A TYPOLOGY OF CHILDREN’S PSYCHIATRIC DISORDERS

I. ITS APPLICATION TO A CONTROLLED EVALUATION OF TREATMENT

Barbara Fish, M.D. and Theodore Shapiro, M.D.

The universal problem of whether changes in a patient’s state can be attributed to a particular treatment requires the critical comparison of treated and control groups. This is especially important in assessing behavioral change in children because of their developmental plasticity and their relatively greater responsiveness to the environment and to the attitudes of significant adults who care for them.

Comparing results in two groups of patients, however, is meaningless unless the groups are matched for prognosis and for their ability to respond to therapy. Clinical diagnostic categories currently in use embody only gross basic differences in natural history. Patients within a single category may differ considerably in initial severity as well as in ultimate prognosis. Most observers would agree that one cannot compare neurotic with schizophrenic children given the same treatment; the range of severity within each of these categories also precludes simply matching treatment groups for diagnosis. The problem is to define subgroups of the classical diagnostic categories which have comparable prognoses.

This paper deals with a descriptive typology which grew out of the need to compare the outcome of drug-treated and control pa-

---

This investigation was supported by Public Health Service Research Grant No. MH 04665 from the National Institute of Mental Health and by a grant from the Harriett Ames Charitable Trust to Dr. Fish.

Presented at the annual scientific meeting of the American Academy of Child Psychiatry, September 21, 1963.

Dr. Fish is Associate Professor of Psychiatry, New York University School of Medicine; Psychiatrist-in-Charge, Children’s Services, Bellevue Hospital, Psychiatric Division. Dr. Shapiro is Instructor in Psychiatry, New York University School of Medicine.
tients. The clinical types were separated according to severity and patterns of integrative defect, as determined by a short series of psychiatric interviews. We used the impairment in integrative functioning as our frame of reference for rating the severity of illness, on the assumption that this is the single most important indicator of prognosis. The ego has been viewed as a group of functions which may suffer from generalized integrative impairment or from isolated defects (Beres, 1956).

To establish categories that could be used by different observers, degrees of ego impairment were translated into descriptive statements of the child's current adaptive patterning, focusing on critical aspects of behavior and thinking. If such an assessment could be reliably determined from the child's current functioning, as established over two to three psychiatric interviews, all those interested in the results of treatment of whatever type could compare their results with comparable groups of children.

**Method**

The pilot study was limited to children six to twelve years of age on the psychiatric ward of Bellevue Hospital. They represent a heterogeneous population, with clinical disturbances ranging from mild neurotic and conduct disorders to psychoses with schizophrenic or organic brain reactions. Children were excluded if they had clearly defined seizures or a focal neurological disorder.

Forty-five of these children were given baseline psychiatric, psychological, and neurological evaluations during the first two weeks after admission, and electroencephalograms were administered to the first twenty-nine children. Three groups matched for age and severity rating were then treated for five to six weeks with either chlorpromazine, diphenhydramine (Benadryl), used as a mild tranquilizer (Fish, 1963), or placebo. All the patients participated in the therapeutic program of the children's ward and attended the hospital school daily.

Two psychiatrists independently rated change in clinical state and in severity ratings. The analyses (see Results, I, below) are based on the ratings of the psychiatrist who was blind to whether drug or placebo was being given (B.F.). We recognize that many changes in subjective well-being are difficult to assess, but we can say something
Barbara Fish and Theodore Shapiro

about the changes which occur in a child on the grossest levels of adaptive functioning, if this is adequately defined.

The children were rated weekly on a 10-point global severity scale, whose focus was the degree of disturbance in integration and gross adaptive functioning, as observed on psychiatric interview. Severe, moderate, and mild disturbances were spelled out for activity, affect, thought, and social behavior (see Table 7 in Fish, 1962). It became apparent that the children did not readily fit into a single linear continuum of severity, but that they could be compared to each other much more precisely within certain groups.

