A COMPARATIVE STUDY OF NEW CASES SEEN AT THE CHILD PSYCHIATRIC CLINIC IN 1975 AND 1985

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ABSTRACT

A comparative analysis of new cases seen at the Child Psychiatric Clinic in 1975 and 1985 is made in this study. There was a three and a half fold increase in the number of patients seen from 245 to 893. There was no significant change in sex ratio or ethnic groups. However, in 1985 more younger children (aged less than 6 years) were seen at the Clinic. The waiting time remained short with half the number of cases seen within one week of appointment. The commonest conditions besides Normal Variation were Adjustment Reaction, Mental Retardation, Conduct Disorder and Neurosis. Three-fifths of cases were discharged from follow-up within three months of therapy. Most cases (90%) did not require pharmacological therapy whilst family therapy was prescribed for a fifth of cases seen in 1985.

Keywords: Child Psychiatric Clinic, new cases.

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INTRODUCTION

A retrospective study of new cases seen at the Child Psychiatric Clinic in 1975 was first conducted by Goh and Bose (1980) (1). This is a similar study done for new cases seen in 1985. A comparative analysis is made in this paper.

MATERIALS AND METHODS

All new new cases (893) seen in the year 1985 were considered in the present study. Only eight case records could not be traced at the time of the study. Information about the patients collected from the case records included age, sex, ethnic groups, educational levels, sources of referral and personal history of perinatal complications. Family data studied included parents' working status and educational levels. Other information considered were diagnoses, types of management, duration of management, period of waiting time and therapists seen by the patients at first consultation. The data collected were analysed using the Statistical Package for the Social Sciences (SPSS) with the IBM 3081 Mainframe.

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RESULTS

These are presented under 3 main categories – personal, family and management data.

PERSONAL DATA

Sources of Referrals

Table I shows the distribution of cases by sources of referrals. Compared to 1975 when the modal source was the government outpatient clinics (32.8%), in 1985 it was the school health service which referred the most cases (22.3%). The government outpatient clinics continued to refer a substantial proportion of the cases seen (20.5%). The referrals also increased from the schools (12.7% to 18.6%) and private practitioners (8.5% to 12.8%). This could be due to the greater awareness of primary health care clinicians as well as educationists in schools of the services offered by the Child Psychiatric Clinic. A smaller percentage of cases were referred from the Ministry of Community Development, the equivalent body of the Social Welfare Department in 1975, as well as from the Juvenile Court.

Table I
DISTRIBUTION OF CASES BY SOURCES OF REFERRALS

Sources of Referrals	1975 (%)	1985 (%)
Govt Outpatient Clinics	32.8	20.5
Govt Hospitals	21.0	15.7
School Health Service	11.5	22.3
Schools	12.7	18.6
Private Practitioners	8.5	12.8
Min of Community Development	3.5	1.7
Juvenile Court	3.5	0.2
Others	6.5	8.2
Total	100.0	100.0

Sex Ratio

The sex ratio remained the same for 1975 and 1985 with three boys to every two girls seen at the Child Psychiatric Clinic.

Table II
DISTRIBUTION OF CASES BY SEX

Sex	1975 No.	1975 %	1985 No.	1985 %
Male	148	60.5	546	61.7
Female	97	39.5	339	38.3
Total	245	100.0	885	100.0
$X^2 = 0.134$	df = 1		$p < 0.5$	

Age

For patients above 12 years old, the ratio of male to female was about the same (125 boys, 143 girls), whereas for 12 years and below, the ratio was 2: 1 (421 boys, 196 girls).

In 1985, 47.6% of the cases were aged 7 to 12 years and only about a third of the patients (30.2%) were above 12 years old (Table III). This was significantly different ($p < 0.001$) from 1975 when almost half were above 12 years old (47.4%). Similarly there was a significant increase ($p < 0.001$), in cases in the age group 1 to 6 years from 6.1% in 1975 to 22.2% in 1985. This could be due to early detection of cases and the willingness of parents to seek help.

Table III
DISTRIBUTION OF CASES BY AGE AND BY ETHNIC GROUPS

	1975 No.	1975 %	1985 No.	1985 %
Age				
1 – 6	15	6.1	197	22.2
7 – 12	114	46.5	421	47.6
13 and above	116	47.4	267	30.2
Total	245	100.0	885	100.0
Ethnic Groups				
Chinese	174	71	678	77
Malays	22	9	87	10
Indians	32	13	83	9
Others	17	7	37	4
Total	245	100	885	100

Ethnic Groups

In terms of the percentages of cases seen among the ethnic groups in 1975 and 1985, there were no significant changes. The Chinese constituted about three quarters of the cases, the Malays and Indians about one tenth each, and the remainder the other ethnic groups.

Educational Levels

More children came from pre-primary and primary schools in 1985 (12.1% and 53.2% respectively) compared to 1975 (4.9% and 40.4% respectively).

