

Classifications in child and adolescent psychiatry

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Summary

The diagnostic approach is essential to medicine. It is one of the binding terms of the doctor-patient relationship. In child psychiatry, the questioning concerning diagnosis and its theoretical background is coupled with the specific nature of the subject being studied. In France infant and juvenile psychiatry is a relatively recent discipline. The following paper discusses the development of child and adolescent psychiatry, taking into account the historical point of view.

child and adolescent psychiatry / classification in psychiatry

INTRODUCTION

The diagnostic approach is essential to medicine. It is one of the binding terms of the doctor-patient relationship. The latter calls on the doctor and entrusts him with his complaint, expecting in return that the doctor will name his ailment, through the understanding of symptoms and their grouping as a syndrome. Once the subject is named, he indicates the therapy. Of course, in medicine two plus two never equal four, but it is the doctor's duty to try to come as close as possible to a precise perception and an approach based on his knowledge and experience.

The same is true in psychiatry, although its subject, mental illness, remains for a large part enigmatic regarding its etiopathogenic processes.

Classifications have always been the subject of debate. At the very beginnings of psychiatry, the first psychiatrists grouped together and classified individuals. The same was true for children. The very first classification separated the "educable" who could be cared for from the "ineducable", for whom one had to consider measures of relegation. Later classification took an interest in patho-

logical entities, the succession of the nosographic proposals reflecting the development and diversity of psychopathological models [1].

From the end of the 19th century, the need to have a unified classification, a kind of common language, became obvious. In our period of globalization in which we have transparency in the rapid development of all kinds of research, a single classification needs to be conceived based on the three pillars of reliability, validity, and sensitivity [2].

The reliability of a classification entails all users ending up with the same result and therefore the same diagnosis. Its validity is dependent on each classified subject meeting the description made of it, and sensitivity must enable the distinguishing of close yet dissimilar subjects, i.e. enabling a differential diagnosis.

However, this classification procedure cannot dispense with reflection on the status of the symptoms and their grouping together as syndromes, in particular in psychiatry. This means that no classification can be free from the way the doctor, who observes, collects and organizes, thinks of semiology. Any classification relies on a theoretical background. In psychiatry two models are under tension, one which relies on an objective approach; the observation of behaviour from a biomedical viewpoint, the other tak-

ing into account the background behaviour, i.e. the subconscious and its effects on visible demonstrations, insisting on the subjective and inter-subjective dimension of any clinical medicine.

This tension has great resonance in child and adolescent psychiatry, through the dialectic established in the last few years between the French classification of child and adolescent mental disorders – CFTMEA – and the ICD-10, as well as the DSM IV.

CHILD AND ADOLESCENT PSYCHIATRY

In child psychiatry, the questioning concerning diagnosis and its theoretical background is coupled with the specific nature of the subject being studied. The child is a constantly evolving person, therefore diagnosing and classifying too early is considered by some clinicians to be dangerous. Labelling could contribute to determining a process that is not yet organized. This risk is also increased by the fact that although the child can demonstrate an established symptomatology, he is never behind the request, and it is partly through discussions with others that the clinician will build up a clinical judgement.

It should also be stressed that in France infant and juvenile psychiatry is a relatively recent discipline. It dates back to the 1950s, when it was recognized academically. It should also be noted that psychopathology in the child took some time to be defined in its own right and to free itself of an adultomorphic approach.

The first nosography of child disorders dates back to the beginning of the 20th century, and is modelled on the adult nosography, looking for similarities. Little by little, the child field appeared with its characteristics and its scope.

Some points of reference concerning child psychopathology: after *Dementia praecocissima* by S De Sanctis, we had child psychoanalysis with Mr. Klein, who highlighted the specificity of mental illness in children. She did not concern herself strictly speaking with nosography, but greatly contributed to identifying psychosis in children.

In 1943, the American psychiatrist, Leo Kanner, described a first specific form of child psychosis, from the age of 11, which he named “early infantile autism”.

In 1946 R Spitz described anaclitic depression enabling the recognition of depression in children and the symptomatology that goes with it.

From after the war nosography in child psychiatry continued to develop and become more complex, reflecting the growing place the child and adolescent have acquired in our society.

But once conscious of this context, and with the necessary precautions, the diagnostic approach must be an integral part of our work, since one form of classification or another is essential when seeking to organize our own clinical observation and to theorize our practice. Moreover, naming what we observe is necessary to be able to communicate with colleagues and consider research, of course, but even more so with the patient and his family.

CLASSIFICATIONS

Thus, in infant and juvenile psychiatry, we have at our disposal three classifications. Two of them, the ICD-10 [3] and the DSMIV [4] are very close in their conception and approach; they are based on a biomedical model.

The ICD [3] is the classification of all diseases, and an instrument of the WHO.

