THE PATTERN OF CHILD PSYCHIATRIC DISORDERS AS SEEN AT KENYATTA NATIONAL HOSPITAL

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D E C L A R A T I O N

This work is original and has not, to my knowledge, been submitted for a degree in any other University.

Date.....18.3.83..... Signed .....

DR. A.W. WAKUBE

This dissertation has been submitted for examination with my approval as a University Supervisor.

Date.....14/3/83..... Signed .....

DR. F. NJENGA

C O N T E N T S

SUMMARY

The study was undertaken to determine the pattern of psychiatric disorders in children attending the Kenyatta Nati Hospital Child Psychiatric Clinic. A total of seventy-one children were seen over a seven months period. The diagnosis each child was presented according to the multi - axial classification of Child psychiatric disorders in relation to Ninth Revision of the International Classification of Disease (I C D - 9), section five. The results revealed a female to ratio of 1:1.15, an age range of four years to fifteen years a duration of symptoms of less than one year among 58% of the children seen. The commonest symptom was fainting attacks. most frequent clinical psychiatric syndromes were neurotic di and conduct disorders which accounted for 47% and 21% of all diagnoses respectively. 18% of the children had evidence of developmental disorder while 30% were mentally retarded. 32% children had an associated medical condition the most frequen was epilepsy. Abnormal psychosocial factors were present in of the children.

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INTRODUCTION

Child psychiatry is a relatively young branch of psychiatry. In most developing countries, psychiatric services are almost entirely hospital - based and therefore only few children with psychiatric disturbances manage to seek and obtain psychiatric help. Studies of prevalence and incidence are quite difficult and often limited to hospital populations which are not representative of the true nature of the problem. In most cases, views on the pattern of child psychiatric disorders in these areas have tended to remain impressionistic (1).

In reviewing the state of child psychiatry in developing countries, Minde (2) noted that there were certain common features which had been reported by various workers in this field. For exampl there was a high percentage of children presenting with mental retardation and epilepsy, the figure ranging from 37% of all clinic patients reported by Rahim (3), to 55% reported by Minde (4). According to Minde (2), the majority of these children in developing countries presented with psychosomatic disorders, while only few children presented with behavioural disorders. Rahim studying 319 children in Port Sudan, Sudan found a high number of children with schizophrenic and neurotic disorders; none of the children had behavior disorders (3).

In East Africa, Minde (5) working in Uganda reported that 10% of the children studied had psychosomatic disorders, 9% had reactive behavioural disorders and only 4% had neurotic disorders. In Kenya, Sidandi and Acuda (6) in 1978 found 12% of adolescents in a rural secondary school to be mentally ill.

According to Minde (2) the majority of children brought to the clinics in developing countries were in the adolescent or pre-adolescent period, most of these children being above the age of 10 years. In East Africa Minde (4) reported the ages of children studied to be one year to eighteen years with a mean age of 10.7 years There is absence of information regarding the age incidence for psychiatric disorders in children in Kenya.

The classification of child psychiatric disorders has been until recently rather haphazard. However, since the development and adaption of the multi - axial classification of these disorders by the World Health Organisation (7,8), this is likely to become more uniform and therefore will allow for a proper comparison of patterns of psychiatric disorders in children of different areas of the world. The present study employs this classification.

While rotating through the department of Psychiatry, the author was struck by the scarcity of available information regarding psychiatric conditions in children in Kenya. Apart from one study (6) all other available publications are case reports. With the setting up of a child psychiatric clinic at the Kenyatta National Hospital in Mid - 1981, the author felt motivated and ancouraged to undertake the present study, despite the potential short - comings that were likely to be encountered in a newly set-up clinic.

Neither the prevalence nor the pattern of child psychiatric disorders in Kenya is known. Only a rough estimate of this problem in Kenya can be obtained using the Celdic Commission (1970) (9) which reported that 10 - 15% all children may require psychiatric help at one time or other. Taking Kenya's population to be 16 million and that of the children under 15 years to be 50% of the population (1979 census), there can be as many as 1.6 million children at risk of developing psychiatric disorders in Kenya. It would be helpful if the pattern of psychiatric disorders in such a population is known as this would facilitate the planning of services and development of appropriate methods of management and most important of all, how to prevent them. This study hopes to contribute towards this goal.

