THE PRESENT CONDITIONS AND PROBLEMS IN CHILD PSYCHIATRY AND PSYCHIATRIC CARE FROM THE STATISTICAL REPORTS OF THE CHILD UNIT AT SEIRYOIN*

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INTRODUCTION

It is said that the development of child psychiatry in Japan is not as advanced as that of Europe and America. Before the Second World War, in fact, there was almost nothing that could be called "Child Psychiatry" or "Child Psychiatric Care." Although there obviously has been much progress over the years, recent developments such as the so-called "problem child syndrome" and the "school refusal phenomenon" have caused many people to express more interest in child psychiatry and its professional fields.

On the other hand, no medical college has yet established an independent course or program in child psychiatry, nor has any child psychiatric department been formally recognized or accepted as a "clinical entity." Solutions to these problems, under these conditions, depend greatly upon the personal efforts of the professionals in these fields.

In order to anticipate and plan effectively for the future, we would like, in this report, to examine the major problems that are now confronting us. Statistics gathered from the Child Unit at Seiryoin are used as the basis for this report.

When Seiryoin was rebuilt in 1973, the Child Unit was also established. It was an epoch-making event for our profession in Hokkaido. Since then the Child Unit at Seiryoin has been functioning as the center of child psychiatric care in Hokkaido.

From the establishment of the Child Unit (October, 1973) to present (September, 1977) we have examined over 1,400 children. Residential treatment was recommended for 106 of these children. Before getting into the outcomes, a few essential points concerning diagnosis, classification and statistical relevance, etc., should be made.

In diagnosing children with mental disorders, we usually follow the DSM's diagnostic categories (Diagnostic and Statistical Manual of Mental Disorders) or those of the GAP (Group for the Advancement of Psychiatry, Tables I and II.) The dynamic process of symptom-formation is considered the core characteristic of these two classification systems. We, personally, also believe that this dynamic and developmental viewpoint is perhaps one of the most important and useful positions in child psychiatry today.

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The second aspect which should be considered is the overall national statistical pattern of child psychiatric disorders in Japan. Regrettably an adequate statistical framework cannot be constructed, due to lack of information. To date, there has been only one nationwide investigation of handicapped children, which was carried out by the Ministry of Education in 1967. According to that report, the pecentage of various handicaps in the population was as follows;

Emotional Disorders	0.43%
Speech Disorders	0.33
Mental Retardation (all types)	2.07
Visual Disturbance	0.08
Hearing Disorders	0.11

Locally, in Sapporo, rather thorough investigations have been carried out twice, once in 1969 and again in 1970. In these investigations 82,664 elementary school children and 34,210 junior high school students were examined. Among the elementary schooi group, 325 children were discovered to have some kind of psychological difficulty or disorder. 139 were considered autistic, yielding an incidence of 0.168 per cent. In the junior high school group, 65 were regarded as autistic, producing a percentage of 0.19. The overall incidence of autism for these two groups was calculated at 0.174 per cent. This figure which, seems to be quite high in comparison to other investigations on the population distribution of autism, is undoubtedly due in part to the differences in categories and definitions of autism. Underlying these figures, however, is an urgent message - the immediate need for attention and action.

If we extrapolate from this data, we can estimate that there are approximately 508 autistic children, or total of 2,219 with emotional disorders in Sapporo.

RESULTS OF OUR EXAMINATIONS

As indicated above, we have examined many children since the establishment of the Child Unit at Seiryoin. The following data are based on an analysis of the psychiatric examinations on 1,480 children seen from the inception of the Unit in October, 1973, to the date of this report, September, 1977.

1. Table III shows the total number of children, grouped according to their residential area, within each disorder category. 76 per cent of them came from Sapporo and its suburbs. The remainder came from various outlying districts except for the Hiyama district. This seems to indicate that the Child Unit is assuming a leading role in Hokkaido. As the distance from the hospital to the area of residence increased, the number of children examined proportionately decreased. In a large area like Hokkaido, easy access to hospital facilities is an important consideration.

