Psychiatric Morbidity Pattern in a Child Guidance Clinic

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Abstract

Background: There is a paucity of Indian studies on psychiatric morbidity in children. Present work was undertaken in a child guidance clinic in armed forces.

Methods: Retrospective analysis of 213 patients who attended a child guidance clinic was done.

Results: Majority (n=138) were boys. 55.9% were referred from paediatric outpatient department while medical officers in periphery referred 38.5%. The diagnoses was mental retardation in 30.97%, behavioral and emotional disorders in 23.06% and neurotic, stress related and somatoform disorders in 15.98% cases.

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Key Words : Child psychiatry; Attention-deficit hyperactivity disorder; Mental retardation

Introduction

In India, though children constitute nearly 40% of the population, child mental health care has received scant attention in service, research and training. Child and adolescent psychopathology is a major concern among health professionals and educators in the developed countries. It is estimated that 10-20% of children and adolescents are affected annually by psychiatric problems and their psychiatric morbidity accounts for five of the ten leading causes of disability for those aged five years and above. Yet mental and psychiatric services for children lag behind those for adults in developing countries [1-6]. A few surveys conducted in India have revealed that 7-30% of children under the age of 12 years need either evaluation or continuing psychiatric care [7,8]. The present study was undertaken to assess the pattern of psychiatric disorders in children who attend the child guidance clinic.

Material and Methods

The present retrospective analysis involved all subjects who attended the child guidance clinic at Command Hospital (SC), Pune during the period 01 May 2001 to 31 May 2003 from the case records, which included the history taken from the parents as well as the children. Psychological testing, electroencephalogram (EEG), computerised tomography (CT) scan were undertaken along with referral to paediatrician and neurologist, wherever needed. Diagnoses were made according to the criteria given in International Classification of Diseases, 10th edition (ICD-10) [9].

Results

A total of 213 new cases comprising of 138 boys and 75 girls attended the child guidance clinic during the period of the study. 119 (55.9%) were referred from paediatric outpatient department (OPD), while 82(38.5%) were referred by the medical officers. The age distribution of the children is shown in Table 1. The diagnostic categories of the children as per ICD 10 is given in Table 2. In the present study mental retardation was commonest (n=66; 30.97%), followed by behavioural and emotional disorders (n=49; 23.06%) and neurotic, stress related and somatoform disorder (n=34; 15.98%). Thirty (14.1%) cases were associated with co morbid disorders, primarily mental retardation (n=28; 13.2%) and attention-deficit hyperactivity disorder (ADHD) (n=2;0.9%). Nineteen patients were suffering from neurological disorders consisting of cerebral palsy (n=5; 2.3%) and epilepsy (n=14; 6.57%).

Table 1

Age distribution of the children

Age group (in years)	Male	Female	Total
0-3	17	6	23
3-6	30	18	48
6-9	38	14	52
9-12	31	20	51
12-15	22	17	39
Total	138	75	213
Mean age (SD)	7.86 (3.49)	8.80 (3.75)	8.13 (3.58)
Mode	10	13	10
Median	8	9.29	8
Range	2-15	2-15	2-15

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Table 2**Pattern of psychiatric morbidity in a child guidance clinic**

