The diagnostic challenge of simple schizophrenia: a case report

Paprastosios šizofrenijos diagnostika: klinikinio atvejo aprašymas

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SUMMARY

Background. Simple schizophrenia – a diagnosis, removed from Diagnostic and Statistical Manual of Mental Disorder (DSM), but still has remained in International Classification of Diseases (ICD). This form of schizophrenia mostly definable by a slow progressive development of negative symptoms, leading into personal and social dysfunction, without any manifestation of acute psychotic symptoms. This type of disease has been hypodiagnosed even in ICD classification guided countries.

Case report. We are presenting the clinical case of 23 years old man, first time diagnosed with simple schizophrenia. The changes in personality and the first signs of psychiatric illness manifested since early adolescentce. The abscene of acute psychotic symptoms did not give base for earlier diagnosis: the diagnose of simple schizophrenia validated only after social and ocupational problems occured.

Conclusion. This case report describes a typical course of simple schizophrenia with premorbidic personality traits and development of prodromic symptoms; and reveals slow disease progression without acute psychotic symptoms.

Keywords: simple schizophrenia; international disease classification; diagnosis

SANTRAUKA

Įvadas. Paprastoji šizofrenija – diagnozė, išbraukta iš DSM (angl. Diagnostic and Statistical Manual of Mental Disorders), tačiau vis dar naudojama Tarptautinėje Ligų klasifikacijoje (TLK). Ši ligos forma apibūdinama pamažu progresuojančiais negatyvia simptomatika, nesant išreikštų pozityvių simptomų. Net ir TLK klasifikacija besiremiančiose šalyse ši diagnozė nepagrįstai nustatoma vis rečiau.

Atvejo aprašymas. Pristatome 23 metų amžiaus vyro gyvenimo ir ligos istoriją, kuriam pirmą kartą patekus į gydymo įstaigą buvo diagnozuota paprastoji šizofrenija. Mūsų paciento besikeičiančią asmenybę ir pirmuosius ligos simptomus galime stebėti nuo ankstyvos paauglystės, tačiau galimybė diagnozuoti ligą, kuri nepasireiškė ūmine psichozine simptomatika, atsirado tik pacientui susidūrus su socialinėmis ir darbinėmis problemomis.

Išvada. Šio klinikiniame atvejo aprašymas puikiai iliustruoja paprastosios šizofrenijos progresavimą su būdingais paciento premormidiniais asmenybės bruožais ir prodrominiais sutrikimo simptomais, bei klinikinę ligos išraišką – ūminės psichozinės simptomatikos nebuvimą ir lėtą ligos progresavimą.

Raktažodžiai: paprastoji šizofrenija; tarptautinė ligų klasifikacija; diagnozė

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BACKGROUND

Simple schizophrenia undoubtedly has an unstable and controversial history. It has originated in 1903, when Swiss psychiatrist Otto Diem in monograph „The simple dementing form of dementia praecox" marked a different insidious type of dementia praecox by typical early onset and progressive course, highlighting absence of acute symptoms. The clinical manifestation was described as "moderate degree of mental debility, dullness and apathy with moments of excitability, a loss of mental alertness, an inability to act independently and a marked lack of judgement; at the same time comprehension and orientation are maintained and memory is not noticeably affected" [1]. Eugen Bleuler in 1908 added a subtype schizophrenia simplex in Emil Kraepelin organized categorization [2]. Since 1948 the term was included into the first official diagnostic manual with a classification of mental disorders – the 6th version of International Classification of Diseases (ICD-6) [3]. After four years, it was published for the first time as a simple type of schizophrenic reaction in the Diagnostic and Statistical Manual of Mental Disorder (DSM-I) [4]. Simple schizophrenia remained there for many years, although criticism about this diagnostic category never ends [5]. The International Pilot Study of Schizophrenia in 1978 concluded a vague description of simple schizophrenia and lack of scientific studies [6]; after that, the simple schizophrenia was omitted from DSM-III [7] and also, did not obtain in further classifications. Otherwise the category of simple schizophrenia has never been abandoned from ICD. One of the greatest impacts was done by Russian physician V. G. Levit: he reported 20 years observational data of 200 patients hospitalized by first episode of schizophrenia and concluded that simple schizophrenia, often presenting sluggishness, apathy and passivity, was precisely compatible with typical schizophrenia simplex description. This research confirmed that negative types of symptoms should be considered as initial signs of schizophrenia [7].