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AIMS AND OBJECTIVES

1. To classify the child psychiatric disorders seen in the child psychiatric clinic at Kenyatta National Hospital in accordance with the multi - axial scheme in relation to the Ninth Revision of the International Classification of Diseases (I C D - 9), section five.

2. To determine the commonest presenting symptoms, clinical psychiatric syndromes and associated psychosocial factors.

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MATERIAL AND METHODS

This study was undertaken at the Kenyatta National Hospital, Child Psychiatric Clinic, during the period of November, 1981 to May, 1982. This hospital is the national referal centre for the whole country. The study was limited to children aged up to fifteen years. Only new patients properly refered to the clinic were included into the study. Children who were not accompanied by a reliable adult informant were excluded out of the study. A reliable informant was either a parent or a gurdian who had been staying with the child since the onset of symptoms.

Children admitted to the study were subjected to the usual psychiatric history taking and examination by the author or one of the Paediatric Senior House Officers rotating through the clinic. The psychiatric formulation was then counterchecked by the child psychiatrist in charge of the clinic. The data was then recorded on a questionnaire by the author personally. The questionnaire (see appendix, back pages) was adapted from the Maudsley Hospital Children's Department questionnaire and was appropiately modified to suit the local conditions.

Investigations which needed to be done were found to be minimal and in most cases these were limited to EEG and skull xrays since many of these children had been refered from other clinics where they had undergone extensive investigations. Nineteen EEGS and twenty Skull Xrays were done. Several children required further examination at the Eye clinic for visual fields and acuity and few others required hearing tests (done at the ENT clinic).

The class position of the children seen during the study was recorded as a rough indicator of the intellectual level of the children. It was not possible to conduct formal psychological testing on each and every child as there was only one psychologist available. Only those cases which had been refered specifically for assessment of intellectual functioning or those children who had been refered for other reasons but appeared mentally retarded from history and examination of mental status were tested. Those children who were tested were tested by the clinical psychologist using mainly school orientated tests. Tests used included

tests of comprehension, general knowledge and number - work. Often two none - verbal tests, the Bender Gastalt test and the Raven's progressive coloured matrices were also administered (10). The Bender Gestalt test requires the subject to copy simple geometrical designs. It tests development of visual - motor co-ordination and is impaired in the presence of organic brain dysfuction. The Raven's test requires the subject to point to the correct design, that is reasoning by analogy. Both these tests are undergoing local standardisation (11). Due to lack of standardized tests, it was not possible to assign a formal intelligence quotient (1Q), only a rough estimate of intellectual function wad deduced from the information obtained from the above testing.

RESULTS

A total of seventy-one children were included into the study. There were thirty-eight males (54%) and thirty-three females (46%) with a female to male ratio of 1:1.15. The ages ranged from four years to fifteen years. 38% of the children were in the five to ten year age group while 61% were in the age group of eleven to fifteen years. Histogram (I) shows the age distribution of the children attending the clinic (see appendix).

45% of the children were resident in Nairobi while 55% were resident outside the Nairobi provincial boundaries. The majority of these children came from the neighbouring Central Province. The areas of residence by District of the children in the study are shown in Table (I) (see appendix).

The majority of the children were refered by Paediatricians (51%) mainly from the out-patient clinics. 27% of the children had been refered by medical officers from the paediatric filter clinic. The sources of referal of the children attending the clinic are indicated in Table II (see appendix).

58% of the children presented with symptoms lasting less than one year in duration, The duration of symptoms of the children attending the clinic is indicated in Table III (see appendix). The various complaints that were elicited were as listed in Table IV. Many of the children presented with more than one complaint. Fainting attacks was the commonest complaint, being present in 23% of the children studied. Multiple somatic pains (headaches, abdominal pains, chest pains) were present in 11% of the children. A similar number of children (11%) presented with a history of being over-active and unmanageable at home. Another 11% presented with generalised (grandmal) type of fits. 10% of the children were brought to the clinic because of their anti-social behaviour, that is, they were alleged to be stealing, lying, and disobedient. Such children were often aggressive as well. Two of these children had already been in contact with the Police, one of them three times. Another 10% of the children were brought to the clinic for being excessively sleepy especially while at school.

