

Child and Adolescent Psychiatry: New Understanding and Directions in Diagnosis

Summarized by Thomas T. Thomas

Every child subjects his or her parents to “difficult days” and goes through exasperating “phases.” Each child has his or her own special needs and problems. That’s just part of growing up. But some children, as many of our members have discovered, exhibit serious mental disorders requiring professional attention. How do you tell the two apart?

The speaker at our September 25 meeting, **Herbert Schrier, MD**, is Director of Psychiatry at Children’s Hospital of Oakland and reputedly the East Bay’s top diagnostician and treatment specialist in child and adolescent psychiatry. He addressed some of the disorders he has discovered and explored in the children he treats.

“My career has been a kind of an odyssey,” Schrier said. “When I started out in New York, I saw parents of severely autistic children put through intense therapy to cure *their* parenting problems—with no treatment suggested for the children themselves.”

Later, as psychiatrists began to appreciate the physical side of the mind and the effects that could be achieved through medication, Schrier encountered parents and physicians who immediately rejected “the devil drug” Ritalin, despite its demonstrable benefits.

The trend in child psychiatry seems to have been, “if you can’t explain something, explain it away.” This supports the shocking tendency of many parents to overlook obvious symptoms of distress in their children: ticks, compulsive behavior, social problems, and learning difficulties.

This tendency is further supported by school officials responding to recent legislation which mandates expensive programs for disabled and special-needs children. If the schools don’t acknowledge a problem, they won’t have to serve it.

Schrier, on the other hand, frankly admits a love of diagnosis. He approaches each troubled child as a puzzle of interlocking deficits and strengths, of positive and negative symptoms, which may help him one day to unlock the mind.

During the course of the evening, Schrier showed the group video clips—without names, of course—of some young patients he uses on grand rounds. For most of them, he does not yet have a firm diagnosis, but he discussed what he calls “non-verbal learning disability.”

Most children who are classified as learning disabled usually have trouble with reading—the verbal part of their education. It’s a red flag: if a child has trouble reading, he has a problem. But the children Schrier presented could be called “hyper-verbal.” It’s in the *other* areas of performance that they have problems.

One boy, age about twelve, spoke at a remarkably sophisticated level. He spoke volubly, cleverly, knowingly—and never did get to the point of what he was saying. In answer to the question, “How was school today,” he rambled on for many minutes about his classroom situation and never completed a whole sentence.

Eerily, this patient managed to use the word “contextualize”—correctly—in relation to his problem. He just couldn’t grasp the context of what he was trying to say.

Schrier also noted that this boy did not make eye contact during the entire interview and could not read facial expressions—something a baby learns to do fairly accurately by six months. Also, he had no sense of humor.

“You can be smart and still have a disorder,” Schrier said. This boy has a verbal IQ of 140 but cannot communicate; in the realm of performance, he is utterly lacking. None of these children, Schrier warned, would ever be confused with the “too bright” child who is bored with school and so restless or hostile in the classroom.

Another boy, at age six and a half, had tried to read Stephen Hawking’s *A Brief History of Time* for himself. By the second chapter, however, he found it pretty hard going, so he listened to the book tapes instead. In the doctor’s office, he could speak knowledgeably about Hawking’s physical disability and linked it correctly to Lou Gehrig’s disease. But it soon became clear that this child, who could read at such an advanced pace, was merely parroting what he had read. He was not interpreting it.

Other children exhibited no sense of social distance—sitting too close or too far from the person interviewing them. Or their voices passed into a singsong pattern—rising and falling without meaning, which made one young woman in her early teens sound like a four-year-old.

Schrier noted that her parents thought she spoke this way to annoy them and that she was a spoiled, mean kid. He identified her as having no “social referencing.” That is, she could not read cues from the faces and gestures of those around her.

“If someone bit his tongue in this girl’s presence and winced with the pain,” he said, “she wouldn’t be aware of it.”

He noted that many of these children have other, more familiar symptoms:

- **Obsessive-compulsive disorder (OCD)**, which involves repeated, ritualistic, usually irrational actions and insecurities. “Everyone has had the momentary fear, while sitting on the edge of the bed, that something might reach out and grab their ankles,” Schrier said. “One of my patients can only get in bed at night by making a running leap from the other side of the room.”
- **Tourette’s syndrome**, which is often thought of as compulsive profanity but encompasses much more—such as a compulsion to touch people, ritual activities, ticking, and general restlessness. “We know these symptoms come from problems in the midbrain,” Schrier said. “Maybe that’s linked to their other deficits, too.”
- **Physical clumsiness and disorganized thinking**, like the boy who rambled and couldn’t “contextualize.” These children often lack fine motor skills, have

terrible handwriting, are not athletic, etc. But Schrier stressed that, although some of these symptoms are also found in schizophrenia, none of these children have been diagnosed as schizophrenic.

- **Hypersensitivity**, which may appear as an exaggerated reaction to sounds, the feel of certain clothing, bright light, etc. “One girl couldn’t eat in the same room with her parents because the sound of their *chewing* bothered her.”
- **Lack of somatic referencing**. “These children literally don’t know where, in the body, they or others feel emotions.”

Schrier has proposed a study in which home videos of these patients—“because everybody has a camera these days, and they are the ideal naive observer”—be collected and compared to see if he and colleagues can detect the onset of these symptoms. He also wants to follow up and see which symptoms, if any, fade out as the child moves toward adulthood.

“No one has done any work on this. We don’t know what happens to, for example, supersensitivity in the adult. Does it go away? Or does the person learn to cope and adapt?” Schrier is pushing the neuropsychologists in his group to work on these symptoms.

In this context, he told of a young woman, now about age eighteen, who had to figure out for herself that, when the corners of a person’s mouth went up, that meant the person was smiling. So she felt it was safe to assume they were happy.

“That’s a tribute to the indomitable human spirit,” Schrier said.