

What is childhood onset schizophrenia psychology essay



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The number of people with schizophrenia in Canada in 2004 was estimated at 234,305 or 1% of the population. The probability of individuals developing schizophrenia is higher for those that have the illness existing in their family history. Men and women are affected equally, but among the individuals who have schizophrenia, the male population is more likely to experience the illness at an earlier age than the female population. On average, males tend to experience symptoms of schizophrenia at the age of 18, compared to females who experience the illness at the average age of 25. Furthermore, schizophrenia in Canada in 2006-2007 was one in 100 Canadians suffers from schizophrenia and another one in 100 suffers from bipolar disorder, or manic depression; 8% of adults will experience major depression at some point in their lives, while 12% of the population is affected by anxiety disorders. The onset of most mental illness occurs during childhood, adolescence and young adulthood. One out of every five Canadians will have a mental health problem at some point in his or her life.

What is Childhood Onset Schizophrenia?

Childhood schizophrenia is the onset of triggers before full flange schizophrenia is diagnosed this usually happens between the ages of 17 to 25. Having an initial onset before age 14 or after age 30 is unusual. Childhood schizophrenia is more common in males than females. Childhood-onset schizophrenia (COS), particularly when diagnosed prior to the age of 13, is considered to be especially rare and severe (Torrey, 2001). It has been estimated that COS occurs in 1 in 10,000 children. Of all schizophrenic disorders, only 0.1 to 1% manifest prior to age 10, increasing to 4% by age 15 (Dulmus & Smyth, 2000). As with other schizophrenic spectrum disorders,

COS is much more rare and more severe than its adult-onset counterpart. Why the onset of schizophrenia occurs in this specific age group is unknown. Schizophrenia is a chronic mental illness that affects the brain. It is a psychotic disorder which involves delusions, hallucinations and a loss of contact with reality. This makes it very different for a person who suffers from schizophrenia to differentiate between what is real and what is not real. However, it is currently believed that most cases of COS are attributable to some form of brain disease with genetic roots. The genetic roots are especially prominent, as nearly 50% of children with COS have at least one first degree relative with schizophrenia or a schizophrenic spectrum disorder (Thaler, 2000). It was initially thought that the age at which psychotic aspects of COS developed was associated with the onset of puberty. In females, the development of secondary sex characteristics has been shown to be associated with the onset of psychosis, but the same is not true for males (Jacobson & Rapoport, 1998). Childhood schizophrenia symptoms are different than those associated with adult schizophrenia. Schizophrenia in children doesn't start suddenly, adults schizophrenia happens in episodes and it occurs relatively suddenly. But this almost never happens with a child's case of onset schizophrenia. Likewise in adults when they lose interests in pleasurable things children exhibit the same symptoms they begin to lose interest in their friends or activities and they may start to display strange behavior like running out of the house in the middle of the night undressed these signs and symptoms have been reported by parents who have children diagnosed with COS.

Causes

Although it is unclear whether schizophrenia has a single or multiple underlying causes, evidence suggests that it is a neurodevelopmental disease likely involving a genetic predisposition, a prenatal insult to the developing brain, and stressful life events. The role of genetics has long been established; the risk of schizophrenia rises from 1 percent with no family history of the illness, to 10 percent if a first degree relative has it, to 50 percent if an identical twin has it. Prenatal insults may include viral infections, such as maternal influenza in the second trimester, starvation, lack of oxygen at birth, and untreated blood type incompatibility. Studies find that children share with adults many of the same abnormal brain structural, physiological, and neuropsychological features associated with schizophrenia. The children seem to have more severe cases than adults, with more pronounced neurological abnormalities. This makes childhood-onset schizophrenia potentially one of the clearest windows available for research into a still obscure illness process.

How Does It Affect Them?

Childhood schizophrenia has a philosophical effect on a child's ability to function effectively in all aspects of life- family relationships, school, social life etc. The onset of schizophrenia in early childhood years usually leads to disruption in a child's education. Child with schizophrenia often experience difficulty maintaining focus in class. Because of their environmental factors, they may feel as if they are being targeted by other students this is a state of delusion as well as figment of the imagination. A child who suffers from the onset of schizophrenia may need to have a teacher's assistant who can

provide them with the positive support while they are in school in order to function.

Genetic predisposition:

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Experts now agree that schizophrenia develops as a result of interplay between biological predisposition (for example, inheriting certain genes) and the kind of environment a person is exposed to. These lines of research are converging: brain development disruption is now known to be the result of genetic predisposition and environmental stressors early in development (during pregnancy or early childhood), leading to subtle alterations in the brain that make a person susceptible to developing schizophrenia.

Environmental factors later in life (during early childhood and adolescence) can either damage the brain further and thereby increase the risk of schizophrenia, or lessen the expression of genetic or neurodevelopmental

defects and decrease the risk of schizophrenia. In fact experts now say that <https://assignbuster.com/what-is-childhood-onset-schizophrenia-psychology-essay/>

schizophrenia (and all other mental illness) is caused by a combination of biological, psychological and social factors, and this understanding of mental illness is called the bio-psycho-social model (Chiko, 1995).

