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Problem Children in Hong Kong

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Rapid industrialization and urbanization have been responsible for the prosperity of Hong Kong over the past 15 years, but they also have had their negative effects. For example, they have created acute housing problems and changed the basic family structure, kinship network and social life as a whole. This change is briefly discussed under housing, family, parent-child relationship and school system in so far as it concerns the children in Hong Kong:–

Housing

There has been a serious degree of overcrowding in many parts of the urban area. Obviously, the people affected are those of the low income group and to some extent the middle class as well. The Hong Kong Government has in recent years provided resettlement estates and low cost housing for over 1 $\frac{1}{4}$ million people. These are multi-storeyed blocks of buildings consisting of small units with a few hundred square feet each and housing a few thousand people in one block. In these areas especially in the resettlement estates the children have no privacy whatsoever and do not have perfectly silent hours for preparing their lessons. Parents here do not as a rule discourage their children from leaving the house and thereby temporarily relieving overcrowding at home. However, there are insufficient parks, playgrounds and recreation clubs and mixing children in the neighbourhood is full of pitfalls. Unless they are properly supervised they are easily led astray. The middle class families also have to live in multi-storeyed buildings with many flats in each floor. In contrast to those living in the resettlement estates, the middle class families appear isolated. One family may be suspicious of the occupation or motive of the others and little contact exists among them. Neighbourhood contact which is the earliest extra-domestic social life for children is almost non-existent in these sort of families. Furthermore, social interaction and friendship practices among neighbours and friends are limited by high density housing and migration especially from Mainland China which also affects the existence, size and strength of kinship networks. It is not inappropriate to say that children brought up in such housing environment are either touchy, irritable and querulous or else submissive, shy and solitary.

Family

Industrialization and urbanization are said to undercut the strength of families. Probably this is true because of the limited time for members of the family to communicate and interact with one another.

Nuclear family structure is now prevalent in Hong Kong and it is not uncommon for both husband and wife to be working when they have only one or two children. If the grandmother is available they leave the children to her but when not available they have to place their children in a nursery since financially they may not be able to employ an

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amah. In the nurseries the staff are usually not trained and the ratio of staff to children is very low. Upbringing of children there is therefore unsatisfactory. Later when the couple has more children the wife has to stay at home. This means that there is an increase in family expenses and a decrease in income. Due to poverty marital tension may arise and the parents' emotional difficulties will reflect on their attitude towards their children.

Parent-child relationship

The parent-child relationship has as many variations as in the West. However, there are a few notable differences: firstly due to long hours of work and frequent financial worries the parents of low social class families exercise less control over their children and are harsher with them. On the other hand some parents often expect their children to achieve a higher standard than necessary and also encourage their children to compete with one another, thus creating a greater tendency to sibling rivalry and jealousy. Secondly, since parents usually have a relatively low level of education they provide little opportunity for the child to introject cultural standards because they themselves do not apply these standards in their own day-to-day living. The children may not pose a problem until the culture outside the home begins to make demands e.g. in the school.

School system

There have been some basic changes in the school system in recent years. Nevertheless, it seems that the system here encourages children to use more of their memory rather than reasoning power as compared with that of the West. Thus, the school-children rely more on recall of what their teachers have taught them in class. The teaching method is stereotyped and does not prompt children to ask questions arising from their curiosity. As a result Hong Kong children are less equipped with the power to adapt to a new situation or to solve a new problem. Perhaps one cannot put the blame on the school authority since the perpetuation of such a system reflects the demand made by the traditional attitude of the community. It appears that the environment of Hong Kong children at home, in the neighbourhood or at school tends to bring about problems culminating in disturbed behaviour and it is reasonable to expect a high rate of referral to the child guidance or psychiatric service. As a matter of fact this has not been so. When one has some experience of child psychiatry in the West one is often struck by the low referral rate of children cases here. It is interesting to speculate the reasons. First it is possible that the Chinese parents are more tolerant of their children's odd behaviour or symptoms. Certain habit disorders, for example, which would cause anxiety in European parents could be outgrown with age. An example of this is nocturnal enuresis. It is true that most Chinese children get dry as early as the Non-Chinese children. Some are delayed for one reason or another e.g. due to maturation defect or neglect in toilet training but given another year or two they will catch up and their enuresis disappears. Even in onset enuresis which is a symptom of emotional illness will stop spontaneously if the parents are tolerant enough until the stress is over. In fact, undue anxiety can only make the symptoms worse. Perhaps, mainly for this reason very few cases of enuresis are referred to the paediatric or psychiatric clinic. The second reason for the low referral rate is the strong face-saving attitude of the Chinese. A disturbed child would reflect their incapacity, ignorance, or hereditary weakness. This is evidenced by the fact that it is not uncommon for parents to distort the history in order to

