

**Development of an Empirically Constructed Psychosis Proneness Scale on the
Personality Inventory for Children – Second Edition (PIC-2)**

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**A Doctoral Project Submitted in Partial Fulfillment of
the Requirements for the Degree of Doctor of Psychology
in the Department of Psychology at Pace University**

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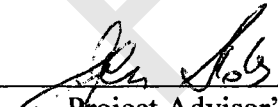
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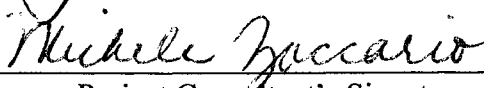
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ABSTRACT

This study attempted to develop a Psychosis Proneness Scale (PSYP) by utilizing empirically-keyed methods to determine which combination of the 275 items differentiate children with psychosis from two other groups: (1) children with other psychiatric conditions and (2) children with neurological conditions. Results indicated that although a new 17-item PSYP scale could be developed, it failed to show significant improvement over the RLT (from the Personality Inventory for Children – Second Edition) scale in its diagnostic ability to correctly identify children with psychosis. The RLT was significantly related to the presence of psychosis in the sample used for scale development as well as in the scale used for cross validation ($AUC = .614$ and $AUC = .699$, respectively). Given that group size was somewhat smaller than the original aim of the study, an explorative step was also conducted to see if utilization of a large sample size would yield more significant results. This scale, PSYP-A, was found to be significantly related to the presence of psychotic symptoms ($AUC = .789$). Item analysis was also conducted in all of the developed scales and comparisons were made to the RLT scale. Limitations and additional directions for future research were discussed, as the relevance of this current study within the field of school-clinical child psychology.

CHAPTER I

INTRODUCTION

Psychotic disorders in childhood present many diagnostic challenges to the clinicians working with this population. Children may have different symptomatic presentation (Volkmar, Becker, King, & McGlashan, 1995) and may be less accurate reporters due to their developmental level (Asarnow & Asarnow, 1996). Parents may fail to notice the symptoms of psychosis, frequently mistaking them for another disorder (Russell, 1994). Research points to the importance of accurate diagnosis, in that it improves the long-term prognosis and outcome of treatment (Larsen, McClashan, & Moe, 1996; Volkmar et al., 1995). Therefore, the necessity to have clear and accurate diagnosis in children who are suffering from psychosis is tantamount.

The Personality Inventory for Children – Second Edition (PIC-2; Lachar & Gruber, 2001) is one of the many parent report measures available to clinicians to aid in diagnosis. It is a 275 item test with clinical scales that have T-score cutoffs which point to which types of disorders may be indicated by the child's symptoms, as rated by the parent. The Reality Distortion (RLT) is one of nine clinical scales on the PIC-2, and its purpose is to assess for psychosis in children.

As opposed to its predecessors, the Psychosis Scale (PSY) on the Personality Inventory for Children (PIC) and the Personality Inventory for Children – Revised (PIC-R), the current RLT on the PIC-2 is rationally developed, as opposed to empirically-keyed, meaning that item selection was based on manifest content of the questions themselves. This represents a fundamental change in the manner in which

the RLT is conceptualized and is just one of the many changes that the PIC-2, as a whole, has undergone. For instance, other scales that have been proven in the research literature to be associated with an increase in psychosis, such as the Developmental Scale (DVL), have been conceptually reorganized in the PIC-2.

Therefore, the aim of this present study was to develop a new empirically derived scale on the PIC-2 to assess for psychosis in children. In general, utilizing an empirically based methodology is meant to improve the predictive ability of the scale, by potentially including items that in some way add to the sensitivity of the measure that may have been overlooked if they did not obviously relate to the construct (i.e., rationally derived methodology). There is a dearth of research on the PIC-2; therefore, another goal of this study was to begin to enhance the validation literature on this measure. The participants of this study were selected from a sample of referrals to the psychological assessment service of a child psychiatric inpatient hospital and from a children's rehabilitation hospital. For the study we examined ROC analyses and sensitivity and specificity calculations in three developed scales (PSYP-P, PSYP, and PYSP-A) as well as from the RLT scale on the current PIC-2 to determine if a more sensitive, empirically developed scale could be constructed.

CHAPTER II

LITERATURE REVIEW

Psychosis in Children

Although there is substantial literature available to clinicians working with children with psychotic disorders, accurate identification and diagnosis still is marked by confusion due to overlapping variables, symptoms and terminology. Therefore it is critical to have these factors discussed so to have a clear picture of the disorder, its presentation and its effect on children. Psychosis is a complex disorder and it is this complexity that inherently leads to difficulty in assessment and diagnosis. A detailed background of the disorder and all of its complexity is necessary in order to understand these challenges faced by clinicians. Therefore the following chapter will provide an overview of psychosis, its definition, symptom presentation, and common diagnoses. Then diagnostic considerations in children will be reviewed and information regarding assessment aimed at the identification of psychosis will be discussed.

