

THE MISUSE OF THE DIAGNOSIS CHILDHOOD SCHIZOPHRENIA ¹

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There has been an enormous increase in the diagnosis of childhood schizophrenia. We find an ever larger number of cases both in the psychoanalytic and general child psychiatric literature(1, 2, 5, 7, 8, 9, 14, 16). Few cases have been followed into adulthood(1, 7, 13), and where it is reported that the diagnosis was then confirmed, this is still open to question because of the prevalence of confused and inconsistent diagnostic criteria also in adults(3).

Schizophrenia is not a disease of childhood. Its onset is in adolescence and pre-adolescence. Studies of childhood behaviour of definite adult cases of schizophrenia(4, 19) show that they are, as a rule, model children, inconspicuous, and quite different from the cases described as childhood schizophrenics.

Child psychiatry is still in the pre-Kräpelinian stage. No valid classification of mental diseases in children has yet been worked out. For the study of schizophrenia in childhood we have to take into account the progress made since Kräpelin and Bleuler in the refinement of diagnosis. This progress has been in two main areas, in the sifting out of other diseases, and in the development of tests.

The development of tests has given a new dimension to psychiatry. We have found the Mosaic test as interpreted by Wertham(23, 25, 26) so helpful for the diagnosis of schizophrenia, that we feel no child should be diagnosed as suffering from schizophrenia without a schizophrenic Mosaic design. Some workers(6) found a 100% correlation between definitely diagnosed adult cases and their typical mosaic.

The present trend to diagnose children with severe emotional and mental symptoms as schizophrenic is scientifically wrong and has had serious practical consequences. It has filled state hospitals and schools for mental defectives. Children in trouble for many

different reasons are now likely to be so diagnosed.

We have studied 60 such cases below the age of 14 at the Lafargue Clinic and in private practice. In practically all of them the diagnosis was wrong.

Seven-year-old Bernard is representative of the many cases where unnecessary hospitalization and harmful treatment followed this wrong diagnosis. His mother took him out of the hospital and brought him to the clinic. She said: "He had only 6 shock treatments, not the full 20. He had forgotten even our dog's name when he came home, and he had known him since the dog was a puppy. It was just like he had to learn all over again. It seemed like he was in a daze most of the time." Clinical examination, tests, playgroup observation showed no evidence of schizophrenia. Our diagnostic task was made even more difficult because of the symptoms and the changes caused by ECT. It is exactly as Dr. Nolan D. C. Lewis stated: "The thing that interferes with using diagnostic intuition more than anything else is shock therapy"(15). This boy recovered with group and individual therapy.

The most pressing unsolved social problem in the United States today as far as children are concerned is that of juvenile delinquency. A child who commits a crime is now likely to be diagnosed schizophrenic and sent to a mental hospital. This puts the problem into a wrong focus, namely into the field of mental illness of unknown origin inherent in the child, instead of into the field of social pathology to which the child is reacting.

George is such a case. He came to the clinic in 1946 because of a severe reading disability and truanting from school. He was the leader of a gang of about 30 boys and feared that a member of a rival gang might stab him in school. When he came to the clinic he brought two body guards who kept watch at the entrance. His gang became involved with the killing of a policeman, and he was arrested and sent to a mental institution where he made 3 suicide attempts before his final commitment to a state hospital where he made another suicide attempt. The diagnosis was schizophrenia. He was discharged once but recommitted after an arrest for fighting while drunk. He was then sent directly to the mental hospital and not to jail because of his previous stay there.

I visited him in the hospital when he was 22 years old. I found him friendly and outgoing. There were

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no delusions or hallucinations. He gave a coherent account of his past life inside and outside the hospital. He attempted suicide because he was depressed. He worried about the other boys in his gang some of whom were in jail awaiting trial for their life. He told me: "I was the baddest boy on the ward. There were boys from another club and we got to fighting. I was all confused. I heard boys hollering, screaming. You get to thinking about it when you are alone by yourself, you shouldn't have done this, you shouldn't have done that."

This is not what patients tell us after an episode of "catatonic" excitement. The doctor in charge told me he did not think that George had schizophrenia. Many boys now on the wards of this and other hospitals got into trouble because of gang membership and are not psychotic.

Our case material shows that symptoms are frequently misinterpreted. This has serious consequences for the child's entire future life.

This happened to Robert, age 9. He was sent to a mental hospital for truancy, running away from home and stealing. The diagnosis of childhood schizophrenia was based primarily on the following factors: "On occasion he thought people were following him and was compelled by some introjected body to do things like steal and stay away from home."

Here delusions of reference are implied but not proven, especially when we take into account that such a serious symptom never occurs only "on occasion." Our cases show that the so-called introjected-body-delusion is most often a fantasy and represents a conscious or unconscious rationalization for forbidden actions. Frequently children tell us: "a voice told me to hit him" or "the devil told me to kick her." The child may consciously want to show that he is not responsible for the bad things he does. Some children grow up in an environment where the devil is considered a reality, and forbidden deeds and thoughts are explained by the devil having entered the person. Some children we see have been told that spirits exist, can come to life, talk to people and influence them. Actually, Robert had run away from home because of a cruel mother and step-father. He stole money because he needed it. Our clinical examination, tests and play-group observation showed no evidence of schizophrenia. He was rehospitalized against

our advice. He was given 20 ECT. After these he became: "agitated, felt that his body had been mutilated, played with words, shouted, ran about, was overtalkative and appeared to have feelings of unreality." This iatrogenic syndrome then led to his commitment to a state hospital.