Table V (appendix) shows the overall codings (for the children attending the clinic) according to the multi-axial classification. The clinical psychiatric syndromes noted in accordance with axis (I) are indicated in Table VI (appendix). Neurotic disorders formed the largest group (47%). 21% of the children exhibited some form of conduct disorder either alone or with the hyperactive child syndrome. The children who were found to have no clinical psychiatric syndrome had been refered to the clinic because of having epilepsy or suspected mental retardation. One of the children had been refered from the adult psychiatry clinic where his neurotic mother was a patient. Apart from living in an abnormal psychosocial situation, he had no gross psychiatric disorder.

Thirteen children or 18% of the children seen were found to be having a developmental disorder. Half of these children had had slow development of speech, while a quarter had had slow motor development. The rest had had delayed milestones.

Twenty - seven children were tested by the clinical psychologist. Twenty-one children or 30% of the children seen were assessed as being mentally retarded. 50% of these children had a conduct disorder while only 9% had a neurotic disorder. 23% had no associated clinical psychiatric syndrome. Of the sixty four children attending school at the time of coming to the clinic, class position was recorded as a rough indicator of their intellectual function. Class position was not available for seven children either because they had never attended school or because they had been out of school for over a year prior to coming to the hospital. The percentage of children in upper, middle, and lower thirds of their respective classes is shown in Table VII, (see appendix). Children with neurotic disorders had much better class perfomance as compared to those children with conduct disorders, the majority of whom were in the bottom third of their respective classes at school.

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Twenty-three children or 32% of the children attending the clinic were found tohave associated medical conditions. 18 children had epilepsy. Two children had chronic brain syndrome resulting from neonatal jaundice (one of them had had an exchange transfusion). There was one case each of rheumatic chorea, microcephaly, and congenital squint. Of the eighteen children with epilepsy, thirteen children had grandmal epilepsy while the remainging five had temporal lobe epilepsy. 28% of the children with epilepsy had associated mental retardation while 22% had an associated clinical psychiatric syndrome. There was no documented evidence of past central nervous system infections among the cases of psychosis, although three of these children had presented as atypical childhood psychosis and were thought to have been precipitated by viral encephalitides. There were no positive virology tests to confirm the suspicion.

Abnormal psychosocial factors were present in fifty children (70%). Normal psychosocial situation (or no abnormal factors found) was present in the remaing cases (30%). Some of the abnormal psychosocial factors identified are listed in table VIII (appendix). Separation from parents was present in sixteen cases (23%) of the children seen. Stress in the school environment was present in twelve cases (17%). These were in the form of punishment by teachers, forthcoming examinations, fear of manual work, dislike for games and physical exercises. Abnormal intrafamilial relationships were present in seven cases (10%). These were in the form of frequently querelling parents, psychiatrically or chronically ill parents or unrealistic parental demands and expectations especially in the cases of first born children, and lastly, sibling rivalry. Poor parental control, either inadequate or incosistent was present in another seven cases (10%).

Most of the children attending the clinic (93%) had both parents alive and only 7% had single parents, who were in all cases, unmarried mathers. None of the children had lost a parent through death. However, only three quarters of the children were living with both parents at the time of coming to the clinic.

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DISCUSSION

There are many problems that one encounters in undertaking a study on child psychiatry in an East African setting (13). Interpretation is often needed because of multi - languages. Such subtleties as tone of voice, hesitancies or evasions which would otherwise be so revealing in this kind of history taking may be altogether lost by the use of an intermediary. The idea of talking to the child is often hard to get across to the interpreter. Often there is failure to achieve rapport because of ignorance about local traditions, customs, and superstitions. Many of such problems were encountered during the study.

Child psychiatry in East Africa being almost entirely hospital - based deals mainly with children who have organic impairements and those with psychosomatic complaints (5). These two problems are perceived by an average parent as "medical" conditions and children with these problems are brought to the hospital. Children with general behaviour problems, learning difficulties and antisocial activities are not usually brought to the hospital but are more likely to be taken to traditional healers and witch-doctors (5). In Kenya, in the authors opinion, the cult of traditional healers and witch-doctors is still strong in many parts of the country, where for example, ancestral spirits are still frequently invoked as causes of many illnesses. Thus the results of this study are likely to underpresent the problem as a whole.

The present study demonstrates a male preponderance of 54% compared to 46% of females. Minde (4) working in Uganda reported similar findings in which the males and females accounted for 64% and 36% respectively. In a WHO study of 255 children (7), again there were more males (60%) than females (40%).