Three clearly defined groups emerged immediately. One was a group of severely impaired schizophrenic children with autistic and symbiotic features (Type I). The other two groups had relatively intact personality organization; one presented predominantly anxiety and neurotic adaptions, ranging from mild neurotic reactions to psychotic pseudoneurotic schizophrenia (Type III); the other group showed primarily denial and behavior manifestations, ranging from sociopathic personality disorders to psychotic paranoid schizophrenia (Type IV). A fourth group of younger children remained who showed borderline impairment of integrative function on interview. They sometimes exhibited fragmentary autistic, neurotic or paranoid features, but they were characterized more by their inadequate and labile functioning than by any crystallized pattern of adaptive behavior. Since the severity of their disorders was intermediate between the autistic children of Type I and the better integrated children of Types III and IV, this group was designated Type II. From earlier follow-up data (Fish, 1960, 1961), we believe that children of Type II frequently develop into one of the three other types as they grow older. However, in a classification which was based only on current functioning, they represent a separate group.

The prototypic profiles for the four types derived from this initial study are described below (see Appendix). They were designated: I: autistic-disjunctive; II: immature-labile; III: anxious-neurotic; and IV: sociopathic-paranoid. These types represent major modes of adaptation on a continuum of severe to mild psychopathological disorder. Some of the children showed borderline features of an adjacent type. It nonetheless proved relatively easy to classify all the children on the ward using these descriptive categories. Within
each type it was much easier to rate the severity of type-specific disturbances and to spell out the criteria for psychotic, moderate, and mild disturbances. Once classified by type and then rated according to global severity, it was possible to draw ready correspondences between this typology and the standard A.P.A. nomenclature (see Table I). Usually approximately 10 per cent of the ward population consists of children with chronic brain syndrome associated with personality disorders, psychoneurotic reactions, or psychoses. The low incidence of chronic brain syndrome in this group may be due in part to the fact that in this study some were excluded by the selection criteria for the forty-five children used for the statistical analysis (see Method).

**TABLE I**

**Distribution of A.P.A. Diagnoses by Typology Group and Severity**

<table>
<thead>
<tr>
<th>GLOBAL SEVERITY RATING</th>
<th>A. P. A. DIAGNOSES</th>
<th>No. of Children in Each Typology Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I</td>
</tr>
<tr>
<td>SEVERE: (Psychotic)</td>
<td>Childhood Schizophrenia</td>
<td>7</td>
</tr>
<tr>
<td>MODERATE:</td>
<td>Personality disorder with chronic brain syndrome</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Psychoneurotic reaction with borderline schizophrenic features</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Psychoneurotic reaction</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Personality disorder with borderline schizophrenic features</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Personality disorder</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Total with Moderate Severity</td>
<td>0</td>
</tr>
<tr>
<td>MILD:</td>
<td>Psychoneurotic reaction</td>
<td>0</td>
</tr>
</tbody>
</table>

**RESULTS**

I. *Correlation of Treatment Responses with Clinical Type*

The ultimate aim of our study was to develop a clinical classification which could be used in matching treatment groups. For this
reason, the typology was constructed using integrative function as the prime indicator of prognosis. According to this spectrum of prognostic severity, Type I was considered to have the poorest prognosis for short-term response to therapy as well as for long-term outcome. The better organized children of Types III and IV were considered to have the best long-term prognosis and to be the most amenable to change by any therapy. Type II was believed to be intermediate in prognosis between those two extremes, but closer to Type I.

In the study of drugs and placebo in forty-five children, we were able to test the differential short-term responsiveness of each type to placebo and milieu as well as to drugs and milieu. The children of Types I and II did not respond to placebo (see Figure 1). Their impairment in integrative capacity was apparently severe enough to limit their ability to adapt to a structured setting, supportive adult figures, psychotherapy and special education, without the addition of effective drugs. Even those who showed definite improvement with drugs still retained residual impairment of intellectual and social functioning.

