Children's mental health

The role of culture, markets and prescribed drugs

Dr Sami Timimi
NHS, Lincolnshire

Since a review by the UK Committee on Safety of Medicines concluded that antidepressants are not effective and may be harmful in the under-18s (Ramchandani, 2004), hardly a month goes by without new concerns emerging regarding the safety and efficacy of prescribing psychiatric drugs to children and young people. A similar debate about the safety and efficacy of drugs prescribed for the most commonly diagnosed psychiatric disorder in children – ADHD (attention deficit hyperactivity disorder) – is emerging as they are increasingly linked with deaths, strokes and psychosis (Dooren, 2006), at the same time as doubt being cast on their long term effectiveness (Jackson, 2005; Timimi, 2005a; 2006c).

This gathering backlash against psychiatric drugs being prescribed to the young was inevitable. Rates of diagnosis of psychiatric disorders and prescription of psychotropic medication to children have increased dramatically over recent years, accelerating sharply over the last decade in most Western countries (Wong et al, 2004; Olfson et al, 2002; Timimi, 2005a) with children from as young as two being prescribed psychotropic medication in increasing numbers (Zito et al, 2000), despite this having no discernable societal impact on young people's behaviour and emotional wellbeing (see Breggin, 2002, Diller,1998 and Timimi, 2005a).

This dramatic change in child psychiatric practice has occurred (until recently) almost without the public noticing, despite its profound implications for those children diagnosed and medicated, and our more general cultural beliefs and practices around childhood and child rearing. Here, I try to contextualise current practice in child and adolescent mental health by arguing that much of current mainstream theory and practice can be understood as an (inadequate) response to the social and economic conditions of the time. I conclude by setting out a radical agenda for new theory and practice development. For an evaluation of the scientific evidence that demonstrates poor validity for common child and adolescent psychiatric diagnoses such as ADHD, childhood depression, and autism, please see Timimi (2005a; 2006a; 2006b; 2006c).

The social construction of childhood

Whilst the immaturity of children is a biological fact, the ways in which this is understood and made meaningful is a fact of culture (Prout and James, 1997). Our ideas about what makes a normal/pathological childhood are not innocent of current political, economic, moral or indeed health concerns. Rather childhood often represents a central arena through which we construct our fantasies about the future and a battleground through which we struggle to express competing ideological agendas. Definitions of normal/deviant childhoods and child rearing varies not only between cultures but also within cultures over time, requiring us to explore how concepts have changed in any given culture (vertical evidence) and between cultures (horizontal evidence).

Western society's ideas about childhood have undergone radical change in the last 60 years.

Since the second world war, the West's attitude to child rearing has changed from viewing relations between adults and children primarily in terms of discipline and authority, to one of guidance, understanding and children's individual rights (Jenkins, 1998). In addition, whilst the pre-war model prepared children for the workplace within a society of scarcity, the post-war model prepared them to become pleasure-seeking consumers within a prosperous new economy (Wolfenstein, 1955). The post-war 'permissiveness' model saw parent-child relations increasingly in terms of pleasure and play. Parents responded to this changing definition of childhood seeing this as a vehicle for fuller expression for themselves.

Shifting economic structures were leading to changes in the organisation of family life. More mothers were working and thus a renegotiation of power within the family was taking place. At the same time, suburbanisation and the economic demands of successful market economies were resulting in greater mobility, less time for family life, and a breakdown of the extended family. Many families (particularly those headed by young women) were now isolated from traditional sources of childrearing information. In this context childrearing guides took on an unprecedented importance allowing for a more dramatic change in parenting styles than would have been conceivable in a more rooted community. This gave professionals greater ownership of the knowledge base for the task of parenting (Zuckerman, 1975).

The new child-centred permissive culture meant increased commercialisation of childhood and a huge growth in consumer goods for children (Weinman-Lear, 1963). Children have gained access to the world of adult information resulting in a blurring of boundaries between what is considered adulthood and what is considered childhood, leading to children coming to be viewed as, in effect, miniature adults (Jenhs, 1996). Children respond to the market push to "adultify" them (at the same time as the culture of self-gratification "childifies" adults) by entering into the world of adult entertainments earlier and without adult supervision. Thus the post-modern Western child is sexually knowledgeable and has early experience of drugs and alcohol (Aronowitz and Giroux, 1991).

Children are cultured into a value system by virtue of living within its institutions and being exposed daily to its discourse (for example through television). In the West children are socialised into a system that embraces a particular idea of freedom through promoting individualism, competitiveness, inequality and the rejection of forms of authority. They also have to live in the unstable family structures such an ideology produces. Rates of psychosocial problems (such as crime, anxiety, unhappiness and substance abuse) have increased sharply among the young in Western societies (Rutter and Smith, 1995), with many studies documenting an association between poverty, marital disruption and a wide range of deleterious effects in children's behaviour and emotional state (McMunn et al, 2001).

