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Вероятность смены диагноза у взрослых пациентов, у которых в детстве были диагностированы психические расстройства

Т.Р. Газизуллин[1,2], В.Д. Менделевич[1]

[1]Казанский государственный медицинский университет, Казань, Россия
[2]Республиканская клиническая психиатрическая больница им. акад. В.М. Бехтерева, Казань, Россия

Автор, ответственный за переписку: Владимир Давыдович Менделевич, mendelevich_vl@mail.ru

АННОТАЦИЯ

Обоснование. Проблема смены психиатрического диагноза относится к числу актуальных.

Цель. Изучить частоту и вероятность смены выставленного пациентам в детском возрасте психиатрического диагноза при переходе под наблюдение к психиатру, обслуживающему взрослое население.

Материал и методы. Проанализировано 246 случаев пациентов, впервые обратившихся к психиатру в детском (подростковом) возрасте, далее взятых на консультативный или диспансерный учёт. Исследование носило катамнестический характер, велось при помощи анализа электронных баз данных Республиканской клинической психиатрической больницы им. акад. В.М. Бехтерева МЗ РТ (г. Казань), а также путём изучения первичной медицинской документации (амбулаторных карт и историй болезни). Результаты исследования обрабатывали на базе программ Statistica 6.0 и MS Excel 2020.

Результаты. Описаны основные варианты исходов психических расстройств, диагностированных в детском возрасте пациентов. Показано, что верификация психиатрического диагноза в раннем возрасте более чем в половине клинических случаев бывает неокончательной, а вопрос дальнейшего диагностического поиска остаётся неисчерпанным и требующим пересмотра. При помощи методов многофакторной статистики смоделированы основные транснозологические (дименсиональные) модели алгоритмов развития психических расстройств.

Ключевые слова: *детские психические расстройства, катамнез, транснозологические исследования, дименсиональный подход, психиатрическая диагностика, кластерный анализ*.

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Probability of change in diagnosis among adult patients diagnosed with childhood mental disorders

Timur R. Gazizullin[1,2], Vladimir D. Mendelevich[1]

[1]Kazan State Medical University, Department of Psychiatry and Medical Psychology, Kazan, Russia
[2]Republican Clinical Psychiatric Hospital named after acad. V.M. Bekhterev of Ministry of Health of the Republic of Tatarstan, Kazan, Russia

Corresponding author: Vladimir D. Mendelevich, mendelevich_vl@mail.ru

ABSTRACT

BACKGROUND. The problem of changing a psychiatric diagnosis is a reality.

AIM. To study the frequency and probability of changing the exposed patient at the age of psychiatric illness when moving under the supervision of a psychiatrist served by a large population.

MATERIAL AND METHODS. We analyzed 246 cases of patients who first applied to a psychiatrist in childhood (adolescence), then taken for consultative or dispensary registration. The study was follow-up in nature, was carried out with the help of the analysis of electronic databases of the RCPB. acad. V.M. Bekhterev of the Ministry of Health of the Republic of Tatarstan (Kazan), as well as by studying primary medical documentation (outpatient cards and case histories). The results of the study were processed on the basis of Statistica 6.0 and MS Excel 2020.

RESULTS. The main variants of the outcomes of mental disorders diagnosed in childhood of patients are described. It is shown that in more than half of clinical cases the confirmation of a psychiatric diagnosis at an early age is not final, and the issue of further diagnostic search remains unresolved and requires revision. Using the methods of multifactorial statistics, the main transnosological (dimensional) models of algorithms for the development of mental disorders are modeled.

Keywords: *childhood mental disorders, catamnesis, transnosological studies, dimensional approach, psychiatric diagnostics, cluster analysis*.

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BACKGROUND

Diagnosing mental and behavioral disorders is a process that includes determining whether a person has any psychopathological abnormalities and developing a therapeutic strategy and a methodology for assessing the prognosis and probable outcome of the disease in a particular patient. The diagnosis, in a sense, "programs" the doctor's activities and forms a "projection into the future" in the patient and his relatives, with an idea of the possibility of achieving or failing to achieve life goals and self-actualization [1]. In this regard, making an erroneous (preterm) diagnosis of a mental disorder in childhood can affect a person's adequate and harmonious "trajectory of future development" [2–4].