Definition

First, a definition of psychosis and psychotic conditions is necessary. The DSM-IV TR (American Psychiatric Association; APA, 2000) first cautions that a number of definitions have been applied to the term “psychotic” and none of them have achieved universal acceptance. However, it generally defines psychotic as “restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature” or “hallucinations that the individual realizes

are hallucinatory experiences” (p. 297). Specific criteria for some of the individual psychotic disorders will be addressed in a later section.

A psychotic disorder is characterized by some serious degree of disturbance in “reality testing,” (Volkmar et al., 1995) most often indicated by hallucinations, delusions and/or disturbances in thinking. The term can also sometimes refer to the group of disorders characterized by these disturbances (i.e., psychotic disorders). Recent research conceptualizes psychosis as a continuum instead of one singular disorder. In other words, it is not an “all-or-nothing” phenomenon (Krabbendam, Myin-Germeys, Bak, & Van Os, 2004) but rather can be thought of as including several symptom dimensions (Van Os, Marcelis, Sham, Jones, Gilvarry, & Murray, 1997). Studies have indicated these dimensions to include factors such as: positive symptoms (e.g., hallucinations, delusions), negative symptoms (e.g., affective flattening, avolition, or alogia), disorganization, manic symptoms, depressive symptoms, bizarre behavior, catatonia, and inappropriate affect (Van Os et al., 1997).

Components to Psychosis

The major components of psychoses (thinking disturbance, hallucinations and delusions) will be reviewed in the following section. Particular consideration will be paid to diagnostic issues related to thinking disturbance, hallucinations and delusions in childhood as these are the most common symptoms noted in children. Symptoms such as mania, catatonia and disorganized behavior have been found in children with psychosis but to a smaller degree than hallucinations. Ulloa et al. (2000) assessed a sample of 2,031 children in a psychiatric clinic for symptoms of psychosis. They found that for those children who were rated as having psychosis, a factor analysis yielded

four factors: hallucination, delusions, thought disorder, and mania. The mania accounted for 6% of the variance whereas hallucinations accounted for 21%. Additionally, disorganized and odd behaviors are symptoms of psychosis which are found in children, and which are also frequently misinterpreted for behavioral problems (Volkmar, 2002).

Thinking disturbance. The term “thought disorder” includes a heterogeneous mix of difficulties and alterations to the thinking process. At times, the term has been synonymous with schizophrenia but, more specifically, it can and does refer to a “group of clinical signs related to the organization and presentation of thoughts in the clinical context” (Volkmar et al., 1995, pp. 523). In other words, disturbances in thinking reveal themselves in terms of the person being illogical, tangential, or circumstantial in the manner in which they think. This is especially challenging to correctly identify in children, since thinking disturbances are primarily revealed through speech. In children, however, speech is continually developing, thus making it difficult to demarcate thinking disturbances from normal speech development. The speech of children younger than 7 years old can sometimes be incoherent given that children frequently change topics in a rapid and unpredictable manner (Caplan, 2004). During early and middle childhood, children commonly use referential devices, substitute phrases for words and make linguistic errors. As children age, these become less and less common. In Caplan, Guthrie, Fish, and Tanguay’s (1989) development of the Kiddie Formal Thought Disorder Rating Scale, they discovered that after age 7, children use significantly less illogical thinking and do not use loose associations. In fact, illogical thinking is infrequent in children older than age 10 and by early adolescence

individuals organize their thoughts in a coherent manner. Therefore, thinking disturbances are difficult to parcel out in children less than 10 years old, but become more similar to those observed in adults as children enter middle childhood and when they mature into adolescents (Volkmar, Cohen, Hoshino, Rende, & Paul, 1988).

Hallucinations. Hallucinations defined as “any percept-like experience which (a) occurs in the absence of appropriate stimulus, (b) has the full force or impact of the corresponding actual (real) perception, and (c) is not amenable to direct and voluntary control by the experiencer (Slade & Bentall, 1988, p.23). The incidence of hallucinations reported in different populations varies considerably (Burke, DelBeccaro, McCauley, & Clark, 1985). Volkmar et al. (1988) reported that hallucinations occur in up to 80% of children with childhood onset schizophrenia. However, other studies indicated base rates of 30% (Askenazy, Lestideau, Meynadier, Dor, Myquel, & Lecrubier, 2007) to 3% (Fennig, Susser, Pilowsky, Fennig, & Brommet, 1997) in samples of psychotic children.