On the other hand, Types III and IV were much more responsive to therapy. Even psychotic children with pseudoneurotic or paranoid schizophrenia frequently showed some improvement with placebo and hospitalization alone; they lost their hallucinations and became somewhat less anxious, hostile, and distressed. When they responded to potent medication (chlorpromazine), they were capable of more complete resolution of symptoms than were the impaired children of Types I and II.

The analysis (Figure 1) points up the importance of matching treatment and control groups for their ability to respond to different treatments. Acute improvements in a group composed predominantly of Types I and II would be more specifically dependent upon the effectiveness of the drug being studied. Improvements in Types III and IV would be more dependent on environmental factors in treatment. If drug-treated and control groups were not matched for mildly disturbed children of Types III and IV, one might erroneously conclude that chlorpromazine was an inactive agent or one could falsely attribute improvement to an ineffective drug.

We consider the usefulness of the classification for short-term prediction a verification of our hypothesis that the clinical estimation of
integrative intactness does point to a prognostic indicator in a current examination. The typology appears to embody significant differences in the ability to respond to psychological as well as to physiological treatments.

In order to determine which factors influence prognosis, functioning was tested concurrently at various levels. Significant relationships emerged when these tests were correlated with the clinical types and with the responses to therapy.

II. The Relationship between Clinical Types and I.Q.

Figure 2 shows the gradient of intellectual impairment in the four types. Most of the children of Type I functioned on a defective level; the majority of the children of the other types functioned above a defective level. Less than 10 per cent of the children of Type II functioned in the average range, whereas the incidence of average intellectual functioning was higher in Types III and IV. The one child of Type IV who initially tested on a defective level showed an increase in both verbal and performance I.Q.s from
defective to average performance after four weeks of hospitalization and placebo.

In an earlier study of an upper- and middle-class population, one of the authors had found that intellectual impairment was correlated with the severity of schizophrenic or organic pathology (Fish, 1962). The I.Q. scores of these children were not depressed by environmental deprivation, but apparently reflected the severity of the clinical psychiatric disorder. The children with "primary" behavior disorders all had average to superior I.Q.s. However, those with severe behavior disorders had a higher incidence of perceptual disturbances and reading disabilities compared to those with mild behavior disorders.

About 80 per cent of our Bellevue population is drawn from very deprived socioeconomic groups. Many factors are present which depress effective intellectual functioning: institutional living with absolute deprivation syndromes, minimal support or stimulation at
Typology of Children's Psychiatric Disorders

home, bilingual background, lack of motivation for school, educational lags and a resulting high incidence of truancy. We therefore anticipated that, unlike the previous study, the correlation between lowered I.Q. and more severe psychopathology would not apply to the current study.

The less disturbed children of Types III and IV of our Bellevue population do show a lower incidence of average I.Q.s than the upper-middle-class population, as one would expect from their social and educational deprivation. However, contrary to our expectations, overwhelming intellectual impairment was still correlated with the most severe psychopathology.

Since we found a higher incidence of average I.Q.s in the children of Types III and IV, the question arises whether placebo response may be correlated with higher I.Q. itself. Table II shows the number of patients in each drug group who improved, classified by I.Q. It can be seen that placebo or drug improvement occurred in all I.Q. categories. Placebo improvement may occur in a child with borderline or defective I.Q. This is in contrast to the absence of placebo improvement in children of Types I and II. Matching treatment and control groups for clinical type appears to be more important in our population than matching treatment and control groups for I.Q.

<table>
<thead>
<tr>
<th>I.Q.</th>
<th>CHLORPROMAZINE (Improved Not)</th>
<th>DIPHENHYDRAMINE (BENADRYL) (Improved Not)</th>
<th>PLACEBO (Improved Not)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average (over 90)</td>
<td>2 2</td>
<td>0 3</td>
<td>1 2</td>
</tr>
<tr>
<td>Borderline (70-90)</td>
<td>6 2</td>
<td>2 8</td>
<td>1 6</td>
</tr>
<tr>
<td>Defective (under 70)</td>
<td>2 1</td>
<td>2 0</td>
<td>1 4</td>
</tr>
<tr>
<td>Totals</td>
<td>10 5</td>
<td>4 11</td>
<td>3 12</td>
</tr>
</tbody>
</table>
III. Relation between Abnormal Electroencephalogram and Clinical Type

The premedication electroencephalograms of the first twenty-nine children studied were read by Julius Korein, M.D.¹ He made clinical evaluations of these records without any knowledge of the clinical types of the patients. Although the results are not statistically conclusive in this small pilot sample, there was a greater incidence of electroencephalographic abnormality in Types I and II (i.e., 66 per cent) than in Types III and IV (29 per cent). Figure 3 shows the results for each type.