lessen the degree of their "stigma". Thus, when a child is brought to the psychiatrist the history given may have no similar symptoms or complaints common to other children. However, when the child becomes well after treatment, his sibs are brought to see the same doctor and a somewhat different family history is given. This attitude will artificially reduce the prevalence of problem children even if an epidemiological study is carried out here in Hong Kong. A third reason is that the existence of a child psychiatric or guidance service is not known to many and most people think that its function is for assessment of handicapped children.

The Child Guidance Centre and the Child Psychiatric Unit

The first child guidance centre was established within the Education Department of the University of Hong Kong in 1957. Initially, the financial support came from the Rotary Club of Hong Kong and the Carnegie Corporation of New York. It was staffed by two psychologists, one Chinese and one non-Chinese and one social worker. The Government specialist in psychiatry acted as consultant. This centre accepted referrals from the parents, teachers, social workers or medical practitioners. The clients had to pay a fee which might be reduced or waived when necessary. However, it seems though in retrospect, that its function was mainly exploratory with regard to the underlying problem including psychological testing, and counselling. Unfortunately, it closed down in 1968 mainly for financial reasons.

In its place the first Government child psychiatric unit came into being in 1967 with the opening of the Yaumatei Psychiatric Centre. It is run part-time (two mornings a week). Team work is the key approach in management and the team consists of the psychiatrists, the medical social workers, the nurses and the occupational therapist. In view of the effectiveness of psychotropic drugs on adult patients, their use has been extended to childhood conditions. Experience has shown that these drugs are helpful in quite a number of children. In addition, the occupational therapy department attached to the Centre has been found useful for children in addition to its many other functions for adults.

Existing Load of Child Psychiatric Unit

In 1970 there were 191 children (i.e. below the age of 14 years) registered at this unit. However, the majority of cases came for assessment only. It would be more telling if the day hospital admissions in the past 4 years are analysed:

There were altogether 117 admissions. Their sex and age distribution are shown in Table 1 and diagnosis in Table 2.

Table 1

Sex	Age		
	5 years and below	6 - 9 years	10 - 13 years
Male	5	23	51
Female	0	12	26
Total	5	35	77

Table 2

Diagnosis	Number of Cases
Primary behaviour disorder	27
Behaviour disorder in subnormal children	24
Childhood schizophrenia and psychosis	17
Childhood Neurosis	15
Subnormality for assessment with a view of placement	14
Epilepsy for investigation	10
Habit disorders e.g. nocturnal enuresis	7
Writer's Cramp	1
Sydenham's chorea	1
Myoclonus	1
Total	117

Treatment

Our experience has shown that for psychotic children the main stay of treatment is psychopharmacology. Milieu therapy is used to push them to get better touch with reality. This includes work therapy, play therapy and recreation activities. It seems that the prognosis for psychotic children is not as bad as that found by the British workers although our diagnostic criteria follow theirs. As for the neurotic children the axiolytic and antidepressive drugs have been found valuable. This does not mean that psychotherapy in one form or another is not required. The advantage of medication is that the rate of improvement can be quickened and this is desirable in cases where parents can scarcely afford the time to attend regularly or in cases when the emotional disturbance is so gross as to make them totally out of control. Furthermore, parents are often impressed by the initial relief of symptoms and they are in a better frame of the mind to co-operate in treatment and accept advice. As regards behaviour disorder this is such a broad term that without formulating the case it can tell very little about the child. The disorder presented may vary a lot or mix with neurotic or psychosomatic symptoms. If it takes the form of restlessness, irritability and aggressiveness tranquillizers may have some palliative effect. On the other hand if it is antisocial behaviour like stealing, truancy and so on drugs are of little value and the more time-consuming method like play therapy, counselling or behaviour therapy may bring about the improvement. For children with brain damage and presenting with hyperkinesis, dexedrine or tranquillizers may be used. More often than not a very high dose has to be used. Indeed, it is surprising that children can tolerate very high doses of the psychotropic drugs without showing undue side effects. Furthermore, the environmental factors as well as the parental attitude have to be taken into account. In this respect the medical social workers can offer valuable help in parental guidance and social manipulation.

