

## ORIGINAL PAPER

Olayinka O. Omigbodun

# Psychosocial issues in a child and adolescent psychiatric clinic population in Nigeria

Accepted: 25 February 2004

**Abstract** *Background* Psychosocial issues and interventions play a very important role in the aetiology, course and prognosis of several child psychiatric disorders. Psychosocial problems in a child and adolescent psychiatric clinic population in Nigeria were documented as a preliminary step towards the planning and development of this new facility. *Methods* A standardised assessment procedure was integrated into the routine at the clinic when services commenced. Psychosocial stressors and life events were measured using the interview method so that in-depth information could be obtained. *Results* Over the 3-year period of study, 79 (62.2%) of the 127 new referrals to the clinic had significant psychosocial stressors in the year preceding presentation. Problems with primary support, such as separation from parents to live with relatives, disruption of the family, abandonment by mother, psychiatric illness in a parent and sexual/physical abuse, occurred in 50 (39.4%) of the subjects. Problems with social environment occurred in 11 (8.7%), 39 (30.7%) had educational problems, 5 (3.9%) had economic problems and 15 (11.8%) of the children had 'other' psychosocial stressors. Significantly more children and adolescents with disruptive behaviour disorders and disorders like enuresis, separation anxiety and suicidal behaviour had psychosocial stressors when compared to children with psychotic conditions, autistic disorder and epilepsy ( $\chi^2 = 9.6$ ;  $p = 0.048$ ). *Conclusions* The importance of the psychosocial diagnostic dimension in routine practice is illustrated in this study. Some psychosocial factors identified are cultural practices. The effects of these practices on child mental health require further study.

**Key words** psychosocial – child psychiatry clinic – Nigeria

## Introduction

The practice of child and adolescent psychiatry is still at the stage of infancy in Nigeria. Despite the fact that 48% of the country's 123 million people are less than 15 years old (Federal Ministry of Health 1996), there are very few facilities that cater for children and adolescents with mental health problems. In tertiary facilities where most of the psychiatric infrastructure and expertise are concentrated, there were no psychiatric treatment facilities for children or adolescents up until recently.

Within the last 3 years, two outpatient child and adolescent specialty clinics within tertiary psychiatric centres commenced services, and referrals to these centres are gradually increasing. In order to develop and improve services, it is important to identify patterns of clinical presentation and associated factors such as psychosocial problems. There are a few studies of the pattern of psychopathology of children and adolescents presenting to general psychiatric facilities in Nigeria (Olatawura and Odejide 1976; Oyewumi 1989; Lustig and Maldonado 1999), but studies identifying specific psychosocial issues in children and adolescents attending psychiatric facilities are yet to be carried out in this environment.

It is well established that psychosocial factors play an important role in the aetiology of several child psychiatric conditions (Berden et al. 1990; Shaw et al. 1994; Biederman et al. 1995; Rey et al. 2000; Rubia and Smith 2001) and an increase in the number of life events has been found in children referred to outpatient child psychiatric services (Goodyer et al. 1985, 1987). Furthermore, psychosocial factors have been found to affect the course and prognosis of these disorders, while psychosocial interventions have been found to reduce and prevent disorders (Goor-Lambo et al. 1990; Bennett and Offord 2001).

O. O. Omigbodun, M.B.B.S., MPH, FMCPsych. (✉)  
Dept. of Psychiatry  
University College Hospital  
P.M.B. 5116  
Ibadan, Nigeria  
Tel.: +234-2/2414102  
E-Mail: 4yinkas@skannet.com

In developing and planning for this facility, several questions need to be answered concerning psychosocial factors in this setting. Are there psychosocial factors of public health importance? What is the association between specific psychosocial factors and diagnostic categories? What influence does culture have on the manifestation of psychosocial factors? This study therefore looks at the prevalence and pattern of psychosocial problems in children and adolescents attending a child psychiatric clinic in Nigeria. This is a preliminary step towards identifying the psychosocial issues in this population and the possible role cultural beliefs, attitudes and practices may play.

