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DISTINGUISHING and CLASSIFYING the INDIVIDUAL SCHIZOPHRENIC CHILD

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observation (for purposes of longitudinal study), the children were distributed as in Table 5-1. By clinical judgment, therefore, while the majority of the schizophrenic children appraised showed evidence of cerebral dysfunction, psychosocial and familial influences contributed in a primary or crucial way to the adaptive failures of the children in almost 73 percent of the cases. We are proposing that sub-classification include an assay of neurological and psychosocial influences.

TABLE 5–1.

Psychosocial factors dominant; no evidence of neurological dysfunction	30.0%
Evidence of neurological dysfunction	70.0%
Neurological dysfunction dominant; no evidence of psychosocial factors	27.5%
Psychosocial factors more dominant than neurological dysfunction	20.0%
Both psychosocial factors and neurological dysfunction significant	22.5%

In conclusion, we are now prepared to recommend a system of sub-classification. It has demonstrated its usefulness for attaining meaningful subgroupings of schizophrenic children. In other words, the subgroupings differ from each other in average adaptive capacity and etiological influence. In addition we have already been able to demonstrate that the subgroupings show significant differences in growth patterns.

Level of Intellectual Functioning

Tests of intelligence are viewed as tests of overall adaptive functioning and the IQ is seen as a measure of clinical status and functional capacity. The

value of the IQ as a predictor of clinical improvement has been demonstrated by a number of follow-up studies. Children who cannot speak and have the most extremely inferior IQs (for example, below fifty) show no significant clinical progress. In a recent study, children with intellectual functioning so inferior at admission as to be unmeasurable in the WISC tend not to show significant improvement in IQ during three years of residential treatment, In contrast, children at higher, measurable levels of intellectual response often do show significant improvement in WISC IQ. While absence of language by the age of five to six years has also been regarded as an important indication of bad prognosis, Rutter has demonstrated, however, that such language failure is of key predictive significance if linked to low intellectual functioning.

Age of Onset and Age of Admission to Treatment

Age of onset has been emphasized by many observers as a factor of major import in defining the diagnosis and life course of schizophrenic children. Quality of onset is in itself related to age of onset. Presumptively insidious onset, for example, is more likely to be associated with very early onset, and acute onset implies later onset. In experience with schizophrenic children of early elementary school age in treatment at the Ittleson Center, virtually all the children demonstrated developmental aberrations and symptoms from the earliest months of life, including the small percentage (about 13 percent) who also showed clear historic evidence of acute

reactions. On the other hand, age of admission may be defined in an objective and reliable fashion. A gross relationship between the constructs age of onset and age of admission to treatment may be presumed. It does emerge that age of admission to treatment does differentiate among schizophrenic children in terms of level of integrative and adaptive response and life course, even where the range of admission age is fairly narrow. This has been noted, for example, in a comparison of early school-age schizophrenic children admitted to residential treatment at eight years of age or older and those admitted below eight years of age. The children admitted at eight years or older showed higher levels of IQ than those admitted to treatment at younger ages. While both groups improved significantly in WISC Full IQ over three years of residential treatment, the younger children improved to a greater degree in IQ. Even so, the children admitted at the older ages maintained their cognitive superiority at each year of treatment over those children admitted at ages below eight years.

Sex

All investigations of childhood schizophrenia have confirmed the greater proportion of boys than of girls in those who are diagnosed as schizophrenic. The boy to girl ratio varies among sub-clusters of schizophrenic children grouped by a variety of other independent variables. For example, the proportion of boys is considerably higher among

schizophrenic children with evidence of neurological dysfunction than among those without evidence of neurological dysfunction, where the proportion of boys and girls are about equal. If we take into account the overlapping between sex and other variables and the evidence that differences between boys and girls in longitudinal change reflect, at least in part, the influence of these overlapping variables and of sampling as well, there is still great validity in including gender in a system of sub-classification inasmuch as the boys and girls seem to differ as groups. At the Ittleson Center, where attention has been paid to the issue of sex, group differences between schizophrenic boys and girls have been observed in psychodynamics, intelligence, level of ego organization, educability, and the influence of cerebral and psychosocial factors.

