CHILDHOOD SCHIZOPHRENIA

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Schizophrenia in childhood is an ill-defined syndrome and poorly understood, and there is every reason to believe that it is frequently overlooked or misdiagnosed. Children with this illness have been classified as epileptic, mentally defective, or having damaged brains, but now in some of the leading Western countries intensive programmes have been started to improve diagnosis, investigate the aetiology and explore the techniques of treatment.

There is no information about the incidence or distribution of the syndrome in this country. During the past 3 years sufficient cases have come to my notice to convince me that the condition deserves the serious attention of psychiatrists, paediatricians and general practitioners. A start must be made with the investigation of all young children who present atypical behaviour or irregular development.

The concept is fairly recent, though Kraepelin stated that in 3·5% of adult schizophrenics, clinical signs could be traced back to early childhood. It used to be generally accepted that psychotic illness did not start until puberty, hence the term *dementia praecox*. Then in 1933 Potter[1] defined schizophrenia of childhood and drew attention to the presence of children with it in institutions for mental defectives. Since then the similarities to and differences from adult schizophrenia have caused much controversy. In 1943, Kanner[2] reported on 11 children in whom withdrawal tendencies had been noticed during the first year of life and he coined the term 'infantile autism'. The children had been referred either because they were considered feebleminded or deaf. Early work was done by Bender[3] at the Bellevue Hospital, New York, by Mahler,[4] Despert[5] and others.

Definitions have varied widely. Some have been so wide as to be meaningless; others have been so narrow that many cases have been excluded. An over-simplified but useful definition is that used by Boatman and Szureck.[6] 'A child is considered to be psychotic when his disorder is so great that: (*a*) almost all affective expression is distorted and (*b*) his capacity to experience real satisfaction and to learn at his age level is seriously interfered with.'

In an effort to define the condition more clearly and to facilitate diagnosis and classification, a working party was formed in London in 1956, and its first progress report was published in 1961.[7] It drew up 9 diagnostic points which were not intended to be absolute criteria, but 2 points, nos. 1 and 9, are considered essential in combination with others which are less constant.

Briefly the points are:

1. Gross and sustained impairment of relationships with people. This includes aloofness or empty clinging (symbiosis), difficulty in mixing with children, using persons or parts of them in an impersonal way.
2. Apparent unawareness of his own personal identity, as evidenced by posturing or exploration and scrutiny of his body, and self-directed aggression.
3. Pathological preoccupation with particular objects without regard to their accepted function.
4. Sustained resistance to change in the environment.
5. Abnormal perceptual experience is implied by excessive, diminished, or unpredictable response to sensory stimuli, e.g. visual or auditory avoidance, and insensitivity to pain and temperature.
6. Acute and seemingly illogical anxiety, often precipitated by a change in environment or interruption of symbiotic attachment to persons or objects.
7. Speech may have been lost, never acquired, or may have failed to develop beyond an early stage.
8. Distortion of motility, e.g. hyperkinesis, immobility, bizarre posturing, rocking, and spinning.
9. A background of serious retardation with islets of normality or exceptional skills.

For proper diagnosis the essentials are a detailed history from birth onwards and an interacting interview with the child, preferably in a play-room.

The parents usually give a history containing many apparent contradictions. The children appear to be stupid and indifferent one moment and keen and clever soon after, they are phobic about and clumsy with some things and fearless about and skilled with others; their frozen and withdrawn attitude can alternate with sudden and violent release of affect and assaultive and destructive behaviour towards themselves and others. They can cry about minor hurts but show stoical indifference to severe pain.

It is not uncommon to obtain a history of normal milestones of development except for speech, which is always either delayed, or developed normally and then became stationary, or developed up to a certain stage, only to be lost or become seriously regressed.

On closer investigation of the early months, it is almost always possible to get some disorder of physical function, such as excessive greed or refusal of feeds, being extremely quiet and passive or very restless and peevish. The mother is usually able to give either the most detailed information about development or else only very patchy information, almost an absence of history.

In the consulting room, the behaviour of such children can show wide variation, depending upon the type, age and the extent to which the developing ego is involved. A constant finding is that their aloofness or empty clinging is associated with a surreptitious watchfulness, and one becomes keenly aware that behind the vacant expression is a recording mind. While conducting an interview with their parents in their presence, one is frequently impressed by the appropriateness of their 'play' with relevance to the verbal material. The parents often report that the children seem to 'understand a lot but we can't get through to them'.

Their unresponsiveness to others is therefore more apparent than real. They behave indifferently and hurtfully towards their mothers, but betray their dependence on them by their resistance to change in the environment and the showing of distress when left by her. This distress is often expressed indirectly by such physical problems as anorexia, bulimia, constipation, diarrhoea, eczema and asthma.

They tend to use all toys in a mechanical and repetitive way. Even dolls and animals, which usually stimulate mothering and nurturing, or games of human relationship with children, are used by them in a detached, robot-like way, portraying their inner life with its lack of meaningful relatedness. This absence of relatedness is not only noticed in the emotional sphere but also physically. They both crave and fear physical contact and when held their bodies are either limply passive or rigid, or they pinch, bite and assault.

It is usually difficult to involve them in any kind of play activity, and when one tries ever so cautiously to be taken up in their play, they more often than not turn away and start on something else.

They often posture, twist, and turn, assuming odd, uncomfortable positions. They can become absorbed with their hands and feet and play with these as though they do not belong to them. They appear to look through and to walk through the examiner, as though unaware of his presence.

