

## *Child Psychiatric Disorders in Ibadan*

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### Summary

**Olatawura, M. O. and Odejide, A. O. (1976).** *Nigerian Journal of Paediatrics*, 3 (1), 9. **Child Psychiatric Disorders in Ibadan.** In a 30-month period, 132 children (70 girls and 62 boys) aged 2 to 15 years were evaluated for various neuro-psychiatric disorders. More than 50 per cent of the children had evidence of brain damage, while 19 per cent had either neurotic or antisocial behaviour disorders. Brain damage was a result of intracranial infections or febrile convulsions, while neurotic and antisocial behaviour disorders followed emotional and material deprivation of the children. There was a high incidence of default in clinic attendance by the patients. This may be attributed to the failure of immediate positive response to therapy as well as non-availability of supporting services. There is therefore, an urgent need in Nigeria for improved health and other supporting social services (special schools, remedial teachers, remand homes, approved schools, mental deficiency institutions and hospital facilities) for these patients and their parents.

ONE important use of the epidemiological method of inquiry in medical practice is to facilitate a meaningful approach to improvements in the health services of the community. Hospital statistics do not give a reliable picture of the prevalence or incidence of any particular health problem in a community. In many developing parts of the world, the use of the available health services by the community often gives a rough idea of the health problems in the particular area (Dormaar, Giel, and van Luijk, 1974). The aim of the present review was to examine the pattern of child psychiatric illnesses at the University College Hospital, (UCH) Ibadan.

### Materials and Methods

The department of Psychiatry operates a separate patients' notes system in addition to the general hospital records. These psychiatric case-notes are kept in the department. Apart from this, a special register for children seen in the department has been kept since 1971, when a separate psychiatric service for children was started. All the case notes of children aged 15 years and below seen from March 1971 till October 1974 were analysed. Information abstracted from these case-notes included age, sex, source of referral, informant, presenting symptoms, diagnosis, management and outcome.

### Results

#### *Sex and Age at referral*

There were 70 girls and 62 boys. The ages of the 132 children when first interviewed are shown in Table 1. The ages ranged from two years to 15 years. It will be seen that 86 (65 per cent) of the patients were in the age group,

TABLE 1

*Age referral of 132 children with psychiatric disorders*

<i>Age (Years)</i>	<i>No. of children</i>	<i>Per cent of Total</i>
Below 5	13	9.9
5-8	33	25.0
9-12	34	25.7
13-15	52	39.4
Total	132	100.0

nine to 15 years. A large number of brain-damaged children with educational difficulties and cases of childhood psychosis were in this age group.

#### *Source of Referral*

In countries where a comprehensive child psychiatric service exists, children with behaviour disorders, may be referred to the psychiatrist from an educational guidance clinic if there is evidence of underachievement at school due to emotional problems. A child may also be referred to the psychiatrist by the family doctor because of behavioural problems. In the present series the source of referral included various departments in the UCH (39 cases); parents and relatives (53 cases); private medical clinics (17 cases); school headmasters (8 cases); other hospitals (14 cases); and a child from the school for the deaf and dumb. Direct referral by headmasters was a result of an earlier circular from the State's Ministry of Education to all hospitals and schools in the State informing them of the child psychiatric services available at the UCH.

#### *Diagnosis*

The diagnostic classification (Table II) used in the present study was based on a modified scheme proposed by Rutter (1965). The diagnoses were:

- (a) 65 cases (49.3 per cent) of brain damage (mental retardation, hyperkinesis, speech difficulties, epileptic fits, reading and writing difficulty, autistic behaviour, abnormal EEG);
- (b) 21 cases (15.9 per cent) of childhood psychosis;
- (c) 14 cases (10.6 per cent) of conduct disorders (aggressive behaviour, stealing, lying, truancy, sexual acting-out and generally difficult behaviour or failure to conform);
- (d) 13 cases (9.9 per cent) of developmental lag (life-long enuresis, speech disorder);
- (e) 11 cases (8.3 per cent) of neurotic behaviour disorders (enuresis, encopresis, fears, pica, over-submissiveness, nervous mannerisms);
- (f) six cases (4.5 per cent) of adult type of neurosis (anxiety state, hysteria);
- (g) two cases (1.5 per cent) of adult type of depression.

