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Spurious childhood psychosis induced by schizophrenia in the parent

Steve Aldridge & Gill Tagg

We describe the case of a child presenting with what initially appeared as a pervasive developmental disorder (ICD F84.1) associated with, and in our view, induced by, schizophrenic illness in the mother. Important issues are raised for both adult and child psychiatry, in particular that the failure of the Mental Health Act (1983) to address the mother's needs adequately, left the child vulnerable to her untreated illness.

Many publications have focused on constitutional factors of the offspring of parents with schizophrenia. These 'high risk' longitudinal studies (Parnas, 1986) have emphasised the genetic risk of schizophrenia, and have been concerned with predictors in the child for subsequent schizophrenia, for example, IQ, physiological measures, personality traits and perinatal trauma.

Research observing environmental factors within families where one member suffers from schizophrenia has focused on relationships exhibiting 'high expressed emotion' and hours of daily contact within these relationships, and ways of reducing these to benefit the patient (Leff & Vaughn, 1985).

In studying the parent–child association of psychiatric disorder, Rutter (1966) found children most at risk of psychiatric morbidity if subject to aggression, neglect, the target of delusions or involved in parental symptoms. In a later influential prospective study of 137 referred families with a parent suffering from a mental disorder, Rutter & Quinton (1984) found that, whereas the children exhibited an increased rate of emotional and behavioural disorder compared with control families, particularly if exposed to hostile behaviour, there was no association between the nature of the child psychiatric disorder and psychosis in the parent. They concluded that parental mental disorder does not give rise to an increased risk for the children that is independent of the family's psychosocial circumstances as a whole, parental psychosis being viewed as a non-specific stressor.

A descriptive study of the experiences of 28 families with a mother suffering from schizophrenia, Webster (1992) highlights two particularly vulnerable groups: children within unsupported single-parent families in which the mother receives treatment under duress and the children assume age-inappropriate responsibilities; and those within chaotic families with high levels of disturbance and poor care of young children. Goodman & Brumley (1990) demonstrated the quality of parenting by mothers with schizophrenia to be inferior to both depressed mothers and well mothers for children under five years in a single-parent setting. In this study the mother's parenting practices, and not her diagnostic status *per se*, accounted for many of the childrens' deficiencies in intellectual and social competence, supporting an interactional model for transmission of psychopathology from mother to child.

Other studies suggest that the nature of a parent's illness is itself important in determining the experience and outcome for the child. In a population on a case management programme for women with severe chronic mental disorder, (White *et al*, 1995) 9% were the primary caretaker for a child (18 years and under) (Box 1). Of these 38% achieved caseness for DSM–III–R (American Psychiatric Association, 1987) psychotic disorder

Box 1. It is common for women suffering from severe mental disorders to have responsibility for children – 9% have primary responsibility for a child.

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and 52% major mood disorder. Compared with case-managed non-caretaker matched control women, utilisation of psychiatric services was the same: 48% of caretakers were psychiatrically hospitalised within the previous year, demonstrating that psychosis disrupts the continuity of childcare, though the study did not examine the effect on the the children. Ramsay & Kumar (1996) highlight the impaired childcare skills of a mother with schizophrenia, who had stopped medication and was admitted to a mother and baby unit, and the consequent dilemmas for staff concerning the best interests of her baby.

Landells & Pritlove (1994) reported a postal survey of professionals involved with the children of 42 parents with a diagnosis of schizophrenia of whom one-third were sole carers. Of their 60 children, 95% had experienced the parent psychiatrically hospitalised (63% compulsorily) during their lifetime and 52% had a parent affected by schizophrenia for over 10 years. Respondents reported the parent's schizophrenia had an impact on 73% of the children. Impairments in the children were reported in 10% for physical development, 13% for educational development, 51% for social development and 69% for emotional development.

