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THE PROBLEM OF AVOIDING THE DIAGNOSIS OF PSYCHOSIS IN CHILDHOOD AND ADOLESCENCE

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INTRODUCTION

the diagnosis of Infantile Psychosis was used since the beginning of the century, both by psychiatrists and psychoanalysts, and has always aroused heated debates. However, when it was removed from the classifications of hegemonic mental disorders, it left a theoretical and clinical gap, which seeks to be repaired by new nosologies.

Instead, many psychotic manifestations have been subsumed under Autism Spectrum Disorder. This change in nomenclature is not without consequences, and causes great difficulties for those suffering from psychosis as well as for their families and the institutions in which they try to be inserted. On the other hand, this absence of diagnosis produces confusion in the forms of evaluation and approach to this condition. Subjects are then left at the mercy of different labels such as *autistic*, *Asperger*, or around an intellectual deficit, or even the disconnection with reality typical of psychosis is simplistically catalogued with the merely descriptive name of attention deficit.

Psychoanalysis, on the other hand, continues to think of psychosis as a psychic structure characterized by the use of disesteem, the appearance of delusions and hallucinations, possibly beginning in childhood and resulting from a pathological structuring of subjectivity.

OBJECTIVES

To make visible through clinical vignettes the existence of psychosis in childhood and adolescence.

To problematize the use of standardized diagnostic and therapeutic approaches in subjects with psychosis.

To alert about the negative consequences of the lack of diagnosis of psychosis in childhood and adolescence on those who suffer from it and their environment; such as the lack of adequate medication because they are not referred to Psychiatry.

Invite reflection on early excessive exposure to screens as a triggering factor of the outbreak.

INTRODUCTION: The diagnosis of infantile psychosis was used since the beginning of the last century, as much by psychiatrists as by psychoanalysts, and has always awakened arduous debates. Such theorizations and therapeutics were addressed by Melanie Klein (1946) and Margaret Mahler (1968), as well as by Bion (1956) and Winnicott himself (1965) just to give some examples. However, its removal from the hegemonic mental disorder classifications has left a theoretical and clinical gap, which seeks to be repaired by new nosologies; it could be said that the concept of Childhood Psychosis "has been dismissed" by science. Instead, many psychotic manifestations have been encompassed mainly in both the former PDD Pervasive Developmental Disorder of the DSM IV Diagnostic and Statistical Manual of Mental Disorders (1994), and Autism Spectrum Disorder of the current DSM V Diagnostic and Statistical Manual of Mental Disorders (2014). However, when reading carefully, in the latest edition of the manual, in its criteria on Schizophrenia and Psychosis, we find the clarification that they could have onset in childhood. But they are not found as version number IV within the Childhood Onset Disorders, since currently an extreme biologicism considers all disorders that begin in early stages as belonging to Neurodevelopment. Paradoxically, in the section on Differential Diagnosis within Autism Spectrum Disorder ASD it specifies: Childhood-onset schizophrenia usually develops after a period of normal or near-normal development. A prodromal state has been described, in which social impairment occurs and atypical interests and beliefs appear, which could be confused with the social deficits seen in ASD. Hallucinations

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and delusions, which are the defining features of schizophrenia, are not features of ASD (Diagnostic and Statistical Manual of Mental Disorders DSM V 2014, p 58).

In the section called Spectrum of schizophrenia and other psychotic disorders specifies the same manual: they are defined by abnormalities in one or more of the following five domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior and negative symptoms. (Diagnostic and Statistical Manual of Mental Disorders DSM V 2014 p. 87) Continued: the essential features of schizophrenia in childhood are the same, but it is difficult to make the diagnosis. In children delusions and hallucinations may be less elaborate than in adults, and visual hallucinations are more frequent and should be distinguished from normal fantasy play (Diagnostic and Statistical Manual of Mental Disorders DSM V 2014 P. 107).

The question arises: what is the reason for such a recondite and even unknown place for many health professionals of child psychosis? That is to say, if we do not read the "fine print" of the manual in its fifth version, the diagnosis of psychosis in children or adolescents seems non-existent and impossible to be granted. The ethical commitment when we work in Mental Health confronts us with a reality: behind these diagnoses there are people, suffering subjects, who may be children. Children suffering from terrifying hallucinations, highly structured delusions, megalomaniacs, erotomaniacs, and even mystics that sometimes lead them to put their physical integrity and that of others at risk; and even worse, they are forced to suffer these psychopathological manifestations in solitude, and often without even being able to belong to a nosological category that could give a name to so much suffering.

