

Pattern of Childhood Psychiatric Disorders in Port Harcourt, Niger-Delta Region of Nigeria (January 1999 - December 2002)

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ABSTRACT

Background: Psychiatric disorders in children are uncommon but remain a great source of anxiety to parents. In view of the paucity of such studies in Eastern Nigeria, this study has become imperative.

Method: All children seen in the psychiatric out patient clinics, psychiatric wards and other departments were studied. Diagnosis was made with criteria of the Diagnostic and Statistical Manual (DSM) IV of 1994.

Results: Out of a total number of 1,645 psychiatric cases seen, 411 were children representing 25%; of these 411 cases, 235 were females (57.2%) and 176 were males (42.8%). Depressive illness constituted 35%, anxiety disorders 30%, drug related disorders 17%, conduct disorders 9%, and others 9%. Gender differences were noted in all the conditions listed above except for enuresis, mental retardation, epileptiform psychosis and schizophrenia.

Conclusion: Government Health Policy to protect the mental health of our children so as to guarantee their full mental development should be developed and implemented.

KEYWORDS: Pattern; Psychiatric disorders; Childhood; Port Harcourt; Niger Delta.

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INTRODUCTION

Psychiatric disorders in children are uncommon but remain a great source of anxiety to parents¹. These anxieties are worsened by the thought of consulting a neuropsychiatrist especially in our cultural setting where it connotes "madness". Unfortunately, childhood psychiatric disorders have continued to deprive these children their rights to qualitative life².

This study attempts to show the prevalence of these conditions, within an area of the Niger-Delta region of Nigeria where there is a paucity of similar studies.

SUBJECTS AND METHOD

All subjects of ages 0-14 years seen at the psychiatric out patient clinics and casualty departments between January 1999 and December 2002 were studied.

Full case histories were taken and details of mental and physical examinations were routinely performed by one of the author (PCS) on every patient within 24 hours of arrival at the hospital.

Socio-demographic and clinic data were recorded in a specially designed data collection sheet. The classification of psychiatric disorders was based on the DSM (IV)¹ as well as clinical judgment of the authors for diagnosis.

Data analysis was performed using frequency tables, chi-square and t-test at the 5% level of significance.

RESULTS

The total number of psychiatric cases seen was 1645. The cases aged 0-14 years were 411. Out of these, 176 (42.8%) were males and 235 (57.2%) were females. The youngest age was 3.3 years (male) and the oldest was 14.4 years (female).

The relationship of subjects to those who brought them to the hospital were as follows; both parents 38 (9.2%), father alone 74 (18.0%), mother alone 158 (38.4%), relatives 77 (18.75%), friends and teachers 65 (15.8%). Those managed on out-patient basis were 238 (57.9%) and in-patients were 173 (42.1%).

The distribution of patients according to age and sex is shown in Table I.

The prevalence of children's psychiatric disorders based on DSM IV and the clinical judgment of the authors is shown below in Table II.

Children with conduct and autistic disorders, schizophrenia, mental retardation, hyper-kinetic syndrome and drug related disorders were likely to have started school

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and more likely to drop out of school than those with depression, school phobia, functional enuresis and manic illness ($P < 0.05$). Table III shows the educational status and age distribution. The outcome of the promotional examinations, outcome of admissions and reasons for dropping out of school were as shown in Tables IV, V and VI respectively.

Table I. Distribution of subjects according to age and sex

Ages	Males		Females	
	No.	(%)	No.	(%)
0-4	34	(19.3)	42	(17.8)
5-9	53	(30.1)	65	(27.7)
10-14	89	(50.6)	128	(54.5)
Total	176	(100)	235	(100.0)

Table II. Prevalence of Children's Psychiatric Disorders in Port Harcourt, Nigeria

