Psychological Disorders of Children

A Handbook for Primary Care Physicians

Mark A. Stewart, M.D.
Ann Gath, D.M.

Psychological Disorders of Children

A HANDBOOK FOR PRIMARY CARE PHYSICIANS

Mark A. Stewart, M.D.

The Ida P. Haller Professor of Child Psychiatry
The University of Iowa College of Medicine
Iowa City, Iowa

Ann Gath, D.M.

Consultant Child Psychiatrist
Borocourt Hospital
Berkshire, England

The Williams & Wilkins Company • Baltimore

Made in the United States of America

Library of Congress Cataloging in Publication Data

Stewart, Mark A
Psychological disorders of children.

Bibliography: p.
Includes index.
1. Mentally ill children. I. Grath, Ann, joint author. II. Title.
RJ499.S795 618.9'28'9 77-10316
ISBN 0-683-97179-9

Composed and printed at the
WAVERLY PRESS, INC.
Mt. Royal and Guilford Aves.
Baltimore, Md. 21202, U.S.A.

Psychological Disorders of Children

This book is dedicated
to Mike McCabe, a colleague
whose warmth, zest, and keen mind
we sadly miss.

Preface

We hope that this book will be a handy introduction to child psychiatry, and that any clinician who works with disturbed children, or any student preparing for such work, will find it useful. As child psychiatrists we have aimed the book primarily at residents in psychiatry, pediatrics, and family practice, nurse practitioners and psychiatric nurses, and medical students, but we hope that it will also appeal to students in clinical psychology and other fields. The book follows the lines of a medical textbook, but we do not believe that the traditional medical model fits all the problems of children. We have presented these clinical problems as though they were cut and dried, but do not want to imply that they are diseases. Furthermore, we have tried to present the data from studies based on psychological theory as well as data on genetic and other biologic determinants.

We have a personal reason for writing this book: to defend ourselves against our friend and constant critic, George Winokur. Adult psychiatrists have recently acquired scientific respectability by making diagnosis reliable, doing follow-up studies, and building knowledge of genetic and other biologic influences. With their new found self respect, our colleagues in adult psychiatry have been looking down their noses at child psychiatrists and wondering out loud when we will start to behave ourselves properly. In fact, there is plenty of hard information in the field of child psychiatry, and this book cites enough data to admit us to good academic company. If it does so, much of the credit is due to the work of Michael Rutter. The quality, breadth, and importance of his research in child psychiatry is illustrated by the fact that almost every chapter in this book includes references to his work.

Finally, we have tried to avoid sectarian thinking as far as possible. This is neither a Freudian nor an "organic" book. We have aimed to present the data and leave readers to interpret them.

Acknowledgments

The authors and publisher gratefully acknowledge the following publishers' permission to reproduce previously copyrighted material:

Penguin Books Ltd., *My Childhood,* Maxim Gorky (Translater: Ronald Wilks), ©1966, Ronald Wilks.

Little, Brown and Company, *The Ordeal of Gilbert Pinfold*, Evelyn Waugh.

Nervous Child, Autistic Disturbances of Affective Contact, by Leo Kanner, Volume 2, 1942.

W. W. Norton & Company, Inc., *The Psychology of Personal Constructs,* Vol. 1, Constructive Alternativism, by George A. Kelley.

Alfred A. Knopf, Inc., *Huey Long*, by Harry T. Williams.

Doubleday & Company, Inc., *Of Human Bondage*, by Somerset Maugham, ©1915, Somerset Maugham.

Harcourt Brace Jovanovich, Inc., *A Collection of Essays,* Such, Such Were the Joys, by George Orwell.

Munksgaard International Publishers Ltd., *Reading Disability,* Autobiographies, by K. Hermann.

Developmental Medicine and Child Neurology, Dyslexia in Children and Young Adults, by S. Mattis, J. H. French, and I. Rapin, Volume 17, 1975.

American Journal of Public Health, An Epidemiologic Study of Behavior Characteristics in Children, by R. Lapouse and M. A. Monk, Volume 48, 1958.

British Medical Journal, Organic Brain Dysfunction and Child Psychiatric Disorder, by P. Graham and M. Rutter, 1968.

American Journal of Orthopsychiatry, The Hyperactive Child Syndrome, Volume 36, Number 5.