In everyday clinical practice using ICD-10 with diagnostic category of simple schizophrenia, we have „a disorder, in which there is an insidious but progressive development of oddities of conduct, inability to meet the demands of society, and decline in total performance" [8]. The pure forms of simple schizophrenia are very uncommon and are not easy to recognize; meanwhile we have some unsettled questions about boundaries on schizotypal disorders. Even nowadays the diagnostic of simple schizophrenia remains unclear. Generally patients with this disorder apply for psychiatric treatment after a long outbreak, especially when symptoms and disturbances of psychosocial functioning become severe or social-economic problems already appear [9, 10, 5].

In this case report we present the clinical case of patients with diagnosis of simple schizophrenia, which represents a patients life and illness history, reveals diagnostics and differential diagnostics complexity, treatment options and future prognosis.

CASE REPORT

History. A 23 years old male patient was admitted to Psychiatric Department due to his mother and general practitioner concerned, that the patient is acting strange, refuses to go to work, has stopped communicating with family members and has showed episodes of anger or uncontrollable laughter. The patient had no previous psychiatric disorders and the main complaint was painful back and knees as a result of the difficult job.

He was born and grew in Lithuanian city Kaunas; the psychomotor development was normal. He had no known family history of psychiatric disorders, any relatives with suicidal and addictive behavior. Patients mother had been working a big part of a day in the sales office, so for a long time she hadn't noticed changes in son's behavior. His father had engineering degree, but most of the time worked as a church clerk. Patient's father described his relationships with co-workers as strained: he had thoughts that someone was trying to poison him, had been feeling „like dizzy". Patient had never had familiar contact with his father. Patient has a two years older sister; she was always very communicative person, with a lot of social activities. When they were little they would be playing together, both of them had a very close relationship and patient enjoyed it. During last 7-8 years period their relations has changed: despite living together and sharing one room, their contact became formal. Since an early childhood, patient has been sluggish, much slower than other peers, always had troubles with social interactions. Although, at school he had some friends for playing basketball, none of them were close friends. He never had conflicts with teachers. Learning outcomes were average (7/10 marks), much better on humanistic subjects than math. Patient had started to feel sexual desire since 14, but after a year his desire became weaker and gradually he lost his libido completely. His romantic relationship with a classmate at 16 years old had been continuing for about one year without any intimate connection and had broken up without any reason. He was sad about this, but in consideration of his social withdrawal, had never started on another relationship. He has not been drinking and smoking, because he has found it gives him no pleasure. On the last school years, from 17 years old, patient gradually became more solitary, gave up playing basketball with friends, and missed all his interests, started feeling fatigued and most of the time was staying at home. After graduation he had no intention to continue studying and had gained his specialty of car repairman just for mothers inducing. Studies did not interest him and he did not try to find a job by qualification. Patient had an auxiliary jobs several times: during all employments he had troubles in maintaining smooth relations with his colleges. For this reason he had changed his workplace at least 4 times. Out-of-work time he was spending aimless at home, watching all TV-programs one after another, without any contacts with family members. According to his mother report, the patient began to show episodes with unmotivated laugh at 15 years old. He has not been able to explain the causes and to control it. From time to time such episodes recur. Once at 21 years old patient had heard mysterious whispering from the outside „like the sounds of wind". He did not understand the meaning of this speech and he did not react to it; however it never happened again. During last year period he became aggressive and assaultive against family members. Also, in current working place, the patient had hostile relationships. He noticed his co-workers were telling stories and joking about him. Therefore, the patient had figured out that co-workers had been uttering slanders against him and making plans to injure him. For this reason he was displeased

with his job and applied to primary-care physician with active complains on painful back and knees limiting his ability to work. A primary-care physician presuming a mental illness addressed him to Psychiatric Department.

