A student from Fatimadevi English School in Mumbai attacked another student during recess time to impress a girl. The weapon used for the attack was a blade of the pencil sharpener. The victim, a tenth grader, was slashed from the right cheek to the neck and got 25 stitches – he was in a critical condition.

This was not the first incidence of violent behavior by the student. A few months back, he had slapped one of his teachers. He was not only thrown out of school but also sent to police custody.

Now, we all think of the school as a safe place for our wards. And yet, imagine when all of a sudden your ward’s school principal calls you to the hospital or police station.

Such violent incidents often result due to some psychological disturbance in the child. Psychiatric problems among Indian children are rising and a large number of cases remain unreported. Disturbingly, if 40% of the Indian population comprises children under 16 then the problem assumes significant importance.

Psychopathology is the science that deals with mental or behavioral anomalies. The problem is generally identified by a combination of how a person feels, acts, thinks or perceives, especially in the social context.

Psychological disorders in a child can be observed by either one or a combination of three kinds of problems like social problems, discipline problems and educational problems. Social problems include withdrawal, loneliness, loss of confidence, anxiety or depression, alcohol and drug abuse (particularly associated with mental illness), suicide or self-harming, theft and criminal behavior. Disciplinary problems include selfishness, defiance, unstable behavior, recklessness, deceitfulness, violent behavior and disruptive behavior. Learning disorder, bullying, decreased learning ability and academic achievements are educational problems shown by these children.

These problems become clinically important when the child shows explicit behavior, emotional states, interpersonal relationships and cognitive functions with certain level of severity for sufficient duration. It is necessary to find out the reasons behind such problems in children so one can intervene at the right time.

Family dynamics play an important role in the psychological development of the child. If the child fails to find an emotional anchor at home she or he lets out the resultant frustration at school.

Dr. P.D. Bansal from Department of Psychiatry, Adesh Institute of Medical Sciences and Research, Punjab carried out research on 3928 school students where questionnaires were directed at mothers regarding the child’s behavior during the past one year.

Answers were scored on two point scales – 0 if that particular behavior was absent and 1 if present. Students who scored 10 or more were considered positive for psychological disorder. When these children were interviewed clinically they showed one of the problems like having specific isolated phobia, sleep disorders like sleep talking, bruxism (teeth grinding) and tension headache. Hyperkinetic disorder, pica (craving for non-food items like chalk, paint), bed wetting, terror and epilepsy were also seen in some students. Dr. Bansal did not observe any significant difference among male and female students as well as children from joint or nuclear families.

Some studies have shown that the prevalence of psychological disorders is significantly higher in the middle income group which increases as socio-economic status lowers. Majority of the children with illness came from the second birth order. Lack of awareness about child-rearing practices, over protection of the first child, neglect of the second child, sibling rivalry, unwanted child, economic burden after second child could contribute to the problem.

Children of the age group of 13-15 years had more problems as compared to younger ones. The burden of studies in higher classes, emotional disturbances related to early adolescence, or mothers’ perception of any resultant undesired
change in behavior as abnormal might be the reasons for this.

In urban areas, where both parents are working with children being away from parents at the crèche or school for 13-14 hours, quality time is replacing quantity of time with parents. Nuclear families, one child policy, day boarding schools, transport from school to home and the atmosphere at crèches are adding new dimensions to the psychological health of urban children.

Visits to many crèches in Mumbai’s western suburbs revealed that the child’s daily schedule is planned in such a way that he stays away from the home at school, tuition and crèche for 13-14 hours. Many children said they don’t like to be at the school/crèche mainly because elder children always bully them. Does bullying cause emotional problems inviting more victimization? This is a point of debate.

The Lyndal Bond of Centre for Adolescent Health, Australia studied this problem in 2680 school students. Lyndal’s research published in the British Medical Journal confirms strong relation between victimization and depression. History of victimization is a strong predictor of the onset of depression and consequently affects social relationship. This study rejects the point that poor emotional health invites victimization. Lyndal suggests that reduction in victimization in school is a potentially useful preventive intervention.

All India Institute of Medical Sciences’ Psychiatry professor, Dr. Rajesh Sagar says, “School teachers and counselors should be sensitized and trained to handle child mental health issues. Special attention should be devoted to academically poor children with an encouraging and supportive approach. There should be adequate provisions for early identification and interventions to cover all children including those who are drop-outs or never attended a school or college.”

He further says, “Adolescence is an age of experimentation.” Automobile and other accidents, violence, drug and alcohol abuse and sexual risk taking are very high in this age.

Researchers of the department of psychiatry at Temple University, Philadelphia began by asking two fundamental questions – first, why does risk-taking increase between childhood and adolescence, and second, why does risk-taking decline between adolescence and adulthood? According to Laurence Steinberg, one of the researchers, risk-taking increases between childhood and adolescence as a result of changes around the time of puberty in the brain’s socio-emotional system leading to increased reward-seeking, especially in the presence of peers, fueled mainly by a dramatic remodeling of the brain’s dopaminergic system.

Risk-taking declines between adolescence and adulthood because of changes in the brain’s cognitive control system – changes that improve the individual’s capacity for self-regulation. These changes occur across adolescence and young adulthood and are seen in structural and functional changes within the prefrontal cortex and its connections to other brain regions. The differing timetables of these changes make mid-adolescence a time of heightened vulnerability to risky and reckless behavior.

“There should be a focus on enhancing social skills in order to resist peer pressure and to develop the ability to say ‘no’. There is a need to encourage alternate activities that can inculcate positive lifestyle behaviors,” says Dr. Sagar.

According to Dr. P.C. Shastri, psychiatrist of Topiwala National Medical College of Mumbai, when it comes to child and adolescent mental health services in India there are very limited services, mostly restricted to urban areas, while 74% of the Indian population stays in rural areas.

At the same time, access to mental health services for children with mental, emotional or behavioural disorder is substandard, not provided early enough, not in sufficient supply and accessible only to a fraction of the children and adolescents. Currently India has tertiary care centers which attend to mental illness in a hospital setting. They are therapeutic in nature and aim to treat and rehabilitate them back into the society. However, a large gap exists in the area of prevention, mental health promotion and early intervention programmes.

“The problem has not received the deserved attention so far. Only a handful of Indian researchers are currently working in child psychiatry and the outcome of disorders has not been studied much in the Indian context. We need to generate quality evidence for cost-effective prevention and treatment strategies,” says Dr. Rajesh Sagar.

“India does not have a separate child mental health policy or a mental health policy for that matter yet. The government may finalize one soon where there is a component of child mental health,” says Dr. Rajesh Sagar. “It will provide a developmental framework to enhance mental health resources and services, and appropriate budget allocation.”

However, India is a complex country of too much diversity. In such a scenario formulation of national policies, programming and planning is quite a challenging task. “Each district will need planning at the local level. For such a diversified country it is difficult to envisage a national program that fits all,” says P.C. Shastri.