Falkov (1996) studied 100 child abuse fatalities, and reported that 8% of the parent perpetrators suffered psychosis (Box 2). This rate, far in excess of community prevalence figures, indicates the diagnosis of psychosis was critically important in the standard of care and outcome for these children.

Enoch & Trethowan (1979), and Hart & McClure (1989) describe *folie à deux*, the most common form of which is *folie imposee*. There is a shared delusion between closely associated people, usually family members, in which beliefs of the principal/dominant member (often a parent) who is psychotic are progressively imposed upon the associate/subordinate person. This may, for the latter, resolve conflict and maintain the family unit. In addition, reports (Mander *et al*, 1987; Crosby, 1989; Cryan & Ganter, 1992; Elliott, 1992) indicate the parent's psychosis may be pivotal in determining the form and content of psychopathology in particular children.

Box 2. Where a child has died in childhood in abusive circumstances, the presence of psychosis in the abusive parent is commonly an important contributory factor – psychosis was identified as present in 8% of parents perpetrating abuse.

Adam's story

Adam, a seven-year-old boy, was referred urgently during 1992 by social services one month after being taken into care following non-accidental injury. Shortly after his reception into care his mother became an in-patient under Section 2 of the Mental Health Act 1983 following a disturbance at her home. She was agitated and grossly deluded, believing the neighbours to be hostile and using tape recording devices to intrude on her and her son. She had involved the boy in her delusions, moving his bed into the middle of the room to avoid the noises and other influences that she believed came through the walls to harass them.

The mother's history included three grown children from a former marriage at age 20, raised by their father after the marriage ended after 10 years. Her notes included a diagnosis of 'postnatal depression' after the birth of the second of these children, and follow-up as an out-patient for seven years until 1976 for a 'depressive state with paranoid ideas'. She was further assessed by a psychiatrist in 1980 but not followed-up. She was not employed and lived alone with her son.

A firm diagnosis of paranoid schizophrenia was made during her admission after the boy's reception into care. However, a mental health review tribunal upheld her appeal against detention. She discharged herself untreated, against medical advice, after nine days (see Box 3).

The boy remained in the care of foster parents who at the time had 12 children in a setting described by the foster mother as "not unlike a small children's home".

At the time of referral Adam was withdrawn, uncommunicative and ritualistic with moderately delayed development observable both at school over two academic sessions and over the one-month period in foster care. At school he had crouched under tables, was fearful of toys and teachers and was excessively ritualistic in relation to

Box 3. Mental health review tribunals are not obliged to consider the welfare of children as 'paramount'. Their welfare is only paramount under the Children Act 1989 in relation to courts making decisions about the welfare needs of a child. The mental health review tribunal and other courts making decisions about adults may consider many issues including the needs of dependent children but are not obliged to consider the child's welfare as paramount.

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time-keeping and going to the toilet. At the toilet he would remove all clothing and reverse into the toilet, appearing fearful of wetting himself. There was paucity of language seen as a component of his developmental delay. In the foster setting he was almost completely mute. His only speech was to repeat the clock time in a ritualistic manner. He established no rapport with foster parents, teachers, or children either at school or in the foster setting. He did not communicate his needs, so that he soiled himself initially in foster care, and did not cry, seek food, or indicate when he was in pain. There was no reported disturbance of sleep or appetite: these tasks being attended to on command.

Helping agencies were unaware of the child's difficulties until first presentation at school aged five years, still in a push-chair and in nappies. School entry was deferred for nine months, by which time he was fully mobile and toilet-trained. His mother did not provide developmental history, refused to acknowledge any problem existed with the boy's development, did not cooperate with the attempts of the health visitor and social worker to be involved, and refused to cooperate with assessment for special school placement so that he remained in mainstream schooling with full-time individual support, from a non-teaching assistant.

No information concerning the boy's father was available at any stage because of mother's disturbed mental state and thought disorder. She evaded answering relevant questions.

