Editor's note: From its first issue in 1900 through to the present day, AJN has unparalleled archives detailing nurses’ work and lives over more than a century. These articles not only chronicle nursing’s growth as a profession within the context of the events of the day, but they also reveal prevailing societal attitudes about women, health care, and human rights. Today’s nursing school curricula rarely include nursing’s history, but it’s a history worth knowing. To this end, From the AJN Archives highlights articles selected to fit today’s topics and times.

For many years, autism was thought to be a type of childhood schizophrenia. In AJN’s May 1958 issue, an article entitled “Childhood Schizophrenia” describes the inpatient treatment of children with autism. Some parts of it are difficult to read, not because the actual treatment was painful or torturous, but because experts decided that children needed to be away from their parents in order for treatment to be successful. The authors of this article, a pediatric psychiatrist and a psychiatric nurse educator, write, “Because the mother’s role is so significant in the child’s development . . . in almost every instance, the schizophrenic [autistic] child must be removed from its ‘sick’ mother in order that adequate remedial measures may be instituted.” To read the full article, go to http://links.lww.com/AJN/A175.

Today, autism spectrum disorder (ASD) is recognized as a neurodevelopmental condition that probably begins during the prenatal to early postnatal period. In this issue, authors Deborah Christensen and Jennifer Zubler provide an update on ASD risk factors, epidemiology, diagnosis, and treatment in “From the CDC: Understanding Autism Spectrum Disorder.”

CHILDHOOD Schizophrenia

The nurse must have an infinite quantity of patience, devotion, and understanding to be able to accept the bizarre behavior of children afflicted with this most serious of mental disorders.

Eugene I. Falstein • Helen A. Sutton

There was a time, not too long ago, when a nurse’s education and experience were considered quite complete without her ever having any experience with childhood schizophrenic disorders. Several factors in recent years, however, have contributed to an ever-increasing need to deal with these very serious problems. More child care units are being established in both general and psychiatric hospitals. Markedly improved diagnostic methods have enabled us to better differentiate between the organic and functional, the mentally retarded and the schizophrenic. Such developments have given rise to many new hospitalized groups of mentally sick children which constitute a real challenge to the nurse and the care she has to offer (1,2,3).

Under the general heading of childhood schizophrenia are classified a number of clinical syndromes all having in common an arrest of the ego (personality) development, usually accompanied by a regression or reversion to earlier and more primitive thinking, communication, and behavior. Very carefully taken histories of the earliest developmental stages in these children will usually help in differentiating them from the mentally defective, since there always should be some evidence of what seems to have been normal development up to the point at which deviant symptoms appeared. Obviously, the most difficult cases to differentiate will be those in which the developmental arrest presents itself within weeks or a few months following birth; such cases are quite rare, however.

More commonly, one may observe children who during the first or second year of life, or at some time before the fifth year, begin to withdraw from relationships and contacts with the people around them. They refuse to communicate by talking, even though they may have already learned to do so. These children are said to be suffering from infantile autism and they constitute the bulk of the youngest schizophrenics that one is called upon to treat. Many such children were formerly regarded as mental defectives and institutionalized as such. It is a general axiom in the field of psychiatry that the earlier a schizophrenic illness strikes, the more dubious is the prognosis. These autistic children, unlike older children and adults, have no ego strength to return to after their psychotic symptoms have abated. One must literally start from scratch with them. On the other hand, a child who has seemingly developed “normally” for at least five or six years may manifest schizophrenic symptoms at any time thereafter, but some of the manifestations of his illness will be on a higher developmental level than those usually observed in the autistic children. In many older children, the clinical picture actually differs little from that seen in adult schizophrenia.

Of course, children who suffer from some degree of mental deficiency or organic brain disease may develop a complicating schizophrenic disorder, actually there may even be an additional predisposition to such illness because the ego is weakened by the pre-existing disorder. Another psychiatric axiom is that, usually, the more sudden and acute the schizophrenic reaction is, the more favorable is the outlook. In most of the children we are considering, however, carefully elicited histories will often disclose long-standing abnormalities in thinking and behavior that have been overlooked by those who would like to regard the illness as a new and sudden development. Consequently, the great bulk of these youngsters are
considered extremely ill, and many of them seem, to intents and purposes, to be incurable. The general conclusion from several studies is that an autistic child who has not developed or has acquired verbal communication is relatively doomed, in spite of advances in treatment, is concerned. We should mention, however, that acute recoverable and curable cases of schizophrenia are observed, usually in older children.

