaptive behavior).

Mentally retardation is not a disease and should not be confused with mental illness, children with mental retardation become adults (develop in the same way but at a slower) and they do learn but slowly and with difficulties rate)

Missing the early detection of mental retardation is common because of the (Myth) misbelieve that Normal appearance and ambulation are less likely to happen with retardation than the testing intellectual abilities in children is not possible.

Warning signs

- Delayed speech
- Dysmorphic features
- Hypotonia
- General inability to do things
- Extremes in infant temperament are often the first clue to an atypical course in child development.

Categories of mental retardation

- Borderline
- Mild
- Moderate
- Severe
- Profound

Table (6-1): Categories of mental retardation

	Borderline	Mild	Moderate	Severe	Profound
I.Q.	70 – 80 Educable	50 –70 Educable	35 –50 Trainable	25 – 35 Ineducable Little training	Below 25 Inducable Untrainable
Preschool	Develop normal milestone	Social & communicable	Can Talk	Poor motor Minimal speech	Semi motor functioning
School	Achieve Sec. School	Achieve 6 grade	Can achieve occupational skills	Elementary hygiene skills	Minimal Self care
Adult life	Normal	Social skills	Self support by unskilled work	Work under close supervision	Minimal self care
Stress needs		Guidance	Supervision	Close supervision	Constant Supervision

Common clinical syndromes associated with mental retardation

1. Down syndrome

Results from extra copy of chromosome 21, 1/600 births.

Risk factors

- Inherited in 2% from a carrier parent
- Early or late pregnancy

Manifestations

- Hypotonia
- Flat facial profile, flat bridge of the nose
- Broad feet with short toes
- Up slanting papeperal fissures
- Small ears, (Small ear canal)
- In curving 5th finger
- Short neck, Small head, Small oral cavity
- Single transverse palmer creases
- Short high pitched cries in infancy

Specific health problems common in Down syndrome

- Congenital heart defect (in one third of the of the babies with Down syndrome)
- Thyroid dysfunction?
- Visual problems (congenital cataract, nystagmus, strabismus far or near visions are more common)
- Developing Hearing loss or difficulties are common in children with DS.
- Atlanto Axial Instability (AAI)

Effectiveness of early detection

- The Paradigm of DS (They are retarded and no treatment) is proved to be wrong with early detection and intervention. They are not born retarded, rather they become retarded.
- Individuals with DS need loving home, early intervention and appropriate continuous medical care.

2. Phenyl ketonuria

- Defect in the phenylalanine hydroxylase with the accumulation of phenylalanine.
- Clinically: absent neonatally, later development of seizures (25%) fair skin, blue eye, blond hair, rash, if untreated mild to profound mental retardation, speech delay, and hyperactivities.

3. Fetal alcohol syndrome

Maternal consumption of alcohol, short stature, midface, microgentalia, mild to moderate retardation, irritability, inattention

4. Social retardation

Mildly retarded children who normally do not show any medical or neurological abnormality. Their retarded development is mainly due social and care deprivation and the lack of the appropriate programs and also lack of cognitive stimulation that help them to achieve their potentials. This may result in a lower level of functioning and more deterioration in their performance

Clinical management of mentally retarded children

There two main categories of mentally retarded population; the first and the larger group are those with mild retardation and do not have any specific or associated clinical disorders, the other group consists of those who are seriously handicapped mentally either because of specific clinical syndrome or due to massive brain damage.

For the mildly retarded children, the main goal of intervention is to integrate them into the society and manage them as equal citizens. Educational programs in special classes or special schools are provided to those who cannot benefit from the regular education, such programs include continuous skill assessment and potentials development.

Supportive programs (Financial, moral, educational) for the families to enable them to retain their handicapped children are recommended.

For behavioral and emotional problems of the mentally retarded children, we follow with them same treatment approaches in other psychological disorders like behavioral therapy, family therapy and psychopharmacological treatment.

Treatable cases like Phenylketonurea should start treatment as early as possible. The treatment is mainly a diet low in phenylalanine during the child's early years; this usually leads to normal child development.

Last few years have witnessed the development special treatment programs for Down syndrome that create more hope for those children and shaken the myth of the Down syndrome as an untreatable condition. It includes medications (antioxidants) and special diets.

Special supportive and educational programs for the families and communities that aim changing the attitude towards the Downs and promote more integration in the society.

Other treatment approaches for mentally retarded children are applicable in Down syndrome depending on the severity of the case, the age and the degree of the mental retardation.

