Cross cultural perspectives on child protection

Tu-S-307
A case of severe physical abuse from Eritrea
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Introduction.– The challenges of gaining access to mental health services in a complex and often fragmented system of health care are well known. However, the situation is even more dire in parts of the world with very few resources or training.

Method.– This presentation focuses on child abuse in Eritrea through a case presentation and the challenges encountered.

Results.– Initially, there was no acknowledgement of any abuse of children in Eritrea. The challenges encountered were:

- lack of recognition and acceptance of the fact that the child was abused;
- lack of intervention;
- how to intervene and who was going to talk to the father;
- how to keep the patient safe.

Conclusions.– Pediatricians have unique opportunities to identify and address the unmet mental health needs of children through mental health screening at routine pediatric visits and ensure coordination of total care through ongoing communication and co-management.

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Tu-S-308
Negligence and violence against children and adolescents with enuresis: What can we do about it?
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Objectives.– To discuss risk factors associated Enuresis and actions to prevent violence against it.

Method.– A review of epidemiological/international studies on Enuresis and Brazilian studies on violence with enuretic kids was done.

Results.– Three main reasons for lacking empirically based treatment for this condition were:

- no concern;
- lack of knowledge;
- ineffective familial strategies delaying the efficient treatment.

These ignorance or parental negligence signs are frequent; studies have also shown that almost 80% of enuretic children did not go to any treatment. Brazilian review on violence with enuretic kids show that most suffer parental violence and are at risk of more severe psychiatric problems in the future, especially, if parents are low level of scholar education. Two Chinese epidemiological studies on Enuresis are focused since they might illustrate the role of clinical researchers besides studying and treating, preventing this aversive condition.

Conclusions.– Researchers shall be more proactive than reactive.

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Tu-S-309
Multicultural issues in child and adolescent psychiatry in Ireland
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Ireland has changed from being a country of emigration to one of immigration. Many families experience significant difficulties acclimatizing to the Irish way of life, and experience significantly more adverse events than their Irish counterparts. Different immigrant groups have different risks and resilience factors and should not all be grouped together.

Additional to non-Irish nationals is another ethnic minority group: the Travelling community, an indigenous minority who has been part of Irish society for centuries and representing 0.5% of the population. They have a value system, language, customs and traditions that make them an identifiable group both to themselves and to others. They have lower levels of education, substantially lower life expectancy and higher rates of unemployment and mental health problems.

In a country as culturally and linguistically diverse as Ireland, specific attention should be paid to the cultural dimensions of mental disorders in service provision and in training.

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Tu-S-310
Analysis of Eastern European child mental health services practice 20 years after fall of communism: Cultural differences or systemic violations of children’s rights
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Objectives.– To discuss obstacles for development of effective child and adolescent mental health (CAMH) services in the region of Eastern Europe (EE).

Method.– A review of reports submitted to the UN Committee on the Rights of the Child from the countries of EE and recommendations of the Committee in the area of CAMH and related services.

Results.– Systemic concerns have been identified which hinder the process of effective change in the field of CAMH and related areas:

- twenty-two years of transition was marked by low priority given by governments to the field of CAMH and failure to replace system based on institutionalization and neglect of child rights with effective child-friendly services;
- critical areas to be addressed as priorities are:
  - services to assist young parents in their parenting skills and thus prevent institutionalization of infants,
  - community based services for children with developmental disabilities,
  - services for troubled adolescents to prevent their stigmatization and crimina-

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Conclusions.– Many traditional services in the EE region continue to violate human rights of children. This unacceptable fact needs to be addressed in most serious way by all stakeholders.  
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Psychological framework in paediatrics