IV. Relationship between Other Developmental Disorders and Clinical Types

Other indicators of developmental impairment in our population are now being analyzed for their incidence in the four clinical types. Preliminary analyses indicate that Types I and II have a higher incidence than Types III and IV of (a) "soft" neurological signs (L. Bender, 1956a, M. Bender, 1952); (b) distortions and "organic"

¹ Assistant Professor of Neurology, New York University School of Medicine.
Typology of Children's Psychiatric Disorders

signs in the Bender Gestalt reproductions (Pascal and Suttell, 1951); and (c) in the human figure drawings. However, to be significant, a larger sample than the pilot study of forty-five is required to correct for the lower age range in Types I and II. These enlarged studies will be presented later.

V. Relationship of Historical and Social Factors to Clinical Type

We are currently accumulating data on etiological factors in the clinical histories, for their possible relationships to the different clinical types. The size of the pilot sample precludes definitive results, but some trends were evident. There was a high incidence of mental illness in the families of patients in all groups; half of the children had a mean of more than two mentally ill relatives per child. There was a higher incidence of prenatal and paranatal insults (toxemia, prematurity, twinning, and so on) in the children of Type II (50 per cent), compared to the other types (16 per cent in I, 9 per cent in IV, and none in III). Similarly, ratings of family social pathology and disruption are being correlated with the different clinical types. Preliminary data suggest that relatively little family social pathology occurred in children of Type I, compared to the other types.

DISCUSSION

I. Comparison with Other Classifications

This typology grew out of a practical need to match treatment and control groups of patients. Rather than create a new set of neologisms, we hoped to develop a useful classification, closely related to the A.P.A. nomenclature (1952), with definitions clearly spelled out by descriptions of current behavior. The integrative disorders of ego functions, which we use as prime indicators of severity, are inadequately characterized by the standard child psychiatric diagnoses. Instead, we found we could get a much better reflection of over-all integrative capacity if we first described a child's clinical type, as classified here, and then rated him for the severity of psychopathology.

The A.P.A. nomenclature does not provide for any subdivisions of childhood schizophrenia. There are correspondences between the clinical subdivisions described by earlier investigators and the four
types of childhood schizophrenics described by the psychotic variants of our four types. The childhood schizophrenics in our Type I would be included in Bender’s “pseudodefective” group; those in our Type III in her “pseudoneurotic” group; and those in our Type IV in her “pseudopsychopathic” group (Bender, 1956b). Those psychotic children in our Type II who are schizophrenic probably overlap all three of Bender’s subdivisions, but mostly her pseudodefective group. Kanner’s (1951) children with “early infantile autism” would be included in our Type I childhood schizophrenics. The strict criteria for childhood schizophrenia drawn up by the British group, chaired by Creak (1961), describe the childhood schizophrenics in our Type I. Mahler’s (1949) symbiotic childhood schizophrenics would mostly be included in our Type I schizophrenics, usually rated as less severe than the more autistic children; some of the better developed symbiotic schizophrenics as well as her “third type” seem closer to the childhood schizophrenics in our Type III. Goldfarb’s (1961) “organic” childhood schizophrenics probably overlap the childhood schizophrenics in our Types I and II and his “nonorganic” schizophrenics parallel the childhood schizophrenics in Types III and IV.

