

A critical survey of psychiatric diagnostics, clinical practice, and the functionality of service system from the point of view of clinical family counseling

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OBJECTIVES: To make visible the fundamental problem of psychiatric diagnostics without comprehensive examinations as a necessity.

METHODS: This prospective research is based on clinical evaluation by three clinicians, of patients assigned to see child psychiatrist Heli Pajari from January 1st to December 31st 2016 at family counseling office. Information of the past medical and family history was also collected.

RESULTS: Participation rate was 100% (52 children). In almost all cases, there were neuropsychiatric-like symptoms (e.g. in executive function) at the same time with psychiatric challenges, and understanding those symptoms seemed crucial in assisting the child.

The lack of comprehensive evaluation was seen to lead to prolonged/ineffective processes that led to at its worst to wrong direction gnawing the wellbeing of the child and his parents and parents' experience of their own

parenthood. This could be seen in all stages of health care system. The data collected of family background history by interviewing parents gave a frequent worry of incomprehensive processes causing serious psychiatric illness in the long run.

CONCLUSION: Psychiatric diagnosis should be reevaluated with a demand for thorough, comprehensive evaluation (including neuropsychiatric viewpoint) before setting a diagnosis, and daily life observations made by patients/parents should be more valued. Also neuropsychiatric diagnoses should be reevaluated by taking into account the daily life observations of diversity/variety/overlapping/transformations/varied appearance of symptoms, and their strong impact to psychic health. If we don't reevaluate diagnostics, we are facing incomplete and ineffective processes, enormous economic costs and ethical problems and questions of human rights.

Key Words: Mental health; Psychiatry; Child and adolescent psychiatry; Neuropsychiatry; Ethics; Human rights

Abbreviations: HFCO: Helsinki Family Counseling Office; EF: Executive Function; HP: Heli Pajari

INTRODUCTION

Problem formulation

People with psychiatric symptoms are often given diagnosis and treatments without comprehensive examinations (also from neuropsychiatric viewpoint). This may cause wrong interpretations and treatments, and in that way problems with ethics and human rights, as well as enormous economic costs.

Purpose of this research

The purpose of this research is to make visible the above mentioned fundamental problem and to gain wide discussions of fundamental basics of psychiatry.

Psychiatric and neuropsychiatric diseases/symptoms in general

According to World Health Organization (WHO), the burden of mental disorders continues to grow with significant impacts on health and major social, human rights and economic consequences in all countries of the world [1]. Of children and adolescents, 10%-20% worldwide experience mental disorders, and half of all the mental illnesses begin by the age of 14 and three-quarters by mid-20s [2].

The most common disorders during childhood are anxiety disorders, and after that behavior disorders, mood disorders, and substance use disorders [3]. Mental disorders cause a large proportion of the disease burden that youth face in all societies [4]. Children with problems of mental health face big challenges with stigma, being isolated or discriminated, and there is also a concern on the availability of health services and education, as well as on the realization of fundamental human rights [2].

Neuropsychiatric reasons are the leading cause for the disability of youth in all regions, and if they are not being treated, this seriously affects the children's development, educational attainments, and chances to live full and productive lives [2].

Challenges of psychiatric/neuropsychiatric diagnostics

Psychiatric diagnoses are made on the patients' symptoms, and many separately categorized psychiatric diseases have represented to have comorbidity.

Heredity has proved to have a great importance in the development of many different diseases. A study [5] showed that certain findings (single-nucleotide polymorphism) associate with certain childhood onset and adult onset psychiatric disorders, the study dealt with autism spectrum disorders (ASD), Attention Deficit Hyperactivity Disorder (ADHD), bipolar disorder, major depressive disorder and schizophrenia, and the study brought along evidence for the need in psychiatry to transfer from descriptive diagnostics towards nosology informed by disease cause [5].

Prognoses of childhood difficulties

The difficulties found during childhood have proven to be strong predictors regarding latter psychiatric morbidity, success at school, being disabled accidentally, and criminality [6-14].

The child's ability to control oneself is proven to be an important predictive factor (more important than socioeconomic status or intelligent quotient) regarding adult's physical health, wealth, life satisfaction, addiction, crime

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and parenting of the next generation [15-18]. Emotion knowledge has shown to have an influence on social competence, and internalizing and externalizing problems [19].

Importance, structure and function of self-regulation ability

The ability to regulate oneself consists of the self-regulation of actions, emotions and cognition (handling information) [20]. It originates from individual himself and is needed to ensure that actions are as well as possible adapted to the purpose and useful for the individual in a long term, and is called "executive function" [21], in this text "EF".

EFs are comprised of a set of cognitive control processes making self-regulation, target-oriented actions, actions deviated from the usual ways of acting, making decisions, evaluating risks, planning the future, prioritizing and sequencing actions, and coping with new situations possible [22-24]. Inhibitory control is considered an important EF due to its ability to control attention, behavior, thoughts and/or emotions from external or internal distraction [25].

Individual differences in the EFs are associated with human health and functioning, and EF impairments are associated with most forms of psychopathology [22] as well as e.g. ADHD or attention deficit disorder (ADD) or ASD [26]. If a person's emotional, social and physical needs are ignored, those unmet needs will work against good EFs [27].

Background information of the structure and functions of Helsinki family counseling office

Helsinki family counseling office (in this text "HFCO") is a low threshold service, which is meant for under 18-year-old children and their families living in Helsinki, with emphasis on early interference in child's/family's difficulties. If there is a serious worry of child's well-being or suspicion of for example a somatic illness behind child's symptoms, the child's parents are directed to contact health care unit rather than HFCO. Professionals who work at HFCO are psychologists and social workers, and child psychiatrists as consultants. Often a child psychiatrist is asked for help when the child's situation causes serious worry or when despite the work done it has not become better. There is no special resource of neuropsychiatry built to HFCO, and in case if that is needed, the child is usually referred to specialized medical care for further examinations, differential diagnostics or treatments (usually to the unit of child psychiatrics, sometimes to the unit of child neurology). Sometimes also referral to the unit of pediatrics is needed.

METHODS

All the clients/patients directed to child psychiatrist Heli Pajari (HP) at HFCO from January 1st to December 31st year 2016 were asked to participate in a study that focused on diagnostics, clinical practice and the functionality of the service system in the case of each individual, with a special interest in neuropsychiatry. In this study, the term "child" is used whenever a person is under 18 years of age, and the form "he" is used for children and their parents, both male and female.