One result of these changes is that the West has taken the bearing and rearing of children out of the 'natural' realm and into the professional realm of 'parenting' expertise, while heightening the apparent conflict between individual choice and 'traditional' notions, of parenthood, obligation and agency. The growing focus on children's rights, combined with parental anxiety that any influence that is discernible may be likely to be viewed as undue influence, makes it more likely that parents will leave essential socialising guidance to the expertise of professionals (Maitra, 2006). This has resulted in a rapid mushrooming in the numbers of professionals dealing with the young. Being viewed as a 'normal' child, or a

'normal' parent, have arguably, become, harder than ever to achieve.

Many non-Western cultures don't have this cultural ambivalence toward childhood, and welcome children into stable, nurturing extended family structures where duty and responsibility override individualism as the dominant value system. Anthropological studies have commented on the ability of family centred cultures to produce happier, easier to control children observing that the communal ethic promotes mental wellbeing by ensuring a degree of joint responsibility for children (Timimi, 2005a; 2005b).

The medicalisation of childhood

The social/political role of the psychiatrist has changed as the political and socio-economic climate of their natural host culture (the industrialised north) has changed. The beginning of the 'psychopharmacology' era – following discovery that chlorpromazine could calm some psychotic patients – eventually dovetailed with the broader neo-liberal political aims of late twentieth century economies, with the values of the market as the guiding philosophy on which social, economic, and political development rests. Now psychiatry could begin to fulfil a new role. Not only was it (falsely) portrayed as more potent in delivering back to society, those who had fallen off its rails (using cocktails of medication whose effects are likened to that of insulin in diabetes), but medicalisation could now serve a whole new purpose. Narrow medicalisation obscures the social, political and other environmental causes of mental distress (letting governments and institutions off the hook). In addition, 'mentalising' the ups and downs of life, previously viewed as normal responses to difficult circumstances, provides the opportunity to create new roles for doctors and allied professions, the opportunity to create new, potentially enormous markets (most notably for the drug industry). It is this expanded remit of psychiatry and its relationship to socio-economic developments that is of particular relevance to child psychiatry. The origins of child psychiatry were in a movement that was delving into the inner world of the child, mother-child relationships and the dynamics of the family. The advent of a new broader role for psychiatrists created the conditions for psychiatry to expand rapidly into the pathologising of young people and the social control of the young through psychiatric technologies (such as diagnosis, drugs and behaviour therapy).

These problematic Western attitudes and beliefs with regard childhood and childrearing are being exported to countries conceptualised as underdeveloped, and taken up by local professionals many of whom understandably believe they are getting something better from the more advanced West. For example the *Handbook of Asian Child Development and Child Rearing Practices* (Suvannathat, 1985), prepared by Thai child development experts is highly influenced by Western medico-psychological ideology. The book sets out to assimilate Western child development theory into a third world context with very little evidence of taking a local perspective into account. The authors suggest that many of the traditional beliefs and practices of Asians prevent them from seeking and using new scientific knowledge in childrearing. They go on to argue, in line with Western thinking, that children should be given more independence with less use of power and authority by the parents.

The problem of imposing onto the countries of the South, Western cultural beliefs with regard children, is evident right up to the level of United Nations (UN) policy. The UN Convention on the Rights of the Child, whilst having many important, progressive measures (such as acknowledging that many children live outside families, in situations of war and abandonment,

and need to be protected against abuse and neglect within families), uses a very Western concept of childhood. Thus the convention recognises the child's capacity to act independently, bestowing not just protective but also enabling rights, such as the right to freedom of expression and association. The convention has been accused of having a strong interest in spreading to the poor countries of the South, the values and codes of practice devised in the public sector of the medico-psychological led visions of childhood of the industrialised North. The view that childhood is a fixed notion, determined by biological and psychological facts rather than culture or society is implicit. This has been criticised by many non-industrialized countries (Boyden, 1997). For example, when the Organization of African Unity (OAU) drew up its own charter on the rights and welfare of the child (OAU, 1990), much of the charter was framed in terms of responsibilities and duties of children and families rather than rights and needs of the child. According to the OAU's charter every child has responsibilities towards their family and society, a duty to work for the cohesion of the family, and to respect their parents, superiors and elders.