The long-term follow-up reports by Bender (1962), by Kanner and Eisenberg (1955), and by Eisenberg (1956) indicate that childhood schizophrenics with the most severe pathology in our Type I have the poorest outcome after nine to fifteen years (Kanner, 1951) and after twenty to twenty-five years (Bender, 1962). In these two series, the less severely impaired schizophrenic children of Type I who later developed communicative speech and obsessive-compulsive patterns might at a later stage in their development have been described as our Type III schizophrenics. The prognostic significance of language and other integrative impairments has been discussed by Fish (1962). A nosology which is to be used for matching treatment groups must account for such differences in natural history.

The A.P.A. nomenclature creates diagnostic problems in classifying the less disturbed children as well. Children’s disorders are seen in the process of formation, still interacting with their family and social environment (G.A.P., 1957; Fish, 1962). Some provisions must be made for the spectrum of childhood disorders which lies between the “transient adjustment reactions” on the one hand, and the more crystallized “personality disorders” and “neurotic reactions” on the
other. Only the two extremes of this series are accounted for in the A.P.A. classification.

We have found it easier to classify these intermediate and less crystallized behavior disorders in children using this descriptive typology which spans the gamut of severity. Children in the mildly severe category of Types III and IV have been seen in a "normal" pediatric population, including mild adjustment reactions and mild personality and neurotic trait disorders. Children with more severe neurotic and personality disorders readily fit into the various grades of mild to moderately severe pathology of our Types III and IV. They do not conform to the A.P.A. categories since these definitions are spelled out for the more differentiated adult disorders.

The behavioral categories described by Robinson and his co-workers (1961) provide finer subdivisions within these milder behavior disorders. His fifth group, "passive apprehensive," appears to correspond to our Type III, whereas the first four categories, "active superficial," "openly antagonistic," "active control," and "passive control," describe various defensive operations of children whom we would most probably place in Type IV, with varying degrees of severity. However, from the single case description provided for each of his behavioral categories, it is not possible to generalize accurately to other populations. There are also parallels between our types and symptom clusters derived by Jenkins and others from a statistical analysis (Jenkins and Glickman, 1946; Lorr and Jenkins, 1953). The categories he designated as "brain injured" and "over inhibited," correspond roughly to our Types II and III respectively. His categories of "unsocialized aggressive," and "socialized delinquent" would be included in our Type IV. His "schizoid" group does not appear to be as disorganized as our Type I children.

II. Use of the Typology in Controlled Studies of Treatment

We hoped that our typology would prove useful for communication between workers in different centers who are interested in evaluating the results of treatment, regardless of the type of therapy. The typology proved to be significantly related to the short-term responses of children to both psychological and pharmacological therapies. Comparison of the four types to populations previously described and followed (Bender, 1962; Kanner and Eisenberg, 1955;
Eisenberg, 1956; Fish, 1960, 1962) suggests that these types may also be significant for long-term prognosis.

We would agree that a nosological formulation is only the beginning of a thorough diagnostic evaluation, which includes a detailed assessment of the child's assets and difficulties, his development and current interaction with his environment (G.A.P., 1957). Our typology complements and does not replace such detailed formulations. The G.A.P. report also notes that "nosological classifications are essential for statistical purposes." Whatever the treatment program, the need for controlled comparisons of outcome is a scientific necessity. It is equally important to develop definitions for these disorders which will make it possible to compare results in treatment centers with different populations and various theoretical orientations.

III. General Implications

Although the typology was developed for a specific purpose in a specific setting, its more general applicability is suggested by its significant correlation with other levels of functioning. These included functioning as observed in the electroencephalogram, on neurological testing, on the Wechsler Intelligence Scale for Children, the Bender-Gestalt test and human figure drawings.