When analyzing hallucinations in children, it is imperative to be sure that developmental phenomena, such as imaginary friends, are not confused with hallucinations (Caplan, 2004). This is because even children under the age of five who have imaginary friends understand that their “friend” is not real. If the child is over five years old and insists that the “friend” is real, this should be investigated further. Other typical developmental occurrences include fantasies, fears and hallucinations that occur while falling asleep. It is important to remember that many children experience their imagination taking on a real, vivid quality and these children may act as though their constructed fantasies are real.

Hallucinations in children can also be relatively benign and not be an integral component of a major psychiatric disorder. These benign transient hallucinations can occur in preschool children especially in reaction to acute anxiety or situational stress, or occur solely during nighttime (Ravenscroft, 1980) and have an acute onset.

Hallucinations in older children and adults are often more persistent (Del Beccaro, Burke, & McCauley, 1988) and associated with more severe pathology (Volkmar et al., 1988). Additionally, hallucinations which are experienced by children may be less realistic and less intricate as compared to adults (Cohen & Volkmar, 1996) and may reflect developmental concerns such as monsters, pets, toys, etc., which are age appropriate in theme.

Delusions. A delusion is a false personal belief that is firmly held in the face of contradictory evidence, and that is not endorsed by other members of the individual's culture or subculture (APA, 2000). Delusions occur in approximately 60% to 95% of children with schizophrenia (Eggers, Bunk, & Krause, 2000). Ulloa (2000) reported that 22% of children in their sample who were diagnosed with psychosis experienced delusions.

Delusions in children are less frequent than they are in adults and when found they tend to be simple and non-systematized. Hypochondriacal, persecutory and grandiose delusions appear more in pre-pubertal children and considerably more often in adolescents (Beitchman, 1985). Delusions need to be differentiated from normal developmental phenomena like magical thinking and fantasies. If magical thoughts and fantasies are pervasive, and the child acts on them, the thoughts are considered delusions (Caplan, 2004).

History

Until about 30 years ago, psychiatrists and psychologists were reluctant to diagnose psychoses in children (Parry-Jones, 2000). Schizophrenia in children has most likely always existed but has been disguised under different terms and diagnoses.

Haslam's account in 1809 of a disorder occurring in young persons that was associated with "hopeless and degrading change" is widely quoted as one of the first pieces of documentation on schizophrenia (Haslam, 1809, p. 64). From the 1860s onward, psychiatric publications included childhood insanity cases, as it was called at the time, and in 1911, Bleuler introduced the term schizophrenia for what had previously been called dementia praecox. Infantile autism was also considered to be a psychotic condition through the 1940s. Although it is currently understood that these are separate diagnoses, it shows how diagnostic categories have been changed to keep pace with current research and findings.

Common Diagnoses

Given the variety of symptom presentation in psychosis, it is not surprising that there are many different diagnoses that are considered to be psychotic conditions. Some of the diagnoses which are included under the large umbrella of psychotic disorders are: Schizophrenia, Schizoaffective Disorder, Major Depressive Disorder with Psychotic Features, Bipolar Disorder with Psychotic Features during both manic and depressive periods, and Psychotic Disorder Not Otherwise Specified (NOS) (APA, 2000).

As a method of gaining more information as to psychotic disorders in general, childhood Schizophrenia, specifically, will be discussed in the following section. Although childhood Schizophrenia is not the most common psychotic disorder

diagnosed in children, and is, in fact, one of the lowest, there is consistent literature available and therefore this disorder will be reviewed. Ulloa et al (2000) discovered rates in their psychiatric sample of children who were deemed to have psychotic symptoms to be 41% for Major Depressive Disorder, and 14% for Schizophrenia. Therefore, given the low incidence of Schizophrenia, other psychotic disorders will then be addressed briefly as well.

Schizophrenia. The DSM-IV TR (APA, 2000) states that a person must meet the following criteria for a diagnosis of Schizophrenia to be made: (a) two of the following each present for one month – delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior or negative symptoms. The person also has to show social and/or occupational dysfunction and the symptoms must be present for at least one month.

The treated prevalence of schizophrenia in children younger than 15 years old is an estimated 0.14/1000, almost 50 times less than for children with onset between 15 and 54 years of age (McKeena, Gordon, and & Rapoport, 1994). Other authors estimate the prevalence of childhood schizophrenia to be one in 10,000 children (Remschmidt, Schulz, Martin, Warnke, & Trott, 1994).