In recent years, there has been a focus on scientific prospective longitudinal studies to learn about the relationship between mental and behavioral disorders and psychopathological disorders that develop in these people as they become older. The occurrence of mental disorders attributed exclusively to "childhood" should be recognized as a distinct diagnostic problem. To date, despite the evident facts of their presence, the issue of diagnosing attention deficit hyperactivity disorder in adults, as well as autism spectrum disorders, has not been explored and insufficiently developed [5–7].

Differential diagnosis of mental and behavioral disorders in childhood is notoriously challenging due to the disease's hazy clinical presentation and the child's inability to formulate complaints clearly and unambiguously. An impediment to objective diagnosis can also be the vagueness of psychiatrists' ideas about the boundaries of forms and modes of behavior typical for children and adolescents during periods of age-related crises [3, 4].

Psychiatric practice shows that obtaining a psychiatric diagnosis is often not a static process that changes as a person matures but instead appears to be a dynamic process [8–21].

In addition, there is a trend toward increased diagnostic relativism in modern psychiatry, which consists of a skeptical attitude toward making an accurate diagnosis associated, first, with the transition from the nosological principle to the phenomenological one and, second, with the idea that even dissimilar mental disorders are treated uniformly with a focus on syndromic therapy.

Diagnostic errors in mental and behavioral disorders in childhood and adolescence, as well as their subsequent correction, revealed that they may be associated with the following causes:

(a) the evolution of mental illness beyond the scope of a single diagnostic category;

(b) neurodynamic aspects of cerebral cortex physiology during various stages of life;

(c) the addition of concomitant disorders (neurological, somatic, and addictive) with psychopathology transformation;

(d) stress–psychogenic factors;

(e) the influence of social and compensatory attitudes associated with attempts to benefit from a psychiatric diagnosis or, conversely, destigmatization; and

(f) the difference in diagnostic approaches across psychiatric schools and the probability of medical errors.

The dynamics of mental disorder and its nominal presentation as a formal diagnosis during the transition from childhood–adolescence to adulthood are particularly interesting for biological and socio-psychological reasons [10–12]. Identifying prognostic criteria for childhood mental disorders can help eliminate several challenges in diagnoses, therapy selection, and rehabilitation measure formulation.

Previous research on the outcomes of childhood mental disorders has focused on the dynamics of particular disorders within a single traditional nosology. Thus, it has been shown that schizophrenia with onset in childhood is more malignant than in adults [10]. The severity of this disorder is evidenced by the high proportion of pediatric patients who remain disabled upon reaching adulthood. When these patients reach adulthood, they typically exhibit severe immaturity of social skills, intellectual incompetence, and personal underdevelopment.

Organic mental disorders are inherently a heterogeneous group of diseases with diverse etiology, pathogenesis, clinical phenomenology, types of course, and treatment methods. Despite long-term studies, particularly on deficient states after childhood organic hazards [12], little is known about the patterns of their outcomes after manifestation in childhood. Data on the dynamic options of other mental disorders (affective–behavioral and autism spectrum) characteristic of childhood are dispersed and lack a unified methodological approach.

Table 1. Distribution of patients by diagnoses made before the age of 18 yr

ICD-10 code	Diagnosis	Number of patients
F20	Schizophrenia	43
F70	Mild mental retardation	36
F06	Organic mental disorders	40
F9	Emotional and behavioral disorders with the onset in childhood and adolescence	54
F84	Childhood autism	73
Total		246

Note. ICD-10, International Classification of Diseases, 10th revision.

Table 2. Group of schizophrenia spectrum disorders

Diagnosis after the age of 18 yr (*n*)		% coincidence/variability
F20	42	98
F06.28	1	2

The above highlights the need for developing and elaborating transnosological research in age-specific psychiatry. The unity of these processes in nominally different diseases is reported from the results of numerous neurobiological studies, and the transnosological approach is consistent with the idea of general pathological patterns in the development of mental disorders.

