

# Emotional Problems in Childhood and Adolescence

## Late Onset Psychosis

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Only recently has definitive evidence become available that there is not a "unitary" psychosis of childhood. Infantile psychosis in no way resembles the psychosis of later childhood: there are clear cut and definite differences between the disorders.

The first of these is the nature of the symptoms. Hallucinations and delusions<sup>4 34 35</sup> frequently occur in the child with late onset psychosis but not in those with infantile autism. On the other hand, the gaze avoidance to the social stimulus of the human face,<sup>29</sup> stereotyped finger and hand flicking movements (stereotypies), resistance to change, and serious delay in speech and communication are characteristic of infantile psychosis.

Secondly, more parents of children with infantile psychosis fall into the higher socio-economic classes,<sup>10 14 15</sup> whereas more parents of late onset psychotics fall into the average<sup>36</sup> or lower social classes.<sup>16</sup>

Thirdly, the very poor intellectual development of infantile psychotic children<sup>14 28</sup> with a high percentage having I.Q.s below 70 contrasts with the substantially higher I.Q.s but still with a tendency to intellectual dullness of the late onset psychotic.

Fourthly the low rate of schizophrenia in the parents of infantile psychotic<sup>14 15 35</sup> and the significantly high rate in the psychosis of later onset suggests a genetic connexion between late onset psychosis and adult schizophrenia.<sup>35 37</sup>

Fifthly, there is an excess of oddities in parental personality in the psychotics of late onset,<sup>26</sup> and lastly, significant excess of perinatal risk factors and evidence of cerebral dysfunction in the infantile psychotic cases has been found.<sup>26</sup>

The above findings have led to the conclusion<sup>4 8-10 23 24 26</sup> that early onset psychosis bears no relation to late onset psychosis but that the latter is similar to the type of schizophrenia seen in adults. Furthermore, follow-up studies<sup>14 37 38</sup> have shown that even when they become adult, autists do not resemble schizophrenics. Schizophrenia may begin with psychotic symptoms in later childhood<sup>38</sup> but only rarely are these symptoms overt before the age of 7 to 8 years.

### Diagnostic Criteria

The importance of the specification of diagnostic criteria has been emphasized by Eisenberg.<sup>1</sup> Kolvin<sup>8</sup> has proposed criteria based on those "first rank symptoms" apparently pathognomonic of adult schizophrenia.<sup>12 39 40</sup> These criteria include three groups: firstly, certain hallucinations—hearing one's thoughts spoken aloud; voices in the form of conversations about the patient; voices giving a running commentary; and bodily hallucinations which the child claims to be produced by external agencies. The second group comprises thought dis-

orders—especially of possession of thought and delusions. The third comprises other symptoms in the sphere of feeling, drive, and volition.

The one proviso to using these criteria is that coarse brain damage must be excluded.<sup>12</sup>

### Differential Diagnosis

This is particularly difficult in late childhood, and especially in adolescence. The insidious form has to be differentiated from the unusual, odd, or eccentric personality which progressively reveals itself with development. The rare acute form has to be differentiated from both depressive disorders and the commonly occurring adolescent crisis. These states of turmoil with irritability and moodiness, bouts of depression, difficulties of affective expression, philosophical ruminations, and serious rebellion and conflict against parents and authorities often give rise to the suspicion of incipient psychosis.<sup>13</sup> However, in the long run they almost invariably prove to be nothing more than transient adolescent crises. It is probably true to say that overdiagnosis is a greater problem in the United States than in the United Kingdom. In the former there is a tendency to use broader definitions and hence a wider concept of psychosis, so that the severe adolescent crisis is often perceived as being a schizophrenic state.

The above "first rank" symptoms are diagnostically useful in helping to distinguish not only adolescent crises but also adolescent depressions with paranoid ideas or hallucinations from adolescent schizophrenic states. Finally, it needs to be constantly borne in mind that acute psychotic-like episodes in later childhood and adolescence may have been induced by drugs such as amphetamines<sup>41</sup> or any of the more powerful hallucinogens.

### Incidence

Both clinical experience and hospital surveys suggest that late onset psychosis condition is even rarer than infantile psychosis.<sup>42</sup> The paucity of knowledge about the condition is determined firstly by its rarity and secondly by the previous tendency to perceive all psychotic disorders of childhood as unitary and hence only autism has been studied until recently.

### Clinical Features

Both Kolvin<sup>24</sup> and Ushakov<sup>43 44</sup> describe an excess of schizoid personalities, though neither claims that such anomalies are sufficient to result in schizophrenic disorder in later years. The most common pattern in schizophrenic disorder (two-thirds of the cases) is an insidious onset. Only one in eight cases are both acute and come completely out of the blue.

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Ushakov<sup>43,44</sup> makes the important distinction between the beginning of the illness and the appearance of unmistakable symptoms. While the former may occur at the early primary school age, unmistakable or diagnostic symptoms usually appear much later. This view is supported by Kolvin *et al.*,<sup>31</sup> who found that many patients have a history of extremely odd behaviour for years but can be labelled psychotic only some years later when unequivocal evidence has appeared.

One way of describing psychotic behaviour is to ignore the diagnostic or discriminative importance of any particular symptom and to draw a profile in terms of symptoms frequency alone.<sup>35</sup> The most commonly occurring set of features have been found to be auditory hallucinations, bodily mannerisms, and a tendency to provide only partial answers to questions. The next set of symptoms which occurred commonly were disorders of association of thought and blocking of thought; delusions; abnormalities of mood in terms of blunting of affect and perplexity; and grimacing and jerky movements. Finally, the set which occurred moderately commonly were mixing poorly with peers and a tendency to avoid adults; ambivalence; and obsessional phenomena.

The older the child the more complex and systematized the symptomatology.<sup>34,35</sup> At the primary school age the content of the symptoms is both simple and crude, but this becomes progressively richer with increasing age. In the fully established state while the symptoms closely resemble those of adult schizophrenics<sup>46</sup> they are somewhat more rudimentary, patchy, and often transitory. Indeed, the elaboration complexity and systematization of symptoms depend essentially on the three key factors of age, verbal ability, and intelligence of the child.

Some have described extreme intellectual deficit in these cases.<sup>46</sup> Nevertheless, formal intellectual assessment showed a full spread of intelligence, though two-fifths of the cases had I.Q.s below 90.<sup>23</sup>

### Treatment

How do late-onset psychotics respond to treatment? Firstly, though analytical psychotherapy has so far made no contribution, supportive psychotherapy is invariably indicated. The child or adolescent often becomes so disturbed by his symptoms that he reacts with anxiety or depression, or both, and it is only when the latter recede that the schizophrenic nature of the disorder becomes evident. Some may question the necessity of making an early diagnosis, but, as I have found that phenothiazines often lead to the rapid disappearance of the more florid symptoms and often an arrest of the schizophrenic process, there is no good reason for delaying treatment. Ideally such clinical impressions need to be confirmed by adequately controlled evaluations but these may be difficult because of the rarity of the condition. The consensus of opinion is that electroconvulsive therapy is of limited value with its usefulness being confined to those cases who present in adolescence with resistant catatonic forms of psychoses. Finally, with the advent of the major tranquillizers, improved hospital services, and educational facilities the outlook is now much more hopeful. Nevertheless, it remains true to say that the

prognosis in the acute forms<sup>33,46,47</sup> is very much better than in the insidiously developing ones.

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