In addition to meetings with children and their parents/families, information was collected from various sources and of various issues (e.g. observations from home/day care/school, investigations made currently/earlier and conclusions drawn from them, child's developmental history, possible acute stress factors/traumas, emotional atmosphere in the family, parenthood). Also filled out forms were noted, e.g. Strengths and Difficulties Questionnaire and ADHD symptom survey form. The evaluation of the importance of gathered data was an individual process for every child, and descriptions of the past and everyday life were also valued. By interviewing parents data was collected of family background considering psychiatric/neuropsychiatric characteristics/symptoms, the development of those from childhood to adulthood and their outcomes. Child psychiatrists Lisa Rekola and Antti Mattila went through the documents of the patients. The same research group evaluated the diagnostics/clinical practice in each case.

The data was collected in an excel sheet for the part which suited to its purpose of the statistical processing. The statistics were complemented by two case examples.

The follow-up of the children's situation was continued until the clientship ended at HFCO or (if it continued) until June 30th, 2017.

RESULTS

The age and gender structure

According to statistics (Helsinki city/Social services and health care sector/Information management services/Statistics services) of the year 2016, 1 619 persons became new patients of HFCO, and 1199 of them were under 18 years old. For the patients under 18 years old, the main reasons seeking help were child's behavior and emotional life (34% and 23% of the new patients). In 2016, the Western work group of HFCO had 213 new under 18-year-old patients (70 girls and 143 boys). The consulting child psychiatrist of Western work group HP was asked to participate in 51 patients' cases (around 24% of all the patients, 21 girls and 30 boys). Those figures of are only indicative, as some client ships had started before the year 2016 even though HP was consulted at year 2016. In addition, one patient was directed to HP from other work group, so the total number was 52 (including two pairs of siblings). They all decided to participate in the study (participation rate was 100%). In two cases of patients, HP had been involved for a period of time already in an earlier phase of their client ship at HFCO, but the contact with HP had ended, and in 2016 HP was being asked to be involved again.

The children directed to HP (n=52) were 1.7-16.8 years old when becoming clients of HFCO (median 6.7 years). The time interval between their coming to HFCO and asking HP to be involved was 0-3.8 years (median 0.4 years).

Maternal and children's health clinics monitoring and supporting the well-being

To knowledge available, all of the children were followed up at maternal health clinics during pregnancy.

All of the children were followed up at children's health clinics, although in three cases, the follow-up was some different from the regular form in Finland (e.g. due to living abroad). Before the contact at HFCO, in cases of 20 children, there had been a speech/occupational therapist or a psychologist/physiotherapist involved (one or more).

Information on the length of pregnancy and well-being of the child after birth

The pregnancy and welfare data was compared to the data of National Institute for Health and Welfare (THL) in Finland from the year 2016. The comparisons are only indicative, as the children of this study were not born in 2016.

The lengths of pregnancies of 47 children were between 37 and 42 pregnancy weeks, one child was born before and three children were born after this time interval, and in case of one child there was no data available. According to THL, 5.7% of children were born before the pregnancy week 37 in Finland. The corresponding data in this research was 1/51 and thus 2.0% (one child in the study was not counted in as in this child's case there was no data available). Three children were born from twin pregnancy.

The birth weight varied from 2.5 kg-4.5 kg in the case of 47 children. Three children were born under 2.5 kg, and in the case of two children, there was no data available. According to THL, the birth weight of 4.3% of the newborn babies in Finland was less than 2.5 kg. The corresponding data in this research was 3/50 and thus 6%.

The welfare of the child after birth was good in the cases of 42 children. Related to the child's own situation, seven children needed intensive monitoring or care after delivery, and in cases of three children, there was no data available. According to THL, 11.8% of the newborn babies in Finland needed support from intensive care unit or monitoring unit. The corresponding data in this research was 7/49 and thus 14%. Icterus/elevated bilirubin values were found in seven newborn.

Social services supporting the well-being of children/families

Families of 33 children got/had gotten help from social services (Child protection/Family coaching/Home services for families with children).

Clinical symptoms according to psychiatric evaluation (Figures 1 and 2.1-2.19)

Figures 1 and 2.1-2.19 summarize the data of the symptoms/characteristics/difficulties of the children. Many had or had had many kinds of symptoms.