	No	%	M	F	P. Value	Mean Age
Mild to Moderate Depression	110	6.6	30	80	<0.05	11.5
Severe Depression with Psychotic Disorder	8	0.5			<0.05	11.5
Schizophrenia	4	0.2	3	1	>0.05	13.1
Manic illness	2	0.1	2	0	>0.05	12.8
Functional Enuresis	27	1.6	11	16	>0.05	8.5
Mentally Retarded	29	1.7	21	8	>0.05	9
Autistic Disorder	4	0.2	3	1	<0.05	5.4
Hyperactivity Syndrome	5	0.3	4	1	<0.05	6.3
Conduct disorders	37	2.2	26	11	<0.05	9.6
School phobia	19	1.1	3	16	>0.05	5.8
Separation Anxiety	20	1.2	3	17	<0.05	5.2
Drug induced psychiatric disorders (Alcohol, cannabis)	68	4	48	20	<0.05	10
Insect/animal phobia	7	0.5	0	7	<0.05	5.3
Generalized Anxiety Disorder	62	3.5	16	46	<0.05	13.6
Organic psychosis	9	0.5	4	5	>0.05	10.5

N= 1645 N= 411

Table III. Educational Status and Age Distribution

Age (Years)	0-4	5-9	10-14
Never been to school	31	36	15
Dropped out	7	28	36
Kindergarten	39	15	-
Class 1-3	-	21	-
Class 4-6	-	8	59
Class 7-9	-	10	74
Class 10-12	-	0	35
	76	118	217

Table IV. Outcome of Promotional Examinations

	Age (yrs) N=30		Yrs N=43		Yrs N=134	
	0-4	%	5-9	%	10-14	%
Passed	18	60	33	71	71	53.0
Failed	12	40	10	29	63	47.0

Table V. Out Come of Admissions

Psychiatric disorders	No.	Mean period of admission in days	Absconded or signed against medical advice	Discharge home well	Died
Mild to Moderate Depression	85	10	5	70	-
Schizophrenia	4	18	Nil	7	-
Manic illness	2	9	-	2	-
Organic psychosis (infective)	3	21.2	Nil	3	-
Epileptiform psychosis	5	16.2	2	3	-
Drug related Psychological disorders	42	19.7	5	34	-
Autistic disorder	13	14.4	7	12	-
Hyper Kinetic Syndrome	13	7	-	13	-
Total	173	94.3	19 (11%)	154(89%)	0

Table VI. Reason for Dropping Out of School

Reasons	N=71
Voluntary withdrawal due to persistent difficult with learning	15
Truancy.	15
Recurrent stealing from other students	21
Regular fighting with dangerous weapons in and out of school	7
Voluntary withdrawal due to financial constraints	6
Expulsion due to persistent disobedience to school regulations	11
	71

DISCUSSION

The present study shows the overall prevalence of psychiatric illness among children to be 25%. The non-psychotic depressive illness was the most prevalent psychiatric disorder (6.6%) among the children seen. This was followed in decreasing order by anxiety disorder (6.3%), drug induced disorders (4%), conduct disorders (2.2%), mental retardation (1.7%), and functional enuresis (1.6%), severe depression (0.5%), attention deficit hyperactivity syndrome (0.3%), mania and schizophrenia 0.2% and 0.1% respectively.

The high prevalence of depressive illness agrees with the finding that depressive illness was not rare among Africans³⁻⁵, might even begin in the teenage period⁶ and commoner among females⁷.

The prevalence rates of 0.25%, 0.4%, 2.5%, 5% and 6% reported previously for autistic disorder, attention deficit, hyperactivity syndrome, conduct disorders, functional

enuresis and mental retardation⁸⁻¹⁴ respectively are higher than the rates found in this study. This may be due to socio cultural and racial differences. Furthermore, it may equally be due to under reportage of such cases in our environment, since most of them would prefer the services of spiritual healers and herbalists, while frantically avoiding psychiatrists. However, the parents of these helpless children may eventually present them to the psychiatrists as the last hope for assistance.

The sex differences reported in this study agrees with the previous studies⁸⁻¹⁴ showing a male preponderance among children with autistic, hyperactivity and conduct disorders. There was no significant sex difference between enuretic and mentally retarded children. Psychotic illness is less common among children^{9,10}. These reports are in agreement with the finding from the present study where schizophrenia, mania and severe depression with psychotic illness, were the least prevalent^{9,10,14}.

