

Childhood Onset Psychosis: A Case Report

Jha A¹, Kunwar A², Dhonju G³

1. Psychiatrist, Child Guidance Clinic, Kanti Children's Hospital, Kathmandu, Nepal. 2. Child and Adolescent psychiatrist, Child Guidance Clinic, Kanti Children's Hospital, Kathmandu, Nepal. 3 Child and Adolescent psychiatrist, Child Guidance Clinic, Kanti Children's Hospital, Kathmandu, Nepal.

E-mail *Corresponding author : urshealer@gmail.com

Abstract

Childhood psychosis is an extremely rare condition. We describe the case of 6.5 yr old male child who presented with symptoms suggestive of psychosis and later responded well to antipsychotic clozapine. This case study reveals that the identification of very early onset psychosis is challenging and treatment is crucial for prevention of long-term disability.

Keywords: Childhood Psychosis

INTRODUCTION

Psychosis is rare in children with a prevalence of 0.2 to 0.4/10,000.¹ Childhood psychosis can present with wide array of symptoms comprising of positive symptoms, negative symptoms, cognitive and affective symptoms and it's challenging to differentiate the psychopathology of childhood onset psychosis with disorders such as autism, mood disorders.² Childhood schizophrenia is characterized by withdrawal, negativism, and strange and unexpected behavior and delusions are rare.³ The psychosis occurring before 13 years of age has been considered to be of very early onset and that between 13 and 17 years to be of adolescent onset.⁴ Clinical manifestation of psychosis is a result of interaction between environmental demands and characteristics of the individual and prevalence of positive symptoms ascends with the increasing age.⁵

CASE - HISTORY

6.5 years male born out of non-consanguineous marriage, with unremarkable birth history and normal developmental milestone presented with insidious onset of illness of one year duration, with history of regression of speech and behavior. His academic activities declined and unlike before most of the time he started to engage in solitary activities. The self care activities also declined. The child occasionally used to get fearful and cling with nearby caregivers and then used to cry without any

plausible explanation. He often feared staying alone, or while going to bed at night insisted the lights to be kept on. Family history was not significant. There was no history of fever, no history of seizure, no history of trauma, no history of repetitive behavior. On initial mental state examination, notable findings were repetitive blinking, poor eye contact, mumbling to self, and paucity of speech. The patient underwent comprehensive investigations, including Complete Blood Count, Thyroid function test, MRI Brain, EEG, Autoimmune encephalitis panel test, Childhood autism rating scale score, which were normal. As there was no family history of mental illness, patient was not referred for genetic testing. He was diagnosed as other non-organic psychotic disorder (F28) as per ICD-10. Initially, there was no response to treatment with two different antipsychotic prescribed for a duration of 4 weeks each, at dose of Risperidone (3mg/day) and Aripiprazole (20mg/day). Ultimately clozapine was started and gradually titrated up to 50mg/day in divided doses. After four weeks on clozapine, client started to improve. The patient tolerated clozapine very well without any significant side effects. However, still the child is not fully asymptomatic, and has dysfunction in expressive language domain but now he does go to school, comprehension of language has improved along with his social interactions. Psychological therapy intervention in the form of psychoeducation,

activity scheduling and Family therapy was also instituted in addition to pharmacotherapy.

DISCUSSION:

We described a patient of 6.5 years age, who presented with psychosis. Given that our medical work-up was negative, our diagnosis of exclusion was that this was a first presentation of non-organic psychosis. In this case child was developmentally normal up to the age of 5.5 years then insidiously he developed regression of speech and behaviors with decline in social and academic performances in some respect it seems similar to childhood disintegrative disorder (CDD); however, the onset of CDD usually occurs by age 3-4 years.⁶ This case highlights that clozapine should be used to treat the psychotic children who do not respond to routine Antipsychotic treatment.

In child the diagnostic stability of an initial psychotic episode shows much variation so longitudinal course needs to be monitored, but schizophrenia in children can be diagnosed reliably using unmodified adult diagnostic criteria.⁷ Since there was no history suggestive of autistic features or problems in social adjustments prior to onset of illness, this case was diagnosed as F28 as per ICD-10 as the criteria for schizophrenia was not met. complex relationship between schizophrenia and autism have been characterized by an almost complete overlapping between childhood schizophrenia and autism disorder, Numerous neurobiological links between schizophrenia and ASD, in particular at a genetic level has been found.⁸ However, developmental differences in language and cognition affect the range and quality of symptom presentation in very early onset schizophrenia and the symptoms resemble the prodromal symptoms of schizophrenia.^{5,9} The failure to meet the expected academic and social milestones may be a better descriptor for childhood onset psychosis/schizophrenia rather than a deterioration in functioning as used in adult who are supposed to have achieved full functioning in social and interpersonal domains.¹⁰ Challenge to diagnose childhood onset psychosis lies in the decision to attribute presenting symptoms to a pathological process given that at such age the child does have an imaginary world. Contextual information is essential in making these distinctions, with

special attention to the preservation of social relationships, higher premorbid functioning, and academic problems.¹¹ The clinical issues in this case study highlights the importance of identification and treatment very early onset psychosis. Prospective follow up studies are necessary to answer the many questions remaining about psychotic/schizophrenic states in childhood.

CONCLUSION:

Childhood onset psychosis is a very rare condition. However, early identification and treatment is of utmost importance to prevent longterm disability

REFERENCES:

1. American Academy of Child and Adolescent Psychiatry. Practice parameters for the assessment and treatment of children and adolescents with schizophrenia. J Am Acad Child Adolesc Psychiatry. 1997;36 :177S-193S.
2. National Institute for Health and Clinical Excellence: Guidance. Psychosis and schizophrenia in children and young people: Recognition and management. Leicester: British Psychological Society; 2013
3. Homburger, A. Vorlesungen über Psychopathologie des Kindesalters. Berlin, Germany: Springer-Verlag, 1926
4. Masi G, Mucci M, Pari C. Children with schizophrenia: Clinical picture and pharmacological treatment. CNS Drugs 2006;20:841-66.
5. Kao YC, Liu YP. Effects of age of onset on clinical characteristics in schizophrenia spectrum disorders. BMC Psychiatry 2010;10:63.
6. Palomo R, Thompson M, Colombi C, Goldröng S, Young GS, et al. A Case Study of Childhood Disintegrative Disorder Using Systematic Analysis of Family Home Movies. Journal of autism and developmental disorders. 2008; 38 . 1853-8.
7. Russel AT. The clinical presentation of childhood-onset schizophrenia. Schizophr Bull 1994; 20:631-646
8. de Lacy N, King BH. Revisiting the relationship between autism and schizophrenia: toward an integrated neurobiology. Annu Rev Clin Psychol. 2013;9:555-87. doi: 10.1146/annurev-clinpsy-050212-185627
9. Moller P, Husby R. Searching for naturalistic core dimensions of experience and behaviour. Schiz Bull 2000;26:217-32
10. Dunn DW. Schizophrenia and other psychoses. In: Giardino AP, Windle ML, Pataki C, Sylvester C, Kappelman MM (Eds.). e-medicine 2006:1-11.
11. Abidi S: Psychosis in children and youth: focus on early-onset schizophrenia. Pediatr Rev 2013; 34(7):296-305