Case Presentation

Early Onset Schizophrenia - Case Presentation -

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Abstract

Early onset schizophrenia (before age eighteen) is a neurodevelopmental disorder characterized by deficits in the following areas: cognition, social interactions, and affect. We chose to present the case of a male adolescent, aged 16, from an urban environment, coming from a disorganized family with a precarious socio-economic status who was brought to the Child and Adolescent Psychiatry Department „Prof. Dr. Alexandru Obregia” Psychiatry Hospital, multiple times (5 admissions in 10 months), for: severe heteroaggressive acts, hallucinatory behavior (imperative auditory hallucinations), disorganized and bizarre delusions, and cognitive deficit. The medical history taken from the mother, together with the clinical and paraclinical examinations, the psychological evaluation and the tests that were performed, endorse our diagnostic of Early Onset Schizophrenia based on DSM IV TR and ICD 10 criteria. Taking into account the particular features of this case, which result from the socio-economic status, the premorbid functioning characterized by a cognitive deficit, and the need to engage the collaboration of the social services, we want to draw the attention to the complexity of this case.

Keywords: early onset schizophrenia, hallucinations, delusion, social services.

Introduction

Recent studies conducted on teenagers with early onset psychotic disorders (including schizophrenia and bipolar disorder) have classified characterizing symptoms in 4 distinct categories: positive symptoms, negative symptoms, behavioral problems, and dysphoria [1]. Positive symptoms are: hallucinations, delusions, bizarre and disorganized thought. Among negative symptoms we mention: paucity of speech and thinking, apathy, abulia, and affect “freezing”. In addition to these symptoms there as an important amount of social functioning deterioration [2].

While treating mental disorders is not an attribute of the social services, supervising chronic patients and solving the social aspects concerning their recovery is [3].

Case Presentation

We present the case of an adolescent male patient, aged 16, diagnosed in our clinic with Early Onset Schizophrenia (EOS) after multiple admissions to the hospital, with symptoms suggesting an Acute Psychotic Episode, during a 10 month’s interval (February 2015 – November 2015).

The adolescent was brought to our department for the first time in February 2015 by the police, in an ambulance, accompanied by his mother for the following: psychomotor agitation, verbal and physical aggressiveness as his mother describes:
“he fights with our neighbors, he threatened us with an axe, he tried to smother his brother and to set a cat on fire”. From his psychical examination, we mention: bizarre gaze, disorganized behavior, aggressiveness towards the medical team, increased suggestibility and suspiciousness. A pharmacological treatment is decided and maintained for a short interval (4 days) due to the fact that his mother checked the patient out of the hospital on demand, against medical advice.

The second event took place in April 2015, when the patient was brought by the ambulance for a severe act of hetero-aggressiveness towards an unknown person (stabbing) after which the patient was found by the police in a state of temporo-spatial disorientation and confusion. The psychical examination reveals: hallucinations and disorganized delusions: “I speak with the vampires in the woods, they tell me to do as they do”, “people tried to hurt me, now I hurt them, their souls ache”, “I follow everybody in order to kill them”, “I kill and set fire to cars all the time, I have money for the gas”, “I am a vampire, I bit my mother, I sucked the blood out of people, I take everybody’s blood to put it in me”, “I let them die without blood”, “I wanted to sell people’s blood to make a lot of money, to get rich, I sold a few kilograms”, “Everybody is searching me, I am prosecuted”. During his admission, under treatment, the patient’s state significantly improved and he was released with the recommendation to continue the prescribed treatment under close supervision.

Due to inadequate supervision and lack of treatment administration, the patient is again admitted to the hospital after kidnapping a 7 month old baby, from outside a church, followed by the baby’s abandonment in a staircase. The psychiatric examination reveals perception distortions, disorders of the thought processes, and a disorganized behavior: “that voice told me to steal the baby and sell him for two millions, to buy cigarettes and food”, “I hear a male’s voice at night telling me to steal, to beat”, “the voice tells me to hurt myself, to cut myself”. During this admission, the patient is aggressive towards the medical staff, threatens to run away, and has repeated flight attempts. Because of the absence of an adequate management of his medical treatment at home, it is decide to use depot injection antipsychotic medication, requiring one day ambulatory admissions to the hospital, at constant time intervals. In addition, social services were asked for help.