Just as problematic notions of child rearing are being imposed on countries of the South, so also are problematic notions of child mental health problems. Economically and politically powerful groups, such as doctors and the pharmaceutical industry, have enabled Western medicine to push back its frontiers of influence. In the sphere of children's mental health this has resulted in the creation, not only of new diagnostic categories, but whole new classes of disorder such as 'developmental neuropsychiatry'. These new disorders are defined using a particular Western cultural idea concerning the boundaries and expectations of normal childhood, and are viewed as belonging to a biological/genetic framework, in which the role of the broader context is relegated to that of triggers or modifiers of the disease process (Timimi, 2005a). Thus rapid growth in the prescribing of psychotropics to children is also happening in many countries of the South (Wong et al, 2004), suggesting that the Western individualised biological/genetic conception of childhood mental health problems is spreading. Individualising children's suffering runs the risk, not only of undermining local ways of solving children's problems, but also of masking the real life circumstances (such as poverty and exploitation) those children may face (Timimi, 2004; 2005b).

The medicalisation of boyhood

The gender distribution for psychiatric disorders in pre-adolescent children is in the region of three to four boys to every girl, mainly made up of behavioural disorders such as ADHD, Oppositional Defiant Disorder (ODD) and Autistic Spectrum Disorders (ASD). Such a gender distribution, that seems to sweep across the entirety of psychiatric disorders found in the primary school years, implies that boys are biologically weaker or 'disabled' in some way, that modern environments adversely affect boys more than girls, or that we have come to be more troubled by boys' than girls' behaviour (or, of course, a combination of these). What is likely to be involved is a complex interplay between shifting ideas of masculinity and femininity, the role and position of men and women in society and the relentless progression of the project of individualism.

Free market capitalism can be seen as the most organised and complete example of a political, social, and economic system based on the values of masculinity that the world has ever seen. Its social and psychological values revolve around aggressive competitiveness, putting the needs of the individual above those of social responsibility,

an emphasis on control (rather than harmony), the use of rational (scientific) analysis, and the constant pushing of boundaries. Such a system produces gross inequalities (both within and between nations), has reduced the status and importance of nurture, and therefore the esteem attached to the role of mother. As a consequence more and more women are brought into the workplace, both to increase the workforce needed to service the market economies demand for continuous growth, and to give women the self esteem which was taken away from them as the role of motherhood lost its status. This movement out of the family and into the workplace has not been matched by a corresponding reverse movement of men out of the workplace and into more family and nurturing roles.

At the same time as there has been a movement of adults out of the family, there has been a movement towards childcare becoming a professional (mainly female) activity. Thus, what appears to be happening in the psychological space of childhood is an increasing feminisation in many aspects, particularly educational ones. There is now a large body of literature that attests to the fact that educational methods currently used in most Western schools (such as continuous assessment and socially orientated work sheets) are favoured more by girls than boys (Burman, 2005). This is then mirrored in national exam results where girls are now consistently achieving higher grades than boys, even in some traditionally 'male' subjects like maths and science. Boys also dominate the special needs provision where they are marked out as having disproportionately high (again in the region of four to one) problems with poor reading and poor behaviour. With schools under political pressure to compete in national league tables, and boys coming to represent a liability, it is hardly surprising that boys have come to be seen as the 'failed' gender, provoking anxiety in their (primarily female) carers and teachers (Timimi, 2005a).

All this throws up interesting questions in relation to common child psychiatric disorders. For example, Professor Baron-Cohen (2004) has recently put forward convincing evidence that the biological component of Autistic Spectrum Disorders (ASD) is that of the 'extreme male brain', suggesting that the male brain is more geared to 'systematising' while the female brain is more geared to 'empathising', with ASD sufferers being at the extreme end of the 'systematising' spectrum, hence the reason why ASD is predominantly found in boys. Although there are many problems with the narrowness of such a construct, if we were to take this theory at face value, it still leads to important questions that Baron-Cohen doesn't ask. Why are 'systematising' boys seen as more problematic nowadays than 'empathising' girls? Other aspects of the ASD construct have clear cultural dimensions. For example, poor eye contact is meant to be another diagnostic feature, yet the Japanese are very wary about establishing eye contact with relative strangers or seniors. Many ASD characteristics are not at all dissimilar to devoted religious lifestyles, for example, seeking solitude, vows of silence, non-materialistic values, lack of personal relationships, and daily following of rituals (Timimi, 2006b).