Figure I: Symptoms/characteristics/difficulties of the children in the research

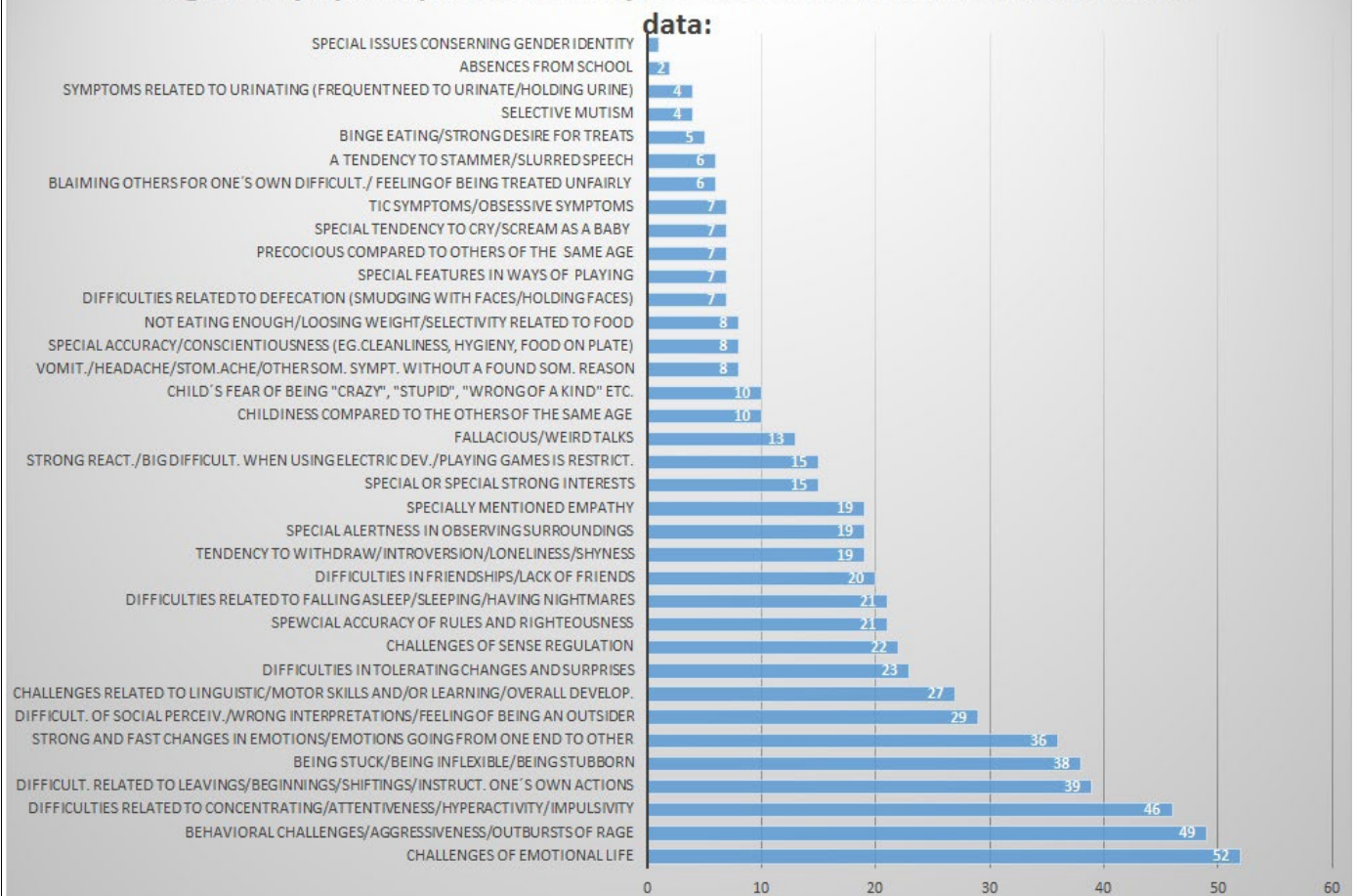


Figure 1) Symptoms/characteristics/difficulties of the children in the research data.

Figure II (1): Children having behavioral challenges/aggressiveness/outbursts of rage (n=49) had in addition:



Figure 2.1) Children having behavioral challenges/aggressiveness/outbursts of rage (n=49) had in addition.

Figure II (2): Children having emotional challenges (n=52) had in addition:

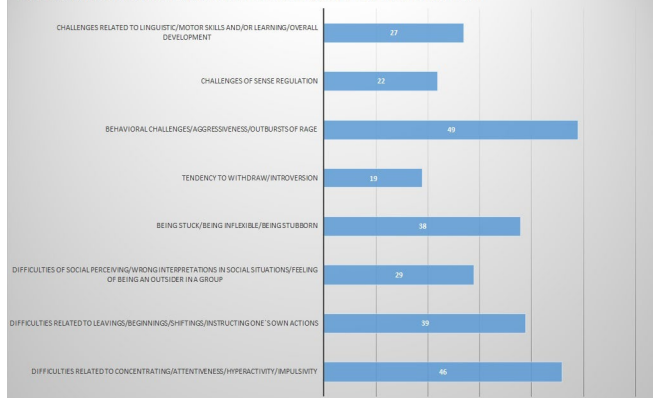


Figure 2.2) Children having emotional challenges (n=52) had in addition.

In the case of two children, HP did not meet the child himself (one was urgently placed to live in another region and the other was directed to specialized health care as crisis *via* hospital's acute unit). For these cases, the evaluation was based on parents' descriptions, examinations done previously, and the already existing documents and filled out forms.

Especially in six cases, the evaluating process was difficult and perhaps also unreliable due to e.g. parents' different observations/view-points of their child's situation, the changed/difficult situation in the family or between the parents, crisis/challenges of the child's well-being or related to puberty.

The most important worries (one or more) when the client ship at HFCO began were (the number of the children is in parenthesis): Behavioral challenges/aggressiveness/outbursts of rage (37), challenges of emotional life (31), difficulties related to concentrating/attentiveness/hyperactivity/impulsivity (18), difficulties related to leavings/beginnings/shiftings/instructing one's own actions (8), tendency to withdraw/introversion/loneliness/shyness (7), difficulties in social perceiving/wrong interpretations in social situations/feeling of being an outsider in a group (7), being stuck/being inflexible/being stubborn (7), challenges of sense regulation (6) and challenges related to linguistic/motor skills and/or learning/overall development (6).

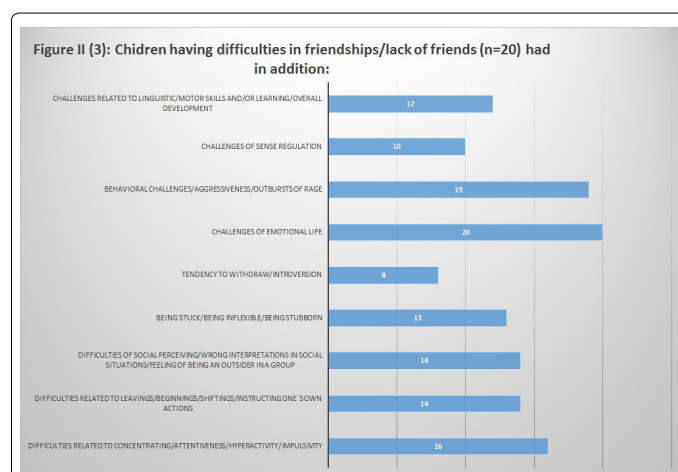


Figure 2. 3) Children having difficulties in friendships/lack of friends (n=20) had in addition.

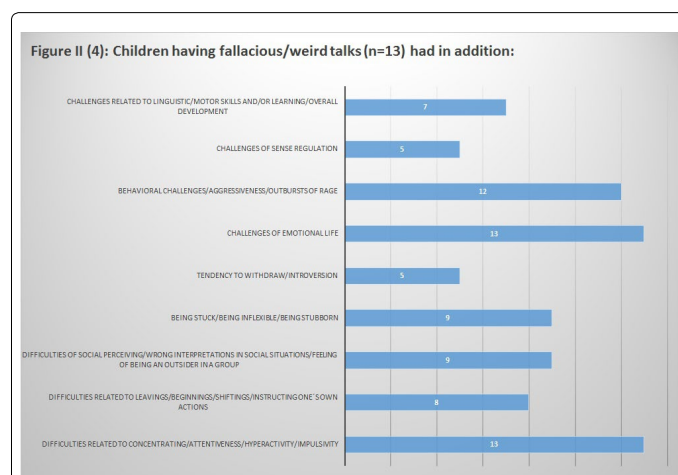


Figure 2. 4) Children having fallacious/weird talks (n=13) had in addition.

