Obsessional onset in paranoid schizophrenia - Case study
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REZUMAT:
Apariția unei simptomatologii din spectrul obsesiv compulsiv la vârsta adolescenței, cum ar fi fobia socială și școlară, idei obsesive și ritualuri, anxietate marcată, asociate cu antecedente heredocolaterale specifice schizofreniei, ne obligă să ne gândim la un debut precoce de tip obsesional al unei schizofrenii. O dată cu dezvoltarea comportamentului bizar și apariția ideilor delirante și hallucinațiilor, ce necesită de urgență instituirea unui tratament corect antipsihotic și a unei terapii corespunzătoare de resocializare.

Cuvinte cheie: tulburare obsesiv compulsivă, schizofrenie paranoidă.

ABSTRACT:
The appearance of symptoms of obsessive compulsive spectrum in adolescence, such as social and school phobia, obsessive ideas and rituals, marked anxiety associated with specific family history of schizophrenia, compels us to think of an obsession type of early onset of schizophrenia. With the development of bizarre behavior and appearance of delusions and hallucinations, it requires urgent establishment of a fair treatment with antipsychotics and an appropriate therapy of rehabilitation.

Key words: obsessive compulsive disorder, paranoid schizophrenia.

The patient I.A., aged 17, comes in with her grandfather on her mother’s side for:
- psychomotor restlessness
- strange behaviour
- delirious ideas
- auditory hallucination
- physical and verbal aggressiveness towards family members

Family heritage: mother with schizoid personality disorder, father with alcohol consumption (from grandfathers’ reports).

The patient comes from a broken family, and the divorce occurred at the time she was two years old. She is currently living with her mother and grandparents, on the mother’s side.

Premorbid personality: the mother states that “she used to be a gifted girl, a bit withdrawn and not very close to the other kids”, “clumsy”, used to get herself into troubles a lot, we had to watch her all the time.”

In her medical history there are many admissions to the Psychiatric Ward, being diagnosed with: 1. Obsessive- compulsive disorder in 2006, 2. Social and school phobia, with typical symptoms: obsessive thoughts and rituals - licking her hands, the nigger idea that something bad was happening, repeating words like “this is how I calm myself down” and asking her grandmother to repeat, myophobia (washing her hands many times), cluster seizures for no apparent reason, situational anxiety – for which she was administered daily doses of 1mg of Risperidone and 50mg of Fluvoxamine for a year, the treatment being then interrupted, with a semi-normal evolution until final withdrawal in 2010. Although during 2006 the patient showed symptoms of Obsessive- compulsory disorder, we consider these manifestations to match an early obsessive-like debut of Schizophrenia. The patient was in fact administered an additional treatment with antipsychotics during that time, besides the antidepressants recommended for the obsessive-compulsory disorder.

Also, during 2006-2010 there were some integration difficulties at school, decreased motivation for study, some bizarre habits connected to some fields of interest: “she wears make-up when she goes to school, she doesn’t care about studying any more, and since Michael Jackson died she’s started to listen to his music a lot”; socializing was poor, the patient being rather isolated from her age group.

During the next hospital admissions (2010-2011) some positive symptoms develop: interpretation- “this boy gave me a bad look, he’s laughing at me”, delirious ideas about filiations- “I’m Michael Jackson’s daughter”, strange behaviour – wearing a hat like Michael Jackson,
dancing like him, constantly listening to the singer and having the other family members listen as well, talking to the wall, irritable mood, heteroaggressiveness to the family members. For these symptoms she received 2mg of Risperidone a day, subsequently replaced with 10 mg of Aripiprazol a day due to weight gain, and 1000mg of Depakine a day, with a decrease in symptoms, school reintegration and improvement in social relationships.

At present the symptoms have reoccurred and are accompanied by auditory hallucinations, delirious ideas of persecution and megalomania.

**Somatic and neurological clinical** tests are normal.

**PHYSICAL EXAMINATION**

General aspect: neat appearance, little cooperation, mild staring, occasionally makes eye-contact, low voice, reduced mimicry, few gestures, suspicious.