Mental state

At initial interview with foster mother the child was extremely withdrawn with severely flattened affect. He demonstrated no rapport with interviewers or carers and physically withdrew from attempts to engage him. His use of toys was limited and his drawings were formless. His only verbalising was to repeat the clock time once near the end of the interview. He indicated 'no' by head-shaking.

At supervised access visits with his natural mother he was also withdrawn and largely mute, sitting at the opposite end of the room from his mother who talked to him throughout.

On interviewing the natural mother with the boy, she was evasive and suspicious of questions concerning the boy's or her own history. She revealed nothing concerning his natural father. She sought to emphasise the boy was normal in every respect. She was guarded in manner and her replies showed formal thought disorder. She claimed that the neighbours caused harm to herself and her son at a distance by influencing their thoughts, but would not elaborate. When she raised her voice her son was visibly aroused and frightened calling out "she's shouting". Adam showed no evidence of attachment behaviour towards his mother, avoiding her rather than seeking proximity.

Initial diagnosis

The diagnosis of pervasive developmental disorder of childhood was made. Discussion focused on atypical autism (ICD F84.1) (see Box 4) as much developmental history was not forthcoming; although childhood schizophrenia (ICD F20-29), particularly in view of the family history, and a severe depressive disorder (ICD F32.2, F32.3) were considered.

Adam also showed moderate learning disability, particularly in language areas either innate or consequent upon the inadequate and at times bizarre rearing.

Progress

During the wait for assessment admission to a psychiatric unit, the foster placement broke down and the boy was placed as an emergency with a single mature woman who had no other children but had personal experience of children with special needs. Although initial problems were identical, improvement began at this time.

Follow-up interview eight weeks after his new placement found the boy smiling, and engaging in the interview. He chatted and answered questions showing a broader vocabulary than had been expected. He showed appropriate attachment to his new foster parent and an appropriate grasp of his environment. His school work started to progress well, he became more spontaneous, less ritualistic and started to show signs of creative play. In the foster home his wetting, soiling and ritualistic behaviour disappeared. His relationship with his natural mother at access also improved. He became able to verbalise his wishes and needs. At follow-up one year later he was developing at a rate consistent with his degree of learning disability. Psychometric tests 18 months after the second foster placement demonstrated full scale IQ (WISC-R) of 71 with verbal IQ of 67 significantly below performance IQ of 81. Two years after referral he was thriving in his foster placement and progressing well at a special school for children with learning disability.

Box 4. Emotional abuse may present as an autistic clinical picture. Adam's experiences illustrate this possibility.

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By the middle of 1996, aged 13 years, Adam had been well established as a well-liked child functioning at the upper end of the ability range within his special school. Socially he was quiet, somewhat obsessive, but he was able to express interest in others. His foster mother had recently married a man with little interest in Adam. The couple emigrated during 1996, whereupon Adam was placed in a further foster home with two other children. These changes precipitated the emergence of behavioural problems including obsessive rituals and for the first time aggressive exchanges with male adults both at school and home.

Discussion

The needs and experiences of children whose parents suffer psychosis are little documented. It was only the severity of his symptoms that led to this boy's referral to psychiatric services. A child as young as seven years is dependent for reality testing upon a parent. Parents are in a uniquely powerful position to distort reality for young children. By mid-childhood children become exposed to influences enabling them to question their parents' logic. In Adam's case he was not only subjected to a very distorted reality, but had little means of validating this independently of his mother's distorting influence. The case highlights two important lessons for both child and adolescent psychiatry and adult psychiatry.

The first is the importance of seeking a dynamic understanding of the context of the symptomatology in addition to an emphasis on the phenomenological approach and, in this case, to bear in mind both the mental state of the mother and the social context (see Box 5). One can speculate that had this boy been admitted to hospital for assessment as initially planned, one outcome might have been a diagnosis of autism or schizophrenia on the basis of symptoms and observations because the hospital environment may well have mimicked the institutional environment of his first foster setting. The depth and comprehensive nature of his difficulties, which caused the breakdown of this foster placement, might indeed have led to further long-term institutional care and an 'established' diagnosis. Fortunately, events intervened and he was placed in a second foster home able to meet his needs. This permits a dynamic understanding of the process of the case, and renders formal diagnosis of pervasive developmental disorder untenable.

