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Disturbed Children Grown-up - Follow-up of a Child Guidance Clinic Population into Adulthood

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Abstract

This retrospective, clinic based study aims at following up 81 children attending a child guidance facility who were subsequently transferred to adult psychiatry units. Emphasis has been laid on stability of diagnosis. In 44% of the children the diagnosis was changed with maximum change occurring in cases of unspecified and reactive psychosis which were rediagnosed as manic depressive psychosis. The paper raises several nosological and diagnostic issues related to a child psychiatric population.

Key words -
Child Guidance Clinic,
Follow-up,
Change of diagnosis

Long term follow-up studies are of particular interest in child psychiatry owing to the links between child and adult psychiatric patients which have been described by many workers and have evoked great interest in the recent past [1], [2]. It has been found that psychiatric illnesses are more common in adults previously treated in childhood compared with the general population [3], [4], [5]. Follow-up of children who are psychiatrically ill thus helps in revaluating diagnosis, providing a diagnosis in those who initially had an unclear diagnosis and in detecting predictors of course and outcome. Follow-up studies might be either retrospective or prospective both of which have their own advantages and disadvantages [5], [6]. In retrospective studies the problems are mainly one of erroneous and incomplete data at initial contact, while prospective studies are more time consuming and expensive. The present study which is based on retrospective reviews of charts, aimed at answering the question of stability of psychiatric diagnosis made in childhood.

Material and Methods

The study sample consisted of children attending the Child and Adolescent Psychiatry unit who had been transferred to the Adult Psychiatric unit at 16 years of age and were being followed up

subsequently. Methodical details of such transfers were available from 1982 onwards. The design was essentially retrospective and file reviews of all patients were made. At intake a case history format was followed which incorporated details of present, past, family and personal history. Though not a structured proforma, the case history format helped in collecting a large amount of information and was comprehensive and exhaustive. Diagnosis was made by ICD 9 criteria. Details recorded in the files were reviewed with special emphasis on changes in diagnosis and recurrence of illness. As part of the evaluation, two checklists were used. The items facilitated possibilities of making diagnosis by ICD 9 criteria in addition to incorporating other history and examination details which would help in complete assessment of a case. The items were marked by the researchers as being present or absent based on the information available in the files. An attempt was made to construct the checklists in an exhaustive fashion so that no important information would be missed. The children grown up (CGU) checklist I, with 70 items consisted of details available at initial contact. These were sociodemographic data, birth and developmental history, family history of mental illness and details of family interaction, schooling and clinical details of the illness, with any evidence of physical illness as well as treatment received. The (CGU) checklist II consisted of 10 items which incorporated information after initial intake till the last follow-up. This had details of recurrence of illness, changes in clinical picture or diagnoses, drug compliance and outcome as evidenced by social and occupational functioning, as well as persistence of psychopathology. Diagnoses at intake and subsequently were made by the clinicians and the researchers using ICD 9 criteria by a consensus rating. 81 children were included as subjects of the study. These children had been transferred from the child guidance clinic to the adult psychiatry unit at 16 years of age and had adequate information in the files for the purpose of the study. The patients attendance was based on their need and no attempt was made to contact them to ensure follow-ups.

Results

Table I gives the diagnostic break up of the cases at intake. 19 cases (25%) had manic depressive psychosis, 9 (15%) schizophrenia, 19 (20%) psychosis not otherwise specified and 6 (6%) had reactive psychosis. 3 children received a diagnosis of obsessive compulsive disorder and 9 (11%) that of hysterical conversion. Males constituted 68% and females 32% of the sample. Average age at first contact was 120 months (10 years) while that at final follow-up was 218 months (18 years). The duration of follow-up was an average of 20 months with 70% being followed up for more than 3 years.

Table - Change in diagnosis from intake to follow-up

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The average number of visits in the child and adolescent unit was 7, range (4-11) over an average period of 20 months while that in the adult unit was 3, range (1-9), in the same period. This indicated an increased attendance in the child unit and a crisis oriented attendance in the adult psychiatry department in most of the cases. Out of the 34 (44%) changes in diagnosis which occurred in the follow-up period, 20 (58%) were changed by psychiatrists at the time of transfer (around 16 years of age) to the adult unit and the rest were changed by clinicians during follow-up in the adult psychiatry unit. The nature of changes in diagnosis have been depicted in Table I.