Time disorientation (does not know the date, time of day).

Visibly decreased social functioning, withdrawal.

Perception: quality changes - auditory hallucinations, “I hear voices from outside”.

Attention: spontaneous and voluntary hypoprosexia.

Memory: recall and store hypomnesia.

Thinking:

- quantity: slow strain of thoughts and rhythm
- quality: delirious thoughts of persecution and prejudice concerning parents and medical staff, “everybody wants to harm me, that’s why they brought me here”.
- delirious ideas about filiations:” Michael Jackson is my father”, “the man with a hat you just saw is my father”;
- delirious megalomania thoughts ,”I’m beautiful, I’m famous, I can dance really well”.

Affection: irritable mood, anxiety, emotional instability.

Activity: psychomotor restlessness “from time to time she is restless, breaks everything in the house”, strange behaviour: "when she gets out of our building she shouts and throws rocks", “she wakes up at night and wants to go for a walk, and during the day she’d just walk, with no destination”, “she keeps listening to Michael Jackson and she makes us listen, too”.

Instincts: increased appetite, defensive instinct present.

Mixed insomnia.

**CLINICAL TESTS**

Laboratory tests are within limits.

EEG and MRI - no changes.

**Psychological examination:** IQ- 74.

**POSITIVE DIAGNOSIS**

Based on anamnesis data, clinical tests, somatic and neurological examination, psychological examination, which meet the ICD 10 and DSM IV criteria (hallucinations, delirious ideas, strange behaviour for more than six months) the following diagnosis is to be considered: Paranoid Schizophrenia.

**MULTIAXIAL DIAGNOSIS**

Axis I: Paranoid Schizophrenia
Axis II: -
Axis III: -
Axis IV: Family separation through divorce
Axis V: GAF score=21

**DISCRIMINATORY DIAGNOSIS**

1. Medical and neurological disorder (CNS lesions, intoxications, infections, tumors, vascular problems, temporal lobe epilepsy), although clinical examination and tests do not confirm a constitutional cause.
2. Other psychiatric disorders.
3. Mood shifts - in Schizophrenia affection symptoms are transitive and short, and social functioning deterioration is visible.
4. Schizoaffective disorders - delirium and hallucinations were present for at least two weeks, without obvious mood changes.
5. Delirium - the patient’s delirium is bizarre and hallucinations are present.
6. Schizophrenoid disorder: in the reported case the symptoms last significantly, and schizophrenoid deterioration would have been less significant.
7. Disharmonious schizoid development, considering behaviour and interrelation features, although these were criterion lacks (the patient is under 18).
8. With other types of schizophrenia:
   a) Unstable schizophrenia - although the affect is not plain, the behaviour is not intensely unstable and the patient is not incoherent.
   b) Catatonic schizophrenia – no catatonic episode.
   c) Indiscriminately schizophrenia – the patient has
delirium and hallucinations, yet she is not completely incoherent and does not have intense inorganizable behavior.

**EVOLUTION AND PROGNOSIS**

A positive factor would be family support (the patient has been coming to the hospital accompanied, and family members are cooperative with regards to her tending).

**Negative factors:** very early onset, parents separation, mother with personality disorder of schizoid type

Given the very early onset and deficient premorbid functioning, prognosis is reserved.

**TREATMENT**

I. Medical treatment: 10 mg of Olanzapine daily, as a more efficient antipsychotic (the patient worsened with Aripiprazol), but weight monitoring will be necessary. The treatment will be maintained long term with the minimum efficient dose of antipsychotic.

II. Psycho-social therapy:

This includes education regarding the illness, learning skills for basic needs, cognitive-behaviour strategies in order to consolidate social skills.

Family therapy is focused on improving understanding of the illness and altering relationships within the family.

**Case particularities** - the most very early onset under the form of an Obsessive-compulsory disorder and perception altering five years from debut.

**BIBLIOGRAPHY**