This study aimed to characterize the structural and dynamic aspects of diagnostic models of mental disorders from a follow-up perspective based on the variability of diagnosis at different stages of the patient's development. The study objectives included a quantitative assessment of the distribution of diagnoses after 18 yr of age based on diagnoses established in patients during childhood and adolescence and the identification of transnosological dimensions that describe the most common stereotypes of the dynamics of mental disorders.

MATERIALS AND METHODS

The study included 246 patients who consulted a psychiatrist for the first time as a child or adolescent, were registered for consultation or at a dispensary, and were diagnosed with a mental disorder. Another condition for inclusion in the study was that the patients be transferred to an adult psychiatric network at the age of 18 yr after additional research and clarification of the diagnosis. The average age of patients examined when they registered for psychiatric registration was 9.29 ± 6.37 yr, the age of patients at the present data snapshot was 20.7 ± 12.07 yr, and the period of prospective follow-up by psychiatrists was 10.83 ± 6.8 yr.

The study was a follow-up, and it was conducted by analyzing electronic databases of the V.M. Bekhterev Republican Clinical Psychiatric Hospital of the Ministry of Health of the Republic of Tatarstan (Kazan), as well as by reviewing source medical records (outpatient cards and prior medical histories).

The obtained data were examined statistically (cluster analysis). The research results were processed using Statistica 6.0 and MS Excel 2020 programs.

RESULTS

The results of the study were analyzed independently for each group of mental and behavioral disorders. Table 2 shows the results of diagnostic coincidence and inconsistencies in a sample of patients diagnosed with schizophrenia in childhood.

The most static group in terms of diagnostic variability was the schizophrenia group (F20), with 98% of diagnoses coinciding after 18 yr; only in one case beyond this age was the diagnosis changed to organic schizophrenia-like disorder (F06.28), with 2% variability. The average age of the disease onset in this group was 9.53 ± 3.37 yr, and as in all cases, a childhood type of schizophrenia with catatonic-paranoid, hebephrenic symptoms, and an increase in gross emotional–volitional and intellectual defects

Table 3. Mental retardation group (F70)

Diagnosis after the age of 18 yr (*n*)		Share of coincidence/variability (%)
F70	21	58.3
F71	7	41.7
F07	4	
Z03	2	
F23	1	
F06	1	

was described. All patients had been disabled since childhood, and upon transfer to the adult psychiatric network, the topic of recertifying disability to group 1 or 2, or occasionally deprivation of legal capacity, emerged in most cases. The previously established diagnosis of schizophrenia was affirmed without any doubts.

It should be noted that after all medical and social issues were resolved, patients in this group had a low frequency of rehospitalizations (compared with patients with paranoid schizophrenia diagnosed after 18 yr), indicating the blurring of psychotic, affective, and behavioral disorders, as well as the predominance of adverse conditions in the mental status.

The percentage of diagnostic coincidence in the group of patients with mental retardation was 58.3%, which may indicate inaccuracies in its qualification in childhood (Table 3).

One of the most important characteristics of mental retardation is its nonprogression throughout the patient's life. According to theory, this diagnosis should be final and only be changed in cases of increased concomitant organic pathology or the onset of a psychotic disorder (schizophrenia).

It is noteworthy that diagnosing mental retardation, particularly mild (F70), at an early age can be a more challenging clinical task than in adults. It is more challenging to use methods to study abilities for abstract logical thinking in pediatric patients; their horizons have not been formed, the basic level of school knowledge has not been obtained, and the factor of socio-pedagogical plays a negative role, all of which contribute to a false-positive diagnosis.

When the study group of seven patients was analyzed, the diagnosis was revised to moderate mental retardation (F71), which was confirmed by the current status, the results of the psychological and experimental research methods, severe social and pedagogical maladaptation (learning disability), and the need to solve medical and social problems. During re-examination, two patients met the formal norm of intellectual abilities, were considered healthy (Z03), and were withdrawn from follow-ups.

The following stereotype of "pathomorphosis" of mental retardation was observed in the case of four patients who obtained lower intelligence norms as they grew older despite perinatal brain damage with psycho-verbal development retardation. However, a pathocharacterological development with psychopathization and criminal-type behavioral disorders was identified simultaneously, and the diagnosis was changed to organic personality disorder (F07). In one patient, the onset of schizophrenia (F23) occurred at an older age; in another one patient, there was a predominance of a partial mental defect, with a change in diagnosis to mild cognitive disorder (F06.7).

