CORRESPONDENCE

CHILD GUIDANCE CLINIC,
Block 99, Ground Floor,
Old Kallang Airport Road,
Singapore, 14.

18th December, 1972.

Dr. K. K. Tan,
Editor,
Singapore Medical Journal,
Singapore Medical Association,
4-A, College Road,
Singapore, 3.

Dear Sir,

The article by Long *et al* 1972 on the Child Guidance Clinic's experience has given a clear and concise account of its local historical background, function and philosophy in the introduction.

Since 31.7.72, there have been a number of changes adopted by the Child Guidance Clinic (hereinafter referred to as C.G.C.). Firstly, it is now operating on full-time basis. Secondly, the upper age limit for its clients has been raised to 18 years to include the pre-university students. Thirdly, it is now screening school children with educational backwardness for the School Health Services. Fourthly, private practitioners can now refer cases for investigation and management.

Much of the value of a statistical study depends on the sampling, accuracy of the data, method of analysis and logical inferences from the results. Mr. Long and his colleagues have erred in all these areas in their study.

POPULATION

The figure given by Long *et al*, does not tally with the actual C.G.C.'s records as shown in the table below. (Table I) There is an omission of 39 cases from the true population, which constitutes 22.8%. In view of this, their data cannot be treated as a factual representation of the C.G.C.

TABLE I

CASES SEEN BY C.G.C. FROM 7.4.70 - 31.5.72

LONG et al	C.G.C.'s RECORDS	Difference	Difference in %
132	171	39	22.8

TITLE

In the light of the above, the title of the article "Two years' experience of Child Guidance Service in Singapore" is misleading, and therefore cannot be justified. If the sample quoted by the authors represented those cases seen by the psychologists themselves one way or other in the C.G.C., the authors should have stated this fact, and made it clear that it does not reflect the experience of the entire clinic.

METHOD OF ANALYSIS

In table II of the paper, only 84 out of 132 cases were analysed. No explanation is given as to why 48 cases, which constitute 33.3% of their sample, are left out. The analysis of 84 cases actually amounts to only 50% of the C.G.C.'s total intake. This is a large error in analysis, the results and conclusion of which can hardly be considered as reliable.

DIAGNOSTIC CLASSIFICATION

The broad classification adopted by the authors is too vague and superficial to be of real value. There is no category for organic and neurological cases, such as epilepsy and organic brain damage. Furthermore, how would the authors fit such categories as developmental disorders, childhood schizophrenia, psychosomatic disorders and special syndromes such as the Gilles de la Tourette Syndrome into their classification?

Not many workers and experts in the field of child psychiatry nowadays will agree fully with the view of the authors that "accurate classification of the types of problems presented by the young patients is difficult because children's problems do not lend themselves to clear-cut nosology". Such a view seems too pessimistic. Psychiatric diagnosis, whether in adults or in children, of course, is not 100% accurate or fool-proof with our present state of knowledge. But this should not preclude the use of carefully worked out and internationally accepted psychiatric diagnostic classification. The authors are referred to the report on the Third W.H.O. Seminar on Psychiatric Disorders, Classification and Statistics held in Paris in 1967 and published in the Journal of Child Psychology and Psychiatry in 1969 (Rutter *et al*, 1969) for an up-to-date view on this matter.

REFERENCES

In the section on ethnic groups, the authors refer to Tsoi's study on attempted suicide and hospital admission rates of psychiatric patients. In my opinion, such a reference is completely irrelevant as Tsoi made his study on adult psychiatric patients belonging to two special groups —attempted suicide and in-patients.

AGE DISTRIBUTION

Long and his colleagues have highlighted the peak at 13-14, but failed to comment on another peak at 7-8. The C.G.C. was started only two-and-a-half years ago. Its annual cases change from year to year with the clinic's development. The method of analysing 2 years' figures together, as done in the paper, has the disadvantage of masking changes that might have occurred in the period under study.