Section 3

Specific Mental Health Problems

Mind-body relationships in children

1. Eating disorder:

The common eating disorders in childhood are:

- Lack of appetite
- Excessive appetite
- Perverted appetite; Pica, which means eating a non nutritive (non-food) substances, it may be a symptom of: MR, Neglect and abuse.

2. Bed-wetting-day time wetting (enuresis)

Enuresis is defined as involuntary or intentional voiding of urine, severity is determined by the frequency of urination not the quantity .The definition precludes a physical cause for the disorder and the child's chronological and mental age is at least 5years.

- **Primary:** the child has never become dry. In most of the cases no specific cause can be found for 1ry enuresis. It is often ascribe to delay in neurological maturation or severely disorganized family and the child receives inconsistent toilet training.

  "Delay in achieving bladder control is a feature of mental retardation; it is marked in severe retardation"

- **Secondary:** enuresis starting after the child has achieved continence after a certain period of time (3 months).

It may be a symptom of regressive behavior appearing in situations of emotional stress; it may be also symptoms of conduct disorder.

Diurnal wetting is probably more often associated with psychiatric disorder.

Other specific causes like UTI, nocturnal epilepsy, anatomical abnormalities were founded.

Enuresis usually complicated by feelings of anxiety or guilt especially if the child is blamed or punished for enuresis.

3. Sleeping problems

Children's need for sleep varies from child to another. At the age of 2 months, infants undergo a shift from endogenous control to more exogenous control as his waking hours become longer. Children use the waking hours for more exploratory behavior

Normal sleep pattern

- Newborn infant sleep an average of 17 hours/ day
- 6 months sleep 14 hours /day
- 2 years sleep 12 / day
- 6 years sleep 11 hours / day
- 6 – 11 years, sleep about 10 hours
- After 11, the average sleep time is about 8 hours.
- Regular wake up time in the morning

Sleep disorders

Insomnia

Primary insomnia characterized by excessive worry during the day time about not being able to sleep or getting nightmares

Secondary insomnia: insomnia related to another mental disorder like anxiety or depression, or related to a known organic factor (psychoactive substance, arthritis)

Parasomnia

Night terrors, Nightmares, sleep walk, sleep apnea

Night terrors: the child wake up in the morning in a terrified state, inaccessible, not responding when spoken to, twilight state, looking at people and objects not actually present (hallucinating)

- **Tics**

A sudden movement of a muscle or group of muscles (may be facial, vocal, trunk or limbs), serving no purpose and not under voluntary control.

Usually associated with other emotional disorders

It is handicapping socially especially when it involve large movements

4. Anxiety disorders

Normal anxiety is the major human motivator, when exceed a certain limit it interfere with the performance level and needs intervention.

It can be general anxiety disorder or anxiety related to specific situations (separation anxiety, phobia and post traumatic stress disorder)

A. General (over) anxiety disorder

- The child tends to be extremely self-conscious.
- Worry about the future events, such as exam, meeting expectations
- Feeling of tension, sense of insecurity, fears of danger from within
- Lack of concentration
- Insomnia and nightmares
- Dry mouth, heartburn, nausea, headache, blurring of vision, fatigue

B. Separation anxiety disorder

Continuous anxiety concerning separation from those whom the child is attached in the form of:
- Unrealistic and persistent worry about possible harm befalling attachment figures
- Reluctance to go to school in order to stay with the attachment
- Difficulties to go to sleep in order to stay with the major attachment figure
- Repeated nightmares
- Physical complaint

C. Phobias

Fears are natural and instinctual feeling like fear from death, heights, dark, and monsters. However when fears persist for long time or irrationally exist, then it is not normal (phobias)

Phobias in children may exist in the form of:
- *Simple phobias:* fears of a specific objector situation
- *Social phobias:* fear of being embarrassed or humiliated in social situation.

D. School refusal

- At the age of 5 – 7, associated with separation anxiety disorder
- At the age of 11, probably associated with school change
- At the age of 14, frequently associated with depression

E. Posttraumatic stress disorder

- **Stressor:** The child must have been exposed to a stressful event of exceptionally threatening nature, which would be likely to cause pervasive distress to almost any one. The symptoms composed of 3 categories:
  1. *Re experiencing:* Flashbacks, reliving the trauma events in the form of vivid memories, recurrent dreams
  2. *Avoidance and Numbing:* Avoiding behavior to the circumstances that resemble or associated with the stress.
  3. *Hyper arousal:* Persistent anxiety symptoms in the form of, difficulties in falling asleep, difficulties in concentration and exaggerated startle response.