Difficulties Encountered in Running a Child Psychiatric Clinic in Hong Kong

1. Problem of trained staff

Child psychiatry is still a young subspecialty. Not only the diagnostic classification has not been universally agreed upon, also the therapeutic approach is still a matter of great controversy. Follow-up studies are few and of these few, heterogenous samples were included which have made it difficult to draw any definite conclusion on the long term prognosis. Even in England training in child psychiatry is unsatisfactory and the trainees are in a greater part left to feel their own way. Due to this lack of practical training in technique medical graduates are hesitant to embark their career in this branch of psychiatry. Obviously, with the limited number of psychiatrically qualified staff (i.e. those with D.P.M.) there are many functions they are expected to perform. In other words it is impossible for these few qualified staff to spend more than a small portion of their time in dealing with children. Without trained medical staff the paramedical staff although keenly interested in handling children receive no explicit direction or supervision from the doctors and will soon feel lost and lose their interest altogether. However, it is possible to assign one junior medical staff to the job part-time while a regular conference is held to facilitate this in-service training. There are psychiatric social workers, psychiatric nurses and occupational therapists who take part in the team approach but there is no psychologist available to make the team complete.

2. Sort of referrals

Many subnormal children have been referred by the Social Welfare Department for assessment. The great number of such referrals have caused a delay to those children who need treatment. This state of affair existed in England 2 decades ago but is not allowed to occur now. The child psychiatric clinic provides clinical service primarily for the investigation and treatment of emotional illness in children and to a much smaller extent for mentally ill (psychotic) children. The presence of low grade mental defectives will deter children with emotional disturbances from attending the clinic. In fact, assessment of subnormal children can be done by the clinical psychologist of the Social Welfare Department. Also it is a pity to see that the majority of children are brought to the clinic only after they have been ill for a long time. Many of them are totally out of control and have to be tranquillized during the initial period. What the parents of these very disturbed children want mainly is admission of the children into hospital. They are not really prepared to discuss the causes of their children's disturbed behaviour. A number of parents think that after the child has been brought to see the doctor, it is then the doctor's responsibility to treat the child and the problem is no more theirs. Another difficulty is that many parents are illiterate and benefit little from discussion with a view to modify their attitude.

3. Mixing children with adult cases

The child psychiatric clinic is running part-time and an attempt has been made to streamline the children cases to come in two mornings. However, due to the heavy load of adult cases, a smaller number of them are still allowed to attend on the same mornings. Even in the day hospital it is impossible to separate children from the adults because of the limitation of space. Adult psychotic patients are likely to have adverse influence on the children. The latter may also identify with the symptoms of the neurotic adults. A separate O.T. room for children has been proposed and may solve part of the problem.

4. Question of psychotherapy

This requires critical appraisal. The so called "superficial psychotherapy" is not much different from counselling and as such various

professions should be able to do so. In essence counselling involves a relationship in which the counsellor's advice is received by the one who seeks it. The success of counselling depends on many factors such as the personality, experience and prestige of the counsellor, the attitude and technique employed as well as the time and the availability of play material in case of children. Social workers may be better counsellors in certain kinds of cases, the priests, the teachers and the psychologists in others. Strictly speaking, psychotherapy means much more than counselling. However, assuming that it simply means relationship therapy what then is the minimal amount of interpersonal interaction in terms of hours which can be called a course of psychotherapy? There is little agreement on this point. It may be argued that the course varies greatly in different cases, depending on the outcome. This raises the question of how to measure and define the outcome. Furthermore, one must take into account the possibility of spontaneous remission which appears to be a function of time.

5. Lack of aftercare facilities

The degree of recovery of problem children depends on the nature and duration of their illness. There are always children who will be permanently handicapped to some extent in one form or another. They need rehabilitation after the active treatment. There is appreciable lack of aftercare facilities for the staff of the clinic to refer them to.

