Psyciatric 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.

MJAFI 2007; 63 : 144-146

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

<table>
<thead>
<tr>
<th>Age group (in years)</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3</td>
<td>17</td>
<td>6</td>
<td>23</td>
</tr>
<tr>
<td>3-6</td>
<td>30</td>
<td>18</td>
<td>48</td>
</tr>
<tr>
<td>6-9</td>
<td>38</td>
<td>14</td>
<td>52</td>
</tr>
<tr>
<td>9-12</td>
<td>31</td>
<td>20</td>
<td>51</td>
</tr>
<tr>
<td>12-15</td>
<td>22</td>
<td>17</td>
<td>39</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>75</td>
<td>213</td>
</tr>
</tbody>
</table>

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
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

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,
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