If the annual cases were analysed year by year in respect of age distribution, it is clear from fig. 1 that during the first year of the C.G.C.'s operation, the highest peak is at 7, followed by a slightly smaller peak at 14. (Fig. 1)

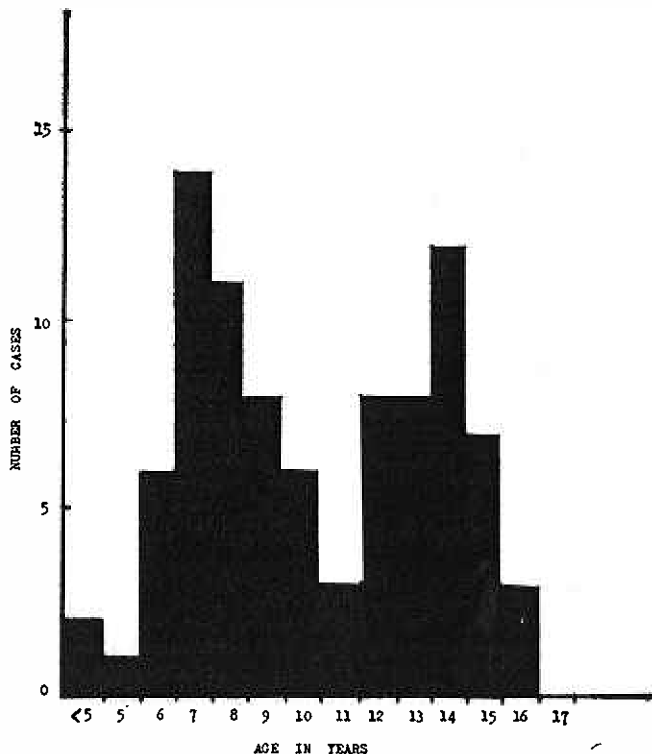

Fig. 1. Age Distribution of Cases seen from 7.4.70 - 31.5.71

On the other hand, in the second year, the C.G.C. received a lot more of adolescent cases. There is only one peak at 13, as evidenced in fig. 2. The number of 7 year olds seems to have dwindled down to a very low level. (Fig. 2)

The analysis of the two years' intake of patients is shown in fig. 3. It is clear that there are two distinct peaks—one at 7-8 and another at 13-14. (Fig. 3)