Management of anxiety & anxiety related disorders

- **Drug therapy:** It may be helpful in some cases that show severe symptoms of anxiety or other emotional disturbances. New generation of antidepressants that characterized by low profile of side effects and rapid onset of action are preferable, short courses of minor tranquilizers may be also helpful in some cases.

- **Psychotherapy:** the essence of the psychotherapy intervention and regardless the specific approach is the building of a relationship between the therapist and the patient. Children are specifically sensitive to the therapeutic context, every contact with the child is emotionally significant and may be either therapeutic or anti therapeutic.

- **General principles to be considered in dealing with children:**

DO NOT
• Criticize or disapprove the child. • Allow the child to feel at fault. • Press for an answer the child is unwilling to give. • Go straight in discussing symptoms unless brought up by the child.

DO
• Listen and feel the child point of view. • Help and facilitate the expression of anger and other negative feelings. • Appraise the ideas expressed by the child. • Gain the child's confidence, remember that children do not come for treatment by them selves, they brought by the caregivers who are worried and concerned and may be angry with the child.

- **Family therapy:** Many children's psychiatric problems can be well understood in the context of family situation. The focus in family therapy is the family system, when this system is dysfunctional, it manifest directly as psychological symptoms in children.
The types of family intervention differ widely depending on the theoretical models of the therapist. Direct intervention consists of offering the family a different way of functioning.

- **Behavioral Therapy:** Commonly used in some child psychiatry like phobias and enuresis. It is based on the learning theory; its goals are either elimination of undesirable way of response or behavior or development of desirable behavior. The treatment is often located in child's environment like home or at school rather than in clinic or therapist's office and in collaboration with the family or the caregivers.

Conditioning process is the basis of behavioral therapy, it may be:

- Classical conditioning where a neutral stimulant (UCS) comes to evoke a new response by pairing it with another stimulant that reflexively (CS) evokes that response

- Operant conditioning based on the fact that responses followed by reinforcement tend to increase in rate; those not followed by enforcement tend to decrease in rate.

5. Attention deficit with hyperkinesias (ADHD)

- The child appears as if does not listen
- Does not stick with any task to the end, frequently shifts from one unfinished activity to another, noisy
- Fails to follow the role of structured game
- Poor peer relation
- Poor social problem solving skills
- Interrupt the others
- Can't wait his role
- Can't remain seated
- Low self esteem
- Impulsive, unpredictable mood
- Poor perspective on the future consequences
- Immature physical size
- Poor motor coordination
- High pain tolerance
- Under reactive CNS
- High frequencies of minor physical anomalies

The course of the disease may be:

- *Self-limited:* In case of early detection and good management, all the symptoms disappear at puberty.
- *All symptoms persist:* this common if the cause is minor brain damage
- *Improvement of the hyperactivity symptoms and persistence of the attention deficit*

Management

The treatment plan should be based on careful assessment of the predominant symptoms (hyperactivity/attention deficit); any associated learning difficulties, perceptual or behavioral abnormalities.

The medications used in ADHD are mainly two categories:

- Cerebral Stimulants like Methylphenidate, Amphetamines and pemoline have been found to improve the on – task behavior, decrease the impulsivity and the purposeless activities, improve the goal directed activities, concentration and the information processing.

- Tranquillizers: like Haloperidol, chlorpromazine and thioridazines, may be helpful to reduce the hyperactivities symptoms but at the cost of sedating the child.

Specific psychotherapeutic programs for behavioral modifications are proved to be helpful in improving the impulsive behavior and the lack of attention. Family and teachers education about the disease and the needs of the child is crucial.

6. Autism

Autism may develop early before the 2nd year (infantile autism). Or later after the third year (childhood autism).

Infantile autism

Usually associated with mental retardation (75%). the mental retardation is not related to the autistic process itself as it tended to remain at about the same level even after the recovery from the condition itself.

Childhood autism

Characterized by:

- Qualitative abnormalities in communication skills; language skills as well as facial expressions and gestures
- Qualitative abnormalities in reciprocal social abnormalities; lack of eye – eye contact, lack of spontaneous seeking to share enjoyment
- Stereotype restricted activities; like moving an object endless repetitive movement
- Attachment to an odd object

Asperger syndrome
Same criteria of autism accept no significant delay in the spoken or receptive language skills.

