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Living for illness: a case report of schizophrenia diagnosed at the age of 63

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Hidden psychiatric morbidity represents an important problem, one to two-thirds of serious cases receiving no treatment each year, often due to lack of awareness of illness. We present a case report of a patient diagnosed of schizophrenia whose first contact with the health system occurred at the age of 63 in extreme social circumstances.

Key words:
Schizophrenia. Hidden psychiatric morbidity. Social problems.

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Vivir para la enfermedad: a propósito de un caso de esquizofrenia diagnosticado a los 63 años

La morbilidad psiquiátrica oculta constituye un problema importante, estimándose que de uno a dos tercios de los casos severos no reciben tratamiento cada año, frecuentemente a causa de la ausencia de conciencia de enfermedad. Se presenta el caso de una paciente con diagnóstico de esquizofrenia y cuyo primer contacto con el sistema sanitario tuvo lugar a los 63 años en circunstancias sociales extremas.

Palabras clave:
Esquizofrenia. Morbilidad psiquiátrica oculta. Problemas sociales.

INTRODUCTION

Schizophrenia is a chronic and weakening mental disorder that affects approximately 1 % of the population. Advances in neuropathology, neuroimaging and molecular genetics have led to better understanding of the physiopathology of the disease and better treatments. However, it is still an enigmatic disease that causes a substantial burden in the patients, their family and society[1].

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Some cases, as that which we present, are an example of up to what point the consequences of the disease may impregnate the patient's and family's life.

CLINICAL CASE

This is a 63 years old female patient who was brought to the hospital by order of the judge on duty due to behavior disorders. Emergency Service staff had gone to her home advised by a neighbor due to the death of the patient's mother and found her with a psychomotor agitation picture, speaking alone and with incoherent speech. her home was in a very bad state of conservation and hygiene. When the patient was examined in the Emergency Service, she denied having any psychiatric background, a denial attitude towards the death of her mother standing out. She was admitted to the Psychiatry Unit by court order with the diagnostic impression of dissociative episode and probable mental retardation.

Once in the ward, she was observed to have an untidy and dirty appearance, and her clothes were significantly deteriorated. Among her belongings, the patient had a National Identity Card that had expired 8 years earlier and several savings account passbooks, some with almost disappeared bank entities, together with a significant amount of cash, mostly bills and coins of the old pesetas.

Given the absence of relatives, the information on the patient had to be obtained from the municipal social services and a neighbor. The social services had known about the case since October 1996, due to a request for telecare due to the health problems of the patient's parents. At that time, her father had begun to suffer cognitive deterioration and had been admitted to the hospital several times (he died in June 1997). When they visited the home, her father was alone. He stated that the patient «spoke about witchcraft and said she had an apparatus in her stomach». However, he asked them to leave because he feared how she would react if she found them there. A few days after, her mother went to the social services, rejecting the care because the patient refused it. In May 1997, due to the situa-

tion, the social services requested the beginning of civil incapacity procedure in the corresponding Court. On two occasions, the legal delegation came to the home, although they could not perform any examination because they did not open the door. Finally, in June 1998, they were able to perform an examination although her mother reported at that time that the patient was well. The incapacity request was rejected at the end of January 1999, without any previous psychiatric examination.

The social services reopened the case in March 2003, due to a new telecare request because of her mother's poor state of health. After some failed visits because the patient did not open the door, they were finally able to perform it, although, once again, her mother said she did not need care and stated that her daughter did not want anyone to enter the home. In May 2003, her mother was admitted to Internal Medicine and the social worker had an interview with the residents of the owner's association, who, although they knew the psychiatric disorders of the patient, were not willing to perform any action, stating they did not want to create problems with the neighbors. After discharge, her mother was referred to a middle stay hospital for convalescence, although she signed a voluntary discharge before being transferred to be able to go to the bank to leave money for the patient. After her convalescence, she refused to request a geriatric residence and returned home. In October 2003, her mother was re-hospitalized, with the following diagnoses in her discharge report: heart failure, ischemic heart disease (unstable effort angina), aortic stenosis, hypertensive heart disease, pacemaker carrier and type II diabetes mellitus. Finally, she died at home in December 2003, at which time the patient was admitted to the psychiatry unit.

According to the social services, her parents were not capable of dealing with the patient's attitude and, on some occasion, were even assaulted by her. When the incapacity steps were begun, the mother agreed, although she never wanted to play an active part. It cannot be ruled out that there may have been shared delusion to some degree at some time. On the other hand, the patient had never gone to primary health care, so that she had no clinical history in the health center.

The neighbor, who had helped when the patient's mother permitted it and who was the person who arranged her burial, stated that they had lived in this apartment since 30 years ago. Since the death of the father, seven years earlier, the patient and her mother had lived together in very deficient hygienic conditions and lacking basic services (for example, they had no running water in the kitchen). During the more than 30 years that she had known the patient, the patient had always had behavior disorders, with suspiciousness, refusal to allow anyone into the apartment, soliloquies and other rare behaviors. She told us that the patient had worked in Germany when she was young without being accompanied by her parents. Her mother generally did the housework, when her state of health permitted it, although the patient was capable of performing simple tasks such as shopping, although with considerable lack of efficacy, considering her to be clearly incapable of being self-autonomous. According to the same informer, she was frequently the object of mockery in the market, although she never showed aggressive behaviors.