British Journal of Psychiatry, The Phenomenology of Childhood Psychosis, by I. Kolvin et al., Volume 118, 1971.

Developmental Medicine and Child Neurology, Dyslexia in Children and Young Adults, by Steven Mattis, J. H. French, and I. Rapin, Volume 17, 1975.

British Journal of Psychiatry, A Five to Fifteen Year Follow-up Study of Infantile Psychosis: II. Social and Behavioral Outcome, by M. Rutter, D. Greenfeld, and L. Lockyer.

American Journal of Public Health, An Epidemiologic Study of Behavior Characteristics in Children, by R. Lapouse and M. A. Monk, Volume 48, 1958.

British Journal of Psychiatry, Tics and Gilles de la Tourette's Syndrome, by J. A. Corbett et al., Volume 115, 1969.

American Journal of Mental Deficiency, Effects of Combining Methylphenidate and a Classroom Token System in Modifying Hyperactive Behavior, by D. E. Christensen.

Macmillan Publishing Co., Inc., *The Cook's Wedding and Other Stories*, by Anton Chekhov. Translated from the Russian by Constance Garnett. ©1922 by Macmillan Publishing Co., Inc., renewed 1950 by David Garnett.

Contents

CHAPTER 1

Diagnosis

> Man looks at his world through transparent patterns or templates which he creates and then attempts to fit over the realities of which the world is composed. The fit is not always very good. Yet without such patterns the world appears to be such an undifferentiated homogeneity that man is unable to make any sense out of it. Even a poor fit is more helpful to him than nothing at all.
>
> George A. Kelly, *A Theory of Personality*, 1963

Classification is so necessary to the acquisition of knowledge that it may seem foolish to defend the value of diagnosis in child psychiatry. We feel obliged to do so, at least briefly, because a generation of psychiatrists and child psychiatrists in the United States has treated diagnosis with disdain and this attitude persists among professors and practicing clinicians. Psychodynamically oriented psychiatrists do have their own system of diagnosis, but this is based on assumed etiology rather than on behavioral syndromes. Given our present ignorance as to what causes children to have emotional and behavioral problems, such a system is not warranted and the proper approach to classification is phenomenologic.

IN DEFENSE OF DIAGNOSIS

Throughout medicine there is a certain conflict between the need to diagnose disease in patients' organs and the need to treat patients as people. In psychiatry the conflict is more acute, for several reasons. First, there are some who believe that labeling a patient's psychological difficulties as one labels disorders of renal or intestinal function affronts his or her humanity. A proper reply to this attitude is King Edward III's famous rebuke, "*Honi soit qui mal y pense.*"[1] There is nothing demeaning about a psychiatric diagnosis. Categorizing the problem is

[1] "Shame to him who thinks ill of it."

a first step in defining the treatment and probable outcome for the patient. In addition, one should appraise the patient's personality and background so as to make a statement about the patient which is both scientific and personal. A complete diagnosis predicts the course of the patient's problem based on general experience with a disorder and knowledge of the particular patient's situation.

Another and more rational objection to diagnosis is that it may imply that psychiatric problems can be treated as diseases, comparable to phenylketonuria or general paresis. In simple terms, this would mean that some pathologic process, anatomic or physiologic, underlies the behavioral symptoms. Some disorders in adult psychiatry (e.g. schizophrenia) may fit this medical model and others not (e.g. antisocial personality disorder); in child psychiatry there are few disorders that fit the model comfortably. The reader will find that Kendell (1975) has treated this issue fully. In any case, there is no reason other than habit that classification of psychiatric problems into syndromes should be taken to imply that they are diseases. Many terms in medicine and psychiatry categorize patients without making this assumption; for example, battered child, mental retardation, grief reaction, and presbyopia.

A damaging criticism is that the reliability of psychiatric diagnosis from one examiner to another, at least in the United States, is notoriously low. Psychiatrists have tended to adopt favorite diagnoses and to apply them indiscriminately. This seems to have resulted from a failure to take diagnosis seriously rather than from a failing in the diagnostic system. The work of Robins and his associates at Washington University has established that when specific and operational criteria are used, psychiatric diagnoses can be made with satisfactory reliability (Helzer *et al.*, 1977). Such criteria have been widely used in clinical research in the last few years[2] and are equally useful in teaching and practice. An immediate benefit of this rigorous approach has been that the validity of diagnosis has been established for the major psychiatric disorders through studies of their natural history and familial distribution.