Discussion

The purpose of the present study was to describe a group of children who had been followed up from childhood into young adulthood. This report has focussed only on certain details and subsequent reports will lay emphasis on areas such as course and outcome and characteristics of separate diagnostic subtypes. It is evident from the results that nearly 66% of the cases had a diagnosis of psychosis, indicating that it is probably because of the very nature of the illness that they were on regular attendance and could be followed up into adulthood. Patients with minor psychiatric problems constituted a small part of the sample. This reflects on the fact that only those who had a severe problem (psychotic vis-a-vis non psychotic) came for follow-up for longer periods of time. This is probably the disadvantage of carrying out longitudinal studies on a clinic population, as the population followed up will be necessarily more ill than those subjects who have stopped coming to the clinic and are in the community. The highlight of the study is the large percentage of children whose diagnosis is changed during their development into late adolescence. As is evident from the results, the maximum number of changes occurred in the children with a diagnosis of psychosis, specially those with a diagnosis of unspecified and reactive psychosis. The latter being reported earlier in literature mainly in adults as changing frequently to affective psychoses [8]. Among psychosis, affective disorder had the maximum stability, though changes were observed in terms of the nature of episode (depression and mania) and also changing from unipolar illness to a bipolar one. Conduct disorder and obsessive compulsive disorder also showed frequent changes in diagnosis.

The final diagnosis (at the end of the follow-up period) indicates a preponderance of affective disorders. The nearly 100% increase in diagnosis of affective disorder (majority of unspecified psychosis and emotional disorders changing to this diagnosis) reflects the ubiquitous nature of affective disorders in childhood. An absence of clear cut manic or depressive symptomatology, presence of disorganised and bizzare behaviour and decreased linguistic competence, often make the clinicians err in favour of a diagnosis of schizophrenia and other psychosis [9]. As development proceeds, phenomena and psychopathology become more lucid and precise and definite affective features emerge. This is probably one of the reasons of affective disorders being underdiagnosed in childhood and early adolescence [10].

It is also evident that the nature of illness changes in a number of conditions, in that, some of the cases of conduct disorder, emotional disorders and hysterical conversion disorders eventually acquire diagnosis such as anxiety neurosis, depressive neurosis, adjustment problems and personality disorders. These changes may not necessarily indicate a drastic change in the stability of diagnosis, reflecting rather a change in nosology and diagnostic nomenclature between children and adults. Alcohol and substance abuse or dependence was not found in any of the subjects, probably because of their relatively young age even at final follow-up. This is unlike Western findings where a significant number of children attending psychiatric clinics eventually develop substance use [11]. Two of the three children diagnosed as obsessive compulsive disorder changed to psychosis, again establishing the presence of varying symptoms in childhood psychosis.

Before presuming the instability of psychiatric diagnosis in childhood, there is a need to have long term prospective studies using stringent nosology and diagnostic criteria in order to establish facts regarding the course of any childhood psychiatric illness (to ensure uniformity and reliability of

clinical data so that diagnoses can be arrived at with some certainity). In addition to stringent criteria it is also necessary to use structured interview schedules. Not withstanding age-related variations in symptom profile, a psychiatric diagnosis must have a predictable course, outcome and prognostic implications, otherwise its validity is questionable. Variable outcomes or instability have been mainly interpreted as
(1) the initial group being heterogeneous and
(2) natural consequence of a disease [10].

Another important issue that is raised by the study is that of comorbidity and its influence on the course of any psychiatric illness. It is possible that the final diagnosis does not necessarily reflect the course of the initial condition (e.g. hysterical conversion reactions changing to affective disorder or anxiety neurosis). Rather, this may be attributable to coexisting pathology or character traits which under various life stresses and in various developmental stages get manifested in different forms. Varying forms of pathology might surface influenced by a number of environmental and personality variables which are more reflective of coexisting psychopathology rather than the course of the initial condition.

It can hence be surmised that follow up studies in a child psychiatric population are imperative in order to evaluate the influences of development on diagnostic subtypes and to assess the magnitude and presence co-morbidity in this group of psychiatric patients.

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