From the psychopathological point of view, she had a denial attitude towards the death of her mother from the beginning, which led to the consideration of a probable dissociated picture. This feature normalized progressively, the patient recognizing what had happened with her mother, although she showed significant lack of affective resonance in this regards. A constant suspicious and untrusting attitude, affective coldness, social withdrawal as well as almost continuous soliloquies, digressive and idiosyncratic speech, even with neologisms, in which non-structured delusions elements were observed, stand out. For example, she believes that she is black and we are Indian.... she believes that there is an «infectiousness» that extends «through smoke» that makes black people like her become white, through the white blood cells.

She has a significant lack of knowledge regarding present reality, for example, she says that «the television news programs have been eliminated, at least in her small neighborhood». She does not know the government's president's name. However, she has good speech abstraction capacity.

Although it was possible to obtain a reflection of her delusion productivity on several occasions, the interviews were difficult during her entire hospitalization due to her attitude of hiding the symptoms, even denying her clear soliloquies. She tended to avoid the interviews or interrupt them, leaving the office when an important subject was approached, such as where she would go on discharge. She never showed awareness of her psychic disease.

The complementary examinations performed (complete blood count, blood and urinary biochemistry, and ECG) showed no abnormal findings, except mild hypercholesterolemia and hypertriglyceridemia.

During the first days of admission, the hospital staff maintained an observation attitude, without administering any psychopharmacological treatment, until the existence of psychotic symptoms could be verified. After treatment was initiated with risperidone, at a dose of 6 mg per day and a regime long duration injection risperidone was prescribed on discharge. Due to the deficits in her capacity of personal autonomy and self-care and in collaboration with the municipal social services, a place in a public residence was requested urgently, since the patient's psychopathological state, without any behavior disorder and with uncertain prognosis regarding the possibility of early improvement of the psychotic symptoms, made it unnecessary to keep her in the acute care unit. The patient refused to sign the request so incapacity procedures were initiated in the

courts and urgent protection measures were obtained. They included authorization of involuntary transfer to a residence. Granted the place, she was transferred to an elderly person's residence in a town in the province of Madrid, a transfer that she never accepted, but which she showed no active resistance.

COMMENTS

In the case presented, from the diagnostic point of view, the initial psychopathology and sociofamilial circumstances led to the consideration of the diagnosis of dissociative disorder in the context of mental retardation. However, a more careful examination showed psychotic florid symptoms together with signs that went against the diagnosis of mental retardation. Thus, the fact that the patient had been working in a foreign country without being accompanied by her parents, together with the existence of the conservation of the capacity of abstraction seen in the examination with simple tests such as the interpretation of sayings, similarities and differences, etc. make the diagnosis of mental retardation unlikely.

On the other hand, the presence of soliloquies, as a strong sign of probable auditory hallucinations, together with the existence of delusional ideas having a fantastic content with certain structuring, absence of affective resonance and tendency to withdrawal makes us consider the formulation of a diagnosis of chronic paranoid schizophrenia.

The prevalence of schizophrenia in those over 65 years has been estimated at 0.3 %[2]. However, this figure is probably underestimated[3].

In any event, the interest of this case is not in its diagnosis, but rather in the circumstances under which it occurred, after several decades of untreated psychotic symptoms.

The onset of schizophrenia generally occurs at the end of adolescence or beginning of adulthood[4] and in many cases, the symptoms continue during a lifetime, there being different forms of evolution. Both the positive symptoms as well as negative ones are generally seen, so that the detection of the disorder is not generally excessively delayed. A recent study found a median duration to treatment of a first psychotic episode of 5 weeks in an area with early detection program and 16 weeks in an area without such a program. However, the wide range in both cases (up to 1,196 weeks, which is equal to more than 22 years) indicates that there are patient who remain without treatment for very long periods[5].

The existence of psychiatric patients who do not receive treatment is frequent. Several studies have found percentages between 35 % and 54 % of schizophrenic patients who have not received treatment in the last 12 months[6-8]. A recent study performed in several countries found that from one to two thirds of the serious psychiatric cases do not receive treatment each year[9].

The most frequent reason for not receiving treatment is lack of disease awareness, with a 55 % percentage in a study[8]. Several studies have found an association between the duration of psychosis until the onset of treatment and clinical evolution, with worse prognosis based on the greater time without treatment[10-14]. The mechanisms of this association have not been explained[15,16], so that a long period without treatment could represent an epiphenomenon or a marker of preexisting factors that would contribute to worse prognosis[16].

In any case, the consequences of the lack of treatment may be devastating, as this case well illustrated, both for the patient as well as the family setting.

Primary health care has an important role in the recognition of psychiatric diseases, epidemiological studies having demonstrated that at least one third of the patients who come to the consultation have a psychic disorder, and between 30 % and 50 % of them are recognized as ill by their physician[17-19]. However, there is a population group which, for different reasons (marginality, drug addicts, senility, etc.), never visits their physician, this making up a significant and unknown group of psychiatric disease[20].

This case leads us to consider the role of the direct caretakers of mental patients. They have to deal with the patients' behaviors, their frequent absence of disease awareness and repeated refusals to visit the physician or to follow prescribed treatments.

In the case we present, the mechanisms available to deal with this situation and the possibility of performing therapeutic interventions against the patient's will by legal authorization were not activated, in spite of the action of the social services which, knowing the case, tried to obtain incapacity several years before her admission. Thus, the patient and her family were denied protection measures which, in all likelihood, would have given them a better quality of life.

In spite of the fact that there is an increase in residential and rehabilitating resources for mental patients in recent years, most of the burden of the care falls on the family, who when they age, constitute a vulnerable point, incapable of detaining the consequences of the psychopathology. This case suggests a reflection on this serious problem, probably underestimated in the statistics.

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