Although we did not set out to outline a typology according to etiological principles, there is a suggestion that we have described a spectrum of disorders whose pattern and degree of integrative disturbance may reflect the level and severity of the defect. The spectrum of severity of illness was reflected both on a neurophysiological and on a behavioral level. We believe that the two ends of this spectrum may represent extremes of a complementary relationship between intrinsic and extrinsic causative factors, factors which interact in varying proportions to create the gamut of psychopathology. This approach is similar to the "continuum of reproductive causality" postulated by Pasamanick (1956a, 1956b), although we would also include hereditary and postnatal brain insults as intrinsic factors. The dichotomy drawn by Goldfarb (1961) between "organic" and "non-organic" types of schizophrenia defines the extremes of causality in schizophrenic children, but not the many intermediate gradations of their interaction.
However, our view is holistic and developmental and therefore must take into account the many factors impinging on development, which ultimately create the child's personality organization and his mode of interacting with the environment. We believe that observations of functioning at different levels—intrapsychic, intellectual, perceptual, and neurophysiological—do not necessarily point to intrinsic or extrinsic etiology, but do indicate the depth to which a disorder affects the substratum underlying behavior. Further studies are in progress to determine whether there are, in fact, significant relationships between this typology and specific biological and social etiological factors.

**Appendix: Prototypic Profiles of the Four Types**

*Type 1: Autistic-Disjunctive*

The children are characterized by grossly unintegrated, erratic, and deviate functioning in all areas. Disturbed functioning is so prominent that the fragmentary attempts at comprehensible goal-directed behavior tend to be obscured by unpatterned behavior not apparently unified by any goal-idea. They frequently appear not to comprehend social or external situations as others do; responses appear to be dictated by inner impulses and experiences and appear “inappropriate” to external stimuli. The children present primarily as fragmented personalities rather than with any predominant adaptive patterning.

*Relation to Examiner:* Unmodulated shifts between vaguely focused, preoccupied withdrawal and sharply hostile or fearful negativism, or diffuse, impersonal clinging behavior; may show stereotyped perseveration of one of these modes. They show little ability to engage in reciprocal activity even with a protective adult and frequently reject even minimal initiative by other persons.

*Relation to Peers:* Usually impaired by above disturbances to an even greater degree than with adults. They may be unable to tolerate most approaches by peers; are usually unable to engage in reciprocal verbal exchange or play; remain isolated or at periphery of group.

*Relation to Environment:* May be impaired by apparent decreased awareness, excessive response to minor irrelevant stimuli or
Barbara Fish and Theodore Shapiro

high distractibility. They usually show gross to moderate disorientation or confusion for time and place; to some degree persons are interchangeable or confused.

Speech: May show mutism, autistic vocabulary, neologisms, echolalia, reversal of pronouns and incoherence. It is characterized by disconnected, confused, irrelevant, or tangential content, as well as fluid shifts or perseveration of goal-idea. Play is similarly marked by autistic and stereotyped use of objects and fragmentary sequences. Comprehension is incomplete and disrupted by preoccupations and shifting attention. Fantasies, if articulated at all, are fragmentary, and show confusion and excessive concern with orientation in time and space, and with problems of identity and physical integrity.

Affect: May be bizarre and inappropriate, with dissociation from thought content, underresponsive and flat, or may show excessive irritability, lability, and unmodulated shifts in feeling states. These are undifferentiated excited, panicky, or angry states, precipitated by minimal change in the environment, or arising without any apparent external stimulus.

Motility: Usually dyskinetic and poorly coordinated. They may show posturing, manneristic choreo-athetotic, or ticlike movements. They may be predominantly underactive with inert flaccid postures, or catatonic rigidity, or repetitive, rhythmic movements; or they may show bursts of darting, tiptoeing, and whirling hyperactivity.

Adaptive Function: They show minimal adaptive capacity. Their ability to function even minimally in social or educational settings depends on the ability of others to adapt to their special needs in relating and communicating. They usually stand out as different, sick, or “crazy” to family, peers, and others.

Type II: Immature-Labile

The children are characterized by immature and poorly integrated functioning in all areas, which gives an impression of uneven, but generally inadequate abilities. They usually appear to be generally aware of the demands of the situation and may intermittently attempt to conform, but function is extremely variable and is impaired by constricted or impulsive behavior. Because of lability only part of this picture may be evident during any single contact.

