Diagnosing children with mental health difficulties: Benefits, risks and complexities

2 August 2018 | Peter Parry

Questions

"How important is still getting a "diagnosis"? It sounds like the different approach that you are advocating might negate the need for such a definite, concrete, prescriptive label.

Dave | 2 August 2018

"The answer is "yes, but" – it varies. It can be vitally important with more discrete conditions and conditions where there is a definite treatable cause, or the particular syndrome is known to respond best to certain evidence-based therapies. Anorexia Nervosa, Schizophrenia, Bipolar-I disorder, classical Obsessive Compulsive Disorder, marked cases of ADHD where other causes of inattention and hyperactivity have been ruled out – these are some diagnoses that have good algorithmic treatments. But most mental disorders and symptoms that people suffer are only properly understandable from a biopsychosocial diagnostic formulation perspective – which may or may not use the diagnostic prescriptive labels – but will make it clear over two or three paragraphs exactly why the disorder/symptoms are occurring. This approach is not ‘different’ in the sense of being new, it is a core way of diagnosing as well as understanding clients’ problems, that as my talk showed, has a long historical tradition in psychiatry. It is different from (and unfortunately has been sidelined too often by) a more reductionist symptom-checklist labelling approach. The reason why the overly simplistic diagnostic labelling and subsequent reification of these labels has occurred is for the reasons Prof Boyce (who I cited in slide 10) outlined in his presidential address to the Royal Australian and New Zealand College of Psychiatrists in 2005.

Peter Parry | 6 August 2018

"Thanks Peter

Dave | 7 August 2018

"As a therapist working with adolescents, I often find my clients refuse to give consent to me contacting their parents or caregivers for more information or support. Dr Parry, what methods have you used to gain this consent.

John | 2 August 2018
Important question and gaining that level of adolescent consent is certainly not always easy to achieve. In my clinical experience the rapport with the adolescent generally trumps that with the parents – after all if the adolescent won’t come back to see you then you can’t help much. This can be discussed with parents who usually understand. The first time I see a family I try to see parent(s) and adolescent together. I initially introduce myself and what the assessment session is about, and at that point outline confidentiality limits: that for the adolescent “because you’re 14/15 etc” they have the right to keep most things confidential, except where people’s safety is at risk. I suggest we discuss the issues with parent(s) and young person together for a bit but then it would be best for me to speak alone with the adolescent to hear their story. I add something along the lines that parents may wish to speak alone with me afterwards and that is only fair (and important to allow parents to speak freely and give information that may be critical). I also say the aim is to be able to understand why whatever the problem or diagnosis for which they’ve been referred has happened and by us understanding all the reasons we should be able to have solutions. I would then start with a “family tree” (genogram) which can uncover many relevant factors. I make a statement along the lines of “to put any problem in context it is important that I can understand what life is NORMALLY like for you.” That leads on to 15 to 20 minutes perhaps of finding out the family situation and also the young person’s school, social and extracurricular strengths and issues. By this stage rapport is hopefully established. I also understand more of the overall life context for the young person and their parent(s). We have had to focus on what is positive and working well and is ‘normal’ – adolescents often appreciate this recognition of their unique selves and strengths, rather than an immediate dive into symptoms and pathology. It is only then that it is easy to start talking about the problem/diagnosis for which they’ve been referred. At this point tension often increases and I let the parent quickly sum up some concerns and then speak with the adolescent alone. I would often start the individual interview with a question like: “So we’ve just heard briefly what mum/parent has had to say, but I’m interested in your views?” This sequence helps the adolescent to be more trusting and feel their voice is given priority (something adolescents like!). I’ve found that approach generally works. A lot of it is in the style of engagement and showing some confidence and directing the interaction while explaining the process.

Peter Parry | 6 August 2018

"Dear Dr Parry, In regards to anxiety (in childhood): Does your research/knowledge indicate childhood anxiety is over diagnosed and recognised as a problem rather than accepting it as a normal human emotion to difficult situations/thoughts at times?