Beliefs of all kinds continue to cloud the vision of their families, such as spiritual factors, magic, demonic possessions as if we were in the Middle Ages, and in extreme situations before psychological consultation, they have resorted to exorcists and "healers" of all kinds who in the midst of a psychotic outbreak tried to remove the demon or the spirit that supposedly possessed them. It is hard to imagine a child with hallucinations being ordered to stop moving or laughing for no reason. But as Freud already taught us, within all popular belief there is a knowledge, since in reality these children are often the spokesmen of a pain that does not belong to them, and that may even come from several previous generations in which unsymbolized contents circulate as secrets, going from the unsaid to the impossible to be thought. From the position of Serge Tisseron (1995): the unspeakable, then becomes the unmentionable and in the third generation the unthinkable. It is not only the spiritual response that comes into play, previously, when supposing or simply considering the possibility of a psychopathology, the etiological hypotheses point to the body. In the most flowery moment of the picture, the so called positive manifestations are those that ignite the alarm in the family ending in transitory internments in which they are submitted to all type of medical studies, throwing in all the cases that I will take as clinical vignettes negative results, that is to say, no organic causes are found (structural or functional) verifiable that can explain the negative or positive symptoms of the psychotic picture.

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CLINICAL VIGNETTES

Clinical vignette n 1: 7 year old boy, according to the grandmother (who was in his care) abrupt onset of symptoms: he *cannot sit still, he moves his hands without stopping as if he wanted to grab something, he cannot sleep, if he does he has terrifying nightmares from which he cannot get out when he wakes up, he seems to talk to someone else, he laughs for no reason, fights with several people that nobody else sees...* Faced with these clear psychotic manifestations he is admitted to a private pediatric health center, where he constantly hallucinates, showing himself terrified. He underwent all kinds of neurological studies, including MRI, CT scan, spinal cord puncture, blood and urine tests, among others, without finding any alteration. When he was admitted to the mental health department of the same institution, after being evaluated by several psychologists, social worker and psychiatrist, he was discharged two days later with the diagnosis of anxiety disorder, without any medication. Upon returning home, the psychotic manifestations intensify, entering into moments of mutism and absolute disconnection with reality and hermeticism. At times he does not even recognize his grandmother. When he comes to my office accompanied by his grandmother, I find a terrified child looking behind my shoulders and curled up on the couch in a fetal position. I offer him to draw, and very fearfully he agrees; his graphics in extreme disorganization are huge, with ghostly facial expressions and all with empty eyes. That same day I give the diagnosis of Psychotic Break to the grandmother who extremely distressed agrees to another psychiatric consultation. After approximately one month of onset, and after the appropriate administration of antipsychotics, the positive manifestations gave way to be able to think and reconstruct everything that had happened. I emphasize, this child was one month in a constant hallucinatory state in a state of absolute desperation of him and his grandmother, the only family of the child in Argentina. Consequently, the absence of differential diagnosis produces confusion in the evaluation and specific approach to child psychosis. So, what leads health professionals to dismiss psychotic manifestations in childhood and adolescence? The soliloquies with sometimes terrifying, violent, hypersexualized characters are minimized as "imaginary friends", the psychomotor excitation as hyperactivity or rebelliousness, disobedience, that sometimes families even try to dominate with punishments of all kinds; the megalomaniac fabulations or answers are taken as lies, the disconnection with reality, the apathy as attention deficit... or even as unwillingness to perform school or daily life tasks.

In order to establish distinctions in the diagnosis, psychoanalysis considers infantile psychosis as a pathological structuring of subjectivity based on disesteem with delusional and hallucinatory manifestations. In 1924 Freud affirmed, in his text "The loss of reality in Neurosis and Psychosis", in Psychosis: the remodeling of reality takes place in the psychic sediments of the links that until then had been maintained with it, that is, in the mnemic traces, representations and judgments that had been obtained from it until then and by which it was subrogated to the interior of the psychic life (...) the psychosis has the task of obtaining perceptions that correspond to the new reality, which is achieved in the most radical way by means of hallucination. (Freud, S. p.195).

Vignette n 2: Schizophrenias tend to lead to affective apathy. Neurosis and Psychosis (Freud, S. 1924.p 157).

N.'s parents are consulting a psychologist for the fifth time; they have already seen three neurologists, three educational psychologists and a psychiatrist. They have never received a diagnosis about their daughter's difficulties,

except for one neurologist who told them that it could be a case of Asperger's disease. N. is 16 years old at the time of the consultation, her mother reports that: she has always been "strange", difficult to understand, very lonely, she had a few friends; during the pandemic she was fine, calm because she did not have to leave the house. At school she is doing very well but does not like to go, at times she has been seen laughing by herself as if she was talking to someone but they did not give her any importance. Also this year she chose to use a different name both at school and on social media.