The sequence in this case is typical. The child misbehaves in school and often, not always, also at home. He can no longer be kept in the class room. His parents are advised to take him to a hospital for observation, or they are referred to clinics, agencies or the children's court. There it is felt that the child is suffering from childhood schizophrenia, and he is sent to a hospital where the diagnosis is confirmed and he receives 20 ECT. The child may react the way Robert did and be committed to a state hospital, or the parents may take him home with or without the doctor's consent. Most of the children we have seen were then not able to function in the community. They either had to be exempted from school for some time and eventually improved with psychotherapy (if this was available to them), or they had to be recommitted soon. After a stay in the state hospital for anywhere from several months to 4 years, they are discharged with the diagnosis changed to "behaviour disorder." This change of diagnosis is so frequent that it has become the rule rather than the exception. So it happens that in an entire caseload of one social worker only one case was discharged with the original diagnosis of schizophrenia.

Some cases are sent not to state hospitals but to state schools for mental defectives. In one state school 95% of children sent to them as childhood schizophrenics turned out to be grossly organic cases, for instance encephalitis, definitely not then certifiable as childhood schizophrenia. Franz Kallman has made similar observations in his study of twins.

We had the opportunity to examine children at different stages of this sequence, either inside or outside the hospitals. Among our cases are children with psychologically caused conditions. We have searched the literature and were unable to find even one fully analyzed and definite case of schizophrenia in which the causative connection

between early or later infantile psychological trauma and the disease was really established scientifically. Children may react in a bizarre way to severe trauma but that does not mean that they then have schizophrenia or will develop it later on in life.

Our material contains organic cases such as epilepsy, epileptoid mood disorder, encephalitis, mental deficiency, endocrine disorders and developmental disturbances. We have found that even mild forms of agnosia, apraxia, aphasia, impairment of auditory perception and dyslexia may cause severe learning and behaviour disturbances and lead to the erroneous diagnosis of childhood schizophrenia. Schizophrenia is not an organic disease in that sense. We know it is a progressive disease, but we do not yet know where the schizophrenic process takes place. Wertham's conclusion in *The Brain As An Organ* is still valid(21):

On the ground of anatomical facts, there is no justification for speaking of an "organic cerebral process" in schizophrenia . . . there is, today, no histopathology of this condition. To draw from this negative statement the conclusion that of necessity schizophrenia can not be due to any organic factors, and must consequently be of psychogenic origin, would be hasty and unwise.

One of our most difficult diagnostic tasks was to differentiate cases of schizoid psychopathic personality. These have mild, chronic, non-progressive symptomatology but may have severely disturbed episodes.

Genuine paranoid delusions have not been described in children. We have observed a type of hostility which may be malignant and possibly a forerunner of delusions. This problem comes up in the very large number of cases referred to us with the chief complaints of: "Hits other children without provocation, is a menace to the safety of other children in his class." We then have to find out whether he hits other children because he is attacked by them and has to defend himself; because he is so anxious and insecure that he feels it is safer to hit first because he thinks they are going to hit him anyhow; because he imitates strong man figures he admires such as Superman; or because we are really dealing with a morbid, possibly schizophrenic suspiciousness and hostility.

One of the most important gaps in our

knowledge is that the limits of normal for children of different ages have not yet been established. In neuropathology many findings which were once called abnormal are now known to belong to the "extent of the normal"(21). We may find this to be true also in child psychiatry. How far in degree and in terms of a child's age can magic thinking go before it can be termed pathological? When should a dreamy child be diagnosed as pathologically withdrawn? Up to what age, in what type of child and to what degree is fantasy preoccupation compatible with mental health? This brings up the question of visual and auditory hallucinations. It is known that children normally have more vivid auditory and visual experiences than adults. They have to learn to distinguish fantasy from reality. Stories, especially in comic book format, on television and in the movies, are taken seriously and carried over into play, daydreams, dreams and projected into tests(17, 18, 24). During episodes of anxiety and especially before going to sleep many children experience visual, tactile and auditory fantasies which they may feel come from the outside and about whose reality they may not be quite certain. Piaget has found that until about the age of 9 a child may believe a shadow is a substance; it is therefore not surprising when a child reacts with fear when he sees shadows. The error is often made that such experiences alone are regarded as symptoms of a serious and malignant disease. The fact that most children have a positive eidetic disposition(22) has to be taken into consideration also. Several of our cases were committed on the basis of such symptoms which are really within normal limits.

John's diagnosis was based mainly on: "visual hallucinations." He described the following: "I just close my eyes and I see elephants. Sometimes when I imagine things I can see it. I have to have my eyes closed. Sometimes I see cowboys. I make myself one of them. They do whatever you want them to do. Sometimes when I can not sleep I do it. Then I'd go to sleep."

What this boy described is what Dr. Jelinek has called "spontaneous imagery"(11, 12). It is not a pathological phenomenon and seems to be easier for children to produce than for adults.

Our cases include neuroses. They bring

up the interesting problem of differentiation between schizophrenic regression and neurotic fixation. Their prognostic evaluation is made especially difficult because some adult cases of schizophrenia have neurotic traits in childhood. The Mosaic test is here particularly helpful (23, 25, 26). With its aid we can also distinguish cases of obsessive-compulsive neurosis on an affective basis with good prognosis from those malignant forms which are really symptoms of schizophrenia.

Our cases show how erroneous dogmatic thinking may lead to contradictory therapeutic procedures. Often they are dangerous for the child. At any rate, they deprive the child of constructive social and psychotherapeutic measures. In many cases anti-convulsive medication and then ECT was recommended in the same case within a period of a few weeks. Children of all ages are being subjected to lobotomies on the same basis (10).

Childhood schizophrenia is at present in the United States a fashionable and much abused diagnosis. Careful clinical study indicates that far more often than not this diagnosis is wrong. This is not only a threat to children living in a socially difficult milieu, but also hinders the progress of psychiatry as a science.

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