MATHEWS

Case Report

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A 100-Hour Observational Study on Treatment-Resistant Schizophrenia: Clinical and Sociocultural Insights from Kashmir

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ABSTRACT

Background: The severity of illness in schizophrenia often goes unrecognized, leading to delayed interventions. More than half of the cases are aggravated by an unawareness of the condition. Treatment-resistant schizophrenia (TRS) is defined as the failure to respond to two antipsychotic treatments at adequate doses and duration. A critical yet underexplored factor contributing to TRS is the lack of awareness about the illness, which delays early intervention and worsens outcomes. **Objective:** This case study highlights the impact of mental health unawareness on the progression of schizophrenia into treatment-resistant stages. It focuses on a patient from a remote village in northern Kashmir whose unawareness of his condition led to years of untreated illness and eventual TRS. **Case Description:** The patient, living in a remote area, exhibited symptoms of schizophrenia during early adulthood but remained unaware of his condition. His family, with a limited understanding of mental health, struggled to provide appropriate care. In search of relief from his discomfort, the patient was observed retreating into the mountains. Over time, his untreated schizophrenia progressed into TRS, resulting in a significant loss of his youth and worsening social and functional outcomes. **Conclusion:** This case underscores the critical need for mental health awareness and early intervention in preventing the progression of schizophrenia to treatment-resistant stages. It also highlights the unique challenges faced by individuals in remote areas with limited access to mental health resources.

Keywords: Schizophrenia, Mental Health Unawareness, Treatment-Resistant Schizophrenia, Kashmir.]

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INTRODUCTION

Schizophrenia is a complex and multifaceted psychiatric disorder characterized by profound disruptions in thinking, perception, and behavior. It is marked by disturbances in individuality, uniqueness, and self-direction, often leading to a fragmented sense of self. Individuals with schizophrenia experience altered perceptions of reality, including delusions and hallucinations, which can involve beliefs in supernatural forces or external control. These symptoms significantly impair daily functioning and quality of life [1]. The disorder is typically categorized into three symptom domains: positive (e.g., hallucinations, delusions), negative (e.g., social withdrawal, anhedonia), and cognitive (e.g., impaired executive functioning) [2].

One of the most intriguing aspects of schizophrenia is its impact on the sense of self. Individuals often struggle to distinguish between internal experiences and external reality, leading to a loss of personal identity and autonomy. This cognitive disorganization can result in fragmented thought processes, irrelevant speech, and social isolation. Despite being physically present in social situations, the person's reality is often defined by internal experiences, such as auditory hallucinations or delusions of control over external events [3]. These symptoms not only disrupt interpersonal relationships but also contribute to significant functional impairment [4].

Despite advances in treatment, a significant subset of individuals with schizophrenia develops treatment-resistant schizophrenia (TRS), defined as a lack of response to at least two adequate trials of antipsychotic medications [5]. TRS is associated with poorer outcomes, including persistent symptoms, chronic disability, and increased healthcare utilization [6]. The underlying mechanisms of TRS remain poorly understood, though research suggests that neurobiological factors, such as dopamine dysregulation, serotonin imbalance, and glutamate dysregulation, play a central role [7,8]. Additionally, neuroinflammation has emerged as a critical factor, further complicating the clinical picture.

The history of schizophrenia treatment reflects a journey from inhumane practices to more enlightened and effective interventions. In the 1930s, insulin shock therapy was introduced, involving the induction of a hypoglycemic coma to alleviate symptoms. However, this method often resulted in severe side effects, including convulsions and hypoglycemia [9]. By 1938, electroconvulsive therapy (ECT) emerged as an alternative, though it too was associated with significant risks and ethical concerns. The mid-20th century saw the controversial use of lobotomy, a procedure that involved severing neural connections in the brain, often leading to irreversible damage and human rights abuses [10].

The advent of chlorpromazine in the 1950s marked a turning point in schizophrenia treatment. As the first typical antipsychotic, chlorpromazine revolutionized psychiatric care by effectively managing positive symptoms. However, its use was limited by extrapyramidal side effects, such as tardive dyskinesia [11]. The introduction of clozapine in the 1970s as the first atypical antipsychotic represented another milestone, offering efficacy in treatment-resistant cases with fewer motor side effects. Clozapine remains a cornerstone of treatment for refractory schizophrenia, underscoring the progress made in understanding and managing this complex disorder [12].

The prognosis for individuals with schizophrenia, particularly those with TRS, is often unfavorable, with many experiencing chronic symptoms and disability. However, emerging treatments, such as clozapine and adjunctive therapies like modified electroconvulsive therapy (MECT), offer hope for improved outcomes [13]. Early intervention and personalized treatment approaches are critical to addressing the heterogeneity of schizophrenia and improving long-term prognosis [14]. Despite these advancements, non-adherence to medication remains a significant barrier to effective treatment, exacerbating the condition and leading to frequent relapses [15].

CASE STUDY: A 27-YEAR-OLD MALE WITH TREATMENT-RESISTANT SCHIZOPHRENIA

Clinical Presentation and Symptoms

The patient, a 27-year-old male from Kashmir, initially presented