Mental state examination. Patient presented as self-cared man, who looked his stated age. He was approachable to verbal contact, but interacted unwillingly. He showed lack of ability to establish good emotional contact: eye-contact was intermittent, face looked hypo-mimic. Patient had blunted emotional reactions, lack of interest to other people or visiting mother, his mood was monotonous. He claimed having no feelings about anything, but talking about his father and his childhood events, patient became more irritable and anxious. During examination he showed the wary and suspicion. His speech was of slow rate, but coherent and appropriate. The vocabulary was poor and limited. He used to respond after a long silence and often used phrases „I don‘t know“, „I don‘t remember “or answered shortly. Patient expressed suspiciousness towards his co-workers: he had thoughts that he could be harmed or beaten by co-workers, all talks and jokes he had heard considered to be against him. Also, he was suspicious towards other patients in the department. He was avoiding therapy rooms, where he could contact other patients, thinking they could make a mockery of him. Patient showed clear negative symptoms: hypo-volition – he had decreased motivation to initiate and perform self-directed purposeful activities, with no goals in his life, he could spend all day lying in bed; anhedonia – felt no pleasure from any activities and he experienced social withdrawal – limited contacts with people, including his own family members. He had concentration difficulties, was distractible by any insignificant stimulus. He denies any hallucinations or suicidal thoughts. His judgement and insight of illness were poor, although he was compliant with psychiatric hospitalization and treatment. The psychological assessment revealed slow thinking process, loss of coherence and direction of speaking, lower abilities for abstraction with predominance of the coincidence associations. The answers had delitescent and peculiar concept. Multiplicity and sluggish thinking were frequent. The physical, neurological exam, laboratory data and brain MRI was essentially within normal limits.

Hospital course and treatment. Considering patient‘s faulty perceptions of co-workers behavior as interpretational delusions – the antipsychotic treatment was started with a typical antipsychotic Haloperidol (a dose was titrated gradually from 5 to 20mg/day). No side effects were observed; no changes in patients’ behavior were noticed during first two weeks of treatment. Considering negative symptoms to following treatment, atypical antipsychotic Risperidone (up to 4mg/day) was prescribed. Also, no significant effects were observed. During all hospital treatment period, patient’s communication was inhibited: he stayed away from contact with other patients and hospitals staff. He answered briefly, with one or two words, mostly looking through the window. He avoided occupational and group therapies, as well as morning exercises by reason of absence of motivation to make contacts with people. Patient remained quite passive, all day lying in bed without any activity.

Diagnosis. The patient meets the ICD-10 criteria for simple schizophrenia. He has a quite long history of mental illness: premorbid personality traits combining slowness and sluggishness, self-restraint, loneliness, lack of involvement in social interactions. The prodromal phase started at age 15 with emotional outbursts, loosening of sexual desire and narrowing of interests. His gradual loss of interests and social isolation were becoming more significant and deteriorative for last five years. Patient has loss of initiation and spends time idle, aimless and wasting on trifles. His social marginalization is characterized by faulty interpretations of people behaviors, classified as overvalued ideas. His occupational performance is marked declined and has caused severe impairment at work. The patient has no confirmations of active psychotic symptoms, except simple auditory hallucinations (phonemes) occurring only once. The clinical examination shows the deepening of "negative" symptoms – apathy, anhedonia, hypo-volition and affective flattening, social withdrawal with suspicious and defensive behavior, slowness in speech, hypo-mimic face, no eye contact and poor judgement. The patient does not meet criteria for any organic brain disorder or substance use disorder. Psychological assessment confirmed the disturbances of thought process specific to schizophrenia.

Differential diagnosis. Despite the fact that all symptoms of simple schizophrenia have been met, most of them are not specific. It was necessary to make a precise differential diagnosis. Similar clinical presentations are really possible in patients with schizoid personality disorder, in affective disorders, autism spectrum disorders, mental retardation or dementias, physical disorders, after brain injuries or neuroinfectious diseases, like meningitis or encephalitis.

A pattern of detachment from social relationships, including own family, no interest in sexual experience, emotional coldness, detachment and apathy led us to differentiate from schizoid personality disorder. However, we distinguish that schizoid personality disorder shows more specific choices in selective activities and moreover these persons have a quite stable autistic behavior with intense decompensation periods after any psychosocial stress experience.