Those who are skeptical that present psychiatric nomenclature, which is still relatively simple, allows one to make distinctions that are important may be convinced by Masterson's (1967) work on adolescent patients. The psychoanalysts' assertion that psychopathology was normal in adolescence seemed to him to obscure differences in the

[2] The paradigm is to be found in the criteria of Feighner *et al.* (1972).

types of disorders experienced by adolescents. He studied a series of 72 patients as they were first seen in a clinic and then followed them for 5 years. His experience showed that it was possible to separate adolescent patients into diagnostic categories used for adults and that the course of the disorders ran true to type. Masterson concluded the nihilism about diagnosis and the idea that all adolescents were subject to psychiatric problems were both likely to harm such patients by hindering them from getting proper treatment for their disorders.

Over the years Levy (1952), Eisenberg (1957), and other prominent child psychiatrists have warned against the dangers of neglecting diagnosis. Lurie (1947) described the case of an adolescent girl whose involuntary movements and obvious distress were patiently accepted for 2 years as signs of an adjustment reaction until she was re-examined and found to have Wilson's disease. Recently, one of the authors learned of a child who had all the signs of Sydenham's Chorea but was being treated by a psychiatrist for depression. A single such experience convinces one that psychiatric diagnosis is worth practicing, whatever its shortcomings.

HISTORY OF NOSOLOGY IN CHILD PSYCHIATRY

In the 1920's and 1930's leaders of thought in child psychiatry, such as Kanner of the Johns Hopkins University, recognized organic syndromes and psychoses in children but saw the common emotional and behavior problems of children as isolated symptoms rather than patterns or syndromes. Diagnostic formulations in Kanner's textbook *Child Psychiatry*, which was published in 1935, read like problem-oriented diagnoses of today. Two examples from the textbook will illustrate the point:

> Anxiety attacks, enuresis, and nail biting in a parentally and medically mismanaged, physically healthy, normally intelligent ten year old girl. . . . Stubborness, daydreaming, feeding problem, thumb sucking, masturbation, and specific reading disability in a normally intelligent seven year old boy with dental caries, mediastinal tuberculosis, and a history of many illnesses, badly spoiled.

Jenkins, of the Institute for Juvenile Research in Chicago, took the first step toward defining behavioral syndromes by applying factor analysis to the symptoms of 500 children seen in a Michigan psychiatric clinic. Hewitt and Jenkins (1946) found three clusters of symptoms which were relatively independent and which they labeled "unsocialized aggressive," "over-inhibited," and "socialized delinquency." Subsequent

work by several investigators in the United States and in England has confirmed the existence of the syndromes, but has so far failed to isolate other syndromes that are thoroughly valid, except for autism.

In the last decade, research in natural history, differential diagnosis, and family background has gone a long way toward defining the syndromes of hyperactivity and school phobia, but, as the reader will find in this book, a great deal of fundamental clinical research remains to be done in child psychiatry before the various disorders of childhood can be adequately described.

The present official nomenclature in the United States (American Psychiatric Association, 1968) includes a rather limited number of diagnoses for children, most of which are derived from the factor analytic studies previously mentioned. The *International Classification of Disease*, Number 6 (ICD 6) (Rutter *et al.*, 1975), which has been used in England for some time, allows a much wider range of diagnoses and is as comprehensive and specific as present knowledge makes possible. The system also enables one to code the child's developmental state, level of intelligence, associated medical disorders, and the possible psychosocial determinants of the problem, in addition to the child's actual disorder. As this book is written, the American Psychiatric Association is testing a third version of its *Diagnostic and Statistical Manual*. In writing the children's part of this manual, the editors have moved quite close to the *International Classification* and they have adopted a multiaxial approach.

INFORMATION NEEDED FOR DIAGNOSIS

The information needed for diagnosis comes from four main sources: reports by parents, the child, and others; observation and examination of the child; tests of the child's intellectual functions and school performance; and laboratory tests. With few exceptions, psychiatric diagnoses of children and adults are made primarily on the historical information provided by the patient and his or her relatives (Graham and Rutter, 1968; Helzer *et al.*, 1977; Rutter and Graham, 1968).