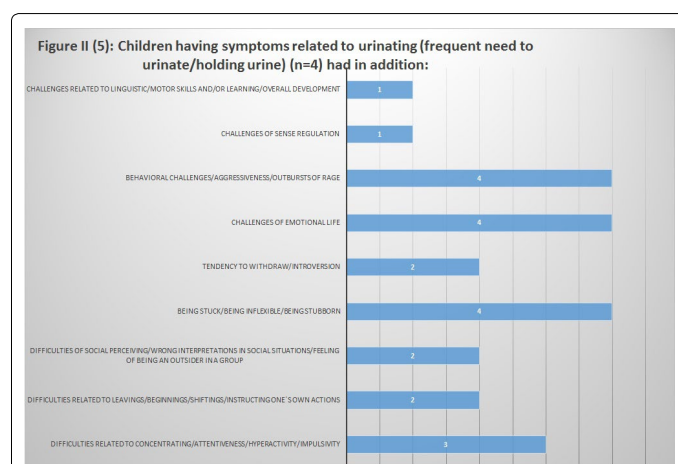


Figure 2.5) Children having symptoms related to urinating (frequent need to urinate/holding urine) (n=4) had in addition.

Figure 1 shows the most important observations and notions of child's symptoms/characteristics/difficulties, according to psychiatric evaluation (either during the client ship in family counseling office or according to previous history).

The most important difficulties of children's emotional life in the research data are more precise specified (the number of the children is in parenthesis): Fearfulness/panic symptoms (26), challenges in emotion recognition/expressions/tolerating emotions (25), difficulties in tolerating

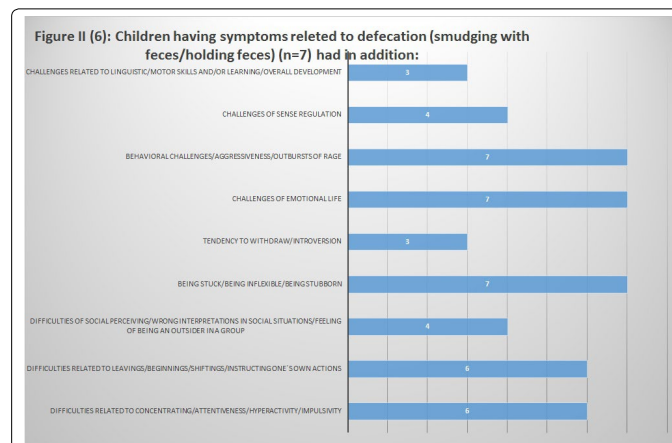


Figure 2.6) Children having symptoms related to defecation (smudging with feces/holding feces) (n=7) had in addition.

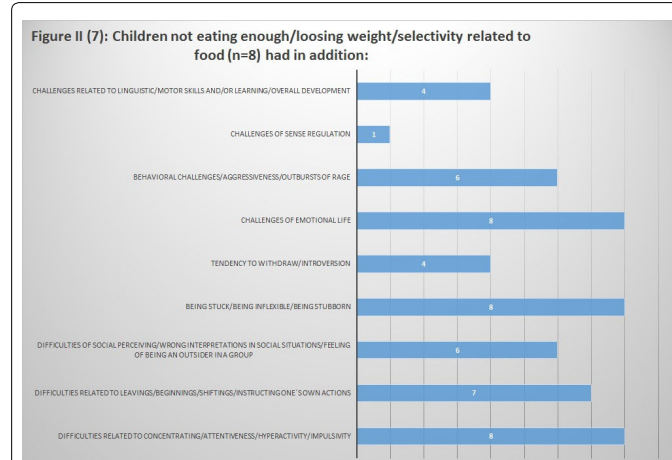


Figure 2. 7) Children not eating enough/losing weight/selectivity related to food (n=8) had in addition.

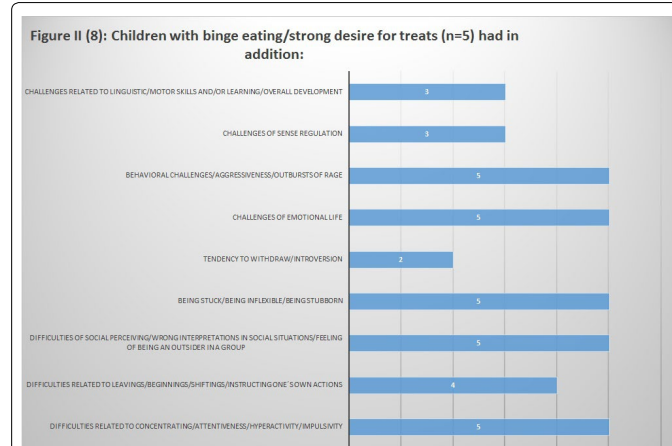


Figure 2.8) Children with binge eating/strong desire for treats (n=5) had in addition.

disappointments/uncertainty/failures/negative feedback (25), low self-esteem/self-criticism (18), anxiety (17), suicidal talks/talks of killing/hurting oneself/incising (13), clinging towards others/timidity (13), feeling down/symptoms of depression/not feeling pleasure/tearfulness (12), dissatisfaction/negativity/nothing seems to be enough (12), seeking attention/seeking attention in negative ways (10), tension (9), "too kind"/does not hold one's own/strong desire to please others (e.g. joins foolish things) (7), jealousy (6), difficulties in handling positive feedback or when being in the center of attention (6) and arrogance/hurting feelings of other children/vitiating younger ones/tendency to manipulate others (4).

