

PSYCHIATRIC MORBIDITY OF OUTPATIENT CHILDREN IN INSTITUTE OF MENTAL HEALTH AND RESEARCH

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Summary :

The study was performed to find out the pattern of psychiatric morbidity among all the children patients who have attended outpatients department of Institute of Mental Health and Research, Dhaka in the calendar year, 1990. Sociodemographic information revealed that mean age of the cases was 7.5 years and more than a half of the total number of patients fell into 5-9 years of age group. About 66% cases came from urban background. Most of the cases were found in poor economic group and 62.5% cases of school attendance was reported. By using ICD-9 criteria in assessment of psychiatric conditions, childhood emotional disorder was the largest group with 32.5% followed by conduct disorder comprised 18.76%, mental retardation comprised 16.25%, psychoses and allied conditions comprised 11.25%, epilepsy with behavioural problems comprised 12.5% and rest comprised of others group of disorders. The findings of the study indicates the necessity of the development of child psychiatric services in the country.

Key word : Psychiatric morbidity, Children

Introduction :

A considerable number of children suffering from psychiatric problems attend psychiatric departments of different hospitals in our country. Several studies have been carried out in developed countries regarding prevalence of psychiatric problems in children and suggest that 5-10% of children have disorder of sufficient severity to handicap considerably in everyday life¹. In an earlier study among 3 years old children in Outer London Borough reported that 21% of preschool children had significant behavioural or emotional problem and about 7% had a disorder of moderate or severe intensity².

In the prominent Isle of Wight survey, the prevalence of 6.8% was found within the total population of 10-11 year olds². Similar survey in Inner London Borough among 10 year olds prevalence of 14% has reported and that was reported 19.4% in Newcastle study².

There are few data from community based epidemiological studies compared with developed countries. However, sufficient evidence does exist to demonstrate significant morbidity from child psychiatric disorders. Surveys in Ethiopia, Sudan and India reported prevalence rates ranging from 3-11% for children and adolescents^{1,3}. A four-country study done in primary health care settings in Sudan, Colombia, India and Philippines by World Health Organization (WHO) gave a prevalence rate which varied from 10-29% for child psychiatric disorder⁴. Controlled studies of school children

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in urban areas of Beijing has demonstrated that the rate of behaviour problems in primary school was 8.3%⁵. These studies show that the rate of psychiatric morbidity among children approximately very closely to rates of disturbances reported from studies in developed countries. Though similar type of survey of psychiatric morbidity among children has not been attempted in Bangladesh yet from this point of view we can assume that the figure would be somewhat similar in our country.

The aim of this study was to find out the pattern of psychiatric morbidity amongst children patients who had attended outpatients department in the year 1990, at the Institute of Mental Health and Research, Dhaka. This study might give some idea about the nature and extent of the child psychiatric problem in our country which will help in planning and development of child psychiatric services in Bangladesh.

Materials and Methods :

The study was carried out in the Institute of Mental Health and Research which was situated in Sir Salimullah Medical College Mitford hospital, Dhaka, during the period of study. All the children patients with psychiatric disorder attending outpatients department of the Institute for the first time from January to December, 1990 were included in the study. A pretested psychiatric history taking proforma was designed for the purpose of the study which consisted of sociodemographic information, psychiatric history and mental state examination. Each case was interviewed by outpatient medical officer who had a good psychiatric background in supervision with one of the investigators. Informations were also obtained from attendants of the patients. Psychiatric diagnosis was done on the basis of ICD-9 criteria of WHO⁶. Relevant informations were carefully recorded. The data so collected were processed and analysed.

Results :

A total of 80 children patients were interviewed. The distribution of patients according to their sociodemographic characteristics are shown in Table -I. Of the patients, 59 (73.75%) were boys

Table-I : Sociodemographic characteristics of the patients

Characterostics	Number (N=80)	%
Sex :		
Male	59	37.75
Female	21	26.25
M/F ratio=2.81:1		
Age :		
below 4	14	17.50
5-9	44	55.00
10-14	22	27.50
Mean age=7.5 (SD=3.22) years		
Social background :		
Rural	27	33.75
Urban	53	66.25
Economic background :		
Higher	3	3.75
Middle	44	55.00
Lower	33	41.25
School attendance :		
Not attending	30	37.50
Attending	50	62.50

and 21 (26.25%) were girls. The male to female ratio here was 281.1. There age ranged between 2 and 14 years with a mean of 7.5 (SD=3.32) Largest number of patients (55%) were in the age group of 5-9 years and next was the 10-14 years of age group with 27.5% of the total number of patients. The urban rural distribution of cases were 66.25% and 33.75% respectively. Most of the cases were found in either middle (55%) or

lower (41.25%) income group and majority of the patients (62.25%) were attending school.

During the study period, 80 children patients were found out of 928 psychiatric outpatients. Therefore, the childhood mental disorders comprised 8.62% of the total psychiatric condition attended at the outpatients department of the Institute. Table - II shows sex wise

Discussion :

This study was for one year period in the outpatients department of Institute of Mental Health and Research, Dhaka. Children psychiatric patients attendance for the first time were included in the study.