As regards to the age of the children, 60% were in the upper age group of eleven to fifteen years. A similar percentage for the same age group was reported by Rahim (3) when he studied 319 children in Sudan in the early seventies. However, in the WHO study (7) the percentage of

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children in the same age group was only 28%, the majority of the patients being in the five to ten year age group. This could possibly be due to the fact that psychiatric problems were picked up at a much ealier age in the WHO study than in the present study. It is of interest to note that there were no children below the age of four years, but in view of the small number of children studied, it is not possible to make any definite conclusion from this observation.

As regards the areas of residence, it had been pointed out that nearly all the children came from either within the Nairobi Provincial boundaries or the neighbouring Central Province, which is relatively close to Nairobi, compared with most other provinces. This, therefore, does not imply that there is a higher incidence of psychiatric disorders in children in these areas than the other parts of the country. It is merely a reflection of the proximity of these areas to the hospital.

Nearly all children in the study had attended one or other clinic at the Kenyatta National Hospital before being seen at the child psychiatry clinic. There were no direct referals from provincial or district hospitals as is the case with most consultant outpatient clinics. This cannot be entirely explained by the fact that this was a new clinic since children were previously seen in the adult psychiatry clinic, and so any child who landed in the adult clinic by mistake was sent to the child psychiatric clinic. Although there could be many reasons for this, the most likely one is the low index of suspicion for psychiatric disorders in children in the peripheral centres where these children first present.

Most of the children attending the clinic had both parents alive although only three quarters were living with their parents. In the authors opinion, children were more likely to be brought for medical help if they were staying in a relatively stable home where there was more likelihood of somebody taking interest or getting concerned with the welfare of the child.

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The average duration of complaints of the children studied was twenty-four months and nearly 58% of these children had had their symptoms for lessthan a year. This is a shorter period compared to the findings of Minde (4) where the presenting symptoms were usually of longstanding duration, having been present for an average of forty-six months. However, even twenty-four months dela before seeking and getting psychiatric treatment as in the present study is unduly long, considering that most of these children were of school going age, and the result was likely to be either frequent interruption of school attendence or prolonged absence from school.

Among the complaints elicited from the children attending the clinic, the most frequent was that of fainting attacks which together with excessive sleepiness were present in 32% of the children. Five of the six children who presented with allegations of abnormal behaviour, usually in the form of episodes of unprovoked aggressiveness and destructiveness of variable duration, were found to be having temporal lobe epilepsy. Problems and guidelines for diagnosing this condition have been well discussed and summarised by Acuda and Lumba (12). No consistent pattern emerged in relationship of symptomatology and the subsequent psychiatric syndrome diagnosed.

Of the clinical psychiatric syndromes diagnosed during the present study the commonest were neurotic and conduct disorders which accounted for 47% and 21% of the diagnoses respectively, a finding which compares well with the W.H.O. study in which neurotic and conduct disorders were the leading diagnoses and accounted for 32% and 25% of the diagnoses respectively (7).

Thirteen children (19%) had evidence of developmental disorders in the present study while the corresponding figure for the W.H.O. study was 15% (7).

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30% of the children in this study had evidence of mental retardation. Minde (4,5) in two of his studies reported a rate of 33% of children to be mentally retarded in both studies. In the WHO study however, only 20% of the children had evidence of mental retardation (7). This difference is probably due to the high percentage of children with organic impairments seen in developing countries (2). The majority of those mentally retarded children in this study were in the age group of five to eleven years (58%) compared to the WHO study (7) in which most of the mentally retarded children were below the age of five years (57%). One possible reason for this difference is that childrenwere screened for mental retardation at an earlier age in the WHO study than in the present study.

Medical conditions were present in twenty-three children (32% of the children in the present study). The most frequent medical condition was epilepsy. These findings compare favourably with Minde's, in which there were 22% (4) and 25% (5) of children with evidence of medical conditions, the majority of which were epilepsy.

A large proportion of children in this study (70%), were assessed as living in abnormal psychosocial situations, a finding that compares well with Minde's finding (73% of the children in his study were living in abnormal psychosocial situations (4)). While none of the children in the present study had lost a parent through death as was the case in Minde's study (4), nearly a quarter of these children came from broken families, that is they were not living with both of their natural parents. Such potential stressful situations in East African families are common (13), and are likely to predispose to psychiatric disorders in children.