2. As the contents of Table IV indicate, it is expected that we be able to deal with many kinds of disorders, such as autism, mental retardation, neurosis, and speech and hearing disorders. Yet we are often embarrassed by the small measure of assistance we can provide in reality.

Although mental disorders in childhood can arise at any age, more than half the children seen in our study (59.9%) were below five years of age. Much further work is required to develop guidelines for care in early childhood. On the other hand, an increase in

the number of older children (above 12 years of age) to all in-patients of the Child Unit at Seiryoin has shown a tendency to increase year after year. It is critical therefore that we begin giving thought as early as possible to the problem of care and placement of older children with mental disorders.

3. The children seen were sent to us from several referral sources, including welfare agencies, public health agencies, hospitals and medical facilities, and university departments and public schools. This is illustrated in Table V.

4. The Child Unit at Seiryoin has both out-patient and residential programs, but the former has not yet to be officially recognized. In the out-patient program there is a staff of three child psychiatrists, six clinical psychologists, and one social worker, all of whom hold additional posts in the residential unit. The staff is engaged in a daily routine of the examinations and therapeutic endeavors. The mean number of out-patients per day is about twenty-five (Table VI). The importance of the out-patient service is often ignored, even though the staff is extremely busy and not always able to respond to all the requests for help or advice.

Since October, 1973, 106 children have been admitted to the residential unit. Age distribution is seen in Table VII. Of these children, five were admitted for short one-day periods due to status epilepticus. There were a total of 28 cases of autism. The majority of the neurotic group were diagnosed as "school refusal." Four children with visual disturbance were admitted with their mothers for a period of one week. This brief hospitalization was aimed at providing the patients with some basic training in daily living skills and gross motor abilities, such as walking. In the cases of autism, short-term hospitalization was often necessary as a relief measure in the event of a crisis, or as respite care for the parents. Residential treatment was also recommended when there was no day unit or special school within a reasonable distance from the home.

Finally, we would like to comment on admissions. The mean duration of hospitalization, which includes short-term admissions as well, was 9.4 months. However, more than 50 per cent of the psychotic and autistic children had been on the ward more than a year. This is simply related to the fact that the older children (over 15 years of age) tend to remain on the ward, due to lack of adolescent facilities in the community.

DISCUSSION

Clearly there are a lot of problems awaiting solutions. It is appalling that no really adequate measures have been taken to remedy this situation, even though an increase in the incidence of psychiatric disorders in children was projected years ago.

The present conditions in our unit have prompted us to consider, in detail, the various problems we face in child psychiatry and psychiatric care. First, we face the difficulty of maintaining contact with all of the organizations and people concerned with child-related services or problems. Children with a wide-range of disorders are referred to our unit for treatment, and owing to the shortage of specialists in local child welfare offices, many children are forced to travel considerable distances for treatment. This is a point which deserves particular emphasis: unless incomplete services in local centers are ameliorated, we will be confronted with a serious deadlock in services sooner or later.

It is an accepted fact that a diagnosis can often be clarified through a therapeutic

approach. This correlation between diagnosis and therapy further enriches our medical care. We regret to say that we have only begun to face this challenging task.

The second major problem, with a peculiarity of its own, is the general reluctance to accept child psychiatry as a legitimate profession. From traditional vantage points our efforts have often been labeled strange or unnecessary. Consider for a moment the kind of questions posed to us: "Why are so many different specialists needed on your staff?" "Why do teachers work in the hospital?" and "Why do the children so often break the toys and equipment?," etc. Some people seem to find it hard to understand that a child's mode of life is different from an adult's. It remains to us, as professional, to try and bridge many of the gaps in understanding.

The third problem area lies within child psychiatry and the philosophy of treatment. Opinion remains devided in our field as to whether children should live in a permissive environment or a strictly disciplinary one. We feel, in almost all cases, that they should be treated in a permissive environment. And, in this regard, it is important that a uniform approach be practiced among all the staff members.