Head and Role of Professional Team

Professional people of various disciplines think that they are the right profession to deal with problem children. In the author's view no matter who runs a child guidance centre or consultative service it is essential that a psychiatrist should be available. The psychiatrist is from the only profession adequately trained both in normal and abnormal psychology, fully qualified to give diagnosis, both psychiatric and physical and acquainted with pros and cons of different forms of treatment including psychopharmacology. This does not mean, of course that the psychiatrist forms a one-man-team. Important parts are played by the psychologist, the social worker and other related professions. No one can deny that the handling of problem children is a team work. What is stressed here is that the psychiatrist, if present, should head the team. He should be responsible for the diagnosis without which research works especially follow-up studies become meaningless, for excluding organic cases especially those remediable by surgery or internal medicine and for directing different sorts of cases to different expert care of various professions. For example, he should single out psychotic cases which are more appropriately treated by pharmacotherapy, but this does not exclude other ancillary methods of treatment. In general medicine or even in adult psychiatry no one has disputed that the doctor is the leader of the team but in child psychiatry there is no consensus. Even in England for years there has been a difference of opinion on whether a psychologist or psychiatrist was better placed in charge of a Child Guidance Clinic. It was usually the former when the clinic was run by the local education authority because it was thought that the problems presented by children would turn out to be scholastic. Later in 1959, the important principle was laid down that the child psychiatrist was the Medical Director of the Child Guidance Clinic, so emphasising that the service was medical rather than educational; a point that is still not everywhere agreed. The disagreement has been due to certain inherent defects of psychiatric diagnosis as well as to the vague idea people have about psychotherapy. Medical diagnoses are rooted in a thorough understanding of anatomy and physiology. Thus, a diagnosis of appendicitis tells something about the condition that can be used to plan treatment. Psychiatric diagnoses have never been based on a concrete body of knowledge and a diagnosis of emotional disturbance indicates

no more than a vague suggestion that the child ought to have psychotherapy of one kind or another. There is another moot question: what is regarded as the underlying psychopathology is based on speculation which may vary with different persons and different disciplines. Thus, an educationist may view a disturbed child as a learning problem, a social worker as a reaction to the intra-family conflict and a psychologist as maladjustment. Admittedly, each of them is right in certain cases and in these they may play the leading role. However, in the majority of cases their judgment is over-simplified and their role over-estimated. The aetiology of disturbed children is usually multiple: heredity, early upbringing, disposition, intelligence, environmental factors and biological changes as well as precipitating factors like a mild physical ailment. No formulation is complete without taking all these factors into consideration.

An observant teacher can detect with fair accuracy early changes in a child's behaviour and indeed in Western countries a good proportion of referrals come from the school. However, in Hong Kong, few children are referred from this source. One has the impression that the teachers here tend to minimize or magnify the degree of behaviour disturbances in the child, depending mainly on how much they are prepared to involve themselves in the management. If the change of behaviour has created no trouble in class, not uncommonly the teacher does not even raise it for discussion. On the other hand if the child's behaviour has repeatedly infringed the class disciplines, the picture is often exaggerated with the view of getting rid of him. More often than not the teachers are afraid and so reluctant to collaborate with the treatment.

Perhaps they should not be blamed since their time is limited and they scarcely have the knowledge, skill or experience in managing the problem children. With the recent expansion of, and increasing role played by the Special Education Section the teachers can seek advice from this section. It may render service for children who need remedial teaching especially in certain types of cases e.g. dyslexia. It is hoped that its staff will be able to instil more mental health concepts into the ordinary school teachers. Nevertheless, with the half day school sessions it is doubtful if they can render more help to the problem children than referring them early to appropriate departments.

In the case of social workers they do not have sufficient knowledge about the psychodynamic aspect and concomitant symptoms of emotional disturbance. No doubt they know very well the social background with its associated privations and deprivations. However, they often attribute all problems to causes inside or outside the family. Indeed, probing of the family environment usually leads to discovery of some family "psychopathology". In fact there is no sharp dividing line between a normal and an abnormal family and a family free from minor stress and strain may not be good soil for cultivating mental health in children. Children need a certain amount of frustration to strengthen their personality. Social workers when working independently may create artificial factors for modification, but working in conjunction with the psychiatric and other related personnel their help in social manipulation is valuable. In view of the introduction of the Government Public Assistance Scheme on 1st April this year, the voluntary welfare agencies are expected to direct more attention to counselling service. There should be a closer coordination between these agencies and the Mental Health Service.