Ami | 2 August 2018"

“Possibly yes by some clinicians. However, if anxiety is causing significant impairment in daily functioning, such as with schoolwork, social life, after school job, or sleep problems etc – then it is important to diagnose as, if left unrecognised, symptoms are likely to worsen. The aim is to reduce symptoms down to the normal range of anxiety. The DSM and ICD manuals incorporate this rather subjective criteria of “significant impairment”. Although different disorders are labelled: e.g. Panic Disorder, Social Anxiety Disorder, Generalised Anxiety Disorder, Post-Traumatic Stress Disorder,

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Obsessive-Compulsive Disorder etc. there is often overlap of symptoms rather than discrete disorders. Prolonged anxiety often leads to depression for various biopsychosocial reasons. As with everything, context is very important. Are there good justifiable reasons to be anxious? Anxious attachment relationships in the family? Domestic violence? Bullying at school? An undiagnosed or under-supported learning difficulty that makes academic work more difficult than normal? Etc. What I find helpful for most clients is to describe the neurophysiology of anxiety – why we get anxious in response to perceived threats – even to the extent of doing simple brain drawings about the autonomic nervous system, amygdalae and frontal lobes – and how we can use slow diaphragmatic breathing and other self-soothing techniques to self-manage anxiety – and that this fits with our neurophysiological relaxation system. This leads on to mindfulness and cognitive-behavioural therapy. In that context the use of medication like an SSRI ‘antidepressant’ (which are probably better thought of as anti-anxiety and mood-numbing agents) is an artificial additive way that might be needed for a time, while getting control of one’s own fears and relaxation responses.

Peter Parry | 6 August 2018

“Do you think Australian practitioners overdiagnose children with psychiatric disorders?”

Julie | 2 August 2018

“From my own and my colleagues’ experience, there are a small number of clinicians who do overdiagnose often. However, the vast majority of ANZ child and adolescent psychiatrists diagnose appropriately and most embed their diagnoses in a biopsychosocial diagnostic formulation. Prof Barry Nurcombe’s chapter in the IACAPAP e-Textbook (slide 68 in my talk) says much more about using a diagnostic formulation. The issue is more difficult for paediatricians who are often having to see a large number of emotional and behavioural problems that children have, but don’t have the same Medicare fee structure to allow prolonged assessments. That can increase the risk of diagnosing to quickly or even making a valid diagnosis but not exploring the full biopsychosocial context to help everyone understand why the symptoms are occurring and maximise the best therapeutic responses. The article by Brisbane paediatricians Dr Mick O’Keeffe and Dr Caroline Macaulay on the art of biopsychosocial diagnostic formulation (slide 39) helps paediatricians to address this. When I worked in the early 2000s at a CAMHS service in North Wales, UK, they had an excellent but time and labour demanding system for making a diagnosis of ADHD. If a referral from a GP or school guidance officer etc sounded like a child was exhibiting symptoms of inattention, hyperactivity and impulsive behaviour (symptoms that could meet criteria for an ADHD diagnosis) then our CAMHS team would send a psychologist to see the parents and the school. The psychologist would: 1. interview the parents at home and the teacher at school and get them to complete a Conner’s Parent or Teacher Questionnaire about the child (this can give a ‘diagnosis’ of ADHD – but has to be interpreted in context), 2. sit at the back of the classroom and do a quantitative time and motion study of the child’s classroom behaviour by ticking whether ‘on-task’ or a series of behaviours like ‘out of seat’, ‘blurring out questions out of turn’ etc (which were modelled on the DSM criteria for ADHD) every 10 seconds for 30 minutes (which would then be turned into a chart), 3. do a similar more qualitative
observation of the child in the lunchtime playground environment, 4. interview the school guidance officer and collate any school reports, psychometric, speech and language, occupational therapy etc previous test results on the child, 5. if a psychometric test had not been done, the psychologist would do one (the WISC-III at that time). I or the other child psychiatrist in the team would then do our usual psychiatric assessment of interviewing the parents and the child together, the parent(s) alone for a detailed family and developmental history, the child alone – and explore their emotions and views of others and situations in their life e.g. with drawings and coloured bar charts – while noting their concentration etc. By the end of this process the various factors contributing to ADHD type symptoms could generally be elucidated. It may be that the child did not have an ‘intrinsic’ ADHD but was reacting to certain stressors. If it seemed to be a significant impairment due to intrinsic inability to sustain attention and control movement then we were reasonably sure of a valid diagnosis of ADHD – although often had ideas of contextual factors that needed addressing as well. But sadly that labour and time intensive approach is not supported by most health systems.

Peter Parry | 6 August 2018

“ There seems a real lack of child psychiatrists. How can parents tap into a professional who is not going to simply blame the parent? 