Similar analysis can be made in relation to ADHD. The gender gap in the child population diagnosed with ADHD is matched by a significant and opposite differential among adults initiating the labelling process. While young males form the majority of those labelled with ADHD, it is overwhelmingly adult females, their mothers and teachers, who make the first determination that a child's behaviour falls outside the normal range of what little boys are expected to do. Though this differential reflects the adult females more immediate involvement in the day-to-day care of

children, mothers and fathers frequently disagree on the 'pathological' nature of their sons' behaviour. Surveys of stimulant use in the US has shown that its use is highest in prosperous white communities where education is a high priority, where the educational achievement of both sexes is above the national average and, most importantly, where the gender gap in educational achievement favouring females is at its highest. This distinctive pattern lends no support to the idea that ADHD represents a congenital abnormality requiring small children to be treated with powerful psychotropic drugs. The ecological pattern is more consistent with the view that ADHD can be seen as a barometer of social anxiety about children's (particularly sons') development, with stimulants being used as a tool for rearing and educating boys' (Hart et al, 2006).

Whatever part of conditions such as ADHD is biological, how we construct meaning out of this is a cultural process. For example, Brewis and Schmidt (2003) carried out a study in a middle class, Mexican school of over two hundred pupils. Using standard diagnostic criteria, they found that about 8 per cent of the children could be diagnosed, as having ADHD, yet there was only one child in that school with the diagnosis. Through interviews with parents and teachers they discovered that these carers regarded ADHD-type behaviours as within the boundaries of behaviours viewed as normal for these children's ages.

New directions for child and adolescent mental health

I have tried to shed some light on the possible socio-cultural reasons behind the phenomenal rise in the numbers of children and adolescents being labelled as psychiatrically 'ill' and prescribed powerful psychotropic medication. Central to my argument is the notion that this rise results from certain cultural conditions that have helped create anxiety about children's (particularly boy's) behaviour and wellbeing, with psychiatry's response to this anxiety being shaped by market forces and increased emphasis on the individual. I believe this response by mainstream psychiatry has become part of the problem as it retains a dogged determination to support its members' personal interests and avoid anything beyond the most superficial debates about the socio-cultural origins of current theory and practice.

New forms of research should be encouraged, particularly those that combine the qualitative and the quantitative, use more naturalistic (such as clinic based) settings, and encourage cross-disciplinary theoretical and methodological approaches. Current reliance on a narrow conception of 'evidence based medicine' (EBM) cannot progress theory, as EBM is essentially parasitic, relying on the flawed assumptions of the current diagnostic system. Adoption of a more open and diverse model of child development that recognises that different cultures have different versions of child development has the potential to reduce the amount of pathologising of childhood that currently occurs in Western medical practice. This would mean the medical and psychological professions actively engaging in questioning the universal validity of the concepts and rating questionnaires they use.

There is also a need for a more context rich approach to practice. This opens up new opportunities for interventions that capitalise on potential resources, rather than just trying to rid the child of their internal disease state. All communities have resources, whether that is within the immediate family, extended family, religious community, schools and other institutions, that may well have positive suggestions and interventions to offer. Ideas from other systems of medicine can be utilised. For example Ayurvedic medicine sees illness as a disruption in the delicate somatic, climactic and social system of balance. Causes are not located as

such but seen as part of a system out of balance with symptoms viewed as being a part of a process rather than a disease entity (Obeyesekere, 1977). Such an attitude based on balance with nature (as opposed to controlling it) has resonance with new approaches that include lifestyle interventions focusing on aspects such as diet, exercise and family routines (Timimi, 2005a).

The rise in the rates of prescription of psychotropic medication for children and adolescents may also be the result of an increase in what might be loosely termed psychosocial suffering amongst children in Western society. Medicalising this can render the psychosocial causes invisible (Timimi, 2004) and professionals need to consider the ethics of their actions and be able to take a long-term socially responsible perspective.

I believe there should be a moratorium on the mass prescription of psychotropic drugs to the under-18s for all but the most seriously affected. For example, it could be decided that medication would only be initiated within adolescent in-patient units. At the very least, clinics for psychiatric disorders (such as ADHD) should not be run by paediatricians (as many are at the moment). In addition, much more needs to be done to evaluate the safety and effectiveness of psychotropic drugs and sever existing links between psychiatry and the drug companies (see Jureidini and Mansfield, 2006 and Timimi and B. Maitra, 2006).

Our increasing reliance on psychotropic medication may well have caused more harm than good in terms of lack of efficacy, dangerous side effects, increased circulation of potential drugs of abuse, and long term socio-cultural effects (Timimi, 2004; 2005a; Jackson, 2005). Alternatives for promoting better child and adolescent mental health includes better nutrition, more support for parents (particularly those who are most isolated), increased role for primary mental health workers, and the creation of community orientated support around schools (such as parent advice and support groups). Of course there are broader measures that contribute to children's mental wellbeing and this must include tackling child poverty, creating more family friendly business practices and criminalising wilfully absent parents. It would also in my view reduce the power that psychiatry has in commodifying children's emotions and behaviour.

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