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Studies in the Childhood Psychoses

I. Diagnostic Criteria and Classification

By I. KOLVIN

A. DEVELOPMENT OF A CLASSIFICATORY SYSTEM

Until the last decade there was considerable confusion about the nosology of childhood psychoses. As Kanner (1958) has pointed out, certain psychodynamically orientated writers (Szurek, 1956; Beres, 1956) have eschewed the important operation of differential diagnosis. This has led to the notion of 'equality of schizophrenias' (Darr and Worden, 1951) and thus to the idea of a single psychosis of childhood. The controversy over this approach has now waned in the face of empirical evidence from aetiological, phenomenological and follow-up studies, and many authors have stressed the importance of age of onset in their typologies or in their attempts at a more comprehensive classification (Kanner and Lesser, 1958; Mahler *et al.*, 1949, 1952; Bender, 1947, 1959; Anthony, 1958, 1962, and Eisenberg, 1967). As this is also central to the present study it merits examination in greater detail.

A necessary condition for Kanner's autistic syndrome (Kanner, 1943; Kanner and Lesser, 1958) was that it appeared before the age of two. Mahler's (1949, 1952) symbiotic psychosis developed later than autism. Bender (1947, 1959) used the terms pseudodeficient (onset in the first two years of life equated with autism), pseudoneurotic (onset between three and five years), and pseudopsychopathic (onset in later childhood). Anthony (1958, 1962) proposed:

Group I with an early onset and a slow chronic course; included Kanner's syndrome, Bender's 'pseudodeficient' and Despert's 'no-onset type'.

Group II at three to five years with an acute course followed by regression, included Heller's disease, De Sanctis and Weygandt's dementias, Bender's pseudoneurotic, Despert's 'acute onset' type and Mahler's symbiotic psychosis.

Group III with a late onset and a fluctuating subacute course; included Bender's pseudopsychopathic.

Subsequently Anthony tried to differentiate between primary or endogenous and secondary or exogenous psychoses by combining his second and third groups to produce his secondary psychosis category.

Anthony (1962), Rimland (1964) and Rutter (1965, 1967) have noted some of the main distinguishing features of the different psychoses of childhood. Rutter (1967) has drawn together the findings of various authors to list some of the distinguishing features of early childhood psychoses and those of later onset. He, and also Rimland (1964), have tentatively concluded that childhood psychosis of early onset is related neither to childhood psychosis of late onset nor to schizophrenia.

B. THE ESTABLISHMENT OF DIAGNOSTIC CRITERIA

Eisenberg (1957a) writes: 'This review has also served to emphasize the lack of uniformity in criteria for diagnosis. This indicates . . . the importance of specification of criteria in all future clinical reports.' The development of diagnostic criteria for infantile autism will show some of the key steps in this research.

Infantile autism and infantile psychosis

Kanner (1943) defined early infantile autism as being extreme aloneness (autism), obsessional insistence on the preservation of sameness, secondary symptoms in the sphere of communication and motor behaviour, with an onset within the first two years of life. The Creak Working Party (1961) provided nine points which were mainly intended as diagnostic

guides but their importance was diminished by differences of interpretation (Creak, 1964), and some inherent ambiguity (Rutter, 1966). Nevertheless, they paved the way for subsequent systematic description of speech (Wolff and Chess, 1965) and also behaviour (Wolff and Chess, 1964; and Rutter 1965, 1966 and 1967), by essentially different techniques. Wolff and Chess systematically recorded detailed information about the children's behaviour and analysed features invariably present or present in the majority of cases. These included abnormalities of eye-to-eye contact (visual avoidance), certain language abnormalities, aimless repetitive behaviour, and a failure to respond to clear-cut stimuli. The two most characteristic features were (a) stereotyped repetition of remnants of earlier behaviour out of step with the child's general level of development and inappropriate to his current environmental setting; (b) a lack of initiative and a reduced responsiveness to changing environmental stimuli.