Leanne | 2 August 2018

“ Yes, there is a lack of us child psychiatrists, my colleagues in private practice get booked out quickly and those of us in the public system are busy too. No professional should blame a parent, all parents do the best they can at that point in time in their lives and many factors impacting on children are beyond parental control. At the same time, parents do have control over factors in their children’s lives and particularly their relationship with their children. So there is very often benefit for parents to do upskilling (we would for any other job) course like ‘Circle of Security’, ‘Triple-P’ or ‘Incredible Years’ parent-training courses. Additionally, family therapy, parent-child dyadic therapies (working through the life story, narrative of the child’s life in the context of the stressors impacting the family over the years), and parents getting their own psychosocial supports and therapy at times – are often very helpful.

Peter Parry | 6 August 2018

“ What are your thoughts on the Power Threat Meaning Framework from the BPS as an alternative to DSM/ ICD?

Justin | 2 August 2018

“ Justin, I’m a bit embarrassed to say my thoughts were “I think I’ve vaguely heard of it but don’t really know what it is.” I’ve now just spent half an hour perusing the webpages at the British Psychological Society and my thoughts are “Wow… very interesting!” The BPS are not just critiquing the DSM model but doing something innovative and practical to improve, supersede or complement it. It draws upon the work of Patricia Crittenden (the DMM model I mentioned in slide 62) and also Paul...
Gilbert who draws on evolutionary biology as I do (slide 52). So it is a way of trying to use a sophisticated biopsychosocial diagnostic formulation with a lot of input from ‘Trauma Informed’ therapy and research of van der Kolk et al. There may be some DSM diagnoses like Schizophrenia, Bipolar-I disorder, Tourette’s Disorder – that are better kept within the ‘disease model’ paradigm – but they would still benefit from this PTMF model too. For the readers this link is a place to start: https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/PTM%20Overview.pdf

Peter Parry | 6 August 2018

Thanks Peter for the talk and for being so generous in taking the time to respond so fully to my question and other questions in this forum. I’m linking (please see below) the Good Practice Guidelines on the Use of Psychological Formulation (44 pgs) from the Division of Clinical Psychology: The British Psychological Society in case others are interested in incorporating what I view as a broad and deep formulation framework for consideration for ourselves and others This could be viewed as a companion document to the Power Threat Meaning Framework (link Peter put above in this thread). It seems to offer an integrated and reasonable view on case formulation, notwithstanding the many issues that arise from the very act of case formulation. https://www1.bps.org.uk/system/files/Public%20files/DCP/cat-842.pdf

Justin | 10 August 2018

At what level of parental neglect would the child need to experience in order to potentially develop mental health issues?

Mariam | 2 August 2018

A wise paediatrician turned child psychotherapist whose career spanned the 1920s to 1960s, Donald Winnicott, theorised about the “good enough mother” (which can apply to father and other parental figures). The mother has to supply enough nurture and safety to her child to make them feel secure (almost total for a young infant) but gradually subtly failing a bit so the child gets to deal with frustration and anxiety just enough to learn his/her own coping strategies and personality strengths. This ‘failing’ to do everything for the child obviously has to shift in line with the child’s development into adolescence. Where the parenting is not ‘good enough’ – the child at whatever stage of neurocognitive development they are will feel either unsafe/unnurtured and insecure or too controlled/suffocated and enmeshed with the parent. So it is a balancing act of giving more and more space to the growing child as time goes on, but being there as a safe haven for even an adolescent or young adult child. Attachment theory and ethology (slides 40-46) as well as the Circle of Security parenting program expand on this.

Peter Parry | 6 August 2018

Do you have a view on the usefulness (or otherwise) of the DC: 0-5 Diagnostic Classification of Mental Health and Developmental
Disorders of Infancy and Early Childhood – not only as a diagnostic tool but as a mechanism for creating a shared language around infant mental health concepts?

Natalie | 2 August 2018

“A really good question. I’m afraid I’ve worked in general CAMHS/CYMHS settings in my career and the age group is generally 5–18-years-old, so this comment is far from a fully informed one: From a brief glance it is closely modelled on the DSM itself and superficially at least does not appear to take into consideration enough the context and attachment relationships – which are even more integral to infant and toddler emotional and behavioural dysregulation, than older children or adults. However, some need for classification of neurodevelopmental problems is also important and the manual lists these. My initial thoughts are that it is following the DSM-III to DSM-5 model of trying to give a ‘shared language’ to all clinicians and researchers. However as my talk covered, the shared language is of little use if contextual factors are ignored and symptom complexes are prematurely reified into discrete entities when they are likely to be reactions to attachment insecurities and other factors.

Peter Parry | 6 August 2018

“If the child is showing the symptoms and behaviours of any disorders does it mean they definitely have the disorder or could there be another reason they are showing these behaviours and symptoms?”