In addition to the history and the clinical observation, a large proportion of such children have abnormalities in the EEG recordings. White *et al.*[5] raise the question whether the findings can be attributed to primary organic abnormalities or whether prolonged anxiety can change the body's chemistry and produce 'psychosomatic cerebral dysfunction'.

Extensive research for aetiological factors has suffered the same fate as with adult schizophrenia and nothing convincing has as yet been demonstrated.

Genetic research has shown very little. Constitutional and hereditary factors have been stressed by Bender,[9] but she also believes 'that the family climate in the infantile period' is a deciding factor.

Psychological factors and the emotional climate in the family have been the areas of research at various centres. Rank,[10] from the James Putnam Children's Centre, reports: 'We are convinced that hereditary and biological factors play a part, but are none-the-less impressed by the vital role of postnatal psychological elements in the aetiology and emergence of this disturbance'.

Boatman and Szureck,[6] reporting on 12 years' work with 100 children and their parents, are of the opinion that 'stress' during the earliest months and years of life, is a constant finding. 'The nature of the stress appears to lie in the anxiety of the parental persons about basic sensual impulses. The pathological moments for the child are ones in which the executive function of the parent has been strained to or near breaking point.' Attempts have been made at isolating and defining the operative psychological factors. Benjamin,[11] for example, subjected a pair of monozygotic twins with asthma and anxiety, together with their parents, to long-term observational and psychotherapeutic study.

He found that the impact of the mother's differential identifications of the two children was a major aspect of their subsequent development. Some minor psychological differences between them contributed to her differential perception of them.

Singer and Wynne[12] tried to assess differentiating characteristics of a group of parents of childhood schizophrenics, neurotics and young adult schizophrenics. They used the Rorschach and TAT tests and found such typical differences in the responses of the 3 categories that blind classifications were entirely accurate.

The evidence that is gradually accumulating requires the investigation and observation of the family as well as the child who presents as the patient.

If the aetiology of childhood schizophrenia is obscure and confusing, the treatment is equally so. The broad aim in therapy is to reduce anxiety and stimulate maturation. The choice of treatment will depend on which aetiological factors are considered most important and on the therapist's orientation. Bender[9] used electric shock as a major form of therapy, but she is not supported by many child psychiatrists or psychologists. Prolonged psychotherapy of one form or another for the child and the parents is most generally favoured.

Boatman and Szureck[6] report a major improvement in 20% of their cases with intensive psychotherapy. Waal[13] describes a technique of physical massage and stimulation of certain parts of the body to release affects and impulses and thus stimulate emotional maturation and integration. There can be little doubt that this is associated with psychotherapy of an emphatic type.

Tranquillizing drugs, especially chlorpromazine and the phenothiazines, are used in combination with all the above.

DISCUSSION

The term 'childhood schizophrenia' is in some respects unfortunate. The relationship with the adult condition is controversial. There are dissimilar hereditary patterns, the childhood condition occurring in the absence of a family history, the parents in the two groups can be clearly distinguished by psychometric tests, and therapeutic measures which have been fairly effective in adults have been worthless in children.[14] One is dealing with a disturbance in a developing ego and the more general term 'childhood psychosis' is preferable.

A tentative diagnosis should offer no great difficulty and this should be made early so as to ascertain organic factors such as brain damage and sensory defects that should then be dealt with appropriately.

All cases of atypical development in young children should be subjected to a full clinical, neurological, electroencephalographic and psychological investigation.

The most urgent needs for early diagnosis are therapeutic and humane. If one keeps in mind that 'gross and sustained impairment of relationships' is the core of the problem, one cannot be blind to the suffering which it imposes on all concerned.

The constant cry of the parents is 'we can't get through to him'; this leads to frustration, despair, and guilt and to the mustering of all available defence mechanisms, which leads to further isolation.

The child finds the external world so discouraging that he denies its reality and relies on his inner world of fantasy to supply what satisfaction it can. This leads to a stalemate and a vicious circle which cannot be broken except by external intervention.

I have found that parents are usually willing and often eager to discuss their involvement, once they are assured of uncritical acceptance. This often relieves their anxiety and guilt, making it easier for them to see the child as a separate individual, struggling for recognition of his needs and uniqueness. This is the first step towards the dissolution of the barriers separating parent and child.

It has been my clinical impression that if the diagnosis is made early and external factors are favourable, the parents, especially the mother, can be helped to perform the major therapeutic task. The task of the therapist is to find out what caused the failure in the 'executive function of the parent'. In therapy the task is to give the parents insight into this and to supply the support required to allow them to re-experience this situation of conflict, with more confidence. Interpretation of the early needs of the infant is essential. One then encourages regression and 'holds' the mother and child while they work through earlier phases of relationships. It goes without saying that the earlier this is attempted, the more likely it is to succeed.

To aid research in this field there seems to be an urgent need for a few centres where research teams can be formed and the work coordinated.

The most typical aspects of the child are his aloofness, detachment and the contradictions in his behaviour. The parents cannot get through to him nor he to them and he therefore withdraws in the private world of his fantasy. The interference with communication is portrayed in the typical speech disturbance which either never develops properly, remains stationary or regresses.

An appeal is made for a greater awareness and earlier diagnosis which would improve the prognosis with treatment.

As so little is known about the incidence of the illness in this country, the need for research centres seems an urgent consideration.

SUMMARY

Childhood schizophrenia is a poorly defined syndrome, which is still misdiagnosed. The aetiology is controversial and the treatment is unsatisfactory.

In the last two decades intensive research work has been undertaken at several overseas centres. This has cleared up some of the confusion at least about the diagnosis. Nine diagnostic points are enumerated.

The family history and personal history of the child are both essential for an understanding of the psychodynamics of the situation in which the child finds himself.

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