It is rare for children to be diagnosed with a psychotic disorder. This can be understood in terms of the low prevalence of this disorder in children, but also the hesitation of making such a diagnosis. If a child exhibits some unusual behaviour, the first impulse may be to say that the child has an active imagination and to hope the child is going through a phase. Sometimes parents fear for their child’s mental health if the child reports hearing voices (e.g., auditory hallucinations). Auditory hallucinations or hearing voices occurs for about eight percent of children (Escher et al., 2004). This experience can be attributed to many factors beyond psychosis. More commonly, this is related to other anxieties the child may be experiencing, such as with problems in the family or at school (Escher et al., 2004).

Childhood-Onset Schizophrenia (COS) is a progressive neurological disorder that causes significant distress and disability (Rapoport & Gogtay, 2011). Rather than being a distinct form of schizophrenia, COS is a rare and possibly more severe form of schizophrenia that has an onset prior to age 18 and worse long term outcomes (Kyriakopoulos & Frangou, 2007).  While there are variations in the symptoms, schizophrenia is understood as involving bizarre delusions (false beliefs), hallucinations (false perceptions), thought disturbances, grossly disorganized behaviour, or catatonic behaviour, the latter of  which include motor dysfunctions ranging from wild agitation to immobility (Psychiatric Association [APA], 2013).

On October 6, 2009, Oprah Winfrey featured on her talk show a seven year-old girl named Jani Schofield, who is diagnosed with Childhood-Onset Schizophrenia. Jani is able to express how she lives between two worlds; she has hallucinations, where she sees many animals that no one else can see. Some of them, such as the rat named Wednesday, are sinister, and direct her to take violent action towards herself and others.

Symptoms of schizophrenia fall into two categories. Familiarize yourself with the two symptoms outlined below:

**Positive symptoms** (also called psychotic or active symptoms) of schizophrenia involve disturbances in normal functioning and include delusions or hallucinations, and in rare cases catatonia (Mash & Wolfe, 2013). Mash and Wolfe (2013) reported that “the most common presenting symptom for children with schizophrenia is auditory hallucinations, which occur in about 80% of patients who have an onset of COS prior to age 11” (p. 189).  Dr. Judith Rapoport from the National Institute of Mental Health (http://www.oprah.com/health/Childhood-Schizophrenia-Symptoms-and-Causes/1) commented that when children with schizophrenia hear voices, it is quite different from other children with imaginary playmates:

…these voices are usually quite strange. The child will be looking, often up, say at the ceiling, and talking and laughing in a way that seems quite inappropriate… It just doesn’t have the same feel, and often the voices are telling them very bad things-talking about death, talking about things that a child should do or that might be done to them.

**Negative symptoms** of schizophrenia may include slowed thinking, slowed speech and movement, emotional apathy, lack of drive, indifference to social contact and self-neglect (APA, 2013).

Outcomes for individuals living with schizophrenia are greatly improved over what they once were. Current treatments for COS emphasize the use of antipsychotic medications (e.g., clozapine, risperidone) combined with psychosocial supports such as family interventions, social skills training and the use of cognitive-behavioural therapy (National Institute of Health and Clinical Excellence, 2013).

Regarding medication, adverse effects with antipsychotic treatments are prevalent and are associated with reduced adherence to treatment (Tiffin, 2007). Depending on the type of medication, side effects can be serious and may include motor dysfunction (e.g., tremors), weight gain or sedation. It is extremely important that the side effects, as well as the administration of antipsychotic medications be carefully monitored (Tiffin, 2007).

Although there is still much to be learned to better understand the etiology of the disorder, schizophrenia can be understood via the Gene-by-Environment Interactions (GxE) philosophy. The GxE philosophy suggests there is an interplay between genetic and environmental factors (Parritz & Troy, 2014).  While there is a clear genetic link with schizophrenia, there appears to be other environmental factors which may contribute to the development of the disorder, such as exposure to infectious diseases, toxins or traumatic insults and stress during the gestational or postnatal period development (Arseneault et al., 2011).