Tu-S-311

Introduction: The psychologically orientated paediatrician/prenatal counseling – a pediatric cardiologist perspective  
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Complex congenital heart disease (CHD) is not infrequently diagnosed on routine prenatal ultrasounds, and/or confirmed at dedicated centres. Such diagnoses lead to considerable stress of the affected parents which may be conceptualised as a “grief reaction”. Termination if such an option is available, is often proceeded with if there is an associated chromosomal or other malformation. Yet the parental decision process need be made in a setting of great emotional turmoil while trying to understand the abnormality, its consequences, and the need of surgical and other interventions with uncertain outcomes. Adding to the stress is a limited time frame — in Melbourne by 24 weeks if termination is contemplated. Despite the considerable information requested, it is often poorly absorbed as the parents describe themselves as being in a state of “shock”. In addition information is sought not only on the immediate outcomes but those extending into childhood and adult life, with questions related to schooling, sports, higher education, employment, marriage and even pregnancy — a daunting task when such counselling occurs at 18 to 20 weeks gestation or earlier. That is made even more difficult when at times there may be an evolving cardiac lesion as the pregnancy progresses with a worsening prognosis. Recognising the psychological constructs has allowed counselling to proceed in a non-directive manner, usually in conjunction with an obstetrician ultrasonologist, describing the abnormality in simple terms, concentrating on the quality of life issues rather than on the detail of the abnormality. The information provided in multiple sessions allows the parents to assimilate this knowledge and to work through their grief. Additional material such as a CD-ROM, diagrams, literature etc. may also be made available for the parents to view in their own time. There is also a need for clinicians to become aware of their own reactions in diagnosing serious cardiac abnormality where despite multiple surgical and other interventions, a poor outcome may be forthcoming. Recognising ones own vulnerability and sharing painful experiences with others allows one to continue to work effectively in this difficult area.  
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Tu-S-312

Engaging with neonatal death and bereavement – a neonatologist’s perspective  
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Neonatal intensive care is a high-pressure environment, because of both workload and also the nature of the task. Death remains a frequent event and the spectre of disability hangs over many babies and management decisions, whether antenatally or postnatally. Managing such pressures with families with widely differing expectations of intensive care and diverse belief systems around the issues of death and disability is a complex task. Families are experiencing the worst time of their lives and emotions are raw. We are also ourselves challenged by death and disability. They can be seen as professional failures, a challenge to our vision of ourselves as healers or “fixers”. Our self-management affects our decision-making and communication with parents. We are also mortal. The management of death by neonatologists is materially affected by their own fee-nings and fears concerning their own death. Neonatologists’ views of the quality of life for disabled survivors also differ materially from those of parents or those of survivors of NICU. The ability to explore such issues with ourselves is an essential prerequisite for balanced counselling of families around perinatal palliative care decisions, decisions around the margins of viability and limitation of treatment in neonatal intensive care. This must also be recognised in the supports provided for our colleagues and ourselves.  
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TOC: Approche thérapeutique intégrative

Tu-S-314

Données récentes sur le trouble obsessif compulsif chez l’enfant  
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Introduction.– Plusieurs nouvelles données de recherche font ressortir les particularités du TOC chez l’enfant ; nous exposerons celles qui nous apparaissent les plus pertinentes pour la pratique clinique reliée à ce domaine. En deuxième partie, nous aborderons les aspects cliniques reliés au traitement psychothérapeutique individuel et familial. En effet, une approche thérapeutique intégrée s’est montrée rapidement nécessaire dans le suivi thérapeutique d’enfants présentant un trouble anxieux de type obsessionnel-compulsif. Nous voulons illustrer ce travail par des cas cliniques et des réflexions théoriques. Traditionnellement, au Québec, une psychothérapie d’enfant est menée en parallèle avec des entretiens thérapeutiques pour les parents. Nous travaillons au sein d’une clinique externe spécialisée de trouble anxieux faisant partie du département de psychiatrie d’un centre hospitalier universitaire pédiatrique (0–18 ans).  
Objectifs de la présentation.– La première partie de la présentation portera sur les toutes dernières données de la littérature scientifique pédiopsychiatrique concernant le trouble obsessionnel-compulsif chez l’enfant. Les domaines abordés seront : la phénoménologie et les dernières recherches sur les présentations cliniques et les types de symptômes ; seront aussi abordées sous le même angle des recherches récentes, les questions des comorbidités psychiatriques, des facteurs étiologiques (génétique, neuro-imagerie, caractéristiques familiales), du devenir et des essais thérapeutiques (TCC et pharmacologie) novateurs.  
La deuxième partie proposera :  
– d’exposer un modèle thérapeutique d’approche intégrée (perspectives cognitivo-comportementale, développementale et systémique) pour comprendre et traiter un enfant (6–12 ans) qui présente une problématique obsessionnelle-compulsive ;  
– de situer les caractéristiques psychologiques fréquemment rencontrées ;  
– de faire ressortir la pertinence de renforcer la cohésion parentale et de favoriser les capacités de mentalisation chez les parents en rapport avec la problématique de l’accommodation.  
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Bipolar disorders in adolescents (Coby study)

Tu-S-315a

Bipolar disorder type I in children and adolescents: Clinical characteristics at intake and 1-year follow-up  
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