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CONCLUSION

Seventy-one children attending the child Psychiatric Clinic of the Kenyatta National Hospital were studied during the period of November, 1981 to May 1982. There was a preponderance of males (54%) and the ages ranged between four and fifteen years with the majority of children being between eleven to fifteen years. Majority of these children were residents of Nairobi Province or the neighbouring Central Province, and in most cases were refered by Paediatricians from the out-patient clinics of Kenyatta Hospital.

The presenting symptoms were multiple in nature and in more than half (58%) of these children were present for less than one year. Fainting attacks (23%), multiple somatic pains, generalised fits and hyperactivity (each 11%) were the most frequent complaints.

The leading clinical psychiatric syndromes were neurotic disorders (47%) followed by conduct disorders (21%) with or without the hyperactive child syndrome. In a small percentage (13%) there was no clinical psychiatric syndrome identified.

Mental retardation was evident in 30% of the children while developmental disorder were present in 18%, majority of which were slow speech development. Associated medical conditions were found in nearly a third (32%), half of which were due to epilepsy. In a large proportion of these children (70%) abnormal psychosocial situations were present in their home and school environment. Although none of these children had lost a a parent through death, nearly a quarter of them were not living with both of their natural parents.

RECOMMENDATIONS

The author recommends a similar study to be carried out, which should have as one of its features a control group such as a school population or children attending a non-psychiatric clinic which would help to clarify the role of psychosocial factors in precipitating psychiatric disorders in children. The study should also be designed to investigate the outcome of the various clinical psychiatric syndromes by following up these children at suitable intervals such as six or twelve months. This would help the child psychiatric team to have an idea of the prognosis of the various psychiatric syndromes in this setting.

Secondly, the author recommends that the staff of the child psychiatric clinic should be provided with adequate facilities to facilitate home and school visits for all the children attending the clinic.

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A C K N O W L E D G E M E N T

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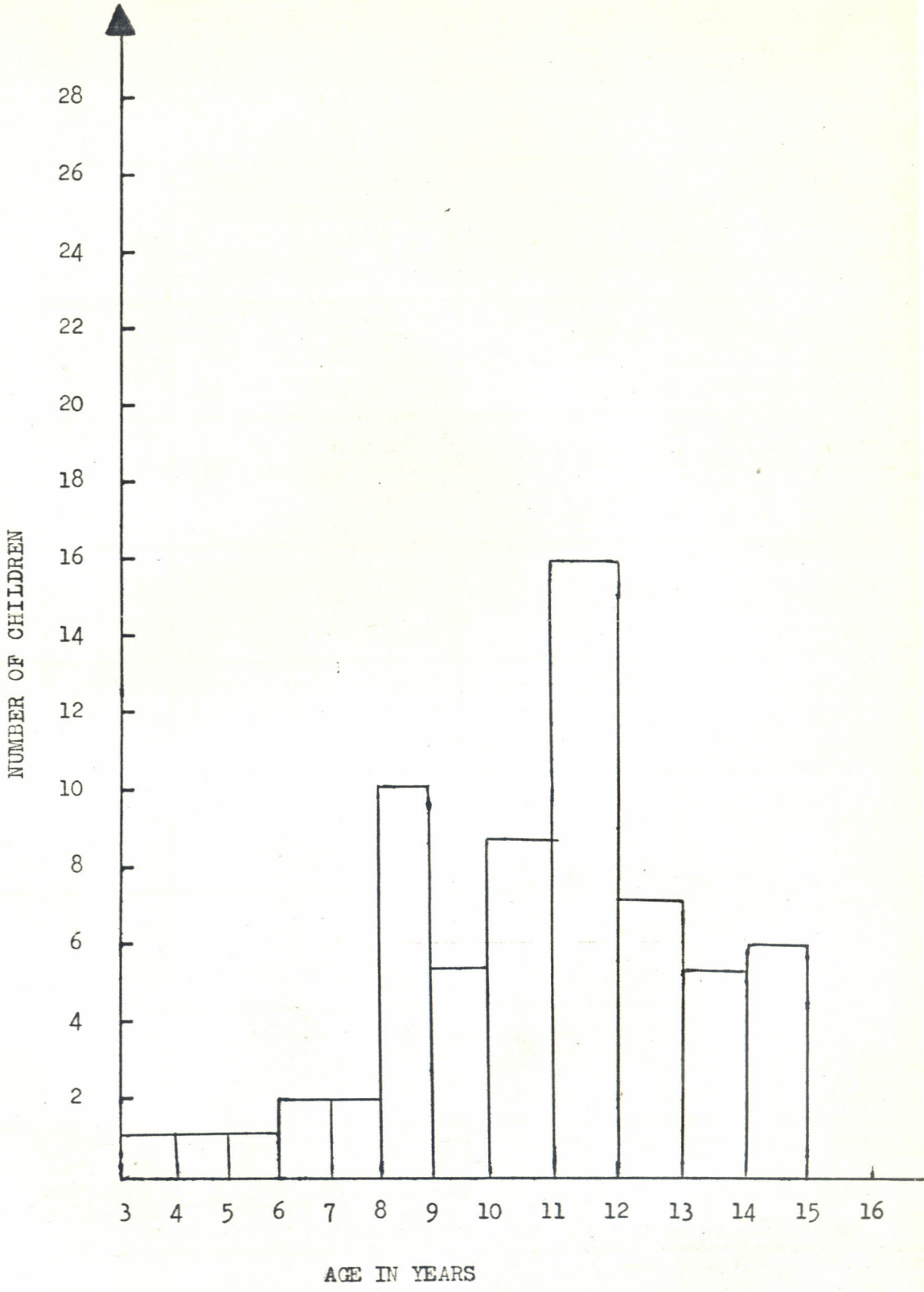