Such unambiguous features can be used for differentiating between functional and organic syndromes, and for estimating prevalence and incidence (Kolvin and Roth, 1970).

Rutter provided an inventory of behavioural features with the further merit of comparing the frequency of their incidence in a control group. Only two items of behaviour were present in all psychotic children—abnormal interpersonal relationships, and retardation of speech. Certain other kinds of behaviour were particularly characteristic of psychotic children but did not occur exclusively in them. He concluded that 'the difference between the groups lay largely in the patterning of symptoms and to some extent in their severity'.

More recently, techniques have been developed for objective recording and analysing of characteristics of autistic children's behaviour in a 'free field', where they may be unattended but observed through a one-way screen (Hutt *et al.*, 1963), and these should lead to a better basis still for differential diagnosis and prognosis and for estimating prevalence and incidence.

Thus the two essential steps in establishing diagnostic criteria are the delineation of a

circumscribed syndrome by careful observation and analysis (Eisenberg, 1957), and a subsequent study to derive a set of 'objective, unambiguous, and non-inferential criteria which can be readily and reliably assessed' (Kolvin and Roth, 1970).

Childhood psychoses of late onset

With the clearer recognition of the entity of the autistic or infantile psychotic child, and the rarity of psychoses with onset between the ages of three and five, a closer look needed to be taken at the remaining psychoses, namely the late onset psychoses of childhood.

Kanner (1957) states that the older the child is at the onset the more closely does the clinical picture mirror that of adult schizophrenia: younger children show less content and less variability. Potter, too (1933), points out that children cannot be expected to display clinical features with the same degree of elaboration as found in the adult. The degree of complexity depends on age, intelligence, language development, verbal facility and capacity for mental abstraction. His criteria (as outlined by Kanner, 1957) were:

1. A generalized withdrawal of interest in the environment.
2. So called dereistic (autistic) thinking, feeling and acting.
3. Disorder of thought, consisting of blocking, symbolization, condensation, perseveration, incoherence and diminution, sometimes to the extent of mutism.
4. Defects in emotional rapport.
5. Diminution, rigidity and distortion of affect.
6. Alterations of behaviour, with either an increase of motility leading to incessant activity or a diminution of motility leading to complete immobility or bizarre behaviour, with a tendency to perseveration or stereotypy.

These criteria were to cover the whole range of childhood psychoses while doing justice to the general concept of schizophrenia (Kanner, 1957). It is not surprising, therefore, that there was no reference to hallucinatory or delusional features as the very nature of autism precludes their detection in early childhood.

Bender (1947) proposed as criterion an onset before the age of eleven, with abnormality at every level of integration and patterning within the central nervous system, but this is too broad a basis for the recognition of circumscribed syndromes.

Many authors—Anthony (1958 and 1962), Rimland (1964), Eisenberg (1957) and Rutter (1967)—have tentatively indicated that childhood psychosis of late onset may well be related to adult forms of schizophrenia, and it is interesting that even Bleuler stated that schizophrenia (he implied in its adult form) might appear as early as the seventh year.

Fish's amplification of the Leonhard-Kleist analysis of schizophrenic clinical pictures appeared to provide a model for the study of childhood psychosis of late onset. He drew attention to Jaspers' suggestion that schizophrenic symptoms were those which are non-understandable, meaning that the form of the symptoms but not necessarily their content was extraordinary, since content is often coloured by situation or culture.

Schneider (1942) described a group of these unusual or bizarre symptoms, 'symptoms of the first rank', pathognomonic of schizophrenia if coarse brain damage can be excluded. As listed by Fish (1959) these symptoms were:

- (a) Hearing one's thoughts spoken aloud;
- (b) Hallucinatory voices in the form of conversations about the patient;
- (c) Hallucinatory voices in the form of running commentary;
- (d) Bodily hallucinations which the patient claims are produced by external agencies;
- (e) Influence on thought—thought insertion and thought withdrawal;
- (f) Thought broadcast;
- (g) Delusional perception;
- (h) All events in the spheres of feeling, drive and volition which are experiences caused by or directly influenced by others.