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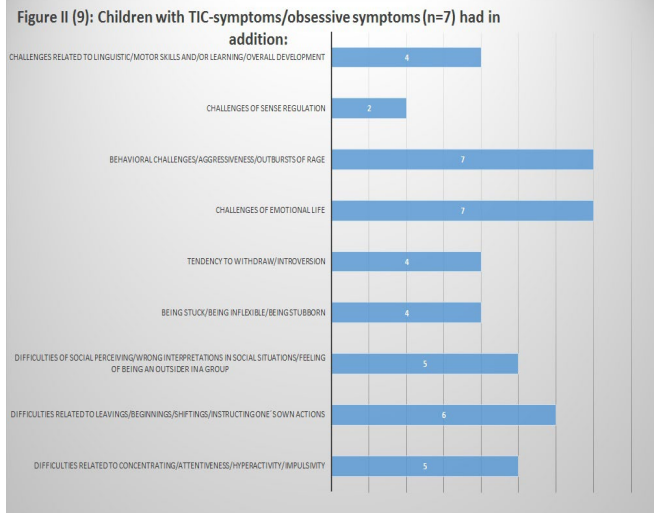


Figure 2.9) Children with TIC-symptoms/obsessive symptoms (n=7) had in addition.

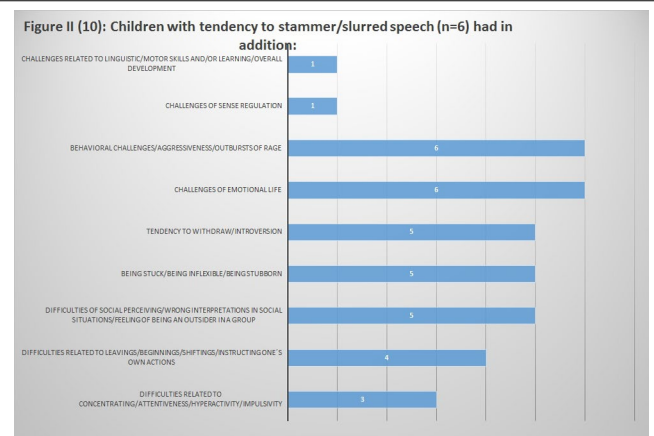


Figure 2.10) Children with tendency to stammer/slurred speech (n=6) had in addition.

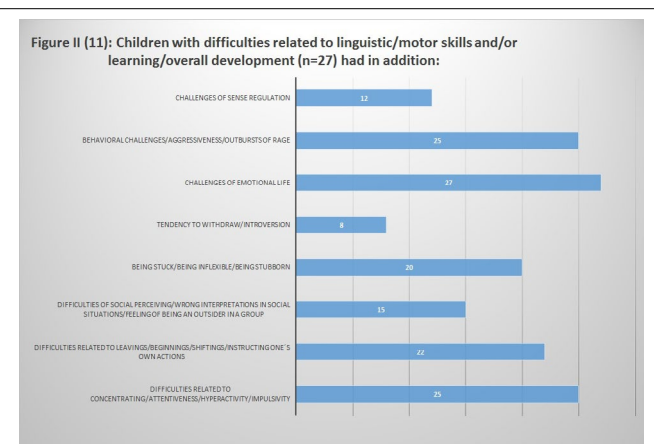


Figure 2.11) Children with difficulties related to linguistic/motor skills and/or learning/overall development (n=27) had in addition.

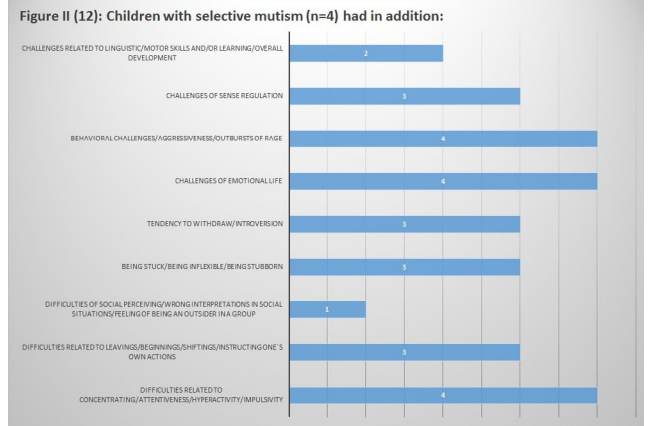


Figure 2.12) Children with selective mutism (n=4) had in addition.

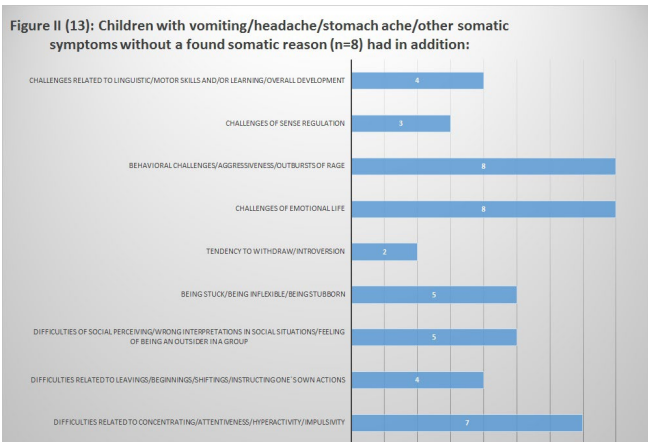


Figure 2.13) Children with vomiting/headache/stomachache/other somatic symptoms without a found somatic reason (n=8) had in addition.

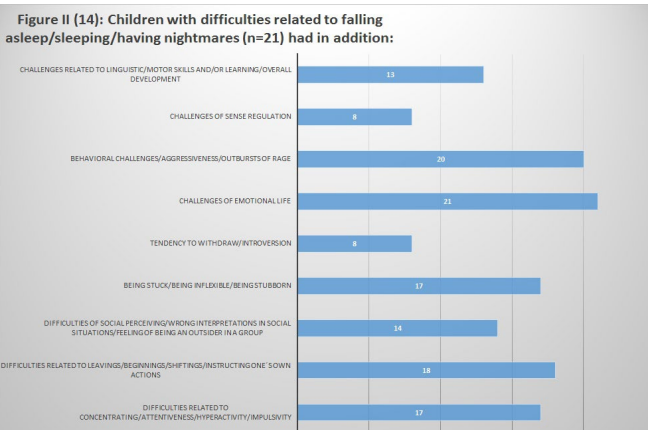


Figure 2.14) Children with difficulties related to falling asleep/sleeping/having nightmares (n=21) had in addition

Figures 2.1-2.19 shows 19 different symptoms/challenges, which are analyzed more closely:

1. Behavioral challenges/aggressiveness/outbursts of rage (n=49)
2. Challenges of emotional life (n=52)
3. Difficulties in friendships/lack of friends (n=20)