HISTOGRAM 1: AGE DISTRIBUTION OF CHILDREN SEEN IN THE CLINIC

AREA OF RESIDENCE BY DISTRICTS	NUMBER OF CHILDREN	PERCENTAGE OF TOTAL NUMBER OF CHILDREN SEEN
NAIROBI	32	45
KIAMBU	20	29
MURANGA	13	19
NYERI	3	4
KIRINYAGA	1	1
MACHAKOS	1	1
NANDI	1	1
TOTAL	71	100.00

TABLE 1: THE AREA OF RESIDENCE BY DISTRICTS OF CHILDREN ATTENDING THE CLINIC.

SOURCE OF REFERAL	NUMBER OF CHILDREN	PERCENTAGE OF TOTAL NUMBER OF CHILDREN SEEN
PAEDIATRICIAN	36	51
PEADIATRIC FILTER CLINIC	19	27
PHYSICIAN	9	13
PSYCHIATRIST	4	5
GENERAL PRACTITIONER	1	1
HEAD TEACHER	2	3
TOTAL	71	100.00

TABLE 11: THE SOURCE OF REFERAL OF THE CHILDREN ATTENDING THE CLINIC

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DURATION OF SYMPTOMS IN MONTHS	NUMBER OF CHILDREN	PERCENTAGE OF TOTAL NUMBER OF CHILDREN SEEN
LESS THAN 6	28	39
6 TO 11	13	18
12 TO 23	10	14
24 TO 35	8	11
MORE THAN 36	12	18
TOTAL	71	100.0

TABLE III: THE DURATION OF SYMPTOMS OF THE CHILDREN ATTENDING THE CLINIC AT THE FIRST PRESENTATION TO THE CLINIC.

COMPLAINT	NUMBER OF CHILDREN WITH COMPLAINT	PERCENTAGE OF TOTAL NUMBER OF CHILDREN SEEN
1. Fainting attacks	16	23
2. Multiple somatic pains	8	11
3. Over-active and unmanageable	8	11
4. Generalised fits	8	11
5. Stealing, lying, disobedient	7	10
6. Excessive sleepiness	7	10
7. Disturbed sleep	6	9
8. Behaving abnormally	6	9
9. Poor or falling school performance	5	7
10. Inability to walk	5	7
11. Poor apetite	5	7
12. Panic attacks	4	6
13. Tearfulness	3	4
14. Truanting	3	4
15. Enuresis	3	4
16. Pyschotic behaviour	3	4
17. Palpitations	2	3
18. Inability to talk	2	3
19. Frequent sighing	1	1
20. Stereotyped neck movements	1	1