## Subjects and methods

The University College Hospital Ibadan, Nigeria (UCH) was the first and the only university teaching hospital in Nigeria, and indeed the West African sub-region, for 10 years after its inception in 1952. It has 45 specialty and subspecialty disciplines, including psychiatry. For many years, there were only general psychiatry outpatient clinics running twice a week, with child and adolescent referrals being seen as a part of these clinics. However, in 2000, two psychiatry specialty clinics commenced operation, an Old Age Clinic and a Child and Adolescent Clinic for children and adolescents (0–17 years) who were referred to UCH for psychiatric assessment.

### Assessment and instruments

#### Psychiatric diagnosis

When services commenced, a standardised assessment procedure was integrated into the routine at the clinic. This procedure involves a psychiatric interview with a psychiatric history and mental status examination carried out. After this assessment, each new referral has a semi-structured questionnaire completed for them using 'The Clinical Interview Form for Child and Adolescent ADHD Patients' (Barkley 1991). This contains questions pertaining to the child's development, medical, academic, social history and also the current symptom lists for most of the childhood psychiatric disorders listed in DSM-III-R, which the author adapted to DSM-IV (American Psychiatric Association 2000). This interview form was selected because of the comprehensive information obtained and its clinical setting applicability, usefulness for preparing clinical reports and the fact that it can be used to set up a database of information (Barkley 1991).

#### Psychosocial diagnosis

Psychosocial stressors and life events were measured using the interview method so that in-depth information such as the impact of the event, reasons why it happened, people involved and living conditions could be taken into cognisance. This qualitative method was used because this study was looking at cultural aspects and practices, which may not be present in standard instruments. The format on axis IV on DSM-IV was used (American Psychiatric Association 2000) and only psychosocial and environmental problems present in the year preceding the initial evaluation were noted, except if it was clear that the problem was contributing to symptoms. All assessments were carried out by the author who is in charge of the child and adolescent clinic or by a resident who had been trained by the author and whose findings were reviewed by the author. At the end of the assessment, each child has a diagnosis using the DSM-IV multi-axial criteria (American Psychiatric Association 2000).

### Analysis of data

■ **Qualitative.** Interviews were coded to identify emergent issues, which were subsequently grouped into the various categories of psychosocial problems.

■ **Quantitative.** Statistical analysis was by means of the Statistical Package for the Social Sciences, SPSS-10.1 (SPSS 2001). Statistical significance was set at  $p < 0.05$  (two-tailed test).

## Results

There were 127 new referrals over the 3-year period. The ages ranged from 2 to 17 years with a mean age of 12.07 (SD 3, 9). The socio-demographic characteristics of the patients are shown in Table 1. A preponderance of boys was observed at all the age groups. At age 6 years and under, there were 13 (87%) boys and 2 (13%) girls, while at ages 13 and over, there were 42 (60%) boys and 28 (40%) girls. Thirty-five children (27.6%) were not attending school and about 20% of the children had travelled from other towns and cities to attend this clinic.

Table 2 shows the psychiatric diagnostic categories on Axis I according to DSM-IV. Some of the children had more than one psychiatric diagnosis on Axis I, but this paper reports on the main diagnosis. Thirty-seven (30%) of the children had an Axis II diagnosis of mental retardation. Two patients had attempted suicide following relationship difficulties. Fourteen children had a DSM-IV Axis III diagnosis of epilepsy (3 had generalised seizures and 11 had complex partial seizures). Children with challenging behaviour did not have a diagnosis on Axis I, but had presented with difficult behaviour which gave their carers some concern. Six of the 9 children with challenging behaviour had an Axis II diagnosis of mental retardation.