In the study group, the average age at initial diagnosis of mild mental retardation (F70) was 9.47 ± 5.0 yr.

The results of studies on coincidence/variability in organic mental disorders are shown in Table 4.

Organic mental disorders (F06) in pediatric practice refer to disorders classified as mild cognitive disorder (F06.7) and organic nonpsychotic disorder with mild intellectual incapacity (F06.8), both of which denote partial cognitive deficits that do not correspond to mental retardation. According to statistical reporting, the remaining types of organic pathology (organic schizophrenia-like F06.28 and organic affective F06.3) were shown to be singular.

Organic psychopathology, unlike mental retardation diagnoses, must have plasticity, particularly in childhood/adolescence. The agreement between childhood and adulthood diagnoses (F06.7 and F06.8) was 37.5% in the studied group of patients. It is noteworthy that 13 (36%) patients achieved total compen-

Table 4. Group of organic mental disorders (F06)

Diagnosis after the age of 18 yr (*n*)		Share of coincidence/variability (%)
F06	15	37.5
Z03	13	62.5
F07	5	
F70	4	
F20	2	
F02	1	

Table 5. Group of emotional and behavioral disorders with the onset in childhood/adolescence (F9)

Diagnosis after the age of 18 yr (*n*)		Proportion (%)
Z03	45	83.5
F06	4	7.4
F07	4	7.4
F20	1	1.85

sation for organic cognitive impairments and were considered healthy (Z03); the addition of pathological personality traits was noted in five patients and organic personality disorder was diagnosed (F07); and mild mental retardation (F70) was registered in four patients with the formation of cognitive deficit. The onset of schizophrenia (F20) was reported in two cases, and dementia (F02) was detected in one case due to the increasing severity of epilepsy and atrophic changes in the brain. The average age of the patients in this group was 8.3 ± 5.7 yr.

The category of emotional and behavioral disorders (F9) is typical for childhood/adolescence and does not apply to patients above the age of 18 yr. Accordingly, it does not appear correct to assume that diagnoses would coincide; however, in this case, it is also possible to track variations toward health (Z03) or pathology (F) (Table 5).

According to the medical records, all patients from this group were in an outpatient consultative group with a local psychiatrist; only two patients were hospitalized in a closed department due to parasuicidal attempts. A mixed behavioral and emotional disorder (F92.8) was diagnosed in all cases, with a slight predominance in certain cases of deviant behavior (socialized or unsocialized conduct disorder) or psychomotor disinhibition (hyperkinetic disorder or attention deficit hyperactivity disorder).

When the patients reached the age of 18 yr, the majority (83.5%) were considered healthy and did not contact the state psychiatric network, did not undergo inpatient treatment, or did not receive psychopharmacotherapy. After reaching adulthood, a military medical examination revealed an organic asthenic (emotionally labile) disorder (F06.6) in four patients and an organic personality disorder (F07) in four patients with further decompensation of behavioral disorders. The onset of schizophrenia (F20) was observed in one case. The average age of patients in this group was 9.29 ± 3.37 yr.

Despite the instructions in the clinical recommendations of the Russian Society of Psychiatrists, "Autism spectrum disorders in childhood: diagnostics, therapy, prevention, rehabilitation" [22], such a diagnosis can be delayed until adulthood or verified initially after the age of 18 yr, there remains a tendency in the practice of Russian psychiatrists to revise it and, accordingly, classify this pathology as specific to childhood (Table 6).

Thus, the percentage of agreement in the studied group of patients was 0%, as the diagnosis of childhood autism beyond the age of 18 yr was revised in favor of other mental disorders in all cases.