Over time, the ICD and its revisions have been increasingly influenced by American classification. Chapter V, dedicated to mental disorders, has two sections specifically dedicated to children: “Disorders of psychological development” and “Behavioural and emotional disorders with onset usually occurring in childhood”. It is in this first group that we find the pervasive disorders of development [which we will come back to), after language, school learning, and motor development disorders. The second group comprises hyperkinetic disorders, behavioural disorders, (with different descriptions to those in the DSM) and behavioural and emotional disorders, in which we find depressive, anxiety, and separation anxiety aspects.

This is a multiaxial classification, because we can also code somatic pathology, as well as psychosocial and family situations

No reference to the concept of personality organization is mentioned; the words of psychosis and neurosis have disappeared in the latest version, which adopted the DSM viewpoint.

The first version of the **DSM** [4] dates back to 1952, the 4th to 1994 and the 5th has just been issued. It aims to strengthen reliability, currently called inter-rater loyalty, in a double perspective of giving psychiatry credibility as a medical discipline, although no known organic lesion, no biological marker or imagery has yet been selected as an etiological cause, and making the work and exchanges between clinicians and researchers easier. It aims to be instrumental in making a diagnosis, free from the influence of the clinician. To achieve this goal, it gives a list of simple, observable criteria for each disorder, situated at the behavioural level, with the diagnosis resulting from a sufficient number of criteria being present within a given period.

Already in the 3rd version the terms psychosis and reactional disorders, which were a reference to psychopathology, had been removed. The 4th version devotes a chapter to children entitled "Disorders usually first diagnosed in infancy, childhood, or adolescence". Moreover, it claims that there is no distinction between disorders in children and adults. The conveyed concept is that the disorder is a thing in itself, independent of age and personal, family and social context. Thus this concept can determine an ordinary target without any form of interrelationship.

We find ten sections in it: mental retardation, school learning disorders, motor disorders, communication (of the language) disorders, pervasive developmental disorders, attention deficit and disturbing behaviour disorders, food disorders, tics, elimination disorders, others childhood and adolescence disorders.

Other disorders are found in the general chapters of the DSM in which we find indications of age, such as the chapter on depressive disorders.

It should also be observed that the word 'disorder' replaces the word 'symptom'; the disorder being a more generic, less specific and less medical term. Disorders, and particularly their description, call on words of everyday life. The language is familiar, avoiding all cultural reference, or medical, psychiatric psychopathological knowledge.

The **CFTMEA** [5] French classification of child and adolescent mental disorders, the first version of which dates from 1988 and the latest from 2012, is the result of the work of a group of

French clinicians, coordinated by Prof. R. Mises, who wanted to translate the psychopathological and developmental concept of French tradition infant and juvenile psychiatry into a nosography. It is based on a reflection that owes a great deal to phenomenology and psychoanalysis. It asserts the specific characteristics of infantile psychopathology, the consideration of development, its individual characteristics and environmental and somatic context; factors on which the expression of the pathology is often dependent. It leaves the question of continuity between infantile and adult pathology open.

In Theme I, the CFTMEA defines the main clinical categories from 0 to 4, in which we favour the notion of structure or organization of the personality. Therefore, we refer to psychosis, neurosis, borderline, and reactional disorders, in addition to the "variations of normal behaviour" category. The clinician is asked to pinpoint child disorders in one of these categories, which, in principle, are exclusive of each other. The other categories from 5 to 9 are used to note isolated symptoms (instrumental, psychomotor, functional disorders, etc.), or which cannot yet be entered into one or other of the structural organizations.

The "variations of normal" category is a translation of the preventive aim of intervention in infant and child psychiatry. It is the observing of risk situations and the attention paid to these can avoid prejudicial development for the child.

In Theme II, the CFTMEA lists, possibly etiological, associated or past factors.

It goes back over the child psychiatrist's approach, who takes the whole of the child's personality in its relationship with the internal and external world into account, in a multidimensional vision. The common theme in this approach is the understanding of the meaning of the symptoms in the organization of the child's personality. Therefore, the CFTMEA tends to suggest categories in which the multidimensional aspect is taken into consideration, going beyond the notion of comorbidity, used more in other classifications; for example, should we consider that mental retardation and childhood autism are in a dialectic of juxtaposition, therefore of comorbidity, or should we believe, rather, that there are instantly multidimensional forms in

which the two aspects are deeply interlinked? The same is true for the diagnosis of hyperactivity.

This search for meaning and organization in a whole that stands up by itself, for a comprehension effort in relation to the developmental particularities of the child, also relies on the clinician's view, on what is provoked in him; the relation with a particular child. It is not only an objective observation, but participative. The subjective and intersubjective data contribute to the diagnosis.

In its latest version, the CFTMEA includes new approaches to pervasive developmental disorders, different forms of hyperactivity, and develops the concept of dysharmony. Correspondence tables between the CFTMEA and the IDC-10 have been around since the year 2000. The last, published in 2012 [6], has a word to word correspondence. It was dictated by the need connected with codifying medical procedures. However, the daily use of transcoding, forces us to speak several languages, ask questions, see symptoms from a variety of perspectives, translate and, of course, take a decision, losing something in this choice.