ICD 10	Disorder	Male	Female	Total	%
F 00-09	Postencephalitic syndrome	1	1	2	0.94
	Other mental disorders due to physical disease	1	0	1	0.47
F20-29	Schizophrenia	2	1	3	1.41
	Acute and transient psychotic disorder	4	2	6	2.82
	Schizoaffective disorder	1	0	1	0.47
F30-39	Mania	1	1	2	0.94
	Depression	2	2	4	1.86
	Recurrent depressive disorder	2	1	3	1.41
	Dysthymia	1	1	2	0.94
F40-48	Anxiety disorder	2	4	6	2.82
	Dissociative (conversion) disorder	11	8	19	8.92
	Obsessive compulsive disorder	2	0	2	0.47
	Somatoform disorder	3	2	5	2.35
	Adjustment disorder	1	1	2	0.94
F50-59	Psychogenic vomiting	1	1	2	0.94
	Somnambulism	2	1	3	1.41
	Sleep terror	1	0	1	0.47
F60-69	Trichotillomania	1	2	3	1.41
F70-79	Mental retardation	24	14	38	17.85
	Mental retardation with cerebral palsy (CP)	5	2	7	3.29
	Mental retardation with CP with seizures	2	1	3	1.41
	Mental retardation with ADHD	6	3	9	4.23
	Mental retardation with seizures	2	1	3	1.41
	Mental retardation with delayed speech	4	2	6	2.82
F80-89	Specific developmental disorder of speech & language	2	1	3	1.41
	Dyslexia	1	0	1	0.47
	Autism	2	1	3	1.41
F90-98	ADHD	15	9	24	11.28
	ADHD with seizures	2	0	2	0.94
	Conduct disorder	2	0	2	0.94
	Mixed disorder of conduct and emotion	1	0	1	0.47
	Separation anxiety disorder	1	1	2	.94
	Tic disorder	1	0	1	0.47
	Nonorganic enuresis	5	1	6	2.82
	Pica	4	2	6	2.82
	Stuttering	1	1	2	0.94
	Thumb sucking	2	1	3	1.41
Others	Cerebral Palsy	4	1	5	2.35
	Epilepsy	9	5	14	6.57
	Headache	1	1	2	0.94
	Hypothyroidism	1	0	1	0.47
	Intentional self-poisoning by alprazolam	1	0	1	0.47
	Intentional self-poisoning by organo-phosphorus	1	0	1	0.47
Total		138	75	213	100

Discussion

Paucity of cases upto three years of age (Table 1) is not an unusual finding, since the psychiatric structure before the age of four to five years is usually not sufficiently developed to permit internal conflicts of pathological significance and is in agreement with earlier studies in India [10]. The trend is different in western countries where children in preschool periods are also brought to the psychiatric clinic for emotional problems,

probably due to identification of the problem by parents [11]. Moreover, in adolescent age group, struggle for self-identity and role differentiation are stressful, thus precipitating such problems. Age related differences in psychiatric problems have been noted by other workers also [8]. The predominance of males may be explained by the attention and care given to male children by parents. Neuroses, mainly dissociative (conversion) disorder was observed in 15.98% of the sample. This is

in agreement with earlier studies [10,12]. It appears that there is a higher prevalence of dissociative (conversion) disorders in South Asian countries as compared to the west. Since the disorder has bodily manifestations, it is brought to medical attention more often. Child rearing is more authoritarian in our country and free verbal expression of emotions in children is not encouraged, therefore expression through conversion into bodily symptom is the only way out left for the child [10].

The high prevalence of mental retardation in the present sample is due to the mandatory testing of all students before admission to special school for handicapped children or for issue of medical certificates. This finding is consistent with the earlier studies of Shrestha [13]. The high prevalence of comorbid psychiatric disorders in patients with mental retardation in the present study is in agreement with an earlier population based study [14], which concluded that children and adolescents with intellectual disability are at significantly increased risk of certain psychiatric disorders. The high prevalence of behavioural and emotional disorder is in agreement with Regmi et al [15] and Pokharel et al [12], who reported prevalence of 23.59% and 25.58% respectively. High levels of disruptive behaviour were also noted in previous studies [16,17].

In the present study, 12% of patients received a diagnosis of ADHD. Few western studies have reported a high prevalence of up to 50% for ADHD [18]. While a study from Thailand reported low prevalence of 5% [6]. This aspect merits further exploration.

Studies have mentioned separation, hospitalisation, bereavement, loss of a parent through divorce, birth of a sibling, physical illness and injury, scolding, stress of exam and failure, quarrel with peers etc. as stressful situations leading to the development of psychiatric disorders [19]. Stresses preceding the onset of disorder were identified in 19.2% cases in our study. This is less than 86.4% and 26.74% identified by earlier studies [10,12], which could be due to the retrospective nature of our study and also the fact that more than a third of the patients in the present study had mental retardation. However this aspect needs further prospective studies.