Relation to Examiner: Extremely variable, may be clinging and
demanding at one moment and negativistic the next, with evidence of excessive reaction to any situation which is interpreted as rejecting, demanding, or restricting.

Relation to Peers: They are unable to conform to demands of group situations and usually "participate" peripherally by provocative behavior. Friendships are usually brief and stormy, but they may engage in simple parallel or reciprocal play with "safe" playmates of similar make-up.

Relation to Environment: Variably impaired by considerable distractibility. Preoccupation and decreased awareness occur only in the most severely disturbed. They are oriented for person and place, but only for those units of time which are concerned with everyday and immediate experiences, as meals and bedtime. They are only vaguely oriented for calendar units of time.

Speech: Sparse, unelaborative, and even monosyllabic, with a tendency to tangentiality and evasion of emotionally charged material. Fantasy is usually expressed more freely in play and shows concern with movement and aggression, diffuse fears of retaliation and loss of love. With increased expression, fluid thinking and illogicality may emerge in the more disturbed. Paranoid or neurotic traits, if present, are poorly defined.

Affect: Labile; shows low threshold for irritability and decreased tolerance for restriction, delay, disappointment or frustration, with angry, suspicious, anxious, unhappy, and silly clowning responses, usually associated with gross body tension or motor discharge.

Motility: Usually variable, impulsive and poorly coordinated. They may sit stiffly, or show restless, fidgety, chewing, sucking, or masturbatory activity, or explode in bursts of tantrumlike activity, with total body discharge (stamping, kicking, banging), or gross hyperactivity (running, crawling, etc.).

Adaptive Function: Due to variable functioning, their impaired adaptation in social and educational situations may not be immediately apparent, but it becomes evident as the picture of their chronic and recurring difficulties accumulates. Adults usually consider them to be dull, immature, demanding, and difficult to manage. Children consider them "babies" and "pests" and tend to reject them in proportion to their excitability or inadequacy. They frequently become the scapegoats of the group.
Type III: Anxious-Neurotic

The children are characterized by generally well-patterned, organized behavior that is marked to varying degrees by manifestations of anxiety and expressions of helpless dependence and inadequacy. They can usually articulate some awareness of their subjective distress or "nervousness," although they may be unaware of its relation to their other difficulties. They are usually acutely aware of social demands, although they interpret these according to their own needs and fears. They generally make some attempt to conform to the demands of a situation and to gain acceptance or approval from authoritative figures, but may become immobilized by anxiety.

Relation to Examiner: Usually compliant and even ingratiating, seeking protection and help. They may react sensitively, with some degree of negativism, if their demands are not complied with.

Relation to Peers: They generally conform in group activity, although frequently without apparent zest or enthusiasm. In friendships they may attach themselves to stronger members of the group for protection, or may remain "loners" while following the group.

Relation to Environment: Impaired only by preoccupation or distractibility in the most severely disturbed. They are well oriented in all spheres and often evidence excessive concern for time, as it bears on separation from significant adults.

Speech: They can be articulate about their subjective distress and sometimes even about related problems. Speech is usually coherent and relevant, but with more severe disturbance it may become constricted or show excessively fluid shifts of thought and fantasy or illogicality. They are preoccupied with feelings of inadequacy and helplessness, the need for parental approval and unmet dependency needs. They appear conflicted with contradictory expressions of guilt, deprivation, and resentment permeating past and current experiences. Guilt and fearfulness may be formulated as such, or may be expressed in feelings of somatic inadequacy or hypochondriasis. In the most severely disturbed, these preoccupations may appear as "foreign" somatic sensations, "introjected bodies," hallucinations, or delusions.

Affect: They appear upset and express the desire to be rid of their distress. They may be worried, tense, or dejected, and verbalize their subjective experiences of fear, anxiety, "nervousness," sadness, loneli-
ness, guilt, and deprivation. They show a lowered threshold for irritability and decreased tolerance of frustration, delay, and disappointment. Vasomotor instability may be prominent.