TABLE IV: THE PRESENTING COMPLAINTS OF THE CHILDREN ATTENDING THE CLINIC

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		NUMBER OF CHILDREN	PERCENTAGE OF TOTAL NUMBER OF CHILDREN
AXIS 1:			
	CLINICAL PSYCHIATRIC SYNDROME	62	87
	NO CLINICAL PSYCHIATRIC SYNDROME	9	13
AXIS 11:	DEVELOPMENTAL DISORDER	13	18
	NORMAL VARIATION IN DEVELOPMENT	58	82
AXIS 111:			
	NORMAL VARIATION IN INTELLECT	50	70
	MENTALLY RETARDED	21	30
AXIS IV:			
	MEDICAL CONDITION	23	32
	NO MEDICAL CONDITION	48	68
AXIS V:			
	ABNORMAL PSYCHOSOCIAL SITUATION	50	70
	NORMAL PSYCHOSOCIAL SITUATION	21	30

TABLE V: OVERALL MULTI - AXIAL CLASSIFICATION FOR THE CHILDREN ATTENDING THE CLINIC.

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CLINIC PSYCHIATRIC SYNDROM	NUMBER OF CHILDREN SEEN	PERCENTAGE OF THE TOTAL NUMBER OF CHILDREN SEEN
NEUROTIC DISORDER	33	47
HYPER - ACTIVE WITH CONDUCT DISORDER	8	11
CONDUCT DISORDER	7	10
ACUTE REACTION TO STRESS	7	10
PSYCHOSIS	4	5
MIXED DISTURBANCE OF EMOTIONS AND CONDUCT	3	4
NO CLINICAL PSYCHIATRIC SYNDROME	9	13
TOTAL	71	100.0

TABLE VI: THE CLINICAL PSYCHIATRIC SYNDROMES SEEN IN THE CHILDREN ATTENDING THE CLINIC.

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CLINICAL PSYCHIATRIC SYNDROME	PERCENTAGE OF CHILDREN IN UPPER THIRD OF CLASS	PERCENTAGE OF CHILDREN IN MIDDLE THIRD OF CLASS	PERCENTAGE OF CHILDREN IN LOWER THIRD OF CLASS
NEUTROTIC DISORDERS	66	18	15
HYPERATIVE WITH CONDUCT DISORDER	0	25	50
ACUTE REACTION TO STRESS	71	14	14
PSYCHOSIS	0	50	25
MIXED DISTURBANCE OF EMOTIONS AND CONDUCT	30	33	33
CONDUCT DISORDER	14	0	57
NO CLINICAL PSYCHIATRIC SYNDROME	44	22	11

TABLE VII: THE CLASS POSITION (SCHOOL PERFORMANCE) OF THE CHILDREN ATTENDING THE CLINIC IN RELATION TO THE PSYCHIATRIC SYNDROME.

ABNORMAL PSYCHOSOCIAL SITUATION	NUMBER OF CHILDREN	PERCENTAGE OF TOTAL NUMBER OF CHILDREN SEEN
1. SEPARATION FROM PARENT(S)	16	23
2. STRESS IN SCHOOL ENVIRONMENT	12	17
3. ABNORMAL INTRAFAMILIAL RELATIONSHIPS	7	10
4. POOR PARENTAL CONTROL	7	10
5. SINGLE PARENT (MOTHER)	5	7
6. SEPARATION FROM A CLOSE FRIEND	1	1
7. ASSAULT BY AN OLDER BULLY KID	1	1
8. LOYALTY TO A DELIQUENT PEER GROUP	1	1

TABLE VIII - THE ABNORMAL PSYCHOSOCIAL FACTORS INDENTIFIED AMONG THE CHILDREN SEEN IN THE CLINIC

KENYATTA NATIONAL HOSPITAL

Childrens' Adolescents' and Family Therapy Unit

Item Sheet

(To be Filled by the Registrar)

Child's Name .....Age ..... Sex .....

Serial Reg. No. .....Unit No .....

Address .....

Parents' Occupation .....

Registrar .....

Consultant i/c .....

DIAGNOSIS .....

.....

.....

AXIS I

Clinical Psychiatric Syndrome .....

.....

AXIS II

Development Disorder .....

.....

AXIS III

Intellectual Level .....

.....

AXIS IV

Medical Condition .....

.....

AXIS V

Abnormal Psychosocial Situation (s) .....

.....