In the present study, it was found that 73.75%

Table-II : Sex wise distribution of types of childhood disorders

Types	Male		Female		Total	
	(N=59)	%	(N=21)	%	(N=80)	%
Emotional disorders	16	27.12	10	47.62	26	32.50
Infantile autism	4	6.78	2	9.52	6	7.50
Other psychosis	2	3.39	1	4.76	3	3.75
Conduct disorder	14	23.73	1	4.76	15	18.76
Hyperkinetic syndrome	3	5.08	0	0.00	3	1.75
Tic disorder	1	1.69	1	4.76	2	2.50
Specific delays in development	1	1.69	0	0.00	1	1.25
Mental retardation	11	18.64	2	9.52	13	16.25
Epilepsy with behavioural problem	6	10.17	4	19.05	10	12.50
Drug dependence	1	1.69	0	0.00	1	1.25

diagnostic distribution of the childhood disorders. Emotional disorder formed the largest group with 16 (27.12%) boys and 10 (47.62%) girls. It is observed that majority of patients with emotional disorders had either anxiety or hysteria. Conduct disorder was the second largest group with 14 (23.73%) boys and only 1 (4.76%) girl. Mental retardation were found 11 (18.64%) cases in boys and 2 (9.52%) cases in girls. Infantile autism was found 4 (6.78%) cases in boys and 2 (9.52%) cases in girls. Hyperkinetic syndrome was found only among the boys with 3 (3.75%) cases. Tic disorder was found only in 2 (2.5%) cases (one male and one female). The male case of tick disorder was rare Gilles de la Tourett's syndrome.

were male child and 26. 25% were female child. The male to female ratio here was 2.81:1 This is poor representation of sex distribution of the population of Bangladesh. According to 1991 population census, male to female ratio of the population was 106.1.⁷ Smaller number of female child in the sample may be due partly to the fact that they are less frequently brought for the treatment than their male counterpart and partly due to the excess of psychiatric morbidity among male child than female child. In Isle of Wight survey within 10 and 11 year old children, a general two fold excess of psychiatric morbidity among boys than girls was reported².

In the present series, 5-9 years of age group contributed more than a half of the total number

of patients. This might be due to the fact that in an early age, identification of psychiatric problems are frequently not possible and are markedly noticed when the frequency, nature and severity of the problems change with increasing of age. Moreover, there is a great lack of awareness about existence of childhood mental disorder among our people.

In our study, patients from urban area were 66.25% which was two-fold excess than from the rural area. This finding is somewhat unusual in comparison with urban/rural distribution of the population which is 19.5% and 80.5% respectively reported in 1991 population census⁷. Selective factors like widely applying definition of town, location of the hospital in the urban areas, economic factor, urban peoples better health consciousness, and better information about the mental health service may explain the preponderance of the urban patients.

About 62.5% school attendance was reported in our study which certainly indicates that same percentage of the patients in this study was literate. Moreover, before the age of 4 years children of our country usually do not attend the school. So the actual literacy rate of the children patients in our study would be about 75%. This figure is much higher than the report of 1991 population census where 24.9% of whole population was literate and the literacy rate of population 7-14 year was 32.4%⁷. Poor representation of illiterate group in our study was most likely to be due to ignorance, poor economic condition of the relatives of patients and prevailing social prejudice and superstition in this country and less opportunity to avail the hospital facilities.

The 80 cases of childhood disorders in the present study was 8.62% of the total psychiatric cases attended at outpatients department reported in the survey of outpatients department of the Mental Institute in the same year⁸. This indicates the growing awareness of the parents

about the existence of psychiatric problems among children in our country. In WHO collaborative study, rate of mental disorder among patients in primary health care setting in the four study areas of developing countries ranged from 10%-29% for children was reported⁴.

In the present series, childhood disorders identified included emotional disorders, developmental delays, psychosis, mental retardation and epilepsy with associated behaviour disturbance similar disorders were reported in various surveys in India and other developing countries^{1,3}. In our study, emotional disorders comprised largest group with 32.5% followed by conduct disorder with 18.75% of the cases. In the well known Isle of Wight study, the prevalence rate of conduct disorder was found twice than that of the emotional disorder². This may be due to ignorance of the parents to recognise the conduct disorder as illness. However, emotional and conduct disorder are two major group of psychiatric illness among children reported both in developed and developing countries^{1,2}.

In our study, mental retardation was found 16.25% of the cases. This reveals that considerable amount of mental retardation are existing in our country. Taking a prevalence rate of 3% of the population under 15 years (WHO estimate) there would be 14.37 lacs retarded children in Bangladesh. Specific delay in development was found only one (1.25%) case which was developmental dyslexia. Similar finding was reported in Indian clinics⁹. It might be the fact that developmental delay does not appear to worry our parents very much except where speech and education are concerned.

In the present series, psychoses or condition akin to psychoses were 11.25% of the cases. In a child psychiatric clinic in India, about 10% of inpatient adolescents were suffering from such conditions⁹. This contrasts strikingly with the UK

scene where adolescent psychosis is rare. The Isle of Wight survey included 2000 adolescents and only one was classified psychotic^{2,9}.