4. Fallacious/weird talks (n=13)

5. Symptoms related to urinating (frequent need to urinate/holding urine) (n=4)

6. Symptoms related to defecation (smudging with feces/holding feces) (n=7)

7. Not eating enough/losing weight/selectivity related to food (n=8)

8. Binge eating/strong desire for treats (n=5)

Figure II (15): Children with strong reactions/big difficulties when using electronic devises/playing games is restricted (n=15) had in addition:

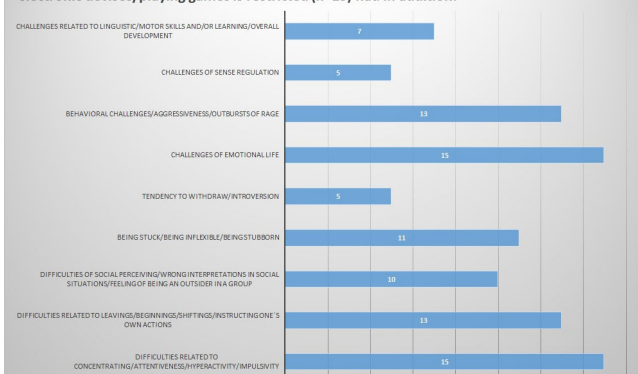


Figure 2.15) Children with strong reactions/big difficulties when using electronic devices/playing games is restricted (n=15) had in addition.

Figure II (16): Children fearing of being "crazy", "stupid", "wrong of a kind" etc. (n=10) had in addition:

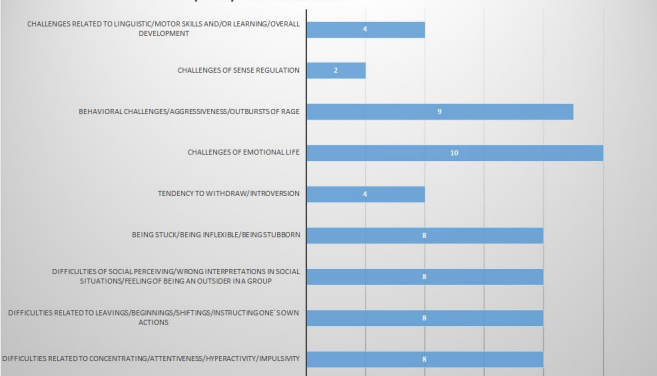


Figure 2.16) Children fearing of being "crazy", "stupid", "wrong of a kind" etc. (n=10) had in addition.

Figure II (17): Children with dissatisfaction, negativity/parent's experience that nothing is enough for the child (n=12) had in addition:



Figure 2.17) Children with dissatisfaction, negativity/parent's experience that nothing is enough for the child (n=12) had in addition.

9. TIC symptoms/obsessive symptoms (n=7)

10. Tendency to stammer/slurred speech/(n=6)

11. Difficulties related to linguistic/motor skills and/or learning/overall development (n=27)

12. Selective mutism (n=4)

13. Vomiting/headache/stomach ache/other somatic symptoms without a

Figure II (18): Children with sadness/symptoms of depression/suicidal talks/hurting himself/difficulties of handling disappointments (n=35) had in addition:

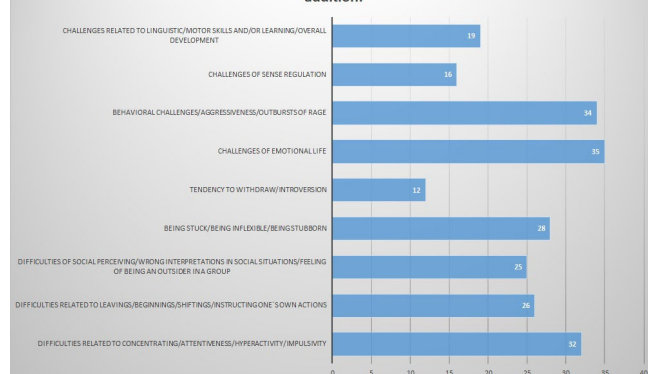


Figure 2.18) Children with sadness/symptoms of depression/suicidal talks/hurting himself/difficulties of handling disappointments (n=35) had in addition.

Figure II (19): Children with anxiety/fearfulness/panic symptoms (n=30) had in addition:

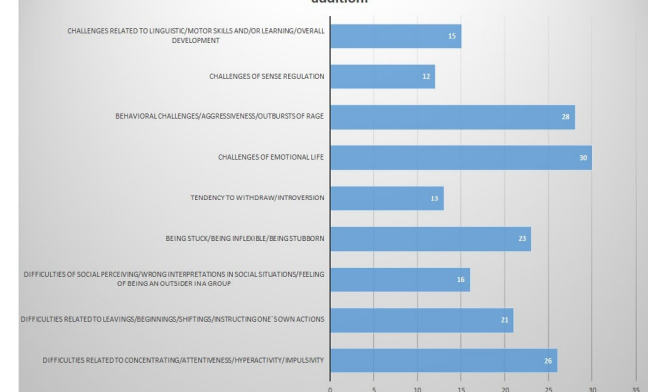


Figure 2.19) Children with anxiety/fearfulness/panic symptoms (n=30) had in addition.

found somatic reason (n=8)

14. Difficulties related to falling asleep/sleeping/having nightmares (n=21)

15. Strong reactions/big difficulties when using electronic devises/playing games is restricted (n=15)

16. The child's fear of being "crazy", "stupid", "wrong of a kind", etc. (n=10)

17. The child's dissatisfaction, negativity/the parent's experience, that nothing is enough for the child (n=12)

18. Sadness/symptoms of depression/suicidal talks/hurting himself/difficulties of handling disappointments, analyzed separately from the challenges of emotional life (n=35)

19. Anxiety/fearfulness/panic symptoms, analyzed separately from the challenges of emotional life (n=30)

The above mentioned 19 symptoms/challenges were examined regarding 9 different variables:

1. Challenges related to linguistic/motor skills and/or learning/overall development

2. Challenges of sense regulation

3. Behavioral challenges/aggressiveness/outbursts of rage

4. Challenges of emotional life

5. Tendency to withdraw/introversion

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6. Being stuck/being inflexible/being stubborn
7. Difficulties of social perceiving/wrong interpretations in social situations/feeling of being an outsider in a group
8. Difficulties related to leavings/beginnings/shiftings/instructing one's own actions
9. Difficulties related to concentrating/attentiveness/hyperactivity/impulsivity

Referring to Figures 2.1- 2.19, all or almost all the children in this research had neuropsychiatric-like features according to the evaluation made by three child psychiatrists, and these features were a burden and contributed to the child's symptoms, and were important to notice when considering what is "wrong" with the child and how to help him.