TABLE II

*Diagnostic classification of 132 children with psychiatric disorders*

<i>Diagnosis</i>	<i>No. of cases</i>	<i>Per cent of Total</i>
Brain damage	65	49.3
Childhood psychosis	21	15.9
Conduct (antisocial) behaviour disorder	14	10.6
Developmental lag	13	9.9
Neurotic behaviour disorder	11	8.3
Neurosis (adult type)	6	4.5
Depression	2	1.5
Total	132	100.0

Of the 65 children with brain damage (37 boys and 28 girls) nine were below the age of five years, 22 were aged five to eight years, 26 were aged nine to 12 years and eight were aged 13 to 15 years. Nineteen of the 65 children were referred by colleagues in the departments of paediatrics and surgery and 23 were referred directly to the department from other sources. Analysis of the causes of brain damage in this group revealed that infections of the central nervous system and febrile convulsions were the leading causes. The 21 children (15.9 per cent) with childhood psychosis were in the age group, nine to 15 years. There was also a high incidence of febrile illness prior to the onset of psychotic symptoms. Of the 11 cases (8.3 per cent) of neurotic behaviour disorders, there was a 10-year old boy with a history of pica and another with encopresis. In this particular patient with encopresis the symptom was part of a neurotic response to stressful life situation.

#### *Educational record of the brain-damaged children*

The most important aspect of the problems of brain-damaged children is education. Usually this group of children are unable to cope with their studies when they are in the same class with normal children either because of limited intelligence or short attention-span. Of the 65 children in this group, 27 were not attending school either because they were not accepted by the schools, or were withdrawn from the schools by their parents because of persistent poor performance. Most of the remaining 38 children attending schools were either epileptics or children with hyperkinesia whose conditions were satisfactorily controlled with drugs.

#### *Management*

The 29 children with childhood psychosis and adult type of psychiatric disorders were managed as in adults. The various forms of management of the remaining 103 children are shown in Table III. In Tables III, IV and V, children with neurotic and conduct beha-

viour disorders are considered as a group because the programme of treatment for these two subgroups is similar. Children categorized under developmental lag are different nosologically because their disorders result from delay in maturation of the central nervous system and are given different treatment regimen. Epanutin, Tegretol and Phenobarbitone were the drugs used for the control of seizures; Dextro-amphetamine, Melleril and Valium were used for the control of hyperkinesia. The group of children who received no treatment consisted of

- (a) those who failed to return to the clinic after routine investigations (skull x-ray, EEG, etc.) had been carried out and
- (b) the under-fives with either speech defect or bed-wetting.

These symptoms were thought to be due to some delay in the maturation of central nervous system; the parents were simply reassured and asked to revisit the clinic for reassessment after six months to a year.

#### *Clinic attendances*

The number of clinic attendances by the different groups is shown in Table IV. The intervals between visits ranged from a week to two months. Twenty-nine (28 per cent) of the 103 patients attended only once and subsequently defaulted. An additional 49 (48 per cent) of the patients attended two to five times before defaulting, and only 16 (15 per cent) attended the clinic for up to 10 times. It will be seen therefore that 94 (91 per cent) out of the 103 patients never attended for up to 10 times. Thus there was a high default rate among the patients in this series.

#### *Outcome of Management*

A global rating of improvement (Table V) using the case-note records and the authors' personal knowledge of the patients was adopted. Of the 65 brain-damaged children 12 (18.4

TABLE III

*Forms of Management of 103 Children with Psychiatric disorders*

<i>Management</i>	<i>Brain-damage</i>	<i>Neurotic and Conduct Behaviour disorder</i>	<i>Developmental lag</i>
Chemotherapy alone	46	8	6
Psychotherapy alone	3	9	1
Chemotherapy† Psychotherapy	3	6	3
No treatment:	13	2	3

TABLE IV

*No. of Clinic attendances by 103 Children with Psychiatric disorders*

<i>No. of attendances</i>	<i>Brain-damage</i>	<i>Neurotic and Conduct Behaviour disorder</i>	<i>Developmental lag</i>	<i>Total No. of patients</i>
Once	13	9	7	29 (28%)
2- 5	31	13	5	49 (48%)
6-10	13	3	-	16 (15%)
11-15	4	-	1	5 (5%)
16 and above	4	-	-	4 (4%)
Total	65	25	13	103 (100%)

TABLE V

*Outcome of treating 103 Children with Psychiatric disorders*

<i>Outcome</i>	<i>Brain-damaged group</i>	<i>Neurotic and Conduct Behaviour disorder</i>	<i>Developmental lag</i>	<i>Total No. of patients</i>
No improvement	12	1	-	13
Moderate improvement	21	7	3	31
Significant improve- ment	4	2	3	9
Status unknown	28	15	7	50
Total	65	25	13	103

per cent) showed no improvement; 21 (32.3 per cent) showed moderate improvement; four (6.2 per cent) showed marked improvement, while in 28 (43.1 per cent) of the children, the clinical status was unknown. Of the 25 children with behaviour disorders, one (4 per

cent) showed no improvement; seven (28 per cent) showed moderate improvement, two (8 per cent) showed marked improvement while the clinical status of 15 (60 per cent) of the children was unknown. Of the 13 children thought to have a delay in the maturation of the central nervous system, three (23.1 per cent) showed moderate improvement, three (23.1 per cent) showed marked improvement and the clinical status of seven (53.8 per cent) of the children was unknown. A high default rate among the 103 children accounted for the strikingly large number of children (48.5 per cent) whose outcome was unknown.