Roughly speaking, one can say that an individual is psychotic when he has never fully developed, or has lost, his reality testing capacity—the ability to distinguish what is real from what is imaginary. To differentiate the self from the various objects and people in the surrounding world. This reality testing function appears during the first year of life under favorable circumstances encompassing loving and mature maternal care. In all of our childhood schizophrénias it is this function which is never fully established, or is lost, either partially or completely.

Because the mother's role is so significant in the child's development and, of the six or seven factors contributing to it, the child's interaction with the mother is one of the most important. This interaction is not a reenactment of the relationship between the mother and her own parents but a development of the mother's own behavior patterns. Although schizophrénic children who are the product of a chronic illness and who have been institutionalized, have been studied and treated in a number of children's psychiatric hospital units, little has been recorded concerning the nursing care of these children. Bowen reported a project in which children with infantile symptoms were treated as infants by nurses as a means of giving the children's confidence in order to achieve gradual retraining (4). Bext described the response of withdrawn autistic young children to an atmosphere of emotional warmth and permissive acceptance created by the nurses (5).

In both of these approaches to the treatment of severe psychiatric disorders of children, the nurses were considered therapeutic agents acting in close collaboration with, and under the direction of, child psychiatrists.

The nursing care program described here was developed over a period of five years in a 12-bed private children's psychiatric hospital unit. There, youths suffering from various psychiatric disorders were diagnosed and subsequently treated with a long-term basis by intensive individual psychotherapy, a remedial school program, occupational therapy, and the milieu of group living in which the child is involved. For the child, the hospital is a special program comprising the same general elements but adapted to their special needs, was devised.

**Special Problems, Special Needs**

When the schizophrénic children mingled with the others, a special program was developed for them, certain problems were evident. They wandered about and secluded themselves in remote places, such as attics, toy chests, and closets, where supervision was difficult, and they had little human contact. They laughed or cried or sang or said things they should not have known. They were the victims of frightening and disturbing attacks by aggressive children. The schizophrénia of children was a reality. They were not the idiosyncrasies of a few individuals. All schizophrénic children were tremendously preoccupied with their bodily functions, but have difficulty in differentiating their bodies from those of people in the world around them. It is thought to be one source of their great anxiety (6). As the child becomes physically mature, the nurse can help the schizophrénic child in many ways to identify his own body and its parts, differentiating it from himself and others, while the same time offering a protective defense to him. Several of the schizophrénic children spoke of themselves in the third person. The nurse's clear use of the pronouns "I" and "you" as she talked to the child was important in helping him to integrate his own self in himself.

Another factor in the nurse's integrative function is the control of disruptive impulses which often overwhelm the ego of the schizophrénic child. His very actions and those of the other children. Attempts to interest them in these organized programs were met with tantrums, increased masturbation, destructibility, and intensified autistic preoccupations. Their anxiety, whenever they were confronted with demands from the real world, was pronounced. When left to themselves, they were absorbed in solitary, ritualistic play with toys, or in bodily preoccupations such as sucking various objects, body-rubbing, skin-picking, and head-hugging. These preoccupations could be interrupted only with great difficulty by the nursing personnel even for such minimal care as bathing, eating, dressing, and going to bed.

**A Pattern Emerges**

Although any plan for nursing care must be built upon the individual patient's needs, a certain pattern of care appeared to be common among these children. First, they had the universal emotional need for mothering which is manifest in all children who are separated from their parents. In addition, these children, regardless of their chronological ages, needed help in integrating their bodies and minds into the world around them. It is thought to be one source of their great anxiety (6). As the child becomes physically mature, the nurse can help the schizophrénic child in many ways to identify his own body and its parts, differentiating it from himself and others, while at the same time offering a protective defense to him. Several of the schizophrénic children spoke of themselves in the third person. The nurse's clear use of the pronouns "I" and "you" as she talked to the child was important in helping him to integrate his own self in himself.