Within our Unit we are striving for improvement in other areas where services to children have, at times, been poor or inadequate. We are, for example, attempting to improve the hospital's delivery of pharmeceutical services. Studies are being made regarding proper dosage administration and the relationship between dosage and adverse effects. Also, we are trying to eliminate the risk of error in drug preparation, which for children can have serious effects. We have been working with our dieticians to further improve the diet for the children, especially taking into consideration the child's age and psychiatric disorders. "Refreshments" form an important part of the daily routine for children. Yet we feel this and other aspects of diet ought to be brought into discussions on eating behavior with the dieticians. We are seeking the cooperation of our maintenance personnel, as well, in preventing the breakdown or failure of our plumbing and heating equipment, to the extent that these inconveniences infringe directly on the daily concerns of bathing and toilet training.

At the risk of overstatement, we feel the following points again need special emphasis in relation to the future of child psychiatry. First and foremost, the department of child psychiatry must be recognized as a seperate clinical entity. As long as the child psychiatric department functions merely as a minor appendage of the general hospital or mental hospital–and this is the situation we are faced with today – psychiatric care for children will always remain critically inadequate. The task of research and treatment takes many skilled hands. And those skilled hands are in most cases poorly paid. The financial problem makes it nearly impossible to construct a system of good medical care.

Due to the large number of chidren in Hokkaido with unidentified mental disorders, we would like to see the creation of regional child centers. The present absence of funding, however, makes the outlook indeed very gloomy.

The second major issue concerns the training of specialists. No position in child psychiatry (even a lecturer's position) has yet been established in any medical college. It is one of the main reasons why child psychiatry in Japan is lacking a firm basis. The only route to becoming a child psychiatrist is through the pursuit of independent study outside the regular medical school curricula. There is, of course, no guarantee of a steady flow of younger clinicians following in the footsteps of those already in the field.

All members of the child psychiatry department's staff, such as clinical psychologists, social workers, nurses, guidance personnel, speech therapists, and teachers, should recieve special professional or para-professional training. Training schools in these fields, where they do not already exist, should be established as soon as possible, because of the time lag required to train and develop these human resources.

SUMMARY

It has been our intent in this report to summarize the present conditions in the Child Unit at Seiryoin, in order that we may affect further progress in child psychiatric care. The following conclusions have been reached :

1. It is vitally important that child psychiatry have an independent organization.

2. In line with this we must grant to child psychiatry its due recognition and status as a seperate clinical department. At that point we can proceed to develop the economic support for the many services desired, and also work toward the goal of the creation of regional child centers within a reasonable distance from the child's home. At the same time we must improve communication between all child-concerned facilities, such as health centers, guidance clinics, schools, etc.

3. And finally, we must address what is perhaps the most urgent of all problems - the lack of training programs to produce trained specialists. It is imperative, we feel, that child psychiatry programs be opened in medical colleges, and other professional and para-professional fields be similarly developed.

Of course, the solutions will not come at once. But news, like the recent formation at Hokkaido University of the "Research and Clinical Center for Child Development," raises our hopes and expectations.

Table I DSM-II Major Disgnostic Categories of Psychiatric Disorders in Children

I. Mental Retardation
- 310 Borderline
- 311 Mild
- 312 Moderate
- 313 Severe
- 314 Profound
- 315 Unspecified

II. Organic Brain Syndromes
- A. Psychoses Associated with Organic Brain Syndromes (290-294)
- B. Non-Psychotic Organic Brain Syndromes (309)

III. Psychoses not Attributed to Physical Conditions Listed Previously (295-298)

IV. Neuroses (300)

V. Personality Disorders and Certain Other Non-Psychotic Mental Disorders (301-304)

VI. Psychophysiologic Disorders (305)

VII. Special Symptoms (306)

VIII. Transient Situational Disturbances (307)
- .0 Adjustment reaction of infancy
- .1 Adjustment reaction of childhood
- .2 Adjustment reaction of adolescence