In this section we summarize the kinds of information needed (Table 1.1) and how it can best be obtained. For simplicity, we will describe a procedure which will fit the most common situation, the assessment of psychiatric disorder in a child of elementary school age. The child's history is the main basis for making the diagnosis; examination is crucial only to the diagnosis of disorders such as autism or brain syndromes.

Interviews with children between the ages of 5 and 12 years often

Table 1.1. Information needed for diagnosis

History
1. Presenting problems (description, frequency, context, duration)
2. Review of current behavior:
   a. Temperament traits (activity level, persistence with tasks, assertiveness, tractability, emotional reactivity, impulsiveness)
   b. Relationships (social responsiveness, affectionateness, relations with parents, siblings, and other children, number of friends)
   c. General attitudes and mood (degree of independence, approach to new situations, self esteem, depression, worrying, anxiety)
   d. Social behavior (response to authority and rules, sympathy and remorse, respect for other's property)
   e. Bodily functions (appetite, sleep, toilet habits, physical symptoms)
   f. Skills (school work, learning, speech and language, athletic ability)
3. Development, medical history, school record, police contact
4. Family background (members of family, who has raised child, parents' marital relationships, psychiatric history of parents and siblings)

Observation
1. Examination of child:
   a. Mental status (interactions with examiner, self confidence, mood, sociability, self expression, understanding, attention span)
   b. Physical (general, with emphasis on neurologic aspects and possible congenital anomalies)
2. Tests:
   a. Psychological (intelligence, school achievement levels, language skills)
   b. Laboratory (CBC, urinalysis, EEG)

provide useful historical information as well as allowing the examiner to assess the child's behavior and cognitive functions. The children are not likely to describe all of their difficulties spontaneously and they may not respond very well to direct questions. On the other hand, they will be surprisingly candid in answering questions like "What sort of things do you do that make your teacher mad?" A conversation of 20–30 minutes with a child of this age allows one to size up the child and get useful leads on what is wrong. The authors believe that it is better to interview the child first because one can then see the child without preconceived ideas as to diagnosis and because the child will appreciate being able to tell his or her story before the adults tell theirs.

The interview with the parents is an opportunity for them to express their worries, to ask for help, and to be reassured that help is possible, as well as being the time for getting information. At the first meeting with the physician, parents are likely to be anxious and the interview should be arranged so that it is therapeutic as well as diagnostic. It is best to start with at least 20 minutes in which the parents are encouraged to tell about the problems in detail and express their feelings fully. This part of the interview should be as spontaneous as possible; the role of the interviewer is to encourage the parents to talk rather than to ask questions.

In the second part of the interview (40–60 minutes) the examiner should review all the important aspects of the child's current behavior. In the course of doing this, other problems will be revealed which were hard for parents to speak about spontaneously or which did not seem significant to them. The main areas covered in this review are shown in Table 1.1. In addition, an interview protocol used by the authors for teaching and research purposes is shown in Appendix 1. Because memories are short and because parents' reports of the past are colored by present events (Chess, Thomas, and Birch, 1966; Yarrow, Campbell, and Burton, 1970), the review of behavior should be restricted to the past year, or an even shorter period of time. Parents may also come to the interview with their own ideas as to diagnosis, influenced by articles from magazines on health and child development. It is therefore important not to ask leading questions which point to certain diagnoses. We have found it best to give parents three alternative replies to a given question; for example, in asking about activity levels we ask if the child's level is about average, unusually low, or unusually high.

Questions that ask for simple "yes" or "no" replies yield high occurrences of individual symptoms among normal children, as can be seen in Table 1.2. However, it is the intensity and frequency of

Table 1.2. The prevalence of some behavior characteristics in a representative sample of 482 children aged 6–12 years as reported by mothers[a]

	%
1. Fears and worries, seven or more present	43
2. Bed wetting within the past year:	
All frequencies	17
Once a month or more	8
3. Nightmares	28
4. Food intake:	
Less than "normal"	20
More than "normal"	16
5. Temper loss:	
Once a month or more	80
Twice a week or more	48
Once a day or more	11
6. Overactivity	49
7. Restlessness	30
8. Stuttering	4
9. Unusual movements, twitching or jerking (tics)	12
10. Biting nails:	
All intensities	27
Nails bitten down (more severe)	17
11. Grinding teeth	14
12. Sucking thumb or fingers:	
All frequencies	10
"Almost all the time"	2

[a] Abstracted from Lapouse and Monk (1958).

symptoms or misbehavior that divide children with psychiatric disorder from average children, not their presence or absence. It follows that the examiner should have a high threshhold for accepting a positive reply. If parents report that a given behavior is deviant, the examiner should ask for examples that would tend to prove or disprove the deviance, or other evidence such as comments by grandparents and neighbors, or reports from school. He or she should also ascertain how often the behavior occurs and gauge how much it disables the child or disrupts the family.