**Motility:** Characterized by muscle tension, restless fidgeting, and jerky respirations, which fluctuate with the current stress and preoccupations. Large muscle activity may appear constricted, hypoactive, or awkward.

**Adaptive Capacity:** Excessive fears and inhibitions may interfere only with spontaneity in certain interpersonal relationships or impede specific areas of performance, leaving major areas of social and academic functioning intact. In the more severely and chronically disturbed, nearly all areas may be affected. Except when very infantile and disturbed, they usually elicit sympathetic responses from adults, and to a varying degree from their peers, as “nice” children. They may achieve some satisfactions and leadership, given assets accorded status in their subculture. The most anxious, dependent, and inadequate-appearing are usually rejected as “babies” or “sissies” by other children.

**Type IV: Sociopathic-Paranoid**

The children are characterized by generally well-patterned, organized behavior that is marked by attempts to control their expression of feeling and to manipulate and control their surroundings. This may be expressed in antisocial behavior. They become disturbed in proportion as they feel the situation beyond their control. They tend to deny anxiety and dependency needs and personal responsibility for feelings and acts; they rationalize and construe these in terms of external provocation. They are usually acutely aware of social demands, although these are often experienced as threatening, controlling, or degrading. They may appear predominantly manipulative, obliquely negative, and sociopathic, or more overtly hostile, agitated, and paranoid.

**Relation to Examiner:** Usually negative, defiant, and belligerent, with varying degrees of guardedness in communication and in nonverbal interaction. At times they may opportunistically be ingratiating, saucy, and manipulative, but if pushed on personal matters, they back off suspiciously and their behavior takes on a guarded, paranoid tinge.
Relation to Peers: When not overly excited, they act domineering and even exploitative. They are usually respected as “strong” or “tough.” They are frequently leaders, and seem to take pride in the fact that they get on by their wits. Their pseudo confidence frequently emerges as more fragile than on first appearance.

Relation to Environment: Impaired only by preoccupation or distractibility in the most severely disturbed. They are well oriented in all spheres, and may show increased memory for subjectively significant details.

Speech: Guarded and calculated, but usually relevant and coherent. They are capable of elaboration, but frequently there is limited content, as areas of personal concern are carefully avoided with negativism or suspiciousness. With increased disturbance, thoughts may become excessively fluid and illogical. They are preoccupied with feeling restricted and threatened by the control of others, and with the need to assert their own autonomy. They may speak of being isolated and rejected but tend to deny feelings of needing support or approval from others. They tend to deny personal responsibility for feelings and difficulties and rationalize their anger and antisocial behavior as legitimate responses to provocation by others—real or imaginary. In the most disturbed, these preoccupations appear in hallucinations and delusions, with expressions of global hostility, feeling different, isolated, “bad,” and threatened by others. Young prepubertal children frequently experience these as foreign impulses and dissociated thoughts originating within their bodies (introjected bodies).

Affect: They may present a bland, controlled façade with bravado and even euphoria if in control of the situation, or may appear overtly suspicious or hostile with a tendency for explosive outbursts of anger and shouting. They show a decreased threshold for irritability, with lessened tolerance for frustration, delay, or being exposed as inadequate or helpless. There is little evidence of anxiety except when they fear the situation is beyond their control.

Motility: Well patterned and even graceful, with sinewy muscle tone. They may tend to be overactive with a ranging restlessness, or show rigidly controlled muscle tension and fidgeting.

Adaptive Capacity: Resentment at being controlled or placed in an inferior position may lead to problems with authority figures and
Typology of Children's Psychiatric Disorders

to antisocial behavior; they may refuse to engage in any activity where they cannot function adequately. They may reject a learning situation or certain group activities on this account. They may conform to strong authority if they respect the strength or expect rewards. They attempt to dominate peers and are aggressive if challenged. Their strength is usually respected or feared by peers, and they may be accepted as competent leaders unless they are overly excitable or disturbed.

REFERENCES


FISH, B. (1960), Involvement of the central nervous system in infants with schizophrenia. A.M.A. Arch. Neurol., 2:115-121.