IX. Behavior Disorders of Childhood and Adolescence (308)
- .0 Hyperkinetic reaction of childhood (or adolescence)
- .1 Withdrawing reaction of childhood (or adolescence)
- .2 Overanxious reacion of childhood (or adolescence)
- .3 Runaway reaction or childhood (or adolescence)
- .4 Unsocialized agressive reaction of childhood (or adolescence)
- .5 Group delinquent reaction of childhood (or adolescence)
- .6 Other

X. Conditions without Manifest Psychiatric Disorder and Non-Specific Conditions (316-318)

XI. Non-Diagnostic Terms for Administrative Use (319)

Table II. GAP Classification of Child Psychiatric Disorders
(Major Categories)

1. Healthy Response……developmental, situational
2. Reactive Disorders
3. Developmental Deviations……eg, maturation
4. Psychoneurotic Disorders……anxiety, phobic, conversion, dissociative, obsessive-compulsive, depressive, other
5. Personality Disorders……compulsive, hysterical, anxious, overly dependent, oppositional, overly inhibited, overly independent, isolated, mistrustful, tension-discharge, sociosyntonic, sexual deviation, other
6. Psychotic Disorders……psychoses of infancy and early transient (early infantile autism, interactional psychotic, other); psychoses of later childhood(schizophreniform, other); psychoses of adolescence (acute confusional, schizophrenia, other)
7. Psychophysiological Disorders
8. Brain Syndromes……acute, chronic
9. Mental Retardation
10. Other Disorders

Table III. Number of Patients Classified according to Diagnosis and District.

Diagnostic Type \ District	Sapporo	Ishikari	Oshima	Hiyama	Shiribeshi	Sorachi	Kamikawa	Rumoi	Soya	Abashiri	Iburi	Hidaka	Tokachi	Kushiro	Nemuro	Total
Psychoses	7	0	0	0	0	2	0	0	0	0	1	0	0	1	0	11
Autism	162	24	2	0	28	16	19	5	9	16	11	9	9	1	1	312
Neuroses	45	3	1	0	1	2	3	1	1	2	1	0	0	0	1	61
Personality Disorders	3	1	1	0	1	1	0	0	0	0	1	0	0	0	0	8
Neurotic Manifestation	95	13	3	0	6	6	2	0	1	0	4	2	0	1	1	134
Behavior Disorders	70	13	0	0	4	6	3	0	0	2	4	2	3	0	2	109
Epilepsy	56	13	0	0	1	4	3	0	0	2	7	0	1	0	0	87
Mental Retardation	109	22	1	0	12	12	2	1	1	2	16	1	2	1	0	182
Organic Brain Syndromes	42	4	0	0	2	5	3	0	3	2	2	1	1	1	0	66
Speech Delay	223	59	2	0	27	44	21	8	8	8	14	8	4	2	2	430(±)
Articulation Disorders	8	1	0	0	0	0	0	0	2	1	0	0	1	0	0	13
Visual and Hearing Disorders	23	6	0	0	3	0	2	0	1	1	0	0	0	2	0	38
Normal	7	1	0	0	1	0	0	0	0	0	0	0	1	0	0	10
Other	12	2	0	0	1	0	0	0	1	0	2	0	0	0	0	18
Total	862	162	10	0	87	98	58	15	27	36	63	23	22	9	7	1,479(±)

One in parenthesis is from Tokyo.