Number of referrals to specialized health care

The number of referrals made by HP to specialized health care for further examinations/treatments were: 40 to child/adolescent psychiatry, two to pediatric unit and two to children's neurological unit. Two those children were directed to two different units. There were thus 10 children without HP's referral to specialized health care. Of those ten, two were directed to the specialized health care by other physicians and one *via* hospital's acute unit. Thus, finally only seven children (13%) were not directed to specialized health care.

Family background related observations and notions of the research data

The possible psychiatric/neuropsychiatric characteristics/symptoms (one or more) of the first/second/third degree family members were investigated in discussions with parents. There was remarkable variation/randomness in the quantity of collected data. The most important characteristics/symptoms were (the number of persons is in parenthesis): Difficulties related to concentrating/attentiveness/EF/ADHD/ADD (40), symptoms of depressiveness (23), problems with addiction/substance use (22), impulsiveness (21), difficulties with linguistic skills/perception/learning skills (14), challenges in tolerating emotions/regulating emotions/sensitivity with emotions (11), autism spectrum characteristics (e.g. being a hermit) (10), problems with life management/attempted suicide/suicide/exclusion from society (9), unstable/narcissistic/other kind of personality disorder or strong doubt of it (8), difficulties in understanding/handling social interactions (7), symptoms of anxiety (7), bipolar disorder or strong doubt of it (7), panic symptoms (6), obsessive thoughts/functioning/perfectionistic characteristics/OCD (5), strong/special interests (5), schizophrenia or other psychosis disorder (4) and aggressiveness/fit of rage (4).

DESCRIPTIONS OF THE EVERYDAY REALITY THROUGH CASE EXAMPLES

Case example 1

The child came to HFCO at age 3 due to oppositional behavior. The working model focused at first on family level (especially supporting the parents), and parents attended also a group for parents of children with behavior disorders. More than a year after becoming a client at HFCO, psychological examinations were done for the child. It was found e.g. no challenges of cognitive skills, but instead the child's negative image of himself and tendency to act according to the negative self-image. The plan was to have supportive appointments for parents and to give support/guidance to the day care. The staff at the day care had e.g. worries of the child's restlessness. At preschool age, psychological examinations were done again. The child's behavior changed more oppositional/self-oriented at the examining situation if he felt that he couldn't do the tasks/giving the instructions was lengthen, for the linguistic understanding and reasoning the results were contradictory, and there was also concerns related to concentrating and attentiveness. Social perception skills seemed to be age-level in a peaceful and person-to-person testing situation. However, in daily life and also during the testing meetings, the child's attachment to his own point of view/difficulties to observe other people's feelings and view-points was seen.

HP was consulted. The parent told HP, that his worries had risen when the child was 1.5 years old, as the child had been running around all the time. When the child started in day care sometime later, they got a lot of negative feedback about the child's restlessness/behavior challenges. According

to psychiatric examination, the child seemed to have neuropsychiatric symptoms (e.g. ADHD type), and he was directed to specialized health care for more specific diagnostics and treatment.

Discussion

Comprehensive evaluating the situation at the earliest stage possible is important especially regarding to the child and his family (to avoid negative interpretations, to support child's self-esteem and self-image as well as parents' own coping), but also regarding the best use of resources.

Case example 2

The child was directed to HFCO at middle school age from the psychiatric unit of specialized health care, where he had been a client for almost two years for support because of a somatic illness. According to a summary from specialized health care, the main working theme there had been an observation that the child got stuck (stuck in his own ideas and thoughts, and then he felt strange to himself) and the lack of initiative skills (things were easily forgotten, and the child needed remarkable support from parents for daily routines), and the situation had seen as the child's unwillingness to take responsibility in age appropriate way. On the other hand, the child was seen to wonder the situation over wisely and self-critically in a healthy way, but he was still not able to change his behavior. Parents considered their part but couldn't change the situation. Instead, the same reactions repeated time after time. In specialized health care the problems were seen to take place mostly on the level of family relations, and to this the family was seen to need help.

At HFCO, the work began on family level (meetings with the child and his parents, later the focus was on parents). HP was consulted in a situation, where despite the carried-out work on family level, worries about the child's well-being and operation models continued bringing remarkable burden. According to the psychiatric examination, a doubt of ADD was raised, and this was later confirmed in the neuropsychological examinations.

Discussion

Comprehensive examining was much delayed, which caused harm for the child and his family but also in financial way (long lasting client ships in specialized health care and HFCO).

DISCUSSION

Supporting parents

An operation model, where parenthood is being supported without understanding why parenting is so challenging is unacceptable. As if a child's symptoms could be helped only by changing parents' ways of action, if the root cause of the difficulty lays within the child's own features/challenges, where understanding/treatment is needed. In this case, it would be important to help the child and his parents to see the child the way he is, to give them support and help to find ways of handling everyday life, despite the challenges. Insufficient investigations and wrong interpretations/treatments themselves can be an additional burden.

A study that researched worries and psychic wellbeing of parents of children with neuropsychiatric symptoms stated that it is necessary to recognize the experienced challenges of parenthood and psychic burden and it is important to pay attention to the wide relation between worries related to parenting and weakening of the psychic wellbeing of care-takers [28]. It is also important to keep in mind that neuropsychiatric characteristics have a strong hereditary background. Sometimes when offering help for parenthood, it should also be considered if the parents themselves need greater understanding of their own situation.

Blending of the boundaries of psychiatric/neuropsychiatric diagnostics and the necessity for redefinitions and reorganizations

Diagnosis is needed for giving a correct name for person's difficulties, leading to understanding of the noted difficulty/phenomenon, its bearing and accepting, and for the treatment/support needed. If the difficulty has a right/understandable name, this often already helps to relieve the pain and lessens indefinite fear/anxiety.

