



## A Brief Note on Psychosis in the Children

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### Abstract

Despite the fact that the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) provides identical symptoms and definitions for children, adolescents, and adults, the diagnosis of childhood psychosis raises a number of unresolved issues. When distinguishing between childhood-onset schizophrenia (COS) (12 years), bipolar affective disorder, major depressive disorder, and even obsessive-compulsive disorder and attention-deficit/hyperactivity disorder), fantasy lives of children, as well as issues with developing language and cognition (including retardation), all impair diagnostic accuracy: For problems that cannot be solved, the all-encompassing classification known as psychosis not otherwise specified (PNOS) is always available. Neurocognitive issues are typical if nonpathognomonic features. There are a variety of screening tools and specialized versions of semistructured diagnostic interviews. Although smooth-pursuit eye-tracking movements may serve as a genetic marker for COS, the etiologies are more likely to be oligogenetic than to be associated with a single gene. Neuroimages and specific biological markers have not been identified. As a result, psychoses might be a sign of a larger pattern of brain dysfunction. Due to a lack of controlled data for children under the age of 18, drug treatments are largely based on adult literature. Psychosocial treatments and psychotherapy for childhood psychosis still lack rigorous research.

**Keywords:** Mental disorders; Biological markers

### Introduction

The conundrum of diagnostic clarity has made psychosis presenting in childhood and adolescence a contentious topic throughout the history of the field of child psychiatry. An important question is whether the various childhood psychoses are contiguous with the adult forms, or whether the symptoms labeled as psychotic in youth, particularly in prepubertal children, are exactly the same as those seen in adults. This is because the necessity of accurate diagnosis informs both treatment and prognosis. Due to confusion regarding the developmentally appropriate role of imagination and fantasy in children and adolescents with and without psychiatric disorders, the definition of psychosis in children and adolescents has historically been particularly ambiguous. The Diagnostic and Statistical Manual of Mental Disorders, 4th edition, Text Revision (DSM-IV-TR) 1 currently does not differentiate between the symptoms of psychosis and the definitions of psychotic disorders for children, adolescents, or adults. The term “psychosis” refers to both a state of being (i.e., a psychotic state) and distinct diagnostic entities. Initially, the concepts of “childhood psychosis” and “psychosis” were conceived of as Extreme negativism or disorganization of thought form or speech, thought content, or behavior are among the DSM-IV-TR’s psychotic symptoms. A psychotic symptom, also known as a symptom cluster, is linked to a specific disorder because it has a certain number of symptoms that show impairment over a certain amount of time. Typically, the diagnosis of psychosis is thought to be established by hallucinations and delusions. However, neither of these symptoms is a pathognomonic sign of psychosis because they can be present in other neurological or organic medical conditions, such as dementia or seizure disorder complications. The definitions of hallucination and delusion seem to apply to normal children with active fantasy lives because they frequently misinterpret their thoughts as actual events and can insist with firmness that a thought or dream actually occurred.

Among adult mental health conditions, schizophrenia has probably received the most research. There is a wealth of neuroimaging, genetic, and neurocognitive research that contributes to our understanding of this illness, as well as well-established phenomenology and symptoms. The diagnosis is frequently accurate when applied to older adolescents,

an age group where first episodes frequently occur. However, the reliability of diagnostic accuracy is hampered in the younger age group by issues with language and cognition development. Adult schizophrenia appears to be a collection of etiologically distinct disorders with similar clinical manifestations rather than a singular entity. There is no extensive or consistent neuropathology that identifies the disease.

These issues are also relevant to bipolar disorder (BPAD). While the situation is less apparent in younger children, the pattern of symptoms and presentation can be easily applied to adults as well as older adolescents [1-5].

### Discussion

Psychotic symptoms that can occur within the spectrum of childhood-onset schizophrenia (COS, age of onset (12 years)), such as schizophreniform disorder, schizotypal disorder, and schizoaffective disorder, are difficult to distinguish from psychotic and nonpsychotic symptoms that are associated with BPAD and major depressive disorder (MDD). This is due to the fact that the presentation of symptoms can vary widely. It is important to distinguish psychotic symptoms in children and adolescents from other intense, repetitive phenomena that are not psychotic, such as obsessive-compulsive disorder (OCD) obsessions, anticipatory anxiety in non-OCD anxiety disorders, rumination in depression, persistent thoughts in developmental disorders, simple disorganization in attention-deficit/hyperactivity disorder (ADHD), and overvalued ideas. In addition, nonpsychotic children may be at

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risk for psychosis if they exhibit language and cognitive impairments caused by mental retardation. In addition, nonspecific symptoms like anxiety, irritability, and distractibility may occur prior to a psychotic episode, making it difficult to make a diagnosis based on the course of the illness. The classification of psychotic symptoms that are not associated with COS, BPAD, or MDD is referred to as psychosis not otherwise specified (PNOS). It is clear that more in-depth research is required to arrive at an accurate and reliable diagnosis of psychosis in children.

Psychosis in children is uncommon, according to scant epidemiological data. The largest study of COS to date, involving 1400 national referrals to the National Institute of Mental Health (NIMH) over ten years, identified 260 children with psychosis<sup>3</sup>. Schizophrenia with onset during middle to late adolescence is fairly common, with a prevalence of 1%, compared to the extremely rare COS, which has a prevalence of 0.2 to 0.4/10 000. At study entry, only 71 patients met the COS criteria, and only 54 children retained the COS diagnosis (Rapoport JL, personal communication, 2000). In contrast, mood disorders with psychosis are much more uncommon in children and adolescents. BPAD affects 1% to 2% of adolescents, while MDD affects 1% to 5% of children. Due to debate regarding validity, it is challenging to determine the prevalence of psychosis NOS and BPAD in children.

Positive psychotic symptoms and negative psychotic symptoms are the two types of symptom clusters that COS presents with, just like schizophrenia that can be diagnosed at any age. Positive symptoms-phenomena that are present but should not be-include a severe disruption of thought process or thought content in children, whereas delusions are likely to develop as a child gets older. Prepubertal children with psychosis appear to have fewer systematic delusions and a lower incidence of catatonic symptoms, but they are still capable of exhibiting hallucinations, disordered thought process, and flattened affect.<sup>8</sup> Insidious course of COS and onset prior to age 12 are predictors of a more serious outcome.<sup>9</sup> Other features of COS that contribute to poor outcome include severity of positive and negative symptoms in acute episodes, lower cognitive functioning [6-10].

## Conclusion

It has been noted that children with COS exhibit developmental differences as early as infancy. These children exhibit abnormal or delayed development, such as hypotonic, poor coordination, difficulties with sensory integration, language delays, and gross and fine motor delays. They also exhibit stereotypies, such as hand flapping, persistent smelling, and touching, which are symptoms that are typically seen in children who have pervasive developmental disorders. These children also meet the criteria for attention deficit hyperactivity disorder (ADHD), which may be an indication of a poor prognosis. Children with other schizophrenia spectrum disorders have a history of developmental delays and cognitive deficits.

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