Acute and catatonic schizophrenia had been reported to begin at a relatively young age¹¹ with the disorganized type, which is less common¹². The present study which showed that three out of the four schizophrenics (75%) had acute and catatonic type, while the remaining one (25%) had a disorganized type agrees with the previous reports¹².

The cosmopolitan status of Port Harcourt, Nigeria with its attendant high oil and industrial related activities creates enormous stress for the inhabitants due to heavy human and vehicular congestion. The fact that most of these children wakeup before 6.00 hours every school day so as to get to school on time is a stressful activity. Worse still, some get to school quite late due to traffic holdups. Oftentimes, both parents are engaged in jobs, which keep them away from home every morning till late in the evening. As a result children who may have left their various homes before 7.00 hours return late in the evening. By this time they are usually physically and mentally exhausted.

The presence of these enduring stressors could lead to various psychiatric disorders such as depression, anxiety disorders, conduct disorders and psychotic illness¹⁵. This agrees with the finding of this study. However it disagrees with previous findings on the order of prevalence⁸. In a study amongst the Caucasian population, conduct disorder was the most prevalent (2.5%) followed by anxiety disorders⁸ which was the fourth most prevalent in our study. Most of the children with conduct disorders seen in this study obviously dropped out of school largely due to inability to obey simple school regulations, poor academic performance, difficulty to cope, habitual lateness to school, truancy, disobedience to their teachers and often engage others in fight, (both in and out of schools) and forcefully took away their colleagues belongings. The findings in this study agree with previous reports^{8, 16}.

Lack of concentration and attention are notable features among children with conduct and autistic disorders, depression and mental retardation. This could explain the poor academic performance and frequency in school dropouts constituting 40% and 20% respectively among our study population.

Furthermore, environmental stressors like, disturbed sleep, and substance abuse may have inevitably contributed to the poor school performance and the frequency of dropouts. Seventy percent of the children were brought in by either one or both parents and the other 30% by other relatives, friends or their class teachers. This agrees with other reports^{1,2}, because often, close family members observe any behavioural changes first among the children. Sometimes, anxious and over solicitous parents and teachers often bring healthy children to the psychiatrist¹⁷.

In our study all of the children seen had at least one psychological problem, unlike the previous study¹⁸. This could be due to the fact that orthodox attention is usually sought last in psychiatric disorders in our environment. Sometimes, anxious and over solicitous parents and teachers often bring healthy children to the psychiatrist. No mortality was recorded during the period of the study. It is similar to a previous study which reported very low mortality among Caucasian children with psychiatric disorders¹⁸.

While suicide cases among other few deaths were recorded in that study, neither suicide nor an attempt was recorded in this present study. This agrees with a community survey in Jos, Northern Nigeria¹⁹ and a study in Europe where it was reported that suicide was rare before the age of 12 years²⁰. Most of the socio-cultural values of most African communities abhor suicides or an attempt to carry it out. It is seen as a taboo; an act that defiles the land. Hence, a family whose member attempts and or commits suicide is usually ostracized¹⁹. This punitive measure certainly serves as a deterrent and may lead to concealment of an attempt or completed suicide even when it occurs.

Twenty-four percent of the total number studied had drug related (mainly alcohol and cannabis) psychiatric disorders. It could be argued therefore that children do in fact abuse cannabis and other drugs and that the habit is increasing among the youth⁶. However very few of these people find their way to the psychiatrist or are in such danger as to require psychiatric intervention. The higher proportion of substance abuse noted in the present study is similar to reports in Nigeria²¹ and

elsewhere^{22, 23}. This may be attributable to easy availability of these substances considering the rapid westernization apparent in Port Harcourt metropolis and its environs, due to oil exploration activities. Substance abuse and its related behavioural disturbance appear to be assuming an epidemic proportion in view of the findings of this present study.

CONCLUSION

This study has shown a high prevalence of childhood psychiatric disorders in the Niger-Delta region of Nigeria. It provides the useful insight that childhood psychiatric disorders are significant in Nigeria, and thus require appropriate treatment.