Preschool worker | 2 August 2018

“That was the overall message – symptoms can have multiple different causes due to contexts both past and present, and also to the individual’s genetic and temperamental inheritance and various lifestyle factors (e.g. sleep deprivation is a cause or at least a risk factor in numerous mental and physical disorders) – most DSM diagnostic labels just encapsulate a cluster of symptoms without reference to cause or context (which was Prof Robert Spitzer’s mea culpa about the model of the DSM-III that he promulgated – slide 64). So the answer is not straightforward – technically enough symptoms for enough time means they ‘have’ the disorder. But if the main cause of say an adolescent’s ‘major depressive disorder’ is chronic sleep deprivation – then giving melatonin, sleep hygiene and some antihistamine may rapidly ‘cure’ the ‘depression’. Similarly, a child might meet symptomatic criteria for ADHD but be inattentive and restless/fidgety and impulsive – because they’re being abused at home, or bullied at school, or have a language disorder but no intrinsic ADHD. I left out a clinical anecdote in my talk due to time constraints – but I recall a 12-year-old boy who’d made it to Year 7 at school and had ADHD and Oppositional-Defiant Disorder (ODD) diagnoses. He was on stimulant medication for his ADHD but symptoms persisted. He looked normal and was athletic for his age and assessment of family situation and school revealed no significant conflict with family or peers. But he was not getting on with teachers and was getting suspensions and detentions for his ODD behaviour. I saw him for a few sessions on his own, which became more and more playtherapy oriented. I noticed as he played and interacted with me in this non-challenging environment there was no sign of inattention, hyperactivity or impulsivity, but he seemed to like playing games suitable to a younger child. We got his school
guidance officer to check for past psychometric testing – it had never been done. We had it done and his IQ was 68, in the intellectually disabled range. Not picked up throughout primary school – and a false diagnosis of ADHD, based on superficial symptoms, was a major reason for the oversight. The problem of ‘reification’ is pertinent to your question too (slide 31).

Peter Parry | 6 August 2018

"Excellent presentation - thank you so much! An acknowledgement around indigenous knowledge and practices was highlighted. Could such perspectives assist in counteracting the morbidity of mental health illnesses across the lifespan?"

Jioji | 2 August 2018

"Thanks Jioji. I would need more detail about particular indigenous practices. However, as a general rule, modern urbanised societies with fragmentation of family networks are a causative or risk factor for mental disorders. A landmark multination WHO study of schizophrenia found that living in a developing world rural village community led to significantly better outcomes (despite lack of mental health resources and medications) than in cities in the developed or developing world. I spent a week with the Balinese psychiatry department 15 years ago. They were adamant that Balinese raised in traditional villages with Balinese child-rearing practices of high respect for pregnant and new mothers, a 35-day lying in period for mothers with newborns (where they only had to focus on the infant and all chores were done by extended family), lots of infant holding, lack of harsh discipline in childhood, focus on daily prayer rituals and rights of passage ceremonies and emphasis on responsibilities in adolescence – led to much less mental disorders or personality disorders in the population, except that they still seemed to get the same kind of rates of Schizophrenia and Bipolar-I disorder, suggesting a strong genetic component to these illnesses. They noted that childhood behaviour problems used to be rare but were increasing in urban and tourist areas. In my talk, slides 42 and 43 illustrate the importance of mother-infant holding. Something which has been lost in much of modern society. For instance, the Welsh practice of maidens weaving a shawl to later wrap their infants in when they became mothers and carry them around is a lost tradition. A social worker in North Wales told me how the young (usually single) mothers in impoverished housing estates were so happy with new light-weight baby car capsules "because it meant you could keep baby in the capsule, when you went to the pub for a pint with the other young mothers" (and place the babies so they could face a TV). As slide 44 shows babies require regular face to face contact. A young baby has a focal length of 8 to 10 inches (about distance from mother’s breast to her eyes when being fed). The environment described to the social worker by these young Welsh mothers shows how impoverished and abnormal their babies’ experience was compared with untold generations beforehand. On the other hand, we know that child rearing practices through history varied and could be quite cruel. Think of ancient Sparta for instance. Many choose to refer to not just a biopsychosocial model, but to a biopsychosociocultural model – because all these factors are relevant to understand mental symptoms and disorders. I’d also refer you to the question above regarding the British Psychological Society’s relatively new model of ‘Power Threat Meaning Framework’ for understanding symptoms."