Table IV. Number of Patients according to Diagnosis and Age

Diagnostic Type \ age	0−2	3	4	5	6	7	8	9	10	11	12	13	14	15	over16	Total
Psychoses	0	0	0	0	0	0	0	0	0	1	1	1	4	0	4	11
Autism	41	50	57	39	37	22	12	18	14	9	4	6	2	2	1	314
Neuroses	1	1	6	2	3	4	7	2	6	1	3	4	10	6	5	61
Personality Disorders	2	0	1	2	0	1	0	1	0	0	0	0	0	0	1	8
Neurotic Manifestation	10	1	4	8	7	19	12	14	9	9	9	12	11	3	4	132
Behavior Disorders	5	17	12	19	11	10	10	9	7	0	3	3	1	0	2	109
Epilepsy	8	6	7	12	8	6	18	6	4	7	1	1	1	2	1	88
Mental Retardation	20	25	35	20	27	13	5	6	6	8	4	2	3	4	4	182
Organic Brain Syndromes	5	9	5	9	13	5	6	3	2	0	2	0	1	1	2	63
Speech Delay	103	145	91	59	25	5	4	1	0	0	0	0	0	0	0	433
Articulation Disorders	2	0	4	1	4	0	0	0	1	1	0	0	0	0	0	13
Visual and Hearing Disorders	14	7	3	3	3	3	2	1	0	1	2	0	0	0	0	39
Normal	2	3	2	0	1	0	1	0	0	0	0	0	0	0	0	9
Other	3	2	2	1	1	0	1	1	1	0	2	1	1	1	1	18
Total	216	266	229	175	140	88	78	62	50	37	31	30	34	19	25	1,480

Table V. Sourse of Referrals

Referral Sourses		Nos.	Referral Sourses		Nos.
Child Welfare Agencies	Child Guidance Clinic	147	University Departments	Dep. of Psychiatry	315
	Family Child Counseling Office	33		Dep. of Pediatrics	28
	Public Office	23		Dep. of Education and Psychology	10
	Institution for Mental Retardation	18		Other	11
	Other Facilities	22		Total	364
	Total	243	Educational Facilities	School Board	11
Public Health Agencies	Public Health Center	181		Public School	24
	Mental Health Center	15		Special Class	86
	Total	196		Special School	24
Hospitals and Medical Facilities	Psychiatrist	74		Kindergarten	34
	Pediatrician	55		Total	179
	General Hospital of Sapporo City	113	Information Media (TV, Newspapers, etc.)		30
	Children's Hospital	4	Relatives and Friends		190
	Other	22	Other		10
	Total	268	Total		1,480

Table VI. Number of Outpatients.

	1973		1974		1975		1976		1977	
	mean nos./day	total	mean nos./day	total	mean nos./day	total	mean nos./day	total	mean nos./day	total
April			16.04	401	26.28	657	26.32	658	20.56	514
May			21.40	535	29.52	738	31.08	746	28.19	733
June			19.96	519	27.72	693	26.85	698	28.77	748
July			23.73	617	26.96	701	30.07	812	28.96	753
August			15.89	429	25.08	652	24.50	637	23.96	623
September			26.95	566	30.70	706	30.96	712	28.68	717
October			25.46	662	34.04	885	30.52	763		
November	16.88	405	25.96	623	31.83	732	32.25	774		
December	13.84	346	31.12	778	31.77	826	27.42	713		
January	13.0	286	22.26	512	23.27	512	23.04	553		
February	17.65	406	28.78	662	28.70	660	25.38	660		
March	18.80	470	27.92	698	30.54	794	31.16	794		
Total	16.08	1,913	23.66	7,002	28.91	8,556	28.59	8,520	26.52	4,088

Table VII. Number of In-patients Classified according to Diagnosis and Sex (Oct., 1973 - Sept., 1977)

	Male	Female	Total
Psychoses	5	4	9
Autism	20	8	28
Neuroses	13	8	21
Personality Disorders	2	1	3
Neurotic Manifestation	8	4	12
Behavior Disorders	5	1	6
Epilepsy	6 (3)	4 (2)	10 (5)
Mental Retardation	1	0	1
Organic Brain Syndromes	0	0	0
Speech Delay	5	1	6
Articulation Disorders	0	0	0
Visual and Hearing Disorders	4	0	4
Normal	0	0	0
Other	0	1	1
Total	63 (3)	33 (2)	101 (5)

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