The most common diagnosis was schizotypal disorder (psychopathic-like variant [F21.4] or "symptom-poor schizophrenia" [F21.5], 36 cases in total). All these patients were classified into the third disability group because they did not undergo treatment in a hospital setting, did not receive psychopharmacotherapy, and, at the same time, demonstrated a low level of social adaptation. The

Table 6. Childhood autism group (F84)

Diagnosis after the age of 18 yr (*n*)		Share of variability (%)
F21	36	100
F70	18	
F20	16	
F06	3	

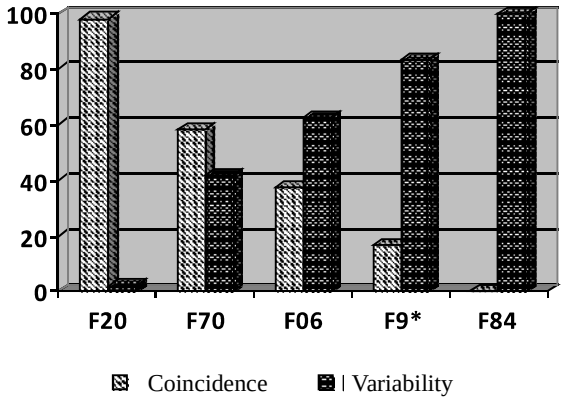

Figure 1. Dynamic characteristics of changes in diagnosis. *Group F9—coincidence; this is any nosology after 18 yr, variability — no mental disorders after 18 yr

second most common diagnostic dynamics were mild mental retardation (F70) with mild behavioral disorders in 18 patients, followed by a simple form of schizophrenia (F20) with a pronounced emotional–volitional defect in 18 patients.

There were three cases of organic schizophrenia-like disorder (F06.28). The average age of psychiatric registration in this group was 6.98 ± 3.9 yr.

Generalized data on the coincidence or variability of mental and behavioral disorders formed in patients examined in childhood and subsequently in adulthood are presented in Figure 1.

The data presented on the coincidence or variability of a pediatric psychiatric diagnosis relative to age-related follow-up divides the selected groups of mental disorders conditionally into static (schizophrenia group), relatively static or labile (mental retardation and organic mental disorders group), and labile, fundamentally changing disorders and, as a rule, drifting toward assessment of recovery after 18 yr (group of emotional and behavioral disorders). The question of dynamic variations and results in autism spectrum disorder diagnosis is a separate subject that requires a more in-depth approach.

To achieve the second objective of the study, which was to identify transnosological aspects of the examined psychopathological disorders, a cluster analysis of the gathered data was performed using Ward's method (tree clustering) and Euclidean space as a metric. The variation series reflected the initial diagnoses up to the age of 18 yr (Diagnosis 1), and all diagnoses qualified after that (Diagnosis 2) were conventionally designated by ordinal numbers 1–7 (single nosologies F02 and F23 were excluded from the analysis).

According to the cluster analysis results, we have identified three main transnosological dimensions that form the closest correlations among themselves and more distant ones among themselves.

According to the mathematical analysis, disorders classified as schizophrenic and autistic spectrums (F20–F84) have the highest level of interconnections (Linkage Distance 11.1). Schizophrenic (F20) and autistic (F84) disorders were combined into a single psychopathological cluster that was autonomous and

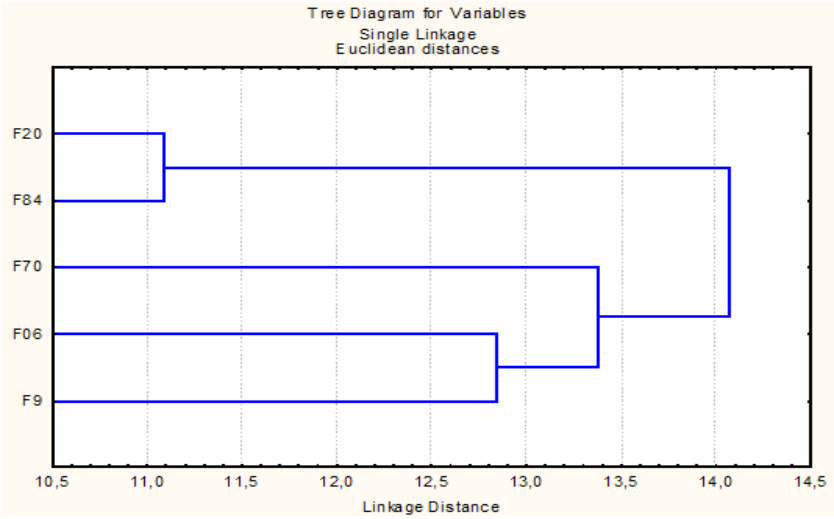

Figure 2. Results of cluster analysis

distantly correlated with other disorders (Linkage Distance 14.1)[1]. It is noteworthy that the group of autism spectrum disorders (F84), according to the results obtained, has a significantly stronger bias toward "schizoendogenous" etiology than organic etiology.