About 70% of children and adolescents with COS met criteria for another diagnosis, most commonly mood disorder or oppositional/conduct disorder (Russell, Bott & Sammons, 1989).  About 10% to 20% of children and adolescence with COS display impairments in attention, memory and executive functioning, as well as global intellectual deficits (Frangou, 2013).  Hall and Bean (2008) noted, “In instances where individuals are dually diagnosed with early onset Schizophrenia and autism/mental retardation, long-term hospitalization or even more intensive services are often required” (Hall & Bean, p. 62).

There are extreme measures that some families have to take to cope with their child’s schizophrenia and keep their family members safe. Parents may become concerned for the safety of siblings when violent episodes are occurring in a psychotic state. For example, parents may resort to living in two apartments in the same complex and dividing their time between their two children. This is a very extreme example. More often, families have to deal with scheduling disruptions that may come with hospitalizations and medical appointments, and they will also have to tailor their level of response to how the family member with schizophrenia is coping.

The chronic illness literature suggests siblings of those living with a chronic illness like schizophrenia navigate a diverse range of feelings and emotions such as guilt, fear, anger, jealousy and sadness (Daneman, Frank & Perlman, 2010). To protect against the identified feelings, it is essential to engage siblings in age appropriate roles which aim to support their sibling living with schizophrenia.  Furthermore, it is important for parents to be mindful of the amount of quality time they afford their healthy children.

According to Mash and Wolfe (2013) schizophrenia is extremely rare in children under 12 years of age, and therefore is diagnosed more often in adolescents than in younger children. Research suggests COS is more prevalent in males than in females (p. 190).

Adolescents with schizophrenia have often reported difficulties with peer relationships. Their tendency to withdraw from others can be investigated further to see if they are choosing this or think they need to isolate due to feeling ostracized. Many express that schizophrenia is a painfully lonely condition (Mackrell & Lavender, 2004).

Another complication when assessing the wellbeing of adolescents is substance use. Youth with schizophrenia can also use substances (alcohol and/or drugs) as a form to self-medicate. One 17-year-old girl reports, “I used alcohol to try to escape the voices in my head. It would work for a time, but not perfectly” (Hall & Bean, 2008, p. 62). There is also a correlation between an adolescent’s use of drugs and an increased likelihood of developing schizophrenia (Hall & Bean, 2008). Even after a clear diagnosis of schizophrenia, if an adolescent continues to use illicit drugs, this can interfere with prescribed medication and potentially the young person’s willingness to take the prescription (Hall & Bean, 2008). Hall and Bean (2008) stressed that mental illness does not necessarily mean the individual will be violent:

Therapists should be aware of how the media often sensationalizes any violence committed by someone with a mental health issue, especially if the person was psychotic at the time of the violent act. Overall contributions to crime in society by individuals with schizophrenia are relatively small and certainly not a rule. Assuming that a client is violent without supportive evidence can hinder the formation of a healthy alliance, which has been shown to be crucial to recovery (p. 65).

An initial, and ongoing, biopsychosocial assessment by a team of multidisciplinary professionals is essential for monitoring the progress of the child diagnosed with COS, and his family. Furthermore, a biopsychosocial assessment is important for optimal opportunities of preserving the overall mental, emotional and physical wellbeing of the child and his family.

For example, it is important for medical professionals to assess and to intervene, as needed, to concerns related to the child’s biological make-up as it relates to living with COS (e.g., medication adjustment, tending to other biological conditions which may surface as a result of living with COS).

Practitioners specializing in the area of counselling therapy can address concerns related to the child’s (or his family) mental and emotional health. As discussed earlier, family therapy and the use of cognitive behavioural therapies have been identified in the literature as helpful in assisting children with COS and their families (National Institute of Health and Clinical Excellence, 2013b).

Practitioners with a level of expertise in grass-roots work with families and children can assist the child with COS and his family with navigating day-to-day practical issues such as engagement with social support groups, advocacy within multiple systems (e.g., school, child welfare, and health care), relationship and family intimacy strategies, and with issues such as day-to-day problem solving.

Lastly, Hall and Bean (2008) encouraged the practitioner to keep cultural considerations in mind; perhaps it is the norm for people of a certain culture to communicate with deceased ancestors, for example. It is particularly important to attend to symptoms of psychosis when working with adolescents since there is a higher risk for suicide ideation (Hall & Bean, 2008).