Despite this less restrictive treatment form, the family failed show up for its administration at the scheduled dates, and the patient is re-admitted to the hospital, in September 2015, for another severe act of hetero-aggressiveness (stabbing of an unknown person). The psychic examination reveals a disheveled appearance, precarious hygiene, bizarre gaze, hypo-mobile mimic, easily achievable and sustained visual contact, bradypsychia, bradylalia, disorganized behavior (he repeatedly kisses his hands), suspiciousness, and perception distortions: “I speak with Satan at nights, he told me to stab my brother with a knife”. The patient has hyperphagia (possibly caused by medication), mixed sleeping disorder (difficulty encountered while falling asleep followed by a number of awakenings during which the patient eats), and absent insight.

Family history:
Mother – psychiatric condition, she cannot specify the exact diagnostic.
Father – there is no information regarding the biological father.
Maternal grandmother – conduct disorder: “I am crazy too, I was diagnosed here”.

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Stepbrother – age 5, oppositional disorder, the mother says: “he never listens to us, he only does what he wants”.

Older brother – without any known pathologies.

Personal history: information about the pregnancy, birth, postnatal period, and psychomotor development was impossible to gather. The mother mentions a convulsive episode at the age of 5 which was not associated with high temperature. The adolescent was diagnosed in a psychiatric service with ADHD and conduct disorder but his mother cannot specify the prescribed treatment scheme.

Living conditions and smoking habit: the patient lives with his maternal grandmother, his older brother, and the latter’s girlfriend, in a rented, one room house where he shares the bed with his grandmother. Prior to his hospital admissions he was a high-school student in a public school, enrolled in the 10th grade according to the Romanian educational system, with very poor school results. His mother lives in another home with her husband and their son. The patient smokes at least a package of cigarettes a day, depending on how he manages to get cigarettes.

The following investigations were performed in order to formulate the positive diagnostic and distinguish between the differential diagnostics: toxicological exam – negative (excluded substance induced psychosis), routine blood tests and serology of viruses – values within normal ranges (excluded hepatitis B, C, HIV, syphilis, anemia, an inflammatory syndrome), neurological examination and electroencephalography – showed no modifications (excluded epilepsy), computerized tomography – shows an arachnoid cyst, located between the cerebellar hemispheres, and excluded other tumoral processes, psychological examination – based on PANSS and KID-SCID we reached the following 2 conclusions: delusional psychosis and disruptive conduct disorder, together with an intelligence quotient of 43 (RAVEN).

Psychopharmacological treatment:

During admission, a pharmacological treatment was established in order to regulate the symptoms. Hence, typical and atypical antipsychotics, in association with a mood stabilizer and a drug to control for extra-pyramidal side effects were used.

Outside the acute episodes, psycho-education aiming to improve the quality of life both for the patient, as well as his family by detecting the difficulties inherent to this pathology, is optimal.

In this family context in which the administration of the pharmacological treatment cannot be adequately supervised, the social services were involved. Together with the social worker, the family decided for a boarding school where the patient could go to school and sleep during weekdays while his family could take him home during the weekends.

Prognostic: Negative – given the pre-morbid functioning (mental retardation), poor socio-economical status, poor adherence to treatment combined with lack of supervision from his family, the early onset during adolescence and incomplete remission of symptoms under treatment, absence of residential centers for minors with impairing psychiatric disorders especially those from poor social environments. A positive prognostic factor could be that a good interdisciplinary collaboration focused on solutions could raise compliance to treatment and improve the quality of life.

CONCLUSIONS

Early onset schizophrenia is a rare pathology associated with significant morbidity and chronicity as well as with important social dysfunction. Diagnosing schizophrenia in children or adolescents
is challenging since the symptoms overlie those found in other mental disorders, not mentioning the fact that certain developmental factors can complicate the interpretation of psychotic symptoms. After the diagnosis is made, treatment will most likely be intensive and long term, while support from the family and interdisciplinary collaboration remain vital.

REFERENCES