### Discussion

The present review of 132 Nigerian children, aged 2 to 15 years, attending the child psychiatric clinic at the University College Hospital over a period of 30 months, has shown clearly that childhood psychiatric disorders are not uncommon in our society. It must be noted that because of:

- (a) selection factors
- (b) the fact that this child psychiatric service is new and is therefore not widely known to the public, the number of patients seems small in the period of the study.

A significant proportion (49 per cent) of the patients in this study were those with brain damage due mainly to post-natal brain injury, particularly infections. This over-representation of brain-damaged children in this series is similar to the findings of Minde (1974) in Uganda where 55 per cent of his series were brain-damaged. Izuora (1972) has reported that 75 per cent of his young clinic attenders has a neurological component to their psychological disorders. The educational record of this group of patients showed that existing facilities for the proper education of these children were grossly inadequate. Asuni (1970), in highlighting the problems of child guidance

in Nigeria made a similar observation. There is therefore an urgent need for provision of the necessary facilities (special schools with trained personnel, special teachers, etc.) for the proper education of these children. A reduction of the number of these brain-damaged children can only be achieved through improved maternal and child health services.

In this series, 10.6 per cent and 8.3 per cent of the children attended the clinic for anti-social and neurotic behaviour disorders respectively. Although only a few of these children were assessed psychometrically, it was difficult to assess the contribution which low intellectual endowment made towards the group classified as suffering from neurotic and antisocial behaviour disorders. The causes identified in this group included separation, divorce, death of one or both parents, leading largely to maternal and emotional deprivation of the children. Thirteen (9.9 per cent) of the series presented with neurosis and various types of speech difficulties. The results of investigations including family background suggest that the main problem was a delay in maturation of the CNS.

One aspect of the family-clinic interactions is shown in the form of the number of clinic attendances. The high default rate in the present study is in keeping with the well-known phenomenon that if a patient's expectations (in this case parents') of the role which the initial contact should assume go unfulfilled, there will be great difficulty in establishing a working relationship and continuing in therapy (Chance, 1959; Heine and Trosman, 1960; Lennard and Bernstein, 1960). Many parents were quite unprepared for prolonged psychotherapeutic measures and would rather have magical cure with chemotherapy. Some of the well-to-do in this series considered taking their children abroad for treatment. These parents were usually advised against such action since the children might regard this as rejection. The group of brain-damaged children included cases with hyperkinesis, specific reading and writing difficulties, speech difficulties,

deafness and mutism. The needs of these children could only have been met if the services of speech therapists, educational psychologists, remedial educationists, etc., were available. The present findings make the case for a comprehensive psychiatric services for children very strong. This is particularly important in view of the planned universal primary education in the country.

Some of the peculiarities among children in the present series deserve further comments. Compared with paediatric psychiatry patients in the western world, the present series contained a higher proportion of girls, while elsewhere the ratio of male to female is 3:2; the incidence of organic brain damage among the children was also high, and clinic attendances for follow-up care were poor. These differences may be partly due to the nature of available child psychiatric services in developing countries. For example, the set up in Makerere University, Uganda was initially for retarded and organically handicapped children (Minde, 1974). In Nigeria, children who were previously in the care of paediatricians, neurologists or neurosurgeons and who develop behaviour disorders are usually passed on to the psychiatrist. The sources of referral of the present series and Izuora's (1972) series testify to this. Most of the psychotic children in the present series had a previous history of fever suggestive of some form of encephalitis and in many respects similar to the history obtained from cases of acute psychosis in adult patients. The outcome was generally favourable. The few cases with autistic features had histories strongly suggestive of previous brain insult. They were not different from those reported from other places.

Although the mental health of the parents of emotionally disturbed children in this study was not specifically examined, it was clear however that in many cases there was striking concern and unhappiness among parents. This may be attributed in part to lack of immediate

response to the therapy as well as to non-availability of supporting services for the parents. Despite the well-known advantages of the extended family system in the Nigerian society, it is sometimes beneficial to the family for a child who is beyond parental control to be placed under institutional care. Judging by the pressure from parents on available social services to have their deviant children accepted for "training" in these institutions, the stigma attached to them in other countries would appear to be less (Oloruntimehin 1970). Unfortunately, in Nigeria today the few approved schools, remand homes, schools for the deaf and dumb, mental deficiency institutions are hopelessly inadequate. Indeed, these institutions are non-existent in many parts of the country. These deficiencies in psychiatric services for children require urgent attention.

#### Acknowledgement

We are grateful to Mr Wole Ojo for his secretarial assistance.

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