Conflicts of Interest

None identified

References

- Murray CJL, Lopez AD, editors. The global burden of disease. Cambridge MA: Harvard University Press on behalf of the World Health Organization & World Bank, 1996: 201-46.
- Sawyer MG, Arney FM, Baghurst JJ, et al. The mental health of young people in Australia: key findings from the child and adolescent component of the national survey of mental health and wellbeing. *Aust N Z J Psychiatry* 2001; 35: 806-14.
- McKelvey RS, Sang DL, Baldassar L, Davies L, Roberts L, Cutler N. The prevalence of psychiatric disorders among Vietnamese children and adolescents. *Medical Journal of Australia* 2002; 17: 410-3.
- Sourander A, Turunen MM. Psychiatric hospital care among children and adolescents in Finland: a nationwide register study. *Soc Psychiatry Psychiatr Epidemiol* 1999; 34:105-10.
- Eapen V, Swadi H, Sabri S, Abou-Saleir M. Childhood behavioural disturbance in a community sample in Al-Ain, United Arab Emirates. *East Mediterr Health J* 2001;7:428-34.
- Wacharasindhu A, Panyayong B. Psychiatric disorders in Thai school-aged children. *J Med Assoc Thai* 2002; 85 Suppl 1: S125-36.
- Banerjee T. Psychiatric morbidity among rural primary school children in West Bengal. *Indian Journal of Psychiatry* 1997; 39: 130-5.
- Malhotra S, Kohli A, Arun P. Prevalence of psychiatric disorders in school children in Chandigarh, India. *Indian J Med Res* 2002;116:21-8.
- World Health Organization. International classification of diseases and related health problems. 10th revision. New Delhi: Oxford University Press, 1992: 1-178.
- Bhalla M, Bhalla JN, Mahendru RK, Singh KB, Singh JB, Srivastava JR. Psychiatric disorders among children attending pediatric OPD. *Indian Pediatrics* 1986; 23: 623-6.
- Elberling H, Skovgaard AM. Children aged 0-3 years referred to child psychiatric department. A descriptive epidemiological study. *Ugeskr Laeger* 2002;164: 5658-61.
- Pokharel A, Ojha SP, Koirala NR, Regmi SK, Pradhan SN, Sharma VD, et al. A profile of children and adolescents referred by paediatricians to the child guidance clinic of Tribhuban University teaching hospital. *Nepalese Journal of Psychiatry* 2001; 2:116-22.
- Shrestha DM. Neuropsychiatric problems in children attending a general psychiatric clinic in Nepal. *Nepal Pediatric Society Journal* 1986; 5: 97-101.
- Emerson E. Prevalence of psychiatric disorders in children and adolescents with and without intellectual disability. *J Intellect Disabil Res* 2003; 47:51-8.
- Regmi SK, Nepal MK, Khalid A, Sinha UK, Kiljunen R, Pokharel A, Sharma SC. A study of children and adolescents attending the child guidance clinic of a general hospital. *Nepalese Journal of Psychiatry* 2000; 1: 90-7.
- Paterson R, Bauer P, McDonald CA, McDermott B. A profile of children and adolescents in a psychiatric unit. Multidomain impairment and research implications. *Australian and New Zealand Journal of Psychiatry* 1997; 31: 682-90.
- Ho TP, Luk C. Comparison of child psychiatric patients in hospital and community clinics in Hong Kong. *General Hospital Psychiatry* 1997; 19: 362-9.
- DeBar LL, Lynch F, Powell J, Gale J. Use of psychotropic agents in preschool children: associated symptoms, diagnoses, and health care services in a health maintenance organization. *Arch Pediatr Adolesc Med* 2003;157:150-7.
- Panyayong B, Wacharasindhu A. Psychiatric disorders in Thai school-aged children: II. Associated factors. *Journal of Medical Association of Thailand* 2002;85 Suppl 1:137S-47S.