Clinical management

Treatment of autistic disorder should be a venture of planners of the program, the behavioral therapist, speech therapist and special teacher. The best location for treatment is at home or within the community itself.

Treatment should aim to promote healthier and more normal developmental progress with the various development delays seen in autistic child.

Focusing on the communication and speech skills is quite important, however it is a long and difficult process.

Involvement of the family is crucial for the progress in treatment although the family itself need support and guidance.

Section 4

Child Abuse & Maltreatment

Definition

Child abuse is not only beating child,

- ***Physical abuse;*** take the form of physical violence that includes beating, burning, suspension and other possible forms of physical punishment and violations.

- ***Emotional abuse;*** results from Rejections, deprivations of affections or stimulations, exposure to domestic violence or severe domestic disharmony, inappropriate criticism, threats, humiliation sand accusations.

Signs

Physical signs

- Skin injuries like cigarette burns or hematoma
- Head and eye injuries
- Long bone or rib fracture or multiple fractures.
- Bite marks
- Signs of lack of care like malnutrition, inappropriate clothing (lack of warm clothing in cold weather, chronic infections)
- Recurrent dysuria or vaginitis, sexually transmitted disease, bruising or lacerations to the vulva or the anus

Behavioral signs

- Aggressiveness, phobias, fears, sexually inappropriate behavior
- Reluctance to be alone with a particular adult
- Repeated running away from home
- Withdrawn, avoidance behavior
- Any form of drug abuse

Emotional signs

- Sadness, detachment or blunted (emotional death)

Family signs

- Young parents under employment of the care givers, poor marital relation, social isolation
- Alcoholic, Drug abusers or psychotic parents
- Positive family history; Parents blame the child, see the child as bad or an evil and not attractive

Female genital mutilation

Is performed on an estimated two million girls world wide every year, it is practiced across diverse socioeconomic classes and different cultural, ethnic and religious groups, commonly girls are circumcised between the age of 4 and 12. This practice has been criticized world wide including the WHO and other major health groups and considered child abuse in many countries

Child abuse: How to manage?

When signs of physical abuse are founded or suspected, full physical exam should be done including careful exam of the genetalia and X ray and any other investigations as indicated. Proper, careful and early physical treatment for the physical injuries is essential in preventing any possible disabilities.

For psychological injuries, we apply the same general principles used in managing anxiety related disorders.

If the child has been abused by a family member or within the family environment, try to adopt an empathetic, non-punitive attitude. Explain to the family member your professional obligations to inform the legal authorities and your willingness to continue offering them the needed help and support for the benefit of the child. It is not helpful to show anger or outrage or to forcefully extract a confession from the family about the abuse.

The case is different when the abusive is some one outside the family; in such cases the family members usually show active cooperation in the treatment and investigation of the case. Make sure that they arte not judging the child or blaming him/her and try to emphasize the importance of being supportive and understanding for the treatment of their child and reducing the sequel of the abusive events.

Treatment of the abused child require a multidisciplinary well trained team that involved the therapist, family member, social authority, legal authority and a school member. Continuous cooperation between the team members is crucial for the success of the treatment plan.

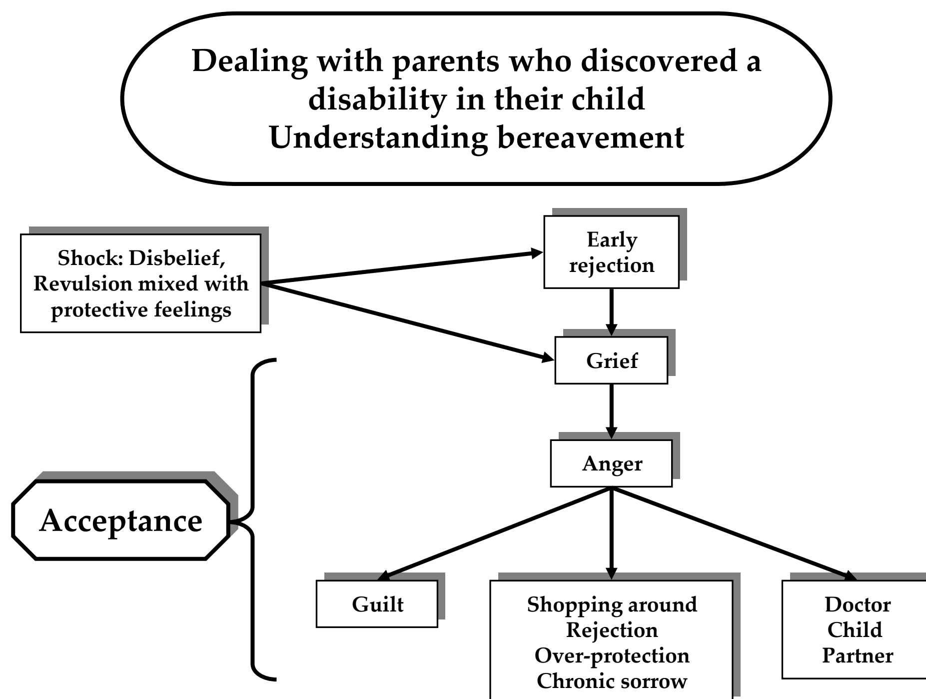
Because treatment of child abuse is quite long and difficult process, it is believed now that the best treatment is the preventive one that involved increase the awareness of the health and social workers in the primary care facilities, especial educative programs in schools and with the families as an essential part of the anti and post natal care. Hotlines for helping abused children and special units at the police and court facilities for the same purpose was established in many of the developed countries and were proved to be valuable in preventing child abuse and reducing its psychological sequels.