Regarding her developmental history, her mother highlights as most significant the lack of emotional connection she felt at birth, which was further aggravated by difficulties in breastfeeding, which the doctors explained was a consequence of food allergies. Upon entering puberty, N. presented episodes of insomnia, tachycardia, unexplained sensations in her body... the psychopedagogue she was attending told them it was anxiety due to lack of physical activity. Digging deeper, directly in the interview with N., I inferred that it could be phenomena of depersonalization and derealization, which resulted in long sleepless nights. On entering the consulting room N. laughs, she says that her mother is still looking for an answer to how she is, "poor nobody helps her". She goes on to say that she does not want to be in the interview, that she is fed up with evaluations, "I already know everything you are going to ask me, I have to draw everything (she answers mockingly), everyone thinks I am autistic but as a child I played (she had researched on the internet and read that autistic children do not play), I played with dolls, but everyone stayed away from me because they did not understand my jokes, they tell me that they are cruel. I never liked sports, I didn't really understand them, nor did I understand when I was little how to talk to other kids. When I was about 10 years old I couldn't think about myself; I had nowhere to hold on to. I felt stupid, I started writing those insults on the computer. Can I go now? It's very hard for me to organize my ideas before I say them... everything I want to say gets mixed up, I'd rather write... or draw... Please, I'm tired.

When I see her enter N. I see a rigid body that moves in a discompassionate way as if it did not belong to her, her clothes are very peculiar, almost bizarre, she holds her gaze deeply, she does not impress any kind of accent that does not correspond to her medium, she does not present any kind of mannerism or stereotypicality. His graphics present transparencies, overlapping of figures, very weak strokes, they are blurred. Expressions convey sadness and despair. After holding interviews with both parents, and three interviews with her, I give the diagnosis of psychotic structure, although not yet triggered; I explain and clear all the doubts about autism, and the possible future consequences as well as alarm signs (insomnia, soliloquies, unmotivated laughter, excessive anxiety or anguish, mutism). I stress the importance of not forcing her to participate in social situations in which she does not feel comfortable (N. made an enormous effort to organize her ideas when having a dialogue). The mother is immensely grateful, relieved, and even expands on how difficult the pregnancy and the first years of N.'s life had been and relates it to her own childhood, recalling a history full of losses and situations not yet understood by herself. The fact of not knowing her daughter's diagnosis plunged her mother into enormous anguish while at the same time she tried to connect N. with situations, interests, people, which paradoxically, generated an increasing disconnection and rejection of reality. The diagnosis of psychosis in childhood and adolescence cannot be

made with standardized assessment methods, sometimes based more on the responses of parents than on the patient's own discourse. It implies putting the body, the look and the listening to that suffering subject; often this takes several sessions of much emotional wear for both the patient and the psychologist, since there are transferential and counter-transferential movements of enormous intensity. Is it perhaps the encounter with pain and psychic suffering so explicit that leads to the dismissal of psychosis in childhood? Is it a resistance of mental health professionals? Does it go hand in hand with this almost total non-existence of diagnosis in the hegemonic psychopathological nomenclatures? What do these subjects and their families do with such heartbreaking pain? On the other hand, it could be considered an earlier onset of the psychotic break, in line with this; can we think of the excessive early exposure to screens as a triggering factor of the psychotic break? It is known by all, that there are children who have access to screens from the first months of life without any kind of limit or supervision, in which they can have access to contents of a lethal, aggressive or sexual order that, not being mediated by words, do not find any possible psychic inscription, and therefore return from outside the psychic apparatus as that which has been forcluded. It is evident the failure of the protective anti-stimulus apparatus which, far from acting as a protective screen, exposes the baby-child to stimuli that are excessive for the psychism under construction, and which we could hypothesize, then return compulsively in an attempt of inscription.

If, instead of a psychopathological diagnosis, parents (family) receive a diagnosis of a neurodevelopmental disorder (such as ASD, ADHD, intellectual deficit), this makes it even more difficult for them to become involved in the treatment of the child or adolescent. Through this diagnosis, the child or adolescent is placed as an object to be cared for, educated, adapted, and further distanced from the possibility of being seen as a subject that can survive differentiated from the alienating identifying labels that have been assigned to him/her. If the answer of science is purely biological and points to neurological development, there is little room left to question, to doubt, to make possible changes, to listen even to the content of delusions and hallucinations, to be able to even think of this child as the suffering subject who is being the spokesperson of what has been unsaid in the family for several generations. Only when the content of the delirium is heard, when the account of the hallucinations is taken as the most direct expression of the psychic reality of that subject, will we be able to bring back through construction as a clinical tool the kernel of truth that is hidden behind the apparent undifferentiated chaos. "Heresy is to show the stark and naked truth", says intuitively the poet Ismael Serrano (2007). The psychotic subject puts in evidence and denounces the family secrets, the unsaid, the unthought, the unsymbolized and because of that dismissed. Is there anyone who dares to listen to that truth? The psychologist together with the subject's family must return this metabolized material and thus build together a family myth that gives some sense to the apparent meaninglessness of psychosis.

