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SCHIZOPHRENIA;
THE UNIQUE PRESENTATION OF SELF-HARM - A CASE REPORT FROM A DEVELOPING COUNTRY

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ABSTRACT: Schizophrenia is a psychiatric disorder and self harm is considered to be a rare presentation of it. Lack of early intervention is mostly suggestive of leading to it. We hereby present a case of a elderly male with chronic schizophrenia who came to our ER with the complains of self assault one day prior to admission, odd behavior, somatic delusions since 8 days, self laughter and self talking since the last 25 years. Being a previously diagnosed case of schizophrenia, he was non complaint with his previous medications, which worsened his condition and led to the patient stabbing himself multiple times after being convinced that there were snakes in his abdomen. The patient was treated with antipsychotics and benzodiazepines, his family was given psycho education and after being stable for a few weeks, he was later discharged and asked to follow up regularly in our OPD.

Key words: Schizophrenia, Self-harm, Early intervention, developing country

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INTRODUCTION

Schizophrenia is a chronic mental disorder and is said to the "costliest mental disorder" due to the amount of suffering and the expenditure incurred.[1]

Self-harm is a process of inflicting tissue damage to one's own body, usually without suicidal intent. Violence to one's own body and others is reported amongst a few uncommon signs and symptoms of schizophrenia, mainly as a consequence to persecutory delusions.[2] At times the somatic sensations that compel a person to "extract "something out of the body results in self harm. Combination of schizophrenia and self-harm is a relatively unique finding in Pakistan and its data are extremely limited throughout the country. Offering early treatment could possibly lessen the number of psychosis related complications as well as suicide; the latter being the most important cause of premature death in schizophrenics.[3] In third world countries like Pakistan, the cultural norms of people often discourage them from seeking pharmacological health care and psychiatric symptoms are often misconstrued as demon possessed traits.

We are reporting a case of chronic schizophrenia in this context where lack of awareness towards psychiatric illness and its management led to serious even fatal consequences.

Case History

A 65yrs old married male, uneducated, unemployed (initially a farmer by profession) hailing from a low socioeconomic status, was brought to us by his family members through the emergency department and then admitted to Psychiatry department of our hospital for odd behavior (self talking, self laughing, aggression), social and occupational dysfunction since the last 25yrs along with a stab wound on his abdomen since 1 day.

Collateral history from various sources including his family members and previous medical records revealed signs and symptoms (social isolation, aggression, unusual quietness, self neglect, self talking and laughing) suggestive of schizophrenia according to DSMIV criteria. He

was being managed with spiritual/faith healers and had an erratic compliance of psychotropic, haloperidol and procyclidine.

His condition deteriorated when the patient revealed with conviction that he had two snakes inside his abdomen and described their characteristic features and precise location in abdomen. Disagreement of family members on this regard made him angry, and he had attempted to kill those snakes multiple times by inserting needles into the localized area in the abdomen and ultimately ended up stabbing himself in the abdomen that resulted in a bleeding wound, 3 x 3 inch in size.

With collaboration from the surgical department, the patient was being managed, initially by excluding any co-morbid organic problems by relevant systemic examination and lab investigations. Wound was managed by daily dressing and a course of antibiotic (augmentin 625mg TDS) and an analgesic (Diclofenac sodium 50mg TDS) with good dietary intake.

His psychosis was controlled by administering depot antipsychotics (Fluphenazine 25mg I/M ATD), oral haloperidol 5mg BD and Clonazepam 0.5mg HS while looking for extrapyramidal side effects. Psychoeducation to family was offered and were advised for regular follow ups in our OPD after his discharge 20 days later, to ensure compliance and to review the duration of depot antipsychotics and to tapered off benzodiazepine.

DISCUSSION

According to the DSM IV criteria, schizophrenia is a disorder that is diagnosed when two or more of the following symptoms manifest extensively for a period of one month accompanied with social and occupational disturbance, as well as continuous disturbance prevailing for at least 6 months. 1) Delusions 2) hallucinations 3) speech disorder 4) catatonic /grossly disorganized behavior 5) negative symptoms. It has been further categorized into types based on the predominant clinical manifestation into paranoid, catatonic, disorganized, residual and undifferentiated. Although DSM IV elucidation of schizophrenia is in use, the elimination of subtypes and the relatively vague “Schneiderian first rank symptoms” and better delineation of schizophrenia from schizoaffective disorders are among the prominent changes in DSM V (2) Daniel R. Weinberger has mentioned the correlation of appearance of symptoms with the process of normal brain maturation affected by an early developmental pathology, particularly in the dorsolateral prefrontal cortex.[4] Harvey, et al reports that a significant minority of the patients self-inflict themselves between the time period of their onset of psychosis till the time they seek medical attention.[5] Data regarding prevalence of suicide in schizophrenics are plenty. One of the largest data base provided by Healy et al states that the suicidal rates in schizophrenics have increased up to 20 fold in the 1990’s as opposed to the late 19th and early 20th century.[6] This highlights the importance of treatment which revolves around antipsychotics, psychosocial rehabilitation like cognitive behavioral therapy and cognitive remediation as well as mitigation of the adverse effects of medications so to ensure a quality lifestyle. For treating chronic schizophrenia, the CATIE and the CUtLASS trials hold relevance whereas the TEOSS trial pertains to the early onset schizophrenia.[7] At present, published data for prevalence of schizophrenia in Pakistan is poor. Pakistan has majority of the people uneducated. Even in the educated pool, data suggest that people attribute non bio medical causes to the symptoms of schizophrenia.[8]

Our patient had not been receiving standard antipsychotic drugs, neither was he in consultation with a psychosocial rehabilitation program. He was non suicidal on admission and even previous attempts of suicide are not as such brought into notice by his wife. This case shows how a patient presenting in a third world country yet successfully diagnosed went on without optimal treatment for two and a half decades. In addition, we see how the case culminates in the relatively rare self-harm through aberrant somatic sensations, and how he defies the odds of committing suicide that is likely given the statistics and his background history.

CONCLUSION

An extensive research eliciting local beliefs among the multi cultured Pakistanis, promotion of education and awareness of mental illnesses, eradication of stigma regarding psychotic behavior through media, and making health care more accessible could be a stepping stone to further unearth and treat schizophrenia effectively in Pakistan.

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Trust the process."

Unknown

AUTHORSHIP AND CONTRIBUTION DECLARATION

Sr. #	Author-s Full Name	Contribution to the paper	Author=s Signature
1	Zain Majid	Managed the patient and wrote the manuscript	
2	Anum Haider	Managed the patient	
3	Habib Feroz Kapadia	Wrote the manuscript	