Box 5. Where a child's welfare or development is adversely affected by living with a parent suffering a psychosis, the form and content of the parent's illness as well as deficits in parenting skills are formative in development of psychopathology in the child.

The second lesson relates to this case identifying that the sufferers of schizophrenia extend beyond the index person. The ravages of the schizophrenic illness in the mother imposed itself on the boy, who could only accede within that distorted reality and sought to survive by reducing stimulation at home for himself and his mother both by minimising spontaneity and with ritualistic compliance to parental commands. This appeared to arrest his emotional development. The fact that this situation remained unsatisfactory was known over a period of many months, but agencies felt they could not intervene but only monitor from a distance. Child protection procedures were implemented following clear evidence of physical abuse. In 1992, it was more unusual than it is currently to call a child protection conference solely on the basis of emotional abuse.

We submit that the interpretation of the Mental Health Act was mistaken in relation to this case in over-emphasising the individual rights of the mother, resulting in failure to provide effective intervention for the family until injury to the child had occurred. The over-restrictive interpretation of the natural mother's rights by the tribunal led not only to treatment being denied to her but ultimately to her losing the possibility of resuming the care of her child which, notwithstanding her limitations as a parent, was undoubtedly what she valued most. This outcome is all the more tragic in that Adam's capacity for successful attachment and progress with his second foster mother suggest that bonding and emotional nurturing by his natural mother were probably substantially satisfactory in earlier times.

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Multiple choice questions

1. In England and Wales, current mental health legislation confers powers which:
   - a enable compulsory admission to psychiatric hospital under the Mental Health Act 1983 applicable to children of all ages
   - b extend to the baby when a mother is admitted under section to a mother and baby in-patient psychiatric unit
   - c can convey a neglected child to a 'place of safety'
   - d embody the principle that 'the welfare of the child is paramount'
   - e in certain circumstances provide for supervision of children of all ages within the provision of the Mental Health (Patients in the Community) Act 1995.

2. Mothers who suffer from schizophrenia:
   - a are only rarely sole carers of a child
   - b exhibit parenting skills deficits compared to mothers who suffer depression
   - c are rarely admitted to psychiatric hospital during the childhood of their offspring
   - d create 'high expressed emotion' family environments
   - e carry a 10% risk of rearing an autistic child.

3. Children who have a parent with schizophrenia:
   - a carry about a 10% risk of developing schizophrenia in adulthood
   - b commonly show impairments in emotional development during childhood
   - c commonly experience their parent compulsorily hospitalised during childhood
   - d commonly misuse their parent's medication themselves
   - e are at increased risk of dystonic reactions to metoclopramide compared to other children.

4. The following features in family life have been shown to prejudice the emotional welfare of children where a parent suffers psychosis:
   - a single parent status
   - b smoking by one or other parent
   - c a chaotic household
   - d a parent receiving psychiatric treatment under duress
   - e active membership of a major religion.

5. A shared delusional system (*folie à deux*) is an uncommon mental disorder which:
   - a only occurs exceedingly rarely outside of extreme religious cults
   - b is most common in family members living together
   - c may help maintain the relationship between those affected by resolving conflict
   - d when occurring within families is primarily the result of shared genetic predisposition to mental illness
   - e is generally the result of bullying of others by a psychotic individual.

MCQ answers

1	2	3	4	5
a T	a F	a T	a T	a F
b F	b T	b T	b F	b T
c F	c F	c T	c T	c T
d F	d F	d F	d T	d F
e F	e F	e F	e F	e F

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