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The Paediatrician and Child Psychiatry in Nigeria

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Olatawura, M. O. (1974). *Nigerian Journal of Paediatrics,* **1** (2), 65. **The Paediatricans and Child Psychiatry in Nigerian.** Paediatricians occupy a strategic position in implementing the three aspects of preventive Psychiatry, namely: primary, secondary and tertiary prevention. First, by collaborating with obstetricians they can reduce or eliminate those factors which contribute to the incidence of psychiatric disorders of childhood. Secondly, paediatricians carry out secondary prevention by prompt diagnosis and adequate treatment. In Nigeria at present, there is no remedial provision (tertiary prevention) for brain-damaged children who form the bulk of our child psychiatric clinic attenders. It is therefore suggested that future plans for expansion of Child Health facilities in the country should include adequate provision to meet the needs of this group of children.

OVER the years it has been recognized that in seeking to remove or ameliorate the numerous afflictions of man, it is no longer profitable to separate the mind from the body, or the psyche from the soma. Although by saying this, the adult situation readily comes to mind, the position is probably even more true of children. Many reasons could be put forward for this but one that seems outstanding is the very process of development of children. During the process of growth, children pass gradually through the nebulous world of make-belief to that of reality; their animistic thinking is gradually replaced by rational thinking. The rational end-point is no consolation to us because they become patients or clients of paediatricians and child psychiatrists when they are still operating with their own imaginary concepts. It is usual for doctors to believe most of their patients' complaints. I suppose paediatricians and child psychiatrists also "believe" their patients. This factor, apart from the unity of body and mind, explains the common frontiers that lie between the two disciplines, namely child psychiatry and paediatrics.

It is generally accepted that in order that the child psychiatrist may function effectively, he must have more than just a nodding acquaintance with paediatrics. The reverse is perhaps even more important for a number of reasons. When a child, by complaining, uses his body to signal any distress, the parents naturally think of the paediatrician. Moreover, it is more acceptable to many parents for their children "to have" physical rather than emotional complaints. To have the latter raises the possibility of defective up-bringing, and the guilt feelings generated by possible parental role in the symptomatology can be stressful to parents. There are other reasons why the paediatrician must be sensitive to the emotional problems of children, but the important point to stress is that paediatricians are often the first to be consulted by parents for emotional problems in children.

The present situation in Nigeria

In most parts of Nigeria where there is gross shortage of medical man-power, parents have no choice in seeking medical help for their children's problems. It is a luxury, for instance, in some parts of the country to have the services of a general duty doctor; it is indeed rare to have the services of a paediatrician or a child psychiatrist. It is by his specialist training that the paediatrician is in a better position than the general practitioner to solve many aspects of children's problems. Supplementing the efforts of the paediatrician and the general practitioner, the few psychiatrists available in Nigeria have been rendering service in the form of treatment of neuro-psychiatric disorders of children and various aspects of child guidance.

No one knows the prevalence or incidence of behaviour disorders among our childhood population. Recently, a child psychiatric service was started in the University College Hospital, Ibadan, not only to treat psychiatric disorders of children, but also to study the pattern and prevalence of these disorders in the community. The aim of the latter programme is to identify areas to which preventive programmes should be directed. Prior to the inception of the present child psychiatric service, the ministries of Education and Social Welfare in Ibadan were requested to inform all schools, probation offices, juvenile courts, approved schools, etc., under their jurisdiction of the service. The general practitioners were also informed.

Few facts which have emerged from this new service so far include a low attendance rate of new patients with emotional problems and a strikingly large number of children with varying degrees of brain-damage and poor performance at school. It is tempting to infer from this short experience that behaviour disorders constitute very little problem in the childhood population around Ibadan. However, we know that this inference is likely to be false since the juvenile courts, the approved schools and remand homes are overcrowded by children with antisocial behaviour disorders. This may be due to the fact that parents tolerate neurotic behaviour better than antisocial behaviour disorders. That this is probably true is supported by our experience of the population of enuretic children in our clinic. Over 65 per cent of patients seen because of enuresis were over the age of 10 years at the first attendance. Although virtually all these children had been enuretic since early childhood, the parents sought help late either because their children were about to enter secondary school boarding houses or the symptom was causing a lot of embarrassment to the children in the boarding houses. Medical consultation might not have been sought if the symptom continued to remain a family secret. The low attendance rate of new patients with emotional problems may also indicate that parents find the present medical and social services in our hospitals inadequate for their own needs and so take consolation in the hope that the children would out-grow their problems. There might be other reasons for the under-representation of children with neurotic behaviour disorders in our clinic. This area requires further studies.

In contrast to under-representation of patients with neurotic behaviour disorders, there is a large number of children with varying degrees of brain-damage and under-achievement at school. Our energies at present, therefore, ought to be chanelled towards the treatment needs of this group of children. The insults to the brain result mainly from reproductive casualty, physical diseases of childhood and possibly malnutrition all of which are very common in our community. The aim in treating these children should therefore be prevention.