Level of Neurological Integration

Employing the judgment of qualified psychiatric neurologists and using neurological history and examination, it has been feasible to subdivide schizophrenic children with and without evidence of cerebral dysfunction. The neurological examination, of course, seeks hard evidence of neurological impairment, such as alteration in normal reflexes, abnormal reflexes, asymmetrical failures in sensory and motor response, and EEG abnormalities. However, in recent years, more emphasis has been placed on refined observation of impairments in gait, posture, balance, motor coordination and

control, muscle tone, and the integration of multiple or multimodal stimuli. When the schizophrenic children are grossly subdivided into those who give these evidences of cerebral impairment (organic) and those who do not (nonorganic), a number of empirical findings distinguish the two sub-clusters. For example, the nonorganic children are superior to the organic children in most adaptive functions, including perceptual, conceptual, and psychomotor response. The nonorganic and organic children also differ in regard to family patterns of interaction, psychiatric status of the parents, and in maternal communication. Direct observations of families have tended to confirm that families of nonorganic children are virtually always deviant in psychosocial functioning, while organic children have families which are more heterogeneous in regard to adequacy of functioning and which include average as well as deviant families. A higher proportion of the mothers of nonorganic children than of organic children are schizophrenic. The mothers of nonorganic children have poorer speech and are less clear in their communication. Finally the two groups of children differ in course of development, in response to day and residential treatment, and in changes in specific ego functions. The organic children include the most impaired and most unchanging children. On the other hand, while the organic children respond equally well today and residential treatment, nonorganic children appear to show more progress in residential care, that is, the most comprehensive form of environmental treatment. Neurological appraisal is a

cardinal step in the differentiation of intrinsic and extrinsic influences.

Social Class Position

Schizophrenic children come from families at every level of social class position. Increasingly, too, it has become evident that the social class position of their families is associated with differences among the schizophrenic children. For example, in a recent longitudinal investigation, the schizophrenic children at high, middle, and low social class position differed in mean IQ at admission to treatment and in amount of change in IQ between admission and third year of treatment. Thus, mean WISC Full IQs at admission and after three years of treatment were as shown in Table 5-2.

TABLE 5–2.

SOCIAL CLASS	HOLLINGSHEAD-REDLICH INDEX	MEAN WISC ADMISSION	FULL IQ THIRD YEAR
High	I, II	61.6	68.2
Middle	III	77.2	82.5
Low	IV, V	79.2	89.2

Conclusions

The reader has been asked to accompany me through a complex discussion of the ambiguities and inconsistencies in the construct of childhood schizophrenia. This discussion first stressed that the emergence of the category of childhood disorders termed “childhood schizophrenia” followed the prior evolution of the category of adult disorders termed “adult

schizophrenia" and the confusing consequences of this historic association were noted. Though there was some apparent overlap between the two classes of disorder, they were not completely identical in symptoms and life course. I concluded that it was still wise to study and treat childhood schizophrenia as a set of conditions apart from adult schizophrenia. In addition, the most relevant focus in the study of schizophrenic children was presumed to be on the disturbances in maturation of purposeful functions and on factors influencing these disorders in psychological growth.

Then I discussed the diagnosis of childhood schizophrenia to arrive at a common basis for the classification of schizophrenic children. I emphasized the empirical finding that in spite of careful diagnosis, schizophrenic children were highly diversified in many important abilities and attributes, interpersonal and family experience, social class, and neurological integrity. Paralleling this diversity, a multiplicity of factors would appear to be linked to the adaptive disorders of schizophrenic children. In some children, intrinsic factors were linked to the schizophrenic child's manifestations. Thus, a high percentage of the children gave strong evidence of deficits in neurological and cerebral integrity. In some children, deviations in family organization and functioning seemed to be associated with the schizophrenic child's behavior. In the latter connection, paralysis in parental functioning and unclear maternal communication have been noted.

In view of the heterogeneity of schizophrenic children and the apparent multiplicity of causative influences, there is little doubt that specific and precise therapeutic design to meet the needs of the individual schizophrenic child requires careful assay of his unique psychodynamic dispositions, functional capacities, and developmental experiences. In research and observation, too, it has seemed most profitable to seek a point of view that does not reject the seeming contradiction in observational data but rather rationalizes them. These inconsistencies are more apparent than real since such inconsistencies are inferred only if one begins with the assumption that schizophrenic children are homogeneous and that there is a single cause of childhood schizophrenia. Disparate findings begin to show a pattern if one assumes that schizophrenic children are highly diverse and that the causes are multiple. I have concluded that the key to the discovery of this pattern is the intensive developmental study of individual schizophrenic children. I have also proposed that the many levels of capacity, motivation, and experience need to be seen in dynamic interplay with one another as the child grows. For example, there is little value in merely labeling the social class position of the families of schizophrenic children as high (a currently favored conviction) or low. There is more profit, however, in defining the developmental implications of low or high social class experience for a specific schizophrenic child.

Finally, we have concluded that just as study of the growth of individual

schizophrenic children is essential to dispel current ambiguities, it is equally essential to characterize these children individually by certain pertinent dimensions. The purpose of such characterization of individual children is to achieve homogeneous sub-clusters of schizophrenic children that permit generalization from the data. The present discussion has offered one system for subdividing schizophrenic children in which the dimensions employed reflect empirical experience as well as theoretic considerations.

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Notes

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