The reliability of interviews such as the one in Appendix 1 is significantly higher than that of interviews which leave the examiner to choose the order and form in which he asks questions (Helzer *et al.*, 1977; Graham and Rutter, 1968). Both parents and patients are comfortable with structured interviews as long as the examiner explains what he or she is doing and why.

The family history needs special mention. It is vital to know about relationships in the family, the state of the parents' marriage, who has raised the child, and whether or not the child has been separated from the parents for a significant period of time. It is also important to know whether the parents or the brothers and sisters have psychiatric difficulties themselves. This information may help to confirm the diagnosis of the child (e.g. reading disability is often familial). If there are relatives who have had the same problem as the child and have had a poor outcome, this is likely to be a deep concern of the parents and one that should be brought out and discussed. For example, there may be a maternal uncle who was hyperactive as a child, wild as a teenager, and continually in difficulties with the police as an adult. It is therapeutic for parents to be able to unburden themselves of concerns about the "bad seed." Finally, the presence of psychiatric problems in the parents strongly affects the work that can be done with the family. It is of little use to set up a program of child management for the parents when the mother is seriously depressed. Equally, knowing that the father is an alcoholic is an important element in understanding a family and helping them. Both these situations are common in child psychiatry.

CRITERIA FOR DIAGNOSIS

Helzer *et al.* (1977) have shown that psychiatric diagnosis achieves high inter-rater reliability when specific criteria are applied to information derived from structured interviews. In fact, the reliability of psychiatric diagnosis in these circumstances is probably higher than

the reliability of some standard diagnostic procedures in medicine, such as interpretation of EKG's. Specific and operational criteria for diagnosis in children are shown in Appendix 2. Many clinicians have found such an approach, sometimes known as the "Chinese Restaurant" system, repugnant. On the other hand, critics have grudgingly admitted that such criteria are effective in research. Except for the fact that the physician allows himself or herself more latitude for judgment, the practice of diagnosis in ordinary clinical work and in teaching is no different from that in research. One can regard these criteria as guidelines from which to stray when one has built experience and critical habits.

VALIDITY OF DIAGNOSIS

In general, the validity of diagnosis in child psychiatry has not been established because the necessary prospective follow-up studies of patients diagnosed by specific criteria have yet to be made for most disorders. The work of Kanner, Eisenberg, Rutter, and others, referred to in Chapter 2, has established the validity of the diagnosis of autism. Studies of the natural history of hyperactivity and school phobia give these diagnoses some validity, but the diagnostic criteria used have not been sufficiently precise.

The validity of diagnoses resting on reports by parents and teachers is an obvious question that has barely been touched. There is evidence that parental reports of deviant behavior separate clinic patients from control children considerably more than direct observations and counts of deviant behaviors separate the groups (Lobitz and Johnson, 1977). The conclusion to be drawn from such evidence is that one should observe children in their natural settings as often as possible or work with colleagues in allied professions (e.g. nurse practitioners) who can and do make these observations.

REFERENCES

American Psychiatric Association. 1968. *Diagnostic and Statistical Manual of Mental Disorders*, Second Edition. Washington, D. C.

Chess, S., Thomas, A., and Birch, H. G. 1966. Distortions in developmental reporting made by parents of behaviorally disturbed children. J. Amer. Acad. Child Psychiat. 5:226.

Eisenberg, L. 1957. The course of childhood schizophrenia. Arch. Neurol. Psychiat. 78:69.

Feighner, J. P. *et al.* 1972. Diagnostic criteria for use in psychiatric research. Arch. Gen. Psychiat. 26:57.

Graham, P. and Rutter, M. 1968. The reliability and validity of the psychiatric assessment of the child: II. Interview with the parent. Brit. J. Psychiat. 114:581.

Helzer, J. E. *et al.* 1977. Reliability of psychiatric diagnosis II. The test/retest reliability of diagnostic classification. Arch. Gen. Psychiat. 34:136.