Paediatric Preventive Programmes

Paediatricians have contributed immensely to many aspects of mental health, particularly in the fields of growth and development, as well as the preventive aspects of mental health. They in fact remain the key and front-line experts in that they have successfully applied the basic concepts of community psychiatry to preventive paediatrics

(Tietze, 1969). According to Caplan (1964) there are three aspects of preventive psychiatry, namely: primary prevention which aims at reducing the incidence of mental disorders of all types in a community; secondary prevention, which aims at reducing the duration of those disorders by early diagnosis and prompt treatment. Tertiary prevention aims at reducing the amount of social ineffectiveness that could result from mental disorders.

With regard to primary prevention, the obstetrician and paediatrician can be very useful in eliminating prenatal and post-natal factors that may cause neuro-psychiatric disorders. In Nigeria infections and dietary deficiencies readily come to mind. At present a staggering proportion of our clinic attenders have varying degrees of brain-damage following, amongst other causes, infection and possibly malnutrition. The diagnostic labels include epilepsy, hyperkinetic syndrome, childhood autism, speech disorders, reading and writing difficulties, in different combinations.

Recently the department of Psychiatry in collaboration with the Institute of Child Health and the department of Preventive and Social Medicine, University of Ibadan has embarked on a preventive project called 'Mothers' self-help programme', which is directed by a clinical psychologist. The project aims at active involvement of mothers in the promotion of physical and intellectual development of their children. Mothers from a rural community and those from the traditional sections of the city of Ibadan are invited to answer questions about child-rearing practices. By means of lectures, film shows and presentation of cognitive materials locally available, an attempt is made to modify the traditional child-rearing pattern by demonstrating to these mothers the differences between the development of their children and other children differently reared in the same city. The programme also pays attention to nutrition as well as intellectual stimulation of children. Because of the success achieved so far it is recommended that this programme should be carried out throughout the country.

It has earlier been stated that paediatricians are often the first expert to be consulted by parents in times of crises. Erikson (1959) has described two types of crises, the developmental and the accidental. Developmental crisis is best illustrated by the identity crisis that characterizes the transition to adolescence and young adulthood. With guidance from a psychiatrist, the family paediatrician may be very useful in averting adverse mental health consequences. Paediatricians are also advantageously placed in times of accidental crises such as disfiguration of a child due to burns or an accident, and prompt admission to hospital of children with acute illnesses, acute poisoning, etc.

Future Goals

Due to the shortage of paediatricians in Nigeria, their primary and secondary preventive efforts have unavoidably been limited. This has resulted in a heavy load of cases of varying degrees of brain-damage associated with behaviour disorders. As stated earlier childhood neurotic behaviour disorders do exist in Nigeria but they appear to be tolerated by parents. By contrast, antisocial behaviour disorders are less well tolerated as shown by the large numbers in juvenile courts, remand homes and approved schools. Brain-damage may predispose a child to either or a combination of both neurotic and antisocial behaviour disorders. There is a proportion of the childhood population who do not obviously fall into these two categories, but whose main difficulty apparently is backwardness at school. It ought to be stressed that under-achievement at school may be purely of emotional origin. However, our experience in the child psychiatric clinic shows that brain-damage of diverse causation accounts for most of the children with educational problems referred to the clinic. Some of the manifestations in these children include hyperactivity, short-attention span, distractibility, lethargy and of course poor intellectual performance.

The tertiary prevention which the paediatrician, the child psychologist, and the child psychiatrist should aim for is first the recognition of the main

problem which includes that category of children who are unable to obtain maximum benefit from ordinary classroom instruction. In order to reduce impaired functioning of the children, (the aim of tertiary prevention) special provisions should be made for this special group now that the health services for children in the country are about to be expanded. Future plans should provide for a large number of specially trained teachers who would manage small classes of these mentally-handicapped children. In this way, each child would receive more "individual" attention than is possible in a large class of normal children. The services of educational psychologists are also invaluable for these category of children. Apart from assessing the intellectual endowment and the degree of brain damage of each child, the psychologists can help in planning the necessary remedial teaching. Apart from classroom activities, this group of children may also benefit from behaviour modification programmes worked out by the psychologists. It has been observed in our psychiatric unit that mothers can act as co-therapists by their being taught simple conditioning techniques. Thus, the conditioning of socially desirable behaviour regularly carried out in the clinic laboratory can be continued by mothers at home.

Conclusion

At present in Nigeria, the average child and the superior one may be able to manage in the present educational system, but the child who has a "treatable" emotional disorder or who suffers from any kind of organic brain pathology is lost. The few centres in Nigeria for handicapped children are used mainly for children with gross physical handicap. These centres do not provide for children with learning problems. Often a "temporary" dysfunction (improvement sometimes occurs with time in cases of brain-damage) puts a child hopelessly behind at a *critical* time, and there is no way, with the present system, that he can catch up. These children need a considerable amount of structured training. They need not be neglected any longer.

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