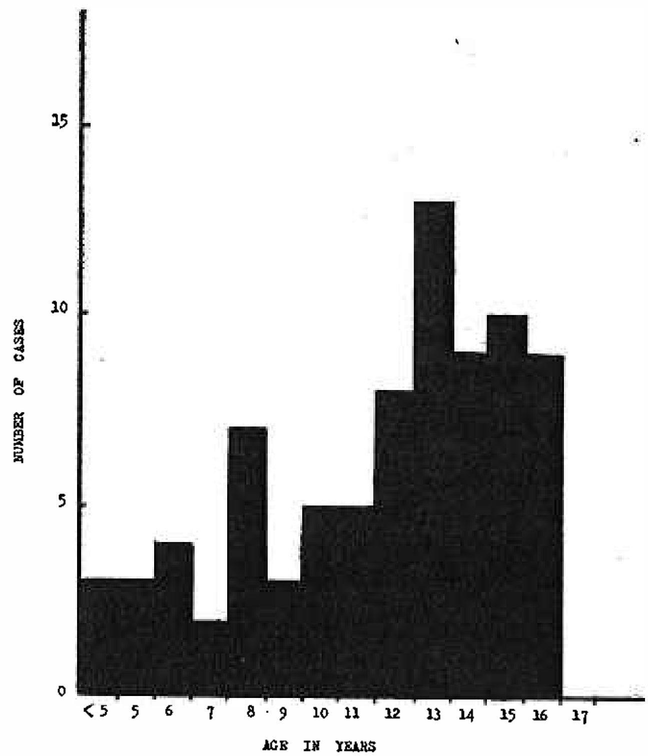

Fig. 2. Age Distribution of Cases seen from 1.6.71 - 31.5.72

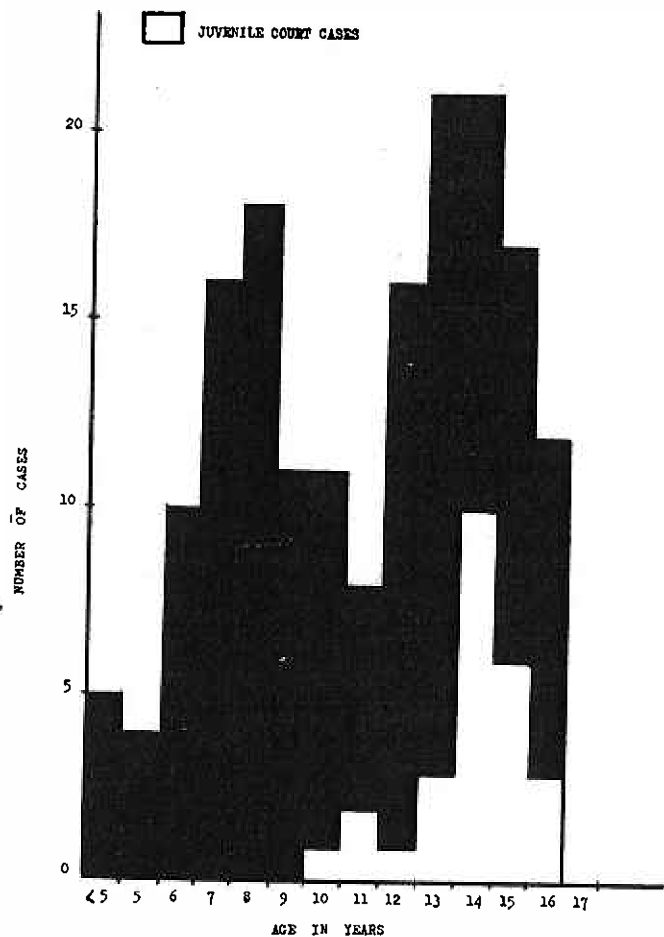

Fig. 3. Age Distribution of Cases seen from 7.4.70 - 31.5.72

I have to take issue with the authors' conclusion that the reason for the high number of cases in the 13-14 age group is "probably due to the fact that the boys and girls have to face the pressure of the Primary VI examinations as well as having to make new adjustments in secondary school." As can be seen in fig. 3, a fair proportion of the cases making up the peak at the adolescent age is comprised of Juvenile Court cases. Many of these cases are not attending school; and in most of those who are still at school, educational pressure and difficulties in adjustment to secondary school do not feature strongly as the most important aetiological factors.

In addition, a considerable proportion of adolescent cases seen at the clinic have long-standing problems, dating back to their early childhood or pre-pubertal period. Some of them have adolescent crises, some with personality disorders, some experiencing psychosocial disturbances in their immediate environment not related to school setting, and some have psychotic breakdowns quite independent of school factors. Without taking into account other relevant factors, the conclusion of the authors seems too sweeping. However, this is not to say that educational pressure and adjustment difficulties to secondary school are not important in some cases.

CONCLUSION

I have discussed the merits and demerits of the article. The authors should have exercised more care in ensuring the accuracy of the clinic's population and defining their aims and limitations of their study. This critique is written to correct the misrepresentations for the benefit of the readers.

REFERENCES

1. Long, F.Y., Oon, P.K. and Lee, M.M.: "Two Years' Experience of Child Guidance Service in Singapore." S.M.J., 13, 245-248,1972.
2. Rutter, M., Lebovici, S., Eisenberg, L., Sneznevskij, Sadoun, R., Brooke, E. and Lin, T.Y.: "A Tri-Axial Classification of Mental Disorders in Childhood." J. Child Psychol. Psychiat., 10, 41-61, 1969.

Yours faithfully,
Signed:

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Ag. Psychiatrist,
Child Guidance Clinic,
Singapore.

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Department of Psychology,
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6th March, 1973.

Dear Sir,

We offer the following reply to your correspondent's letter according to his own headings:

POPULATION

The critic seemed to be confused between "population" and "sampling." Assuming his own stated figure is correct, the 171 cases were given as the population. The 132 cases quoted in our study represented cases accepted by the Clinic for management and which were also seen by the psychologists. In this light, the 132 cases quoted in our study is a sampling of the Clinic's total population. We disagree with his logic that unless data are obtained from the total population, the results are nonfactual. It is sometimes not possible nor necessary for a study to be based on 100% of the population.