National Mental Health Policy should include attention to the prevention, treatment and rehabilitation of Childhood Psychiatric disorders. The National Drug Law Enforcement Agency (NDLEA), National Orientation Agency (NOA), Non Governmental and other Governmental Agencies must rise in unison to fight this hydra-headed monster ravaging the stock of our tomorrow's hope.

The need for an integrated mental health programme for children should be considered a priority. Inter-disciplinary collaboration is hereby strongly advocated.

REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical manual of mental disorders. 4th edition. American Psychiatric Association Washington, D. C. 1994.
2. Graham P. Child Psychiatry: a developmental approach. Oxford: Oxford University Press, 1986; 12-15.
3. Field M J. Mental Disorders in Rural Ghana. *J Ment Sci* 1958; 104: 1043-57.
4. Olatawura M O. The problem of diagnosing depression in Africa. *Psychopath Africa* 1973; 9: 389-403.
5. Binitie AO. Psychiatric Disorders in rural practice in Bendel State of Nigeria. *Archives Psych Scand* 1981; 64(4):273-280.
6. Turkson S N A. Psychiatric Disorder among Adolescents Attending outpatient clinic in Accra, Ghana: A seven-year Review study (1987-1994). *West African Journal of Medicine* 1996; 15(1):31-34.
7. Brown GW, Harris TO. Social origins of depression. 4th Edition. London: Tavistock, 1978; 36-40.
8. Rutter M, Graham P, Birch H G. A neuropsychiatric study of childhood. *Clinics in Development Medicine* No. 35/36 Heinemann, London 1970a.
9. Tanguay P E, Cantor S L. Schizophrenia in children. *Journal of the American Academy of Child psychiatry* 1986; 23:591-94.
10. Ryan N D, Puig-Antich J. Affective illness in adolescence. In: France AJ, Hales RE (eds). *American Psychiatric Association Annual Review* 5. Washington DC: American Psychiatric Association, 1986.
11. Stromgen E. Subclassification of schizophrenia. In: Wing J K, Wing L (eds). *Handbook of Psychiatry* 3, 3rd edition. Cambridge University Press, 1982.
12. Hecker E. Die Hebefrenie. *Virchows Archiv Fur Pathologie and Anatomie* 1871; 52: 394-429. (See *American Journal of Psychiatry* 142:1265-71).
13. Kanner L. Autistic disturbance of affective contact. *Nervous child* 1980; 2:217-50.
14. Krauthammer C, Klerman G L. The epidemiology of mania. In: Shopsin B (ed). *Manic illness*. New York: Raven Press, 1979; 11-28.
15. Brown G W, Birley J L T. Crisis and life change at the onset of schizophrenia. *Journal of Health and Social Behaviour* 1968; 9: 203-24.
16. Power D J, Benn R T, Homes J N. Neighbourhood, school and juveniles before courts. *British Journal of Criminology* 1972; 12: 111-32.
17. Hersov L, Ruther M. *Child Psychiatry: Modern approaches*. 2nd edn. Oxford: Blackwell, 1985; 111-18.
18. Sim A C P. Hypothesis linking neuroses with premature mortality. *Psychological Medicine* 1978; 8: 255-63.
19. Stanley P C, Odejide A O. Socio-Demographic and Forensic characteristics of Alcohol Abusers in Jos, Nigeria. *Nigerian Journal of Medicine* 2002; 11(3): 113-117.
20. Shaffer D. Suicide in childhood and early adolescence. *Journal of child psychology and psychiatry* 1974; 15: 275-91.
21. Adelekan M L, Ndom R J E. Trends in prevalence and pattern of substance use among secondary school pupils in Ilorin, Nigeria. *West Afri J Med* 1997; 16:157-164.
22. Healey K. Bolivia and Cocain: a developing country dilemmas. *Br J Addict* 1988; 93:179-189.
23. Queipo D, Avarez F J, Velasco A. Drug consumption among university students in Spain. *Brit J Addict* 1988; 93:91-98.