Table IV
DISTRIBUTION OF CASES BY EDUCATION LEVELS

Educational Levels	1975 (%)	1985 (%)
Pre-Primary	4.9	12.1
Primary	40.4	53.2
Secondary / VITB	26.1	25.4
Pre-University	0.8	1.2
Special Schools	4.1	1.6
Not Schooling	19.6	6.5
Others / Unknown	4.1	
Total	100.0	100.0

Diagnoses

Adjustment Reaction, Mental Retardation, Conduct Disorder and Neurosis together constituted more than half the number of cases seen in both years. Slightly more than a tenth were Normal Variation. They were seen because their parents were uncertain whether these children were having psychiatric problems. For this group assessment, advice and reassurance were all that were necessary.

Table V
DISTRIBUTION OF CASES BY DIAGNOSIS (ICD-9)

Diagnosis	1975 No.	1975 %	1985 No.	1985 %
Normal Variation	27	11.0	119	13.4
Adjustment Reaction	56	22.5	180	20.4
Developmental Disorder	10	4.0	39	4.4
Neurosis	21	8.5	84	9.5
Conduct Disorder	25	10.5	94	10.6
Personality Disorder	11	4.5	7	0.8
Psychosomatic Disorder	5	2.0	6	0.7
Schizophrenia	30	12.5	35	4.0
Affective Disorder	—	—	7	0.8
Mental Retardation	47	19.0	173	19.5
Disturbance of Emotions Specific to Childhood and Adolescence	—	—	31	3.5
Special Syndromes not Elsewhere Classified	—	—	67	7.6
Others	11	4.5	11	1.2
Unknown	2	1.0	32	3.5
Total	245	100.0	885	100.0

Perinatal History of Note

This category included perinatal conditions in both mother (eg. pre-eclampsia, antepartum haemorrhage, diabetes in pregnancy, etc.) and patient (eg. neonatal jaundice requiring therapy, breech delivery, preterm baby etc.). A substantial proportion of cases (23.8%) gave a positive history but a greater number of cases (33.5%) reported uncertainty with regard to this information. As such, no conclusive inference may be drawn from the data collected.

FAMILY DATA

Parents' Educational Levels

For cases seen in 1985, 36% of fathers and 31% of mothers had at least secondary education, while 31% of fathers and 43% of mothers had either attended primary or received no formal education. In a substantial proportion of cases (about 30%), this information was not available (eg. patients whose parents were divorced or separated) or not obtained (eg. patients who were referred for IQ assessment only).

Parents' Working Status

In 1985, 86% of fathers and 40% of mothers were working at the time of consultation. Less than 4% of fathers and more than 50% of mothers were not working; for the rest this information was again not available.

MANAGEMENT DATA

Therapists seen by Patients at First Consultation

The psychiatrists saw 43.6% of cases at first consultation. The medical officers saw a quarter of cases (24.5%) whilst the psychologists and the medical social workers saw almost the same numbers of cases at first consultation (16.0% and 15.9% respectively). Usually the respective therapists would continue management of the cases throughout.

Duration of Waiting Time

The average duration of waiting time was 1.86 weeks in 1985 with almost four fifths of cases attended to within 2 weeks. This compares favourably to 1975 when less than half the cases were seen within the same period. Urgent cases could be seen without appointment and on the same day ('walk-in' cases). Indeed 7.7% (n = 68) of cases belonged to this category.

Table VI
DISTRIBUTION OF CASES BY DURATION OF WAITING TIME

Duration	1975		1985	
	No.	%	No.	%
No Waiting	12	4.9	68	7.7
1 week	59	24.0	426	48.1
2 weeks	42	17.1	198	22.4
3 weeks	48	19.6	75	8.5
4 weeks	31	12.7	78	8.8
5 weeks	43	17.6	9	1.0
>5 weeks	10	4.1	31	3.5
Total	245	100.0	885	100.0

Types of Management

The majority of cases came for assessment and advice only. Such cases included a bulk who were referred for IQ assessment by the psychologists or those diagnosed as Normal Variation. A wide variety of treatment modalities were practised in the management of children and adolescents. Some required more than one modality of treatment. A fifth of cases were given family therapy besides the more conventional individual psychotherapy, behavioural therapy and pharmacological therapy.

Table VII
DISTRIBUTION OF CASES BY TYPES OF MANAGEMENT (1985)

Types of Management	%
Diagnostic Assessment and Advice	62.5
Individual Psychotherapy	4.7
Family Therapy	19.8
Pharmacological Therapy	9.8
Behavioural Therapy	6.6
Remedial Teaching	2.1
In-Patient Treatment	3.3
Educational Placement	8.9
Residential Placement	0.2
Consultation to Agencies	1.7
Others	0.9

Duration of Management

For both years, three-fifths of cases were discharged from follow-up within three months. Patients requiring longer than one year of treatment were mainly those with psychotic illness, affective disorders as well as some cases of conduct disorder.