Children who don't receive medication treatment may not have a positive support system they may possibly have a much greater chance of experiencing hardship throughout life. Because medication would help stabilize a child's triggers from becoming worst as well as strengthen their cognitive functioning for a better outcome in life. The cognitive functioning is related to the types of symptoms experienced. Individuals with higher intelligence experience more positive symptoms, while those with lower intelligence experience more negative symptoms (Gonthier & Lyon, 2004). Children who don't take medication for schizophrenia will have a difficult time creating optimistic coping strategies to help them with their adversities they may be encountering. Children who have received early medication interventions have a more likelihood of developing a stronger ability to deal with COS because of the early interventions they have receive (Gonthier & Lyon, 2004).

Treatment:

Treatments that help young patients manage their illness have improved significantly in recent decades. As in adults, antipsychotic medications are especially helpful in reducing hallucinations and delusions. The newer generation " atypical" antipsychotics, such as olanzapine and clozapine, may also help improve motivation and emotional expressiveness in some patients. They also have a lower likelihood of producing disorders of movement, including tardive dyskinesia, than the other antipsychotic drugs <https://assignbuster.com/what-is-childhood-onset-schizophrenia-psychology-essay/>

such as haloperidol. However, even with these newer medications, there are side effects, including excess weight gain that can increase risk of other health problems. Children with schizophrenia and their families can also benefit from supportive counseling, psychotherapies, and social skills training aimed at helping them cope with the illness. They likely require special education and/or other accommodations to succeed in the classroom.

The medication interventions that are available for COS are treatment based. Treatment for schizophrenia through medication is pharmacological therapy. Pharmacological treatment usually takes form of neuroleptic drugs and antipsychotics. Children who are taking this medications need greater care; not only because of the side effects but because there is a negative association between the dose administered and the patient's level of social functioning. The most commonly used medications that are prescribed to children are: the antipsychotics risperidone Risperdal and olanzapine (Zyprexa (Nicholson, 2000)).

Antipsychotic drugs, like virtually all medications, have unwanted side effects along with their beneficial effects. During the early phases of antipsychotic drug treatment, patients may be troubled by side effects such as drowsiness, restlessness, muscle spasms, tremor, dry mouth, or blurring of vision. Most of these can be corrected by lowering the dosage or can be controlled by other medications. Different patients have different treatment responses and side effects to various antipsychotic drugs. A patient may do better with one drug than another (Nimh, 2007).

The long-term side effects of antipsychotic drugs may pose a considerably more serious problem. Tardive dyskinesia (TD) is a disorder characterized by involuntary movements most often affecting the mouth, lips, and tongue, and sometimes the trunk or other parts of the body such as arms and legs. It occurs in about 15 to 20 percent of patients who have been receiving the older, "typical" antipsychotic drugs for many years, but TD can also develop in patients who have been treated with these drugs for shorter periods of time. In most cases, the symptoms of TD are mild, and the patient may be unaware of the movements (Nimh, 2007).

Antipsychotic medications developed in recent years all appear to have a much lower risk of producing TD than the older, traditional antipsychotics. The risk is not zero, however, and they can produce side effects of their own such as weight gain. In addition, if given at too high of a dose, the newer medications may lead to problems such as social withdrawal and symptoms resembling Parkinson's disease, a disorder that affects movement. Nevertheless, the newer antipsychotics are a significant advance in treatment, and their optimal use in people with schizophrenia is a subject of much current research (Nimh, 2007). However an children who has received medication treatment based interventions will have the ability to better cope with tribulations.

Counter Argument:

There are parents who support COS without the use of medication intervention. These caregivers believe in a more holistic approach to dealing with COS. The holistic approach includes: the child's caregivers, school as well as doctor and community; they can implement strategies to help a <https://assignbuster.com/what-is-childhood-onset-schizophrenia-psychology-essay/>

child's successes without the use of medications. It takes a village to raise a child this means if the child has a great support system surrounding them it can be possible for them to do well without the use of medication. From an ecological perspective if the risks in a child/youth life overpower the positive factors the child/youth are at a greater destitution of environmental events and transitions over the course of life.

Some would agree with this point because a youth can build up a natural resilience to cope with their dilemmas. This in fact can be stronger than youth who have been exposed to early interventions. Because they have learned to either fight or flight when it comes to difficulties they may face. Youth are able to demonstrate the fight or flight theory when it comes to adjusting to their context without any major downfalls, they can better become accustomed when adapting to lives trials and tribulations.

Many families choose to support their child who has been diagnosed with COS with cognitive therapy. Cognitive therapy with COS patients involves education about schizophrenia, including treatment options, social skills training, relapse prevention, basic life skills training, and problem solving skills and strategies (AACAP, 2001). Social skills and basic life skills training can overlap, as children learn the age-appropriate skills necessary to function in their environment. This often includes communication skills such as eye contact, assertiveness and self-advocacy training, conversation skills, coping strategies, and basic self-care skills, such as grooming and hygiene, cooking, basic money management skills, and vocational training (Dulmus & Smyth, 2000). Many of these skills should be taught within an educational

setting and worked into a systematic classroom curriculum (Gonthier & Lyon, 2004).