**Table 1** Socio-demographic characteristics

	N (%)
Gender	
Male	79 (62)
Female	48 (38)
Age	
6 years and under	15 (12)
7–12 years	42 (33)
13 years and over	70 (55)
Class at school	
Nursery/Primary school	34 (26.8)
Junior Secondary School	17 (13.4)
Senior Secondary School	37 (29.1)
Special school	2 (1.6)
Koranic school	1 (0.8)
University	1 (0.8)
Out of school	35 (27.6)
Location of residence	
Within Ibadan	100 (79)
Out of Ibadan	27 (21)

**Table 2** DSM-IV Axis I diagnostic categories indicating the presence or absence of mental retardation (N = 127)

Diagnosis (DSM-IV Axis 1)	Mental retardation		Total N (%)
	Absent	Present	
Bipolar Disorder	14	–	14 (11.0)
Schizophrenia	14	1	15 (11.8)
Other Psychotic Disorders	22	4	26 (20.5)
Autistic Disorder	3	12	15 (11.8)
Major Depressive Disorder	2	–	2 (1.6)
Enuresis	3	1	4 (3.1)
Separation Anxiety Disorder	1	1	2 (1.6)
Conversion Disorder	1	–	1 (0.8)
Pica	1	1	2 (1.6)
Conduct Disorder	14	–	14 (11.0)
Attention Deficit Hyperactivity Disorder	1	5	6 (4.7)
Oppositional Defiant Disorder	1	–	1 (1.6)
Suicidal behaviour	2	–	2 (1.6)
Challenging behaviour	3	6	9 (7.1)
Epilepsy	8	6	14 (11.0)
Total	90	37	127 (100.0)

#### ■ Axis IV: psychosocial and environmental problems

Psychosocial stressors present in the year preceding presentation to the child and adolescent psychiatric clinic were identified in 79 (62.2%) of the patients. These included problems with primary support group [50 (39.4%)], problems related to the social environment [11 (8.7%)], educational problems [39 (30.7%)], economic problems [5 (3.9%)] and 'other' problems [15 (11.8%)]. Within each of the aforementioned groups, the specific psychosocial stressors encountered are displayed in Table 3. Many of the children had two or more psychosocial stressors. Severe traumatic experiences include involvement in a serious road traffic accident, armed robbery or having to undergo major surgery.

#### ■ Qualitative analysis of specific psychosocial stresses

The following cultural practices, beliefs and social problems influencing psychosocial stressors, which may be peculiar to this environment, were identified:

- Separation from parents to live with other persons for financial reasons or to correct behaviour
- Abandoned child with epilepsy due to beliefs about the disease
- Kept in a traditional healer's home for several years
- While on admission in hospital, relatives give 'traditional' treatment (patient had scarification's applied to parts of body while on admission)
- Physical abuse by carers to get rid of the demons responsible for psychosis or conduct problems
- Use of child labour as housemaids

**Table 3** Specific psychosocial stressors identified (N = 127)

Problems with primary support group	50 (39.4)
Separation from parents	41 (32.3)
Disruption of family	20 (15.7)
Abandoned by mother/parents	4 (3.1)
Serious psychiatric illness in a parent	9 (7.1)
Sexual/physical abuse/emotional neglect	10 (7.9)
Problems related to the social environment	11 (8.7)
Living on the streets	4 (3.1)
Living in an institution	6 (4.7)
Educational problems	39 (30.7)
Poor academic performance	11 (8.7)
Out of school/lack of appropriate school	24 (18.9)
Discord with teachers and/or classmates	3 (2.4)
Removed from formal school into Koranic school	1 (0.8)
Economic problems	5 (3.9)
Extreme poverty	4 (3.1)
Other stressors	15 (11.8)
Parent/s removing child from hospital against medical advice	3 (2.4)
Presence of tribal marks on face leading to discrimination	1 (0.8)
Spent considerable time in traditional healer's home	5 (3.9)
Engaging in prolonged fasting for religious reasons	2 (1.6)
Severe traumatic experience	6 (4.7)
Unavailability of drug that may help improve condition	2 (1.6)

- Living on the street with mentally ill parent for several years before removal to a safe place
- Parents obtaining discharge against medical advice to seek alternative treatment
- Children embarking on prolonged periods of fasting for religious purposes.

