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Some Aspects of Childhood Schizophrenia

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I. The Question of Diagnosis

It is not an uncommon experience among medical practitioners that when one is looking for a disease entity more patients suffering from it seem to have emerged. This appears to be especially true with childhood schizophrenia. Unless a careful history-taking and psychiatric examination can be carried out, many schizophrenic children would be disposed of under the category of mental deficiency. Some of them would then be placed in an institution and the diagnosis may never be revised at a later date.

One important question in any study of childhood schizophrenia is the criteria used for the diagnosis. Unless these are made explicit the study would involve a serious methodological defect either from aetiological or prognostic viewpoints. Furthermore, this defect would make comparison of different studies, especially cross-cultural ones, impossible. However, the diagnostic criteria have not been definitely established. Recently, the British Working Party led by Creak (1961), on schizophrenic syndrome of childhood outlined 9 points as a guide to the diagnosis. There are, however, ambiguities which led different psychiatrists to interpret some of these points in different ways. In this study they were modified and amplified in the light of other studies by Norman (1955), Vaughan (1964), O'Gorman (1965), Rutter (1967), and Chess (1969), to give the following behavioural characteristics:–

1. Affective withdrawal The child shows gross and sustained impairment of emotional relationship with people and instead becomes intensely interested in objects. This is the most important and common characteristic.

2. Defective mental functioning In a background of serious retardation there are indications of variability or islets of intellectual functioning or skill at or above the level expected for his age. In many cases it is extremely difficult to distinguish mental deficiency and schizophrenia. It is to be noted that not all schizophrenic children have a normal development up to the onset of their symptoms and not all retarded children have a consistently slow development from birth.

3. Intense desire for 'sameness' He resents any change in routine or even furnishings in the home and likes to arrange things like toys and shoes in straight line or squares. Anxiety or rage may be aroused by threatened interference with sameness of the environment.

4. Speech defect He may be mute or his speech may fail to serve any useful purpose of communication. There may be interchange of pronouns, echolalia or mannerism of use or diction.

5. Distortion in mobility patterns He may have hyperkinesis, immobility, bizarre postures or ritualistic behaviour which appears to have no aim beyond the activity itself.

Source: The Mental Health Association of Hong Kong Newsletter, January, 1970, 2-4

II. Theories on Aetiology and Problems in Method of Study

There are two schools of thought on the aetiology of childhood schizophrenia. The biogenic school contends that it is due to some organic brain pathology although the lesion is still un-identified. Bender (1942) attributes the lesion to acute encephalopathy. As pointed out by Greenebaum and Luria (1948) it is not uncommon for encephalitis complicating acute infectious disease to present with psychotic behaviours and as infectious disease is so common in childhood its presence as an aetiological factor may be forgotten. On the other hand the psychogenic school regards childhood schizophrenia as reactions of the child to the impact of pathological attitudes of the parents. Kanner (1943) took this viewpoint and described a syndrome known as early infantile autism characterized by profound withdrawal from contact with people and obsessive desire for the preservation of sameness. Mahler (1952) postulated that symbiotic infantile psychosis with symptoms centred about a desperate effort to avert the catastrophic anxiety of mother-child separation is the result of pathological mothering. However these two conditions are not common.

Apart from the question of diagnosis which has been touched upon earlier another important problem is that of classifying parental attitudes. Kanner (1957) analysed parental attitudes into 4 principal types each of which would lead to certain behavioural reaction in the child. This analysis was based on his clinical experience and as such is subject to bias on the part of the assessor. Furthermore, there is no sharp dividing line between "normal" and "abnormal" attitude. In recent years another way of assessing parental attitudes has been introduced and this is by means of questionnaires and rating scales. An example is the Parental Attitude Research Instrument (PARI) and from the work of PARI by Klebanoff and Bell (1958) 5 relatively independent factors of attitudes were extracted by factor analysis. However, paper and pencil scales have limitations e.g. they cannot penetrate into the parents' surface attitude. Bell (1968) admitted that the PARI were not quite a satisfactory tool of assessment. In view of this and also the fact the questionnaires devised in western countries may not be used in Hong Kong because of cultural differences, the interview method despite its defect has been used.