Some psychologists consider themselves as the most suitable persons in handling problem children. They think their training enables them to approach the child's problem in a more scientific manner. They tend to explain all disturbed behaviour in terms of a lapse or distortion from the normal psychological development. They seldom

view phenomena as arising from morbid processes which they are not acquainted with. Also they cannot keep abreast with the recent development in biochemistry and psychopharmacology. They are good counsellors for a number of parents and children. When more psychologists are produced by the newly established Department of Psychology at the University of Hong Kong, their role in counselling will become better known to the general public. Obviously, there are certain difficulties they will encounter. First, assuming that their speculation on the causative factors in a number of problem children is correct yet they may not be able to effect a solution because these factors cannot be modified or because the parents cannot afford the time to attend with their children for more than a few times. Secondly, for very disturbed children no contact can be established and as a result they will get lost since unlike the psychiatrists they cannot prescribe drugs to sedate them. Finally even in counselling the psychologists do not possess the same degree of prestige as the psychiatrists, and prestige is one factor responsible for the therapeutic success. Furthermore, working in a child psychiatric or guidance service they do not have the well recognized authority to gain the confidence and full co-operation of the nurses and the occupational therapist, or even the social workers. In Hong Kong for the time being at least they are handicapped by lack of psychological tests which have been standardized for the use in this community.

Suggestions

As the educational standard of the people of Hong Kong becomes higher, there will be an increasing demand for child psychiatric or guidance service. In 1960 the Royal Medico-Psychological Association recommended 1 full-time consultant child psychiatrist with complementary junior psychiatric staff and allied professional staff per 200,000 population. The ideal ratios of staff would be 1 psychiatrist, 1 social worker, 1 half-time clinical psychologist, 1 half-time psychotherapist. The latter can be non-medical staff. It is impractical to implement the R.M.P.A.'s recommendation here. Nevertheless, we should be prepared for the future need.

1. Existing facilities should be fully utilized and made more efficient. Unless this is done it is difficult to win support from the Government for creating new ones. It is the author's opinion that a child psychiatric clinic can serve better purpose if priority is given to cases who can be best helped by our current methods of treatment. This preliminary process of selecting cases can best be done by an experienced nursing officer who has some knowledge of child psychiatry. He can obtain some ideas from the letter of referrals and ask the parents some relevant questions. It appears more sensible to use the time-limited brief treatment so that more families can be reached with the available personnel. In fact, there has been lack of definite evidence that intensive psychotherapy is better than the short term psychotherapy.

2. Since earlier diagnosis and treatment will give a better prognosis, perhaps attention should be directed to case-findings. This can be done by collaborating with the parents, teachers and health visitors as well as the welfare agencies. If necessary children may be referred direct without the need of a medical referral.

3. Parents should be encouraged to actively participate in the treatment process especially in cases where parental attitude needs modification. They may drop off because of the home-clinic distance, inability to take time off work or overloaded domestic work. Special arrangement for someone from the voluntary agencies to take care of the other children or special Sunday sessions for those who are unable

to come otherwise may be considered. The attitude that "once the child is under the doctor's care, it is then the doctor's responsibility to cure the child" should be corrected at the initial interview. They should be told that the staff are helping them to solve their problems and not taking over the problems.

4. The provisional establishment of the parent-child consultative service should be given full financial support by all concerned. This service is for the time being staffed by social workers of the Caritas and under the supervision of the consultant team from the University of Hong Kong and relevant Government departments. There are certain administrative difficulties when a team is formed by consultants of various disciplines and of equal status but these can no doubt be overcome. This consultative service is expected to cater for more variable sorts of child clientele since a wider range of experts is available. Moreover, it may also have its value in mental health education because it shows that the management of problem children is not the job of only the psychiatrists but also of all interested professions.

5. Incentives should be given to graduates who are interested in child psychiatry and they should be sent for a course of training exclusively in this specialty. In England, a consultant post in child psychiatry has been easier to get than one in general psychiatry. There should be a specialist in child psychiatry since there are already 2 paediatric specialists in Hong Kong. Creation of such a post will bring closer the link between paediatrics and psychiatry.

6. In the absence of enough qualified medical staff perhaps the psychiatric nurses can be trained as assistant therapists. The aim of child therapy is to encourage the child to reveal his problems as he knows them and within the child-therapist relationship, the child expresses his fears, guilt and hate and shares his experiences with the therapist. There are reasons to believe that the nurses can be trained to do so. They have some basic knowledge in physiology, normal and abnormal psychology, pharmacology and experience in dealing with psychiatric patients. Many of them are keen in handling children and have the patience and an understanding attitude to do so.