For the purposes of this study, the diagnoses were further conflated into five discrete groups:

1. Psychotic (Schizophrenia, other Psychotic Disorder, Bipolar Disorders)
2. Epilepsy (Generalised and Temporal Lobe)
3. Autistic Disorder
4. Disruptive Behaviour (Attention Deficit Hyperactivity Disorder and Conduct Disorder)
5. Others [Depression (without psychosis), Pica, Enuresis, Separation Anxiety, Suicidal Behaviour, other challenging and difficult behaviour].

Table 4 displays the association between these diagnostic categories and psychosocial stressors. Children with an Axis I diagnosis of disruptive behaviour disorder or 'other' disorders were more likely to have a psychosocial stressor. Problems with the primary support group were also significantly more frequent in children with disruptive behaviour disorders, while educational problems were commoner in the autistic group.

## Discussion

The preponderance of boys among the patients is in keeping with epidemiological studies of psychiatric ill-

**Table 4** Association between diagnostic categories and psychosocial stressors

Psychosocial categories	Diagnostic categories					p
	Psychotic N = 39 n (%)	Autistic N = 15 n (%)	Epilepsy N = 14 n (%)	Disruptive N = 21 n (%)	Other N = 22 n (%)	
Psychosocial stressor	30 (54.5)	9 (60)	6 (42.9)	18 (85.7)	16 (72.7)	0.048*
Primary support group	17 (30.9)	3 (20)	4 (28.6)	16 (76.2)	10 (45.5)	0.002*
Education problems	11 (20)	9 (60)	3 (21.4)	7 (33.3)	9 (40.9)	0.03*
Social environmental	3 (5.5)	–	2 (14.3)	4 (19)	2 (9.1)	0.234
Economic	3 (5.5)	–	1 (7.1)	–	1 (4.5)	0.69
Others	8 (14.5)	–	1 (7.1)	3 (14.3)	3 (13.6)	0.57

\* Significant difference

ness in childhood (Sheerin et al. 1999). The increase in the proportion of older girls is also typical of most child psychiatric samples (Sandberg et al. 1993) as an increase in mental health symptoms in girls at the onset of puberty has been observed (Lawlor and James 2000). A quarter of the children who attended the clinic were not in school. This important observation is discussed below alongside educational psychosocial problems. A fifth of the children had travelled from other towns and cities several kilometres away to attend this clinic. This further substantiates the rarity of child and adolescent mental health services and the need for available, accessible services.

The diagnostic categories observed in this setting are similar to what has been described in other child and adolescent psychiatric populations both here in Nigeria and other parts of the world (Oyewumi 1989; Lustig and Maldonado 1999; Sheerin et al. 1999). The main difference is in the presence of children with epilepsy in this clinic. Most of the children who had a diagnosis of epilepsy had the complex partial type and had presented with recurrent episodes of abnormal behaviour with a confirmation of complex partial seizures made on the electro encephalogram (EEG). Therefore, the presentation of these children to this clinic may be due to these clinical features of complex partial seizures. Complex partial seizures are usually preceded and followed by behavioural changes which may be mistaken for psychiatric disorder (Graham et al. 2001). The presentation of children with grand mal epilepsy to this clinic may be due to cultural beliefs, as many communities in Nigeria perceive grand mal epilepsy as a form of severe mental illness (Curran 1984).

The importance of a psychosocial diagnostic dimension in routine clinical practice is illustrated by the fact that more than 60% of the children and adolescents had experienced severe stressors in the year preceding presentation to the clinic. Unfortunately, in actual practice, the psychiatric diagnosis (Axis I) is still given greater importance than the psychosocial dimension (Zalman et al. 2001).