CODING (For symptoms and signs in the last year)

Symptom/Sign not present	0
Doubtful or minimal	1
Definitely present	2
Not known	9

I. EMOTIONAL SYMPTOMS

(1) Abnormal suspiciousness or sensitivity ( )

(2) Morbid anxiety, worrying or panic ( )

(3) Morbid depression, sadness, unhappiness or tearfulness ( )

(4) Specific object, situation, fears or phobias ( )

(5) Ruminations, obsessions, rifuals, compulsions ( )

(6) Suicidal ideas - attempt or threat ( )

(7) Hypochondriasis ( )

(8) Morbid irritability, screaming, temper tantrums, breathholding attacks ( )

(9) School refusal, phobia or crying on arrival at School ( )

(10) Abnormally elevated mood ( )

(11) Depersonalisation or derealisation ( )

(12) Conversion or hysterical symptoms ( )

II. SOMATIC

(1) Disturbance of eating (picca, refusal, abnormal faddiness) ( )

(2) Disturbance of sleeping (insomnia, nightmares, sleep walking ( )

(3) Pains of mental origin (headache, backache, abd. pain etc ( )

(4) Encompresis or faecal soiling ( )

(5) Enuresis ( )

(6) Non-epileptic disturbance of consciousness e.g. fainting ( )

III. DISTURBANCE OF RELATIONSHIPS

(Involving the child as the active agent (Subject)

(1) Overt disturbance of child-mother relationship (including hostility, dependency) ( )

(2) Overt disturbance of child-father relationship ( )

(3) Overt disturbance of relationship with other adults ( )

(4) Overt disturbance of patient-sibling relationship (Morbid rivalry or jealousy) ( )

(5) Autism, Social withdrawal, alloofness or detachment ( )

(IV) SPEECH AND LANGUAGE

(1) Disorder of rhythm e.g. stuttering ( )

(2) Disorder of articulation ( )

(3) Disorder of spoken language ( )

(4) Disorder of production of spoken language ( )

(5) Elective Mutism ( )

(V) MOTOR

(1) Tics ( )

(2) Other abnormal repefitive movements (Whirling, flipping, twisting of hands etc) ( )

(3) Clumsiness or poor co-ordination ( )

(4) Restlessness or fidgetiness ( )

(5) Gross overactivity ( )

(6) Hypoactivity ( )

(VI) HABITUAL MANIPULATIONS

(1) Thumb sucking, tongue sacking, naitbiting, masturbation, head banging etc. ( )

(VII) ANTISOCIAL BEHAVIOUR

(1) Disobedience (active or passive), lying ( )

(2) Stealing ( )

(3) Destructiveness or causing damage ( )

(4) Fire setting ( )

(5) Running or Wandering away from home ( )

(6) Sexual misbehaviour (ass lt, exposive) ( )

(7) Fighting, bullying, aggression, etc. ( )

(8) Violent assault (stabbing or use of weapons ( )

(9) Taking drugs (including cigarrettes) ( )

(10) Other antisocial behaviour ( )

VIII) OTHER

(1) Disorder of sex (e.g. Cross dressing) ( )

(2) Hallucinations, delusions, ideas of reference or morbid persecutory ideas ( )

(IX) REFERAL SOURCE

(1) Filter Clinic ( )

(2) Consultant Paediatrician ( )

(3) Other Consultant ( )

(4) Hospital Social Worker ( )

(5) Other ..... ( )

(X) DURATION OF CHILD'S PSYCHIATRIC DISORDER

(1) Six months or less ( )

(2) More than six months but less than one year ( )

(3) One to two years ( )

(4) Two to three years ( )

(5) More than three years ( )

(XI) CURRENT SITUATION OF PATIENT

(1) Living with two parents ( )

(2) With mother alone ( )

(3) With father alone ( )

(4) With mother and other eg. stepfather ( )

(5) With father and other eg. stepmother ( )

(6) Neither parent but with relatives ( )

(7) Number of children under age 20 Years in the household including patient ( )

(8) Ordinal position oldest child ( )

Youngest child ( )

Actual position ..... ( )

(9) Twin Yes ( )

No ( )

(10) Sexual Maturity - Prepuberty ( )

-Evidence of Sexual development ( )

XII) ASSOCIATED ABNORMAL PSYCHOSOCIAL SITUATION

(1) Mental disturbance in other family members ( )

(2) Lack of warmth with intrafamilial relationships ( )

(3) Inadequate or inconsistent parental control ( )

(4) Inadequate or distorted intrafamilial communications ( )

(5) Inadequate living conditions ( )

(6) Stress or disturbance in school or work environment ( )

(7)

(8) Other .....

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