Section 5

Guidelines in Dealing with the Families

• Current mental literature describes families of the children as the most important resource. The role of the professionals should be to assist in meeting their goals and to empower them to achieve control over their life circumstances.

• Families and mental health professionals know that the stresses of caring for a child with mental or psychological disorders are real. It includes changes to daily family life, anger, worry; feelings of loss (grief), social isolation, feeling blamed, and increased financial expenses.



• In addition to the stress of having a child with mental disability, some families have the added stress of social and economical- cultural origin.

Questions that frequently asked by the parents

1. *Why is this happening to us?*
2. *What have I done wrong?*
3. *When does it end?*

• The best model for empowering the families to care for their children with mental disorders is a partner ship between families and the professionals involved in their child's care (therapeutic alliance). This partnership relationship is based on sharing the skills, knowledge and experiences of each partner. This empowers the parents; they begin to take

an action to get what they need and they begin to contribute and offer valuable information to help in developing the best and most appropriate treatment decisions.

Some ideas that will help to foster a professional parents partnership

• Families with children who have special needs are more like other families than they are different, though they are handling more intense stresses and they are handling them more often, they are trying to achieve the same quality of life and are using the same methods for coping stress as are all families in our culture.

• Experiences and research have shown that parents of children with special needs are generally welcome parent to parent support and often seek it in times of need. Parents who have been there can be effective resources for information and guidance and can act as role models and advocate for other parents.

• Take long range perspectives rather than focus on accomplishing short term objectives.
Family members can provide valid and well in formed assessment and information including identifying and describing their child in regard to their strengths and needs.

• When parents are not involved in decision making and service delivery, they can develop feelings of helplessness and dependency on t he one hand, and resentment on the other.
Listen carefully to what parents tell you and be open to new perspectives.
Support system such as extended family, neighbors mosques, churches, schools and volunteers organizations are critical for family success.

• Parents are very aware of their responsibilities to provide care for their children but they are seldom aware of their rights as care givers. Remind the parents their rights as human beings:

1. You have the right to accept that you are doing the best you can, and that is good enough.
2. You have needs that are as important as the needs of your child.
3. You have your own hobbies and interests.
4. Have a vacation away from your child every year.
5. Have celebrations, weekends away, and time together with your partner to enhance your relationship.

Chapter Summary

Mental Disability

Risk factors

- Constitutional: hereditary and congenital anomalies
- Temperamental: difficulties in coping
- Physical: Malnutrition,
- Environmental: Broken family, Loss, migration, severe poverty

Warning signs

- Congenital anomalies
- Failure to thrive
- Involuntary movements
- Epileptic activities
- Disturbance in bowl control
- Sleep disorders
- Eating disorders
- Lack of basic social and linguistic communication skills

Screening procedures

At the PHC level

- General medical exam
- General Psychological exam
- Assessment of the risk factors

Management and rehabilitation guidelines

- Multi disciplinary assessment (Bio- Psycho- Social)
- Multi axial treatment (Bio Psycho social}
- Family or care givers are involved from the beginning
- Supportive, educational measures for the local community, family and teachers are crucial

Suggested referral places

- Ain Shams Child Psychiatry unit
- Kasr El Aeiny child psychiatry unit
- Child Psychiatry clinics, school health insurance
- General Psychiatric hospital

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