The commonest psychosocial stressor found in this clinic population is the problem with primary support. In a study of 1,284 life event experiences by 108 children

and adolescents over an 18-month period, about a third of all events were related to the child's family life (Sandberg et al. 1993). The events with a high long-term threat were those involving marriage and separation, death, family conflicts and moves. Higher family event scores have also been found in children referred for psychiatric assessments (Berden et al. 1990).

Physical abuse, sexual abuse or emotional neglect was found in 8% of this sample. Child maltreatment is a major public health problem that has a wide range of effects. Children and adults who have suffered child sexual abuse are known to have higher rates of psychiatric disorders (MacMillan and Munn 2001). Physically abused children are also known to have higher rates of psychiatric disorders and are more likely to abuse their own children (MacMillan and Munn 2001). The children in this study who reported physical abuse described repeated beatings with belts and rods and had physical evidence of such on their bodies. This is an important issue which must have a balanced approach in this culture. Corporal punishment is used quite freely on both boys and girls in Nigerian society (Ebigbo 1993), both for minor infractions and serious offences, and this is widely reported by school children. Corporal punishment is, however, not limited to the Nigeria setting, but cuts across several different cultures. It is described as an important child-rearing technique in the Caribbean (Smith and Mosby 2003). Forty per cent of a general public sample interviewed in Canada felt that it is a necessary means of punishment (Ateah and Parkin 2002), and 58% of the physicians working in a paediatric department in Israel said they approved of corporal punishment (Tirosh et al. 2003). The authors in the Canadian study suggest that, since the attitudes to corporal punishment are known, parent education must include information related to the risks of this mode of discipline. In this environment, the practice is based on cultural and religious beliefs. In preventing physical abuse in our society, the use of corporal punishment must be studied in depth for possible modification and a clear separation made from overt physical abuse (Lan et al. 2003).

The universality of the types and distribution of stressors show up in the greater influence of stressors in the disruptive behaviour disorders. Similar to this study,

poor family environment has been shown to be more important for conduct disorder (Rev et al. 2000) and ADHD (Biederman et al. 1995). This finding indicates that psychosocial categories are relevant to the setting and to the understanding of child and adolescent psychopathology (Zalsman et al. 2001).

Other aspects of culture identified are separation from parents to live with relatives and other people, physical abuse as a remedy for demonic possession in conduct disorder, and children being sent out of school due to beliefs about epilepsy being contagious.

Separation from parents was the most frequent stressor experienced in all the diagnostic groups, although this was significantly higher in the disruptive behaviour disorder group. Studies on childcare in Nigeria reveal that as a part of the culture, families send their children to other relatives living in other cities, towns and villages (Hake 1972). This was more common in situations when the other relative is more prosperous. In a community survey of adults, 20 % of subjects indicated that their real mothers did not raise them. In the same study, 8.4 % of the respondents described the unhappiest times of their childhood as when they had to leave home and live with others. Some reported that they felt deserted by their parents, felt lonely and the deferential treatment the other children in the family received was unbearable. This practice of sending children away from their parents early in childhood leading to great distress was also the observation in Sri Lanka (De Silva et al. 1988). In Sri Lanka, it was observed that many parents would leave their children in the care of the extended family in order to work, only to return several years later to take the child back, oblivious to the distress they may have caused the child. The impact of this practice on child mental health requires further study in this environment.

Other cultural aspects identified in this study are beliefs of demonic possession giving rise to mental health problems. This belief led to child abandonment, physical abuse and children being kept away in traditional healers' homes for several years. As a result of these practices, many children and adolescents were kept out of school and suffered dire complications as a result of their experiences. Beliefs about causation also led some parents to remove their children from hospital to take them for alternative treatment, in some instances, just a few days after admission. In a study of the attitudes of families caring for patients with mental illnesses in Nigeria, the commonest aetiological belief about the causation of these illnesses was 'Satan's work' found in 35.8 % (Ohaeri and Fido 2001). These findings reveal an urgent need for health education in the community.

