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Prevalence of the attention deficit hyperactivity disorder in the primary school children and its association with the family function in Abou-Khalifa village

Thesis Submitted for partial fulfillment
Of the master degree in family medicine

By

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بسم الله الرحمن الرحيم

وقل اعملوا فسيرى الله عملكم ورسوله والمؤمنون

صدق الله العظيم

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Introduction and Rational

Over the last decade, it has become increasingly evident that hyperactivity and attention problems are significant contributors to serious psychiatric disturbances in childhood and adolescence. **(Szatmari et al. 1989).**

Surveys have consistently demonstrated that hyperactivity disorder is common, at certain ages, perhaps the most common psychiatric disorders of childhood. The prevalence rate ranges from 3.2% to 17% **(Szatmari et al. 1989).**

Although hyperactivity in children is frequently diagnosed, the condition is poorly defined and prevalence data in this part of the world, are not available. There are many good reasons for demographic studies of hyperactivity syndrome. First, hyperactivity is the most frequent cause of referral of children to clinics, special services in schools and other professional resources. Second there is increasing awareness that hyperactivity in children is a risk factor for problems in adolescence and adulthood **(Gittelman et al. 1985; Weiss and Hechtman, 1986);** hyperactivity has been implicated in social behaviour, alcoholism. Third cross-cultural studies offer an opportunity to compare rates of occurrence, and if differences

are found, this may provide information regarding the causes and pathogenesis of the disorder (**Luk et al. 1988**).

Prevalence estimates for the hyperactivity syndrome in children vary considerably, ranging from a low slightly over 1% to 15% (**Sharag and Divoky, 1985**). The most frequently quoted estimates arc in the range of 5-10% , but in 40% of children seen by psychiatrists in the United States (**Greenberg and Lipman, 1971**), but only 1.6% of psychiatrically diagnosed children in the Isle of Wight studies (**Rutter, Tizard and Whitmore, 1970**). Such large differences are very difficult to account for may by due to nothing more than the condition in different countries being labeled differently.

Many of the troubles youngsters and adolescent experience in their lies at school or home require early and special effort at diagnosis and intervention. Recent data indicate that 10 t 20 percent of all students in schools need some sort of mental health support and/or intervention (**Costello, 1989**) and that many require help with their learning problems (**Silver, 1989**).

(**El-Sherbirni et al. 1981**) in their survey of three primary schools in Egypt identified psychiatric problems in 10% of the children studies. However, their findings did not include mental retardation and psychiatric disorders or

epilepsy. Clinically attention Deficient Hyperactivity Disorder (ADHD) worsens as the child grows older resulting in adolescent problem, academic failure, severe antisocial behavior and depression, if it persists into adulthood it my encroach upon every aspect of adult life. **(Satterfield et al. 1994).**

In Egypt, **El-Defrawi, (1992)** suggested in his study on a sample of psychiatrically referred children that 34% of them have attention deficit hyperactivity disorder, 29% functional enuresis, 16% have undifferentiated attention deficit disorder and 10% have disruptive behaviour disorders. Moreover, school children with early cognitive and definite problems are at risk for late educational delays, child abuse and poor school performance **(Zeitoun and Sarhan 1992).**

There are three main reasons for the concern of mental health professionals about psychiatric intervention within the school-age stage of development. First is that recent evidence from developmental and experimental data suggests that effort for primary prevention and early intervention needs to begin early in life **(Horacak et al., 1987).** In a report of a study of seven primary care centers, 5 to 15 percent of untreated children were recognized as having behavioral problems **(Strafield et al, 1980).** Follow-up data of children diagnosed as having attention deficit hyperactivity disorders showed that they suffer drug problems, sociopathy and were not successful in their social and occupational functioning, **(Borland and**

Haekman, 1976). Second, most school-age children are sent to psychiatric clinics because of behavioral problems in school or problems that interfere with, of affect their academic performance **(Strafield et al, 1980).** Third, in primary prevention and for early intervention when applied can only occur on a mass basis in system already targeted to professional involvement with school-age children and adolescent **(Silver and Brunstetter, 1987).**

The impact of the environment of the mental health of children has been reviewed . The studies concludes that a range of features of both physical and social environments contribute to the increased rates of psychological problems in urban settings. This situation appears to arise because families with a range of psychological difficulties are found in certain urban areas with poor physical environmental influences poor housing particular.

A strong potential mediator of any increase in behaviour problems in the school child is the mental state of the mother. A wide range of studies have identified adverse influences of depression in the mother either immediately, postnatal or subsequently on the behavioral development of the child. Mothers who move to urban areas are more likely to be depressed, probably through a fragmentation of social support a link between maternal depression and adverse aspects of the physical environment was found that Children with a depressed