Some affective disorders, particularly atypical types of depression (adynamic, stuporous, „anaesthesia psychica dolorosa“), could mimic some symptoms of this case. Loss of interests, experience no pleasure in any activity, a social withdrawal led us to differentiate from depressive disorder. However mood disorders always have more or less significant (sometimes it could be masked) affective component of illness, which is the primary cause of psychosocial dysfunction. In our case, the emotional flattening as dominant emotional symptom allowed us to exclude affective disorder.

Such symptoms, like an impairment in social interactions – difficult to keep eyes-contact, hypo-mimic facial expression, no body posture, absence of seeking contact to other people, supposed us to differentiate from autistic spectrum disorder – Asperger‘s syndrome. However, the progressive development of described symptoms and a gradual development of isolation after quite normal social functioning in childhood allowed us to exclude autistic disorder.

We have no data about mental retardation or dementia. The development was normal for his age. There were no periods with potential mental function‘s lesion in patient‘s life. With the same occasion we denied neuroinfection possibility – we had not got any anamnestic data or paraclinic diagnostics confirmations, so there is no need for expectancy

of any infection in the past or in the present. In addition, our patient in late childhood had a brain injury, but trauma was not severe and after long period of time, no residual brain injury symptoms had occured. Also, no somatic disease is confirmed, because of negative paraclinical diagnostic tests and abscene of psychostenic or psychoorganic syndrom.

DISCUSSION

We introduced a case report of simple schizophrenia, which meets all ICD-10 ciriterions and seems like a typical insidious psychosocial deterioration without obvious psychotic symptoms [11]. With this publication we want to remind of hypodiagnosis of simple schizophrenia and make clear why it is difficult to diagnose these patient. This report confirms that patients with such conditions are undisposed to consult a doctor because of their self-neglect [9, 12, 10]. We want to notice that these patients often are brought into hospital by theirs relatives [12, 5] or seek doctors help with other non psychiatric complaints as in our case. It is important to emphasize that in an absence of psychotic signs diagnostic is complicated. Anamnesis oriented into premorbidic personality, prodromal traits and progressively developing negative symptoms leading into total dysfunction possibly could help diagnostic determination [13, 14].

After reviewing some comparable publications we made a comparison and marked a few basic directions concerned with developmental history and clinical features. Premorbidic personality is very common in schizophrenia development [15], especially simple type [13]. Our patient since an early childhood was slow, had troubles with social interactions, became more isolated. Identical social withdrawal and interests lost after normal childhood and academic achievements are found quite often [10, 16, 5]. Prodromal traits is further sign which are indicative of beginning illness [14]. However symptoms are fairly variable. In our case it manifests with increased social isolation and episodes of unmotivated laugh and anger, libido lost, episode of simple auditory hallucination. Literature refers simple schizophrenia prodromal opens with supposedly stress induced acute psychotic episode [12], depression-anxiety alike symptoms [17], aggressiveness and irritability [5], muttering and smiling to self [10] and other odd behaviours [10, 16]. Simple schizophrenia is described mostly by negative schizophrenia symptoms, including anhedonia-asociality, avolition-apathy, affective flattening or blunting, alogia, inattentiveness [18]. Our patient had most of these symptoms, althought his grooming and self hygiene were expressed slightly,but self-neglect is one of most specific and observable simple schizophrenia symptoms [9, 12, 10, 5, 13]. Also we noticed that overvalued ideation at first sight not compatible symptom is presentable not only in our case [12, 13]. Nonetheless these thoughts are far from the delusional thinking such as persecutory or grandiose delusions in paranoid schizophrenia. Unfortunately almost every case end up with total social life and functional breakdown [9, 10, 5]. Therefore a simple schizophrenia is insidious and life destructive mental illness.

The International Classification of Diseases and Related Health Problems (ICD) is currently in its tenth revision. In ICD-11 Beta Draft version, which is not final yet and not proved by WHO also, a diagnostic category of simple schizophrenia (likewise all types of schizophrenia) has been eliminated. So, that truly could mean an end of this psychiatric diagnosis [19].

CONCLUSION

Our case report reminds us to be wary and keep in mind a simple schizophrenia diagnosis in everyday mental physician practice. Also, it describes a typical picture of this type schizophrenia patient and points out main aspects of purposeful anamnesis.

Conflicts of interest

Authors declare no conflicts of interest.

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