Many children were out of school because there are no schools suited to handle their peculiar needs. The children with autistic disorder were significantly more likely to have this psychosocial problem. The few available schools for children with special needs in Nigeria tend to cater for the physically disabled. In the city where this study was carried out, there is just one school for

children with mental disabilities and this school has no facilities and no human or material resources to cater for the peculiar needs of these children. This is unfortunate as clear benefits have been found with the early behavioural intervention and education of autistic children (Bryson et al. 2003).

This study identified children who had lived on the streets with a psychotic parent for several years before being rescued. In a situation analysis of children in especially difficult circumstances in Nigeria, it was observed that poverty had contributed to the breakdown in family structures, which in turn had produced more abandoned children and destitute families (UNICEF B Zone 1996). Many of these children and adolescents suffered greatly in situations that are preventable. Unfortunately, they are frequently left in these adverse situations until complications occur.

Another interesting psychosocial issue affecting these children is prolonged fasting. This also requires urgent attention. There appears to be increased religious activity in Nigeria which will partly account for the children seen after prolonged periods of fasting. If a lot of children and adolescents are participating in this activity, this has far-reaching implications.

The unavailability of psycho-stimulants such as methylphenidate for the control of ADHD limits the choice of medication to the tricyclic antidepressants in Nigeria. This causes a lot of distress for parents, children and health workers. It is hoped that drug companies will increase the variety of drugs available for this and other conditions.

Limitations of this study are that a non-structured approach was used to obtain information about psychosocial stressors, thereby leaving the possibility of missing out some aspects. Besides, all the children and adolescents had mental health problems; therefore, results from such a sample cannot be generalised to the community.

---

## Conclusion

This is a preliminary study identifying psychosocial issues in a new child psychiatry clinic in a developing country. The importance of the psychosocial diagnostic dimension in routine practice is illustrated in this study. The universality of the types and distribution of some stressors such as poor family environment on disruptive behaviour disorders is identified. Some interesting cultural practices were also identified as potential stressors. Studying the effect of some of these cultural practices in the community is highly desirable.

---

## References

1. American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders, Fourth Edition, Text Revision (DSM-IV-TR). American Psychiatric Association Washington, D.C.