TITLE

Although it was not explicitly stated as such (as demanded *post hoc* by our critic) the title and stated purpose of the article implied that it represented only the experience of the three authors and not anyone else. If the article purported to represent the entire Clinic, a more suitable title would have been: "Two Years' Experience of the Child Guidance Clinic in Singapore."

METHOD OF ANALYSIS

We fail to understand the critic's heading of "Method of Analysis" under which he discussed sampling instead. The 84 cases were figures for the year 1971 only. This was so stated in the footnote. The editor did not foul us on that score although our critic took the opposite view. The results obtained for the period 1.1.71 to 31.12.71 were valid for that year and the conclusion thereof. The trends for future years may well be different.

DIAGNOSTIC CLASSIFICATIONS

The critic felt that the statement: "Accurate classification of the types of problems presented by the young patients is difficult because children's problems do not lend themselves to clear-cut nosology" was too pessimistic and that few experts will agree fully with it. Our statement was influenced by Kessler, (1966, p.87) whom we gave

as our reference. Quoting her directly: "The standardization of diagnostic terminology in childhood psychopathology is an unsolved problem. There is no general agreement as to whether the nomenclature should be based on the symptoms, the etiology, the prognosis, or on a combination of these factors. All authors decry the lack of standard classification because, without it, it is impossible to compare data from different sources or to have an accurate interchange of diagnostic information."

As we see it, numbered among the "few" would be Leo Kanner (1972) and John G. Howells (1971). Quoting them directly: "As things stand now, we have gradually been able to observe and describe a number of profiles with characteristic syndromes that speak for themselves. Beyond this, we have many combinations, overlaps, and fluctuations for which there is no provision in the more clearly defined profiles. Some children do not, for the sake of our convenience, merge into any of the well-known, clear-cut patterns. It is then up to us to go on studying those children as individuals with their own unique peculiarities patiently and pluralistically from every angle, without the air of feigned omniscience, without pressing them into any preconceived diagnostic and etiologic dogma, and with the hope that thus we shall from time to time discover more profiles which speak for themselves." (Kanner, 1972, p.197). "Developments in a field depend on a number of factors, but probably none so retards progress in psychiatry today as the confusions of its nosology and, linked with it, the lack of agreement on criteria for defining syndromes together with the imprecision of its nomenclature." (Howells, 1971, p.209).

We fully agree that ideally, internationally accepted psychiatric diagnostic classification should be used. We resorted to very broad classification in our article largely because quite a few cases in the series have not been clearly diagnosed. The point we attempted to make was that the problems encountered were mainly complex in nature.

REFERENCES

Our reference to Tsoi's (1970) study may appear to be irrelevant to the critic. However, the reference was alluded to not for direct comparison of statistical data but to compare and/or contrast possible trends. In our view, rates of hospital admission of psychiatric patients, attempted suicide, and child psychiatric problems may be regarded as variations of the same theme—the theme of mental ill-health.

AGE-DISTRIBUTION

Aside from providing further analyses of the data, the critic did not produce evidence to show that the peak is *not* 13-14 for the specified two years understudied. In fact, in all his three diagrams, 13-14 was still noted to be a high point. In our study we merely recorded that fact.

As for the reasons why that was so, we agree that there were other plausible explanations. We note that our critic did not deny that educational pressure and adjustment difficulties in secondary school could still be one of the explanations.

CONCLUSION

The purpose of our study was simply to record *some* of our observations made during two years of our child guidance experience in Singapore as stated in the opening paragraph of our article. Our results and conclusions were limited to the two year period understudied. We made no claim that the same results and conclusions would hold true for the future. In his zeal, our critic appears on the verge of wanting to throw away the proverbial baby with the bath water.

REFERENCES

1. Howells, J. G. (ed.): "Modern Perspectives in Adolescent Psychiatry" Edinburgh, Oliver and Boyd, 1971.
2. Kanner, L.: "Child Psychiatry" 4th ed. Springfield, Charles Thomas Publisher, 1972.
3. Kessler, J. W.: "Psychopathology of Childhood." N. J., Prentice-Hall, 1966.

Yours faithfully,
Signed: F. Y. Long.