Conciusion :

The psychiatric morbidity among children in the present study was considerable. It is to be born in mind that majority of the cases of childhood disorders still do not come to the hospital for treatment. However, this significant proportion of attendance of child psychiatric patients was not perceived so long. This indicates the necessity of the development of child and adolescent psychiatric services in our country.

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LOBUS HYSTERICUS — AN OVERVIEW

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Introduction

Globus hystericus, Globus pharynges, Functional dysphagia, Globus syndrome are synonymous¹. It is a psychogenic disorder of alimentary tract extremely common, the cause is poorly understood, indeed may be relieved by swallowing food or drink, occurs in tense anxious individuals^{2,3}.

Natural History :

Persistent feeling or sensation of a lump in the throat, usually in mid line, localised just above the supra sternal notch around the level of cricoid cartilage, is the commonest complain, mainly occurs in anxious, middle aged, menopausal ladies^{3,4}. There is interference with swallowing but no true dysphagia for solid & liquid and the symptoms often noticeable in empty swallowing of saliva, are often diagnosed as globus if on examination nothing found⁵. The symptoms brought by or made worse by anxiety, have no other throat symptoms, no loss of weight, no hoarseness of voice, no sore throat⁶.

Diagnosis :

Globus is functional though cineradiography study may show abnormalities in rhythm of swallowing, Ba-swallow & Ba-meal & oesophagoscopy reveal

no abnormality⁷. The condition may be due to spasm of upper oesophageal sphincter. Many of the patients have reflux oesophagities. Oesophageal reflux due to abnormality in cardia may produce vague upper end symptoms, antacids reported to help if this is the case^{5,8,9}.

Globus hystericus should not be diagnosed until an organic lesion especially a malignancy has been excluded¹⁰, all other causes of dysphagia has to be excluded carefully. The patient often admits to psychological stress or cancer phobia¹¹. An attempt should be made to offer insight in the nature of the problem, a detail history, careful examination with x-ray if appropriate will help to reassure a certain number of patients. A history of friends or relatives with throat disease requires sympathetic probing¹².

One also has to remember that even most neurotic patient, however on rare occasions is found to have a serious disorder present^{1,4}. Recent bereavement is often relevant⁷. It is important to request psychiatric attention for those who need it. Serious underlying emotional disturbances requires expert psychiatric evaluation^{8,11}.

Early Carcinoma or Pharyngeal web must also be excluded. Pharyngeal Pouch may be preceded by a globus syndrome due to hypertonic cricopharyngeous³. Hiatus hernia is a common problem and measuring the pH in the oesophagus is helpful⁹.

Examination usually reveal no abnormality, the condition may be due to spasm of pharyngeal constrictor muscles, but some patients on examination reveals reflux oesophagities¹². Every

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one should have a Ba-swallow and oesophagoscopy if symptom persists. Study by oesophageal manometry may be performed². The diagnosis should never be made if the patient has difficulty in swallowing solid food, such a patient has Cancer until proved otherwise⁵.

Some cases are easy and safe to diagnose as globus if there is an obvious emotional precipitating cause. The difficult cases are those in which there is no obvious psychological cause⁷, great care must be taken not to miss an early carcinoma, in the latter group oesophagoscopy must be done in spite of a negative barium study⁸. This is a diagnosis by exclusion⁹.

Acid reflux or cricopharyngeal spasm does not appear to have significant relationship thus casting doubt, that "globus syndrome" due to reflux oesophagitis. It now appears that the old name of globus hystericus while semantically wrong was never, was nearer the truth⁹.

Globus syndrome versus hypopharyngeal tumour : Diagnosis of early cases presents difficulty, the patient complains of feeling of some thing in throat round the level of cricoid¹². Globus hystericus a differential diagnosis of pattersen - brown kelly syndrome, it can produce sore throat, similar local symptoms. Middle aged menopausal ladies may have hiatus hernia or they may have globus hystericus a condition in which they focus their problem - usually emotional ones on to their throats².

Now it is realized that there are many causes for this, other than psycho-somatic one, although this remain the commonest cause, the other causes whose are differential diagnosis are hiatus hernia with reflux, cervical osteo phytosis, pattersen brown kelly syndrome, thyroid swelling/nodule, pharyngeal pouch, post cricoid Carcinoma, early carcinoma or pharyngeal, cricopharyngeal spasm^{5,7,11}.

The diagnosis is based on history, examination, blood film, Ba-swallow and meal⁴. If the lower part

of the oesophagus is irritated because of reflux than the cricopharyngeous goes into spasm¹².

Management :

Globus is diagnosed much less now than formerly, because it has been realised that oesophagitis and reflex spasm of cricopharyngeous can mimic the symptoms⁶. In this cases antacids will help the globus symptoms. In the true globus cases reassurance that no organic disease or cancer present helps the patient to accommodate to the symptoms, which will usually be self limiting. Management is by reassurance, anxiolytics, psychotherapy and treatment of underlying cause viz psychogenic or organic^{1,4,7,11,12}.

Conclusion :

Globus is not uncommon in clinical practice in our country, it should be kept in mind in evaluating the patients of dysphagia.

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