According to the literature, the early course of schizophrenia has three phases: the premorbid period, the prodromal period and acute psychosis (Larsen, McClashan, & Moe, 1996). The premorbid period is the term for the “individual’s psychosocial functioning before the onset of the schizophrenic illness” (Cannon-Spoor et al., 1982, p. 470). The prodromal period is the period when the disease process begins, but without any prominent psychotic features (Malla & Norman, 1994). During this time a child

can experience preoccupation with bizarre play where themes frequently include monsters and/or death, and demonstrate impairments in language, IQ, and executive functioning (Vincent, 2007). The onset of an episode of psychosis is the period when the patient experiences psychotic symptoms and others in the child's life, including most often the parents, can identify the symptoms (Larsen et al., 1996).

Schizophrenia can also be classified depending on the type of onset, or the method in which the disorder first presents itself in relation to time. Insidious onset (which is frequently how it appears in childhood) means that there is the emergence of smaller-scale problems prior to the presence of full-blown psychotic symptoms that usually spans a longer duration of time; in other words, it is a gradual development and worsening of symptoms. Conversely, acute onset occurs suddenly without warning (Castro-Fornieles et al., 2007).

There is also classification according to when schizophrenia develops. Early onset schizophrenia (EOS) is diagnosed in response to symptoms experienced before the age of 18. Typically, peak onset for males is 15 to 24 years old and for females is 25 to 34 years old (Vincent, 2007). However, childhood onset schizophrenia is defined as a pre-pubertal onset of psychotic symptoms before age 12 (McKeena et al., 1994).

Bipolar I Disorder (BPD) with Psychotic Features. Bipolar I Disorder is a mood disorder that, when severe is its presentation, can also have accompanying psychotic symptoms. The diagnostic criteria for BPD with Psychotic Features includes: the presence of at least one manic episode and perhaps past depressive/mixed episodes as well. A manic episode requires three of the following criteria present for at least one week: (1) inflated self-esteem or grandiosity; (2) decreased need for sleep; (3) more

talkative than usual; (4) flight of ideas; (5) distractibility; (6) increase in goal-directed activity; and, (7) excessive involvement in pleasurable activities. The qualifier of “severe with psychotic features” is given if there is the presence of either delusions or hallucination during the current episode.

Volkmar (1996) stated that the concurrence of mania and psychosis has been recognized for many years. Manic symptoms vary with age and children younger than 9 years old are more likely to present with aggressiveness, emotional lability and irritability while older children display more euphoria, grandiosity, and flight of ideas. Epidemiological data on BPD in children and adolescence is limited. Ulloa et al. (2002) reported for the patients with definite psychotic symptoms in their study, 24% had BPD. Furthermore, a meta-analysis (of only seven studies) about BPD in children concluded that overall, slightly more than one-third showed psychotic features (Kowatch, Youngstrom, Danielyan, & Findling, 2005). Jerrell & Prewette (2008) found in 82 children with BPD, 40% has psychotic symptoms.

Major Depressive Disorder (MDD) with Psychotic Features. MDD with Psychotic Features is defined by the DSM-IV TR (APA, 2000) the presence of a single depressive episode (or more if a diagnosis of recurrent is given). A depressive episode involves five or more of the following: (1) depressed mood most of the day; (2) diminished interest in activities (3) significant weight loss or weight gain; (4) insomnia or hypersomnia; (5) psychomotor agitation or retardation; (6) fatigue; (7) feelings of worthlessness; (8) diminished ability to think or concentrate; and, (9) recurrent thoughts of death. At least one of the first two criteria must be present. In children, irritable mood or failure to make weight gains should also be considered. Again, the qualifier of

“severe with psychotic features” is given if there is the presence of either delusions or hallucination during the current episode.

In Ulloa et al (2000), children in their sample who were psychotic were more likely to have MMD than nonpsychotic youths. Additionally, the diagnosis of MDD was significantly associated with the presence of hallucinations. In fact, in their sample 4.5% of the children had a depressive mood disorder with psychosis. Overall, the authors made the statement that: “Although schizophrenia spectrum disorder is most strongly associated with psychosis, mood disorder was the most common condition presenting with psychosis in the clinical sample” (p. 343).

Developmental and Diagnostic Considerations to Psychosis

Diagnostic considerations in childhood must include how symptom presentation is similar or dissimilar to that of adulthood. Since psychosis is, by its very nature, a thinking and perceptual disorder, one must consider where children fall in terms of development in order to distinguish what is a typical developmental presentation and what is a psychiatric manifestation. Others such as Erikson (1950) and Piaget (1955) outlined normative changes in children’s concepts of reality. In understanding this, it only stands to reason that thought content and processes are more difficult to diagnoses in children since they are at a lower developmental stage than adults (Cohen & Volkmar, 1996) and therefore less crystallized and coherent.

Diagnostic Considerations

There are a number of diagnostic considerations of which to be aware in discussing psychosis in children as opposed to psychosis in adulthood. It cannot be