This continues into early school age, when impairments in attention and behavior begin to manifest, affecting school performance. Because of these impairments, it is often the child's teacher who first notices early problems (Brown, 1999). The real onset of schizophrenia consists of four phases through which children continue to cycle corrosion increases with each cycle. Nevertheless more or less 10 year after initial cycle the acute phases tend to diminish. The first phase of COS is the prodromal phase, which involves some type of functional deterioration prior to the onset of psychotic symptoms. This can include social withdrawal, isolation, bizarre preoccupations, deteriorating self-care skills, and physical complaints, such as changes in sleeping patterns or appetite. These changes can occur swiftly or the child's abilities may steadily decrease over time (DeCesare, Pellegrino, & Yuhasz, 2002).

Amount of time during a one-month period: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms including flat affect, deficiency of speech, or lack of resolve (American Psychiatric Association [APA], 2000, p. 312). Duration of these symptoms may be shorter if they respond well to treatment. Only one of the aforementioned symptoms is necessary if " delusions are bizarre or hallucinations include a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other" (p. 312). In addition, the person must show a deterioration of social, occupational, and self-care functioning. With children this can include the "<https://assignbuster.com/what-is-childhood-onset-schizophrenia-psychology-essay/>

failure to achieve expected levels of interpersonal, academic, or occupational achievement” (p. 321). Symptoms must be present for at least 6 months. There is, on average, a 2-year delay between the onset of psychotic symptoms and a diagnosis of COS (DeCesare et al., 2002). Several studies have been completed examining the suitability of the adult DSM-IV criteria for child and adolescent onset schizophrenia (Hollis, 2000; NIMH, 2001; Schaeffer & Ross, 2002). These have found that there is a high degree of consistency between the two disorders in terms of symptoms, anatomical findings, physiological changes, and genetic presentation. One commonly recognized difference between the child- and adult-onset types is that, in children, psychosis develops gradually, without the sudden psychotic break seen in adults (Rapaport, 1997). Also, it should be noted that the poor functioning found in children with COS is more a result of failure to acquire skills rather than deterioration of skills, as is found in adult schizophrenics (Gonthier & Lyon, 2004).

Late-onset Schizophrenia

Just like there is early onset schizophrenia that begins early in childhood, there is also late onset schizophrenia. Late schizophrenia is a range of clear as beginning after the age of 40 or 45. Its accurate occurrence is unclear, but not rare. It seems possible; clinically late-onset schizophrenia is similar to the earlier onset variety except for having a predominance of females affected. Having more schizoid and paranoid delusion and more visual, tactile, and olfactory smell hallucinations, and having fewer “negative” symptoms or thinking disorders (Torrey, 2001). Symptoms of late

schizophrenia are similar to those in early-onset schizophrenia, especially paranoid type.

To diagnose LOS, the patient should meet the DSM-III-R (2) criteria for schizophrenia (including duration of at least 6 months), with the additional requirement that the onset of symptoms (including the prodrome) be at or after age 45. The prototypical patient is a middle-aged or elderly person who functioned moderately well through early adulthood (despite some premorbid schizoid or paranoid personality traits) and who exhibits persecutory delusions and auditory hallucinations and shows some improvement in positive symptoms with low-dose neuroleptic therapy, yet has a chronic course (Harris, 2000).

Effects of Medication on Cognition in Late-Onset Schizophrenia

It can be argued that some of the neuropsychological deficits in schizophrenic patients may be due to the effects of medication. There is evidence that anticholinergic drugs can interfere with cognitive functioning, especially learning and attention (21, 62). Typically, learning impairment is associated with higher anticholinergic dosage or acute change in anticholinergic medication regimen. In terms of the reported effects of neuroleptic drugs on cognitive and psychomotor functions in patients and normal controls, there has been some variability and inconsistency in the literature (34). In general, sedative phenothiazines have been found to depress psychomotor function and sustained attention, but higher cognitive functions are relatively unaffected. In the majority of studies of schizophrenic patients, both cognitive function and attention improved with neuroleptic

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treatment, in parallel with clinical recovery. In general, the studies of neuropsychological effects of neuroleptic therapy have not been addressed specifically in older schizophrenic patients.

Childhood onset schizophrenia is persistent; it affects all areas of development and functioning. The symptoms vary significantly from one person to another making it difficult to determine what symptoms are “core” or identifying features. Childhood psychoses such as pervasive developmental disorder is very similar to childhood onset schizophrenia it is difficult to identify the difference between the two disorders because the characteristic overlap this makes it difficult when it comes to diagnosing a child who can be potentially be suffering from one of the two disorders.

Conclusion

Such a disease, which disorders the senses, perverts the reason and breaks up the passions in wild confusion-which assails man in his essential nature-bring down so much misery on the head of its victims, and is productive of so much social evil-deserves investigation on its own merits, by statistical as well as other methods.... We may discover the causes of insanity, the laws which regulate its course, the circumstances by which it is influenced, and either avert its visitations, or mitigate their severity; perhaps in a later age, save mankind from its inflictions, or if this cannot be, at any rate ensure the sufferers early treatment.