THE EXAMPLE OF AUTISM AND PERVASIVE DEVELOPMENTAL DISORDERS

I am going to stop for a while on the question of autism and PDDs, since it is paradigmatic of the tension currently existing between different models, a tension fed by the social role occupied by this pathological entity. I will confine myself to presenting two classifications, since these are the ones habitually used.

I will not list the categories of the two classifications here. Let us recall that in the IDC-10 any reference to psychosis has disappeared, autism is inserted in pervasive developmental disorders and these are found in the "psychological development disorders". It distinguishes 8 categories ranging from a typical form to a pervasive disorder form, with no further information.

Let us recall that according to the IDC, the symptomatological triad is what characterizes childhood autism: **communication, social interaction, as well as restricted and repetitive interest disorders**, Their degree and intensity can vary; an essential element of the prognostic is the intellectual level. The model is neuro-devel-

opmental and the theoretical and practical approach refers to neurosciences, including cognitive psychology. It finds expression in high priority educational assistance.

CFTMEA 2010 situates autism in Theme I, keeping the precocious psychoses category and adds the term PDD. However, wishing to correspond to international classifications, we also find eight categories, in which the details concerning clinical forms are more explicit: such as Kanner, precocious deficit psychosis, psychotic dysharmony or multiple and complex development, as well as non-specific precocious psychoses.

The CFTMEA claims the possibility of wider psychopathological research and psychodynamic reference. It differentiates forms in which the pathological process is organized in a very precocious manner in a traumatic perinatal context with massive withdrawal, forms which are characterized by the failure of the separation-individuation process, later forms with inadequacy of investment and cognitive deficit in the foreground, and lastly forms whose psychopathological mechanisms are linked with serious attachment disorders. The significance of this differentiation is also linked to the therapeutic side. Similarly, the psychotic dysharmony or multiple dysharmony category is maintained. The last categories are difficult to distinguish and lead to confusion which results in ambiguity and epidemiological bias.

I would like to emphasize that these category correspondences between the two classifications come with a certain amount of harmonization on the level of the concepts and the opening of French child psychiatry to other approaches.

It would seem to me that we can summarize that the IDC vision of autism is that of a neurodevelopmental disorder and that the theoretical and clinical approach is cognitive and educational.

The CFTMEA vision is mainly psychopathological, conceiving autism in terms of a defence mechanism confronted with a massive real or fantasized alienating trauma considered in the primary relation and for which the therapeutic and psychotherapeutic approach takes priority. This vision has changed, integrating data from the cognitive approaches and neuroscience, demonstrated by taking into account the IDC PDD

definition and also in the increasing amount of space given to educational approaches.

This new dialectic is linked with the ground covered by autism over the last few years. It encourages us to review our practices.

It is true that autism has been the focus of many debates, to the point of confrontation, it has given rise to a great deal of research with contributions from disciplines that are fairly distant from one another, such as genetics, neurology, cognitive social science, neuroscience, psychology, psychiatry, psychoanalysis, etc.

It has become a social and political issue and signed the introduction of parent associations as partner users appropriating a decisional and political capacity and challenging the medical capacity.

The diagnostic approach has become more rigorous and more divided: the diagnosis of autism itself being a photograph of a given time, it can change, and needs to be reassessed. It continues to be part of a therapeutic approach. This aims to mobilize the child and its parents, so as not to fix the pathological process and imprison the whole of the family.

The diagnosis has a role of social recognition and status: the handicap gives rights, enables compensation and inclusion, the only downside of which is sometimes to remove the psychological work through which the suffering linked with the disorder and handicap can be established.

We must also agree to introduce objective tools in our practice. Their use is profitable to our work, helping us to look, compare and observe together as a group.

We have also learned how to take into account the importance of etiological research, on a genetic and neurological level, and to assess the child's sensory condition.

Autism has also opened up theoretical and clinical approaches to us, which were not part of our baggage, and to make connections.

We have learned how to take anxiety and defence mechanisms into account, as well as sensorial anomalies, specific treatment of information, and theory of mind deficit. We continue to search for and distinguish different types of anxiety, but we also observe that some children are not anxious and that for the great majority of them structuring time and space makes

the world more comprehensible and therefore possible, through adapted aids, and decreasing their maladjustment. We have also got to grips with the learning process of the autistic, his inability to cope with symbolization, the implicit, the impossibility of anticipating, as well as the need to help them to acknowledge and identify their emotions, thanks to the use of suitable aids, which come from cognitive approaches.

The meeting between psychoanalytical and cognitive approach links essential and fruitful practices. It is based on the essential relationship between a member of the medical profession and a child. The adult is available, empathetic, and receives what the child offers, seeking to relay it in an accessible fashion.

CONCLUSION

This process relates the tension between different psychopathological concepts clarified by classifications. At the start, everything opposes these, but, in my personal experience, the attempt to find common points and the possibility of moving off centre to get to grips with a new code have been an opportunity to maintain what is essential to me in my knowledge and practice and to open up to other manners of seeing and conceiving an approach, which also stems from the classification code.

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