P. is 14 years old. She has lost both parents. Her only relative is an aunt. Since she was a child she has been diagnosed with the label of "maturational delay", since in her speech there is an enormous chronological confusion and confusion of places; in her childhood she lived with different neighbors and relatives after the death of her parents. At the age of thirteen she begins with persecutory delusions, there is a man waiting for her at the door of her house to hurt her, she cannot go out for fear of seeing him, she stops eating and cannot sleep. When she is taken to a psychiatric hospital

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for consultation, she is diagnosed with BPD, Borderline Personality Disorder. She is prescribed sleep inducers and a little more stable, she attends my office. Very fearful, she responds to everything with monosyllables, she is hyperalert to any sound. When I ask her about those moments in which she could not answer, with much embarrassment she says that they heard her being called .... Who? "I don't know... they are men... they say hello my love, come here my love". As the sessions progressed, she recounted situations of abuse and rape that had been inflicted by her brothers and even a neighbor. In other words, this apparent meaninglessness was the only way she could remember the sexual abuse she had suffered in childhood. We constructed together a timeline full of pain and losses that allowed her to locate herself in time and space; taking into account the information provided by the aunt, we found together some organization to the representational chaos that dominated her memories, and that even appeared in her dreams that usually ended in nightmares. Disregarding psychosis results in a child becoming an object to be adapted; for example, in school situations without taking into account how invasive reality, the bustle of peers, academic demands, can be. Sometimes this effort to normalize triggers an outbreak in psychotic structures that were previously stable. With very good intentions, we often try to make them "socialize" and "integrate" without considering that the other person at that moment may be representing some persecutory character for the subject.

Vignette 4: M. is 16 years old and has been diagnosed by a neurologist as ADD since he was 4 years old, according to his mother's words. He has been receiving medication for it since that age, and continues with the same drug with dosage adjustments. M. comes to my office accompanied by his mother, listless, with a stooped posture almost dragging his body. I am struck by his hypotonicity as well as by his speech, he has a very thin voice as if it were an imposture, he seems annoyed with the situation. He says he is there at the school's request, because he sent a drawing of some guns in a group chat, and he has no friends inside or outside the school. His clear disconnection with reality, his impossibility to relate to others than his mother with whom they maintained a clear symbiotic bond, evidenced schizoid features of a weak psychic structure pushed to the abyss with stimulant medication (for attention deficit) and with the obligation to integrate into the school with peers whom he did not know and with whom he had practically never interacted. Following the Argentine psychoanalyst Beatriz Janin, we agree that when we work with children and adolescents we are in front of a "subject in structuring... and therefore with multiple possibilities. However, sometimes more than a subject, a child looks like a doll, a plant... then the first task will be to humanize him/her." (Janin, 2011, p. 185).

In conclusion: What are the problems of avoiding the diagnosis of psychosis in childhood and adolescence? Such avoidance and replacement by other biologistic diagnoses produces the invisibility of the worst possible types of psychic suffering, and places the suffering subject in an even more passive and defenseless position in the face of psychotic manifestations. On the other hand, it can lead to extending the period of positive manifestations beyond what is expected, since it delays the start of medication, and also the relatives, due to the lack of correct orientation, when trying to make them socialize and learn, aim at an adaptation that can paradoxically distance them markedly from reality or destabilize the weak and precarious equilibrium, even putting the subject's own life at risk. Psychoanalysis, as a form of psychotherapy, aims at reducing the psychic

suffering of the patient and his family, directed towards clinical stabilization, accepting the limitations that the structure itself imposes on the subject. Several Argentine psychoanalysts have obtained important therapeutic achievements, at the same time that they present a particular approach characterized by structural interventions such as Beatriz Janin, Velleda Cecchi and Silvia Tendlarz among others. Thus, it does not escape from bearing the intense and massive transference, knowing that only in the encounter with the delirious activity of the subject, something can be heard and read in the chaos and apparent meaninglessness, to be later returned to the patient, as metabolized content that hides from its beginnings a core of truth; Will there be anyone who dares to lend their psyche to undertake such a task?

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