According to this study, behind/involved with child's "psychiatric" difficulties were neuropsychiatric-like features/symptoms (figures 2.1-2.19). The most difficult cases of neuropsychiatry are probably not directed to HFCO, and the degree of difficulties seen at HFCO does not usually exceed

the threshold of further investigations or interventions in the specialized medical care of child neurology. It seems that the cases that reach the actual neuropsychiatric diagnoses are only the “top of an iceberg”, whereas what remains underneath has a strong impact in developing symptoms thought to be psychiatric. Many of the children had various special features, and the symptoms might have changed within the years. The boundaries between different neuropsychiatric disorders seem often weak, it looks more like spectrum/continuation of (various) neuropsychiatric features. Diagnostic definitions seem also challenging if the child’s symptoms are seen well in only one environment.

There are many factors that affect regulating skills, e.g. experiences of early interaction and the attachment developed, child’s parents’ attachment style/skills of co-regulation, interactions within the family, ways of upbringing of the child, emotional atmosphere, child’s life history, traumas, somatic/neurologic aspects, treatment the child received etc., but also the structural characteristics of the child. Sometimes it is hard to know which the root cause is, as everything seems to influence everything, taking into consideration also the plasticity of the nervous system, and there is not one simple or always correct answer. However, many parents described that ever since the birth, their child had been somehow “different” (e.g. in comparison with his siblings), as if he was “carved of a different type of a tree”.

The difficulty of self-regulation (e.g. senses/attention/impulses/emotions/different aspects of EFs) is often connected to the “psychiatric” symptoms, but the diagnostic system does not notice this. Discussion is also needed whether disorders of self-regulation are primarily psychiatric disorders, or rather a psychiatric disorder be caused by this difficulty, if it has not been recognized/understood/accepted/treated.

Disorders of EFs are usually seen the best when observing the patient’s coping in different situations, and thus observing the patient’s behavior and him performing tasks, as well as interviewing the patient and his family, has a great importance [29]. Normal-range performance on EF measures should not be used to rule out ADHD, if careful diagnostic interviewing and behavioral rating scales support the diagnosis [30]. The clinical examining of difficulties of EFs has stated to need methods that describe reliably the skills and challenges of everyday life [31]. Sometimes the observations about the real daily life, made by a patient or his parents, are not taken seriously enough.

Before the contact at HFCO, in cases of 20 children there had been different therapists/psychologists (one or more) involved, and in cases of 33 children there was or had been social services involved. The need for comprehensive examining and the issue of its delay can be seen in all stages of health care, but also involving social services.

Via discussions with the children’s parents about family history, neuropsychiatry was not examined behind psychiatric symptoms for the most part. It was touching to hear the parents or other close family members (who had had according to the heard description as a child very similar symptoms than the child who participated in the study had) strongly wished comprehensive examinations and support for the child, so that his fate would be different. There were also descriptions of adults’ excessive risk-taking (e.g. in traffic), with very sad outcomes.

New information about neuropsychiatry has been spreading out fast, and the traditional ways of thinking and research/treatment structures have not always been able to catch up with the speed. There seems to be randomness in taking neuropsychiatry into account in different processes depending on to where or to who has been sought for help. Obviously, this should not happen.

It is a shameful, that psychiatric diagnostics is still based on categorizing different symptoms without a comprehensive evaluation process as a necessity before making a diagnosis! In a case of an aching knee, would anyone agree on an operations model like this?

Could changing the point of view make an “old” disorder sometimes look different? Could it sometimes be so that:

- Personality disorder is caused by a special (e.g. neuropsychiatric) feature in one’s own personality that has stayed very unfamiliar/strange/scary for oneself, and the disorder has developed from one’s own and his environment’s difficulty to integrate the feature to entity?
- Behind narcissism are difficulties in ability to observe and understand other people and social situations, making also one sad for not being understood?

- Autism spectrum tendency of “getting stuck” is behind OCD/compulsive neurosis?
- Autism spectrum tendency of “getting stuck” with symptoms of fear and anxiety, ADHD/ADD issues or challenges of sense regulation are found behind anorexia type of eating difficulties?
- Addiction and alcoholism/drug-use and e.g. binge eating are caused or influenced by complex difficulty of EF and especially inhibition skills?
- Problems of regulating, especially of emotions and impulses, are behind bipolar disorder?
- Observing and interpreting wrong social situations are behind social phobias?
- Symptoms of depression are caused by neuropsychiatric features that have remained unfamiliar and that make daily life difficult to handle?
- Behind psychosis (e.g. schizophrenia) are challenges in regulating and processing senses, issues of getting lost in one’s “own world” with features of autism spectrum/attention difficulties, or negative interpretations of social interacting situations?
- Behind anxiety/fears/panic/tension is an oversized psychic burden related to an individual’s skills of self-regulation or e.g. autism spectrum features that causes rigidity/getting stuck/not seeing any options, if the situation doesn’t go as planned/wanted?
- And so on.

The fact that a psychiatric diagnosis can be given without genuinely comprehensive examining is ethically very questionable and very expensive (lengthened processes with poor results). The biggest cost can be caused for persons’ mental health if the diagnosis (based on the symptoms) starts to define the person, both by himself and his environment. Comprehensive examination (also from neuropsychiatric view-point) should be a cornerstone and necessity in psychiatric diagnostics.

When the child’s wellbeing causes worry for the first time and “home methods” or general advice are not enough, the comprehensive thinking of the child’s situation from various directions should begin. Comprehensive approach in investigation should be constructed as a part of the first-line operation model, and observations of the past and daily life should be valued. Many children and families (especially those having difficulties in tolerating changes) would benefit from not changing the professionals after having made a good contact with them, and immediate continuation in service system as well as cohesive co-operation between different professionals with clear responsibilities is important. It is well reasoned that a resource and knowledge should be created for the basic level of health care system to examine the child’s psychiatric/neuropsychiatric wellbeing comprehensively, as well as for treatments of children for the part that has been agreed together with specialized health care. It has been stated that there should be more teaching for doctors and health care professionals about children’s mental health, recognition, investigation and especially treatment methods suitable for services at ground level [32].

CONCLUSION

In psychiatric diagnostics comprehensive examinations should be a necessity in order to gain comprehensive understanding of the difficulty as well as comprehensive help. Many neuropsychiatric characteristics/symptoms have their good and bad sides, and it is of vital importance to harness their good sides to support growing up and developing, e.g. into activity, fast reaction ability, perseverance and not giving up, punctuality and accuracy, creativity and sensitivity, empathy and justice, huge knowledge and know-how on the matters of interest and originality and uniqueness.

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