According to Bleuler, in formal thought disorder there is fundamentally a weakness of association which leads to an increase of autistic and dereistic thinking (i.e. fantasy thinking which is entangled with private fantasy, and is not therefore goal-directed). This

brings us close to the first three criteria in Potter's scheme.

C. PRACTICAL APPLICATIONS

The detailed behavioural analysis of Wolff and Chess was undertaken on a small group of autistic children without use of controls; Rutter compared the frequency of abnormal behavioural items in a large group and used controls. Neither of these studies differentiated or made comparisons between childhood psychoses of early and late onset. This was the main theme of the Oxford and Newcastle comparative study, begun in 1962, which supposed that:

- (i) psychotic disorders are dependent on the age at which the process begins; disorders with different ages of onset are fundamentally different;
- (ii) the two main childhood psychoses (infantile or I.P., and late onset or L.O.P.) differ in aetiology and phenomenology;
- (iii) patients with I.P. show different symptoms from L.O.P. when reaching the age at which the latter begins;
- (iv) if L.O.P. is related to adult schizophrenia there should be similar aetiological factors at work.

Our study aimed to test these hypotheses, to collect accurate information on the frequency of occurrence of the different symptoms in the different childhood psychoses, and to establish criteria for diagnosis of childhood psychoses of later onset on a statistical basis according to frequency analysis rather than on clinical impression.

D. OPERATIONAL DECISIONS

Because development complicates the manifestation of symptoms we decided in patients with infantile psychosis to record the features present at later ages which seemed more appropriate to a psychosis of later onset and in L.O.P. patients to look for past or present features reminiscent of infantile psychosis. There is a risk that findings may simply reflect ascertainment criteria—the fallacy of circularity. It was hoped that the application, where possible, of both sets of ascertainment criteria

to both groups of childhood psychotics would avoid this risk and help to clarify the clinical pictures.

Our ascertainment criteria were:

(a) *Infantile Psychosis (I.P.)*

1. Age of onset before the age of three years.
2. A self-isolating pattern of social behaviour.
3. At least one of the following:

- (i) Catastrophic reactions to environmental changes, particularly of a topographical variety.
- (ii) Gross stereotypies either of a global class such as head-banging, pirouetting or rocking; or of the idiosyncratic type, such as finger flicking, specific motor patterns, and self-stimulation.

(b) *Late Onset Psychosis (L.O.P.)*

1. Onset during the main school period of five to fifteen.
2. Adult schizophrenic symptoms of the first rank (Schneider).
3. Other adult schizophrenic symptoms in the fields of affect, motility and volition.

Allowances were made for language limitations or limited ability for complex abstractions. Delusions and hallucinations were expected to be relatively simple and unsystematized, and allowance had to be made for the vivid imagination and extensive fantasizing which may be seen in the early school era and which

can be differentiated from hallucinations and delusions by the ease with which the child gives them up when challenged.

Fish pointed out that the prolonged or chronic case presents little diagnostic difficulty, but the acute case may lack important signs. It was therefore our practice in cases of late onset lacking pathognomonic signs to delay diagnosis until such signs emerged, and to exclude patients with less clear-cut symptoms or who presented with severe obsessional symptoms only.

SUMMARY

1. Three major groups of psychoses in childhood can be distinguished by their age of onset: under 3 years, 3-5 years and over 5 years.

2. Diagnostic criteria are proposed for the first and third groups, based on the work of Kanner and Creak for the first, and Fish (in adult schizophrenia) for the third.

3. The study reported in the following papers tests the value of distinction by age of onset and establishes the frequency of occurrence of the different signs in the different clinical groups, leading to discriminants for differential diagnosis.

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