Affective–cognitive disorders (F09–F06) were found to represent the second level of intrastructural relationships between emotional and behavioral disorders (F09) and cognitive organic disorders (F06). The nature of behavioral disorders has a relationship (Linkage Distance 12.8) with an organically determined base (so-called minimal brain dysfunction), which is reversible at an older age (group of emotional and behavioral disorders [80.5% after the age of 18 yr] without mental disorders).

Organic register disorders (F70 and F06–F09) include those mentioned above affective–cognitive component (F09 and F06) in the structure, which is reinforced by mental retardation (F70; Linkage Distance 13.4). It does not appear to be an independent unit to the full extent but rather a continuation of the dynamic variant of affective and cognitive disorders (F09 and F06) reaching the degree of mental retardation.

[1]Limitations: the correctness of the correlations obtained could be influenced by the fact that the diagnosis of autism spectrum disorder established in pediatric patients under 18 yr of age, upon transition to the adult network, changed to schizophrenia spectrum disorder in 71.2% of cases.

DISCUSSION

Thus, the research and the cluster analysis enable us to assert that, from a follow-up perspective, psychiatric diagnoses established in patients in childhood have a high degree of variability (51.55% without taking into account the group of emotional and behavioral disorders with onset in childhood and adolescence, F9). It can be assumed that the restoration of normative mental functioning is associated with the dynamic and plastic properties of brain structures and the erroneous diagnosis of so-called childhood mental disorders, which are phenomenologically comparable with aberrant forms of behavior.

The study results revealed that the most static disorders on the schizophrenia spectrum remained stable during the study period, with diagnostic errors being casuistic. The most dynamic diagnoses were childhood emotional and behavioral disorders, which were fully compensated in 83.5% of cases upon reaching adulthood (Z03). This pathology does not appear to predict the development of borderline disorders (psychopathic, neurotic, and addictive).

CONCLUSIONS

The results may indicate that this pathology is more associated with puberty than with psychogenic and social causes because when it is overcome, recovery occurs rather than pathological development.

Cluster analysis revealed three main transnosological dimensions corresponding to dynamic stereotypes of psychopathological formations. The dimensions form a single "longitudinal axis" of disorders ranging from the most profound and autochthonous schizophrenia disorders to organic and affective–cognitive disorders bordering on health status.

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Contribution of the authors. *T.R. Gazizullin* — collection of material, mathematical analysis; *V.D. Mendelevich* — analysis of literature and research results.

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ОБ АВТОРАХ

Газизуллин Тимур Рустемович, канд. мед. наук, врач-психиатр, зам. глав. врача;
ORCID: http://orcid.org/0000-0002-3100-6291;
eLibrary SPIN: 8872-3118;
e-mail: kary85@mail.ru

Менделевич Владимир Давыдович, докт. мед. наук, проф., зав. каф., каф. психиатрии и медицинской психологии;
ORCID: http://orcid.org/0000-0002-8476-6083;
eLibrary SPIN: 2302-2590;
e-mail: mendelevich_vl@mail.ru

AUTHOR'S INFO

Timur R. Gazizullin, M.D., Cand. Sci. (Med.), Psychiatrist, Deputy Head Physician;
ORCID: http://orcid.org/0000-0002-3100-6291;
eLibrary SPIN: 8872-3118;
e-mail: kary85@mail.ru

Vladimir D. Mendelevich, M.D., D. Sci. (Med.), Prof., Head of the Depart., Depart. of Psychiatry and Medical Psychology;
ORCID: http://orcid.org/0000-0002-8476-6083;
eLibrary SPIN: 2302-2590;
e-mail: mendelevich_vl@mail.ru