2. Ateah CA, Parkin CM (2002) Childhood experiences with, and current attitudes toward corporal punishment. *Can J Commun Ment Health* 21:35–46
3. Barkley RA (1991) *Attention-Deficit Hyperactivity Disorder: A clinical workbook*. New York: The Guilford Press, London
4. Bennett KJ, Offord DR (2001) Conduct disorder: can it be prevented. *Curr Opin Psychiatry* 14:333–337
5. Berden GF, Althaus M, Verhulst FC (1990) Major life events and changes in the behavioural functioning of children. *J Child Psychol Psychiatry* 31:949–959
6. Biederman J, Milberger S, Faraone SV (1995) Family environment risk factors for ADHD. *Arch Gen Psychiatry* 52:464–470
7. Bryson SE, Rogers SJ, Fombonne E (2003) Autism spectrum disorders: early detection, intervention, education and psychopharmacology. *Can J Psychiatry* 48:506–516
8. Curran V (1984) Nigerian Children: Developmental perspectives. Routledge & Kegan Paul, London
9. De Silva M, Nikapota A, Vidyasagara NW (1988) Advocacy and opportunity – planning for child mental health in Sri Lanka. *Health Policy Plan* 3:302–307
10. Ebigbo PO (1993) Child abuse and neglect in Nigeria – a situation analysis. *Niger Pop* 10:4
11. Federal Ministry of Health (1996) *Health in Nigeria: 1994/95 Health Management Information System*, Federal Ministry of Health. Abuja
12. Goodyer IM, Kolvin I, Gatzanis S (1985) Recent undesirable events and psychiatric disorders in childhood and adolescence. *Br J Psychiatry* 147:517–523
13. Goodyer IM, Kolvin I, Gatzanis S (1987) The impact of recent undesirable events on psychiatric disorders in childhood and adolescence. *Br J Psychiatry* 151:179–184
14. Graham P, Turk J, Verhulst F (2001) *Child Psychiatry: A Developmental Approach* 3<sup>rd</sup> Edition. Oxford University Press, London
15. Hake JM (1972) *Child rearing practices in Northern Nigeria*. Ibadan University Press. Ibadan
16. Lau JT, Chan KK, Lam PK, Choi PY, Lai KY (2003) Psychological correlates of physical abuse in Hong Kong Chinese adolescents. *Child Abuse Negl* 27:63–75
17. Lawlor M, James D (2000) Prevalence of psychological problems in Irish school going adolescents. *Ir J Psych Med* 17:117–122
18. Lustig SL, Maldonado JR (1999) Diagnoses of children and adolescents on initial presentation to a Nigerian outpatient psychiatry clinic. *Int J Soc Psychiatry* 45:190–197
19. MacMillan HL, Munn C (2001) The sequelae of child maltreatment. *Curr Opin Psychiatry* 14:325–331
20. Ohaeri JU, Fido AA (2001) The opinion of caregivers on aspects of schizophrenia and major affective disorders in a Nigerian setting. *Soc Psychiatry Psychiatr Epidemiol* 36:493–499
21. Olatawura MO, Odejide AO (1976) Child psychiatric disorders in Ibadan, Nigeria. *Niger J Paediatr* 3:9–14
22. Oyewumi LK (1989) Inpatient adolescent psychiatry in a teaching hospital in Nigeria. *Acta Psychiatr Scand* 80:639–643
23. Rey JM, Walter G, Plapp JM, Denstire E (2000) Family environment in attention deficit hyperactivity, oppositional defiant and conduct disorders. *Aust N Z J Psychiatry* 34:453–445
24. Rubia S, Smith A (2001) Attention deficit hyperactivity disorder: current findings and treatment. *Curr Opin Psychiatry* 14: 309–316
25. Sandberg S, Rutter M, Giles S, Owen A, Champion L, Nicholls J, Prior V, McGuinness D, Drinnan D (1993) Assessment of psychosocial experiences in childhood: methodological issues and some illustrative findings. *J Child Psychol Psychiatry* 34:879–897
26. Shaw DS, Vondra JI, Hommerding KD, Keenan K, Dunn M (1994) Chronic family adversity and early child behaviour problems: a longitudinal study of low income families. *J Child Psychol Psychiatry* 35:1109–1122
27. Sheerin D, Maguire R, Robinson J (1999) A 15 month follow-up study of children admitted to a child psychiatric inpatient unit. *Ir J Psych Med* 16:97–103
28. Smith DE, Mosby G (2003) Jamaican child-rearing practices: the role of corporal punishment. *Adolescence* 38:369–381
29. Tirosh E, Offer Shechter S, Cohen A, Jaffe M (2003) Attitudes towards corporal punishment and reporting of abuse. *Child Abuse Negl* 27:929–937
30. Unicef B Zone (1996) *Situation analysis of children in especially difficult circumstances (CEDC) in Nigeria*. UNICEF B Zone, Ibadan, Nigeria
31. Van Goor-Lambo G, Orley J, Poustka F, Rutter M (1990) Classifications of abnormal psychosocial situations: preliminary report of a revision of a WHO scheme. *J Child Psychol Psychiatry* 31: 229–241
32. Zalsman G, Horesh N, Arzi R, Edelist D, Even DH, Tyano S, Poustka F, Apter A (2001) Psychosocial diagnosis in psychiatrically hospitalised adolescents. *Compr Psychiatry* 42:223–227