#  SCHIZOPHRENIA

**BIODATA**

**Name**: Laurence Mwenda

**Age**: 24 years

**Marital status:** Single

**Occupation: Miraa** seller

**Residence: Meru**

**Mode of admission**: Voluntary, brought by the father’s friend and uncle.

**CHIEF COMPLAIN**

He was brought because violence and vandalism

**HISTORY OF PRESENTING ILLINESS**

The patient was brought to the Mathare hospital in July 2014for being violent and engaging in vandalism acts. On the day he was brought, He had just arrived from church when he started being violent and stoning cars at Gikomba market where he stayed. He says at that time he was “not himself” .He has felt the same before in 2009 when he claims that he had been diagnosed with cerebral malaria. The patient explains that the he attributes the illness to the time he underwent circumcision in 2009.That is the time he started becoming violent. He claims to have undressed himself then leading to his admission at Meru District Hospital.

**PAST PSYCHIATRY HISTORY**

In the past he has had a similar psychiatric condition in 2009 where he undressed himself and in 2010 when he stole his father’s miraa .He says he was also violent in school. He was taken to Meru district Hospital where he was treated.

He does not remember how long he was admitted.

**VEGETATIVE SYMPTOMS:**

At the time of examination, he has normal appetite, normal sleep and normal bowel movements.

**PAST MEDICAL CONDITION**

He claims to have been diagnosed with cerebral malaria in 2009.He also says he suffered from chronic cough and his mother would give him raw egg yolk as medication.

He has no known allergies to any medications.

**FAMILY HISTORY**

Both parents are alive and in good health.

His father, Silas Bare (45yrs) and mother Raeli Gathei (40) are business people operating a retail shop in Meru.

The patient has a good relationship with his parents.

He has 4 siblings and he is the 1st born. All his siblings are of good health and none has had a similar psychiatric condition.

**PERSONAL HISTORY**

**Birth and early childhood**

His birth was planned, born at home with the help of local midwives and the mother did not experience any complications before and during pregnancy.

He remembers that when he was growing up he used to suffer from chronic cough and his mother would give him raw egg York as treatment.

**Schooling and adolescence**

He attended Mtwati primary from nursery to class 8 where He scored 350/500 marks in KCPE and joined Nadho secondary school in 2009 completing form four in 2013.

**Sexual life**

He does not talk much about his sexual life. His responses are vague

**Marital history**

He is single but he has plans of marrying after coming out of hospital.

**Social history**

He has close relationship with his friends.

He has no specific hobby.

He does not confess to using any drug, even the miraa he is selling.

The patient recognizes that he has a problem and He wishes he gets well soon.

**Forensic history**-

He has never been arrested by the police. He has been a law abiding citizen

**MENTAL STATE EXAMINATION**

**Appearance:** Young-looking male, with a normal gait, poorly groomed with poor personal hygiene.

**Posture**: relaxed and normal

**Behavior**: The patient looks very sleepy and tired (he actually asked for the interview to be hurried so he could go to sleep; it could not be confirmed if it’s the effect of the antipsychotic drugs)

**Speech**: sparse, slow rate, normal volume, spontaneous, low pitched, normal rhythm.

**Mood**: Happy

**Affect**: normal affect, there is congruence

**Thought process**: normal

**Thought content;** He claimed to have special powers that he is able to communicate with God, hallucinations

Normal

**COGNITIVE FUNCTIONS**

Consciousness –fully conscious

Orientation-well I oriented in place, time and person.

Concentration- passed the serial seven test subtraction

Memory: good both long term, short term and intermediate memory.

Abstract thought: good as he could interpret a local proverb, Haba na haba hujaza kibaba(saving little by little will add to more)

Judgment: Good, The patient was given a scenario of a child drowning in a swimming pool and responded as expected of a reasonable person

Insight: The patient is fully aware and he thinks he will get well then he will go home and marry.

Rapport: it was easy to make rapport with the patient

**FORMULATION**

Lawrence Mwenda is a 24 year old male who is single, was brought to the hospital by his father’s with complaints of violence and vandalism. He has no history of any drug abuse. The patient presents with positive symptoms of grandiose delusions. The patient is currently on his way to recovery and apart from poor grooming and neglect of personal hygiene, the prognosis is good.

**DIAGNOSIS**

**AXIS I**- Relapsing Schizophrenia-Due to positive grandiose delusions, violence and evidence of previous treatment of the condition

**Differential diagnosis**

Schizoaffective disorder-(patient has not had uninterrupted period of illness or major depressive episode, manic episode or mixed episode concurrent with criteria schizophrenia)

Mood disorders-(Patient did not develop symptoms of depression or mania along with psychosis, no biological relative with a remitting psychotic illness.

Organic mental disorders-(To investigate by routine lab investigations to rule out metabolic cause (liver disease), HIV, Neurological condition or even infection), the patient is not disoriented, confused or having impaired memory.

Personality disorders-(become psychotic under stress and however compensate s within hours or days.

Delusional disorder-(delusional beliefs do not markedly impair daily functioning)

Brief psychotic disorders-(subside rapidly, frequently seen in adolescents)

**AXIS II**

None was noted. The patient had normal childhood development

**AXIS III**

Childhood chronic cough, cerebral malaria

**AXIS IV**

The patient seems to have good relationship with friends and family, except when he is sick

**AXIS V**

Global assessment of functioning

**50-41** -serious symptoms e.g. impairment in social, occupational duties, He is violent and is not safe to be integrated into the society

**MANAGEMENT**

**Investigations** (to rule out medical conditions)

Peripheral blood film, to investigate malaria

CSF screening, to rule out cerebral malaria

HIV virus testing (routine test for all patients)

**PHARMACOTHERAPY**

Antipsychotics-Chlorpromazine, haloperidol, clozapine, Risperidone, Quatiapine

Antidepressants-serotonin reuptake inhibitors (citalopram, fluoxetine) these patients are prone to depression.

**PSYCHOSOCIAL TREATMENT**

**Hospitalization**

 The patient needs to be hospitalized because of his history of violence and therefore he poses a danger to self or others because he lacks the judgment and impulse control during attacks of disease.

SUPPORTIVE INDIVIDUAL CARE

The patient should trained by a psychologist on how to cope with stress and how to identify early warning signs of relapses that can help him manage his illness.

Encourage the patient to avoid factors that precipitate his condition

**Family therapy**

The patient’s family should be educated about genetic and biological causes of schizophrenia to help reduce the family’s guilt and self-blame for the patients illness.

This also helps for the family to know the stressors within the home that can cause a relapse and help them improve their communication skills and problem solving techniques.

Support and educate families dealing with schizophrenia

**Social therapy**

Join programs in the community that help people with schizophrenia

Vocational rehabilitation and employment which helps people with schizophrenia find jobs.

Social skill training that focuses on improving communication and social interactions

**PROGNOSIS**

With adequate support of the patient both through pharmacotherapy and psychosocial therapy frequent episodes of schizophrenia can be reduced and this is also possible since the patient has good premorbid social functioning, has no premorbid personality disorder, the precipitating events and factors are identifiable, it was of abrupt onset during midlife.