Table VIII
DISTRIBUTION OF CASES BY DURATION OF MANAGEMENT

Duration	1975		1985	
	No.	%	No.	%
One Week	22	9.0	209	23.6
Two Weeks	10	4.0	29	3.3
One Month	35	14.0	94	10.6
Two Months	26	10.5	89	10.1
Three Months	57	23.5	110	12.4
Six Months	30	12.0	131	14.8
One Year	14	6.0	107	12.1
> One Year	40	16.5	110	12.4
Uncertain	11	4.5	6	0.7
Total	245	100.0	885	100.0

DISCUSSION

The Child Psychiatric Clinic continues to provide services for the diagnosis, assessment and therapeutic intervention of children and adolescents with emotional and behavioural problems. The age limit is 16 years if they are not in school and till Pre-University classes if they are schooling. Compared to 1975, the number of new cases seen had increased by more than three and a half folds from 245 patients to 893 patients in 1985. However, this does not necessarily mean a rise in psychiatric morbidity amongst children in Singapore. The increase in referrals from schools, private practitioners and primary health care clinicians as well as the willingness of parents to seek consultation and professional advice probably contributed to this increase.

For reasons just mentioned, in 1985 the proportion of new cases increased significantly from the younger age groups (i.e. aged 1-6 and 7-12). Similarly, a higher proportion was from the pre-primary and primary school levels (Tables III & IV).

More boys were seen at an earlier age than girls – with a predominance of conduct disorder, whereas the difference narrows with increase in age, followed by a higher incidence of emotional disorders in girls at the older age groups. The overall sex ratio was two girls to every three boys; for age 12 years and below it was one girl to every two boys seen (196 girls, 421 boys); and for age 13 years and above, it was almost the same for both sexes (143 girls, 125 boys). Long et al 1974 (2) in a study of 132 cases referred to the Child Guidance Clinic in Singapore reported 71.9% boys and 28.1% girls. The Isle of Wight study by Rutter et al 1970 (3) covering 10- and 11-year-old children showed twice as many boys as there were girls. Leslie 1974 (4) who studied 13- to 14-year-olds in Blackurn also demonstrated a higher prevalence rate of psychiatric disorders of 20.8% in boys and 13.6% in girls.

With regard to diagnoses, there were proportionate increases in cases in most diagnostic groups e.g. Normal Variation (11.0% in 1975, 13.4% in 1985), Neurosis (8.5% in 1975, 9.5% in 1985) etc. An apparent "decrease" was the diagnosis of Schizophrenia with a drop from 12.5% in 1975 to 4.0% in 1985. However, in terms of the number of cases, there was little change – 30 and 35 respectively. This could be explained by the referral pattern. In 1975, fewer cases especially non psychotic ones were referred. Moreover, the percentage calculated in this study was based on cases seen at the Clinic, not in the community.

The duration of waiting time continued to be short. Indeed, in 1985 more than half the referrals were seen within one week (28.9% in 1975) and almost four-fifths within two weeks (46% in 1975). The ability of the Child Psychiatric Clinic to keep the waiting period short inspite of the three and a half fold increase in cases was due mainly to the introduction of family therapy approach and the distribution of cases amongst the different therapists whereby only one therapist was involved in the management of a case. Thus doctors, psychologists as well as medical social workers managed new cases right from the start. Regular case conferences were held (each team met two times per week, each lasting an hour) whereby the team of psychiatrists, psychologists, medical officers and medical social workers presented and discussed the management of their cases.

The duration of management was short with three-fifths of cases discharged from follow-up within three months for 1975 as well as 1985. Those who were referred for IQ assessment need to come once or twice only. Generally, psychotic cases required long term treatment, usually more than a year, otherwise relapses might occur.

Finally, only a minority (9.8%) required drug treatment mainly for psychotic conditions, severe anxiety states, or enuresis. Behavioural therapy was also prescribed for patients with enuresis or phobias. Educational placement was made for 8.9% (n = 79) of the cases although the diagnosis of mental retardation was made in 19.5% (n = 173) of cases. Parents of educationally subnormal (ESN) children may have difficulty accepting their children's limitation as demonstrated by Ko and Oon's study in which only half the number of parents accepted special education for their ESN children (5). Almost one-fifth of the patients were provided with family therapy. This speaks of the importance of the family dynamics in child and adolescent psychiatry.

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REFERENCES

1. Goh CW, Bose P: Child psychiatric problems in Singapore – a retrospective study of a year's new patients. Sing Med J 1981; 21:467-72.
2. Long FY, Oon PK, Lee MM: Two years' experience of child guidance service in Singapore. Sing Med J 1972; 13:245-8.
3. Rutter ML, Tizard & Whitmore K (1970): Education, Health and Behaviour. Longman, London (Reprinted 1981).
4. Leslie SA: Psychiatric disorders in the young adolescents of an industrial town. Br J Psychiat 1974; 125:113-24
5. Ko SM, Oon PK: A retrospective Study of the profile of ESN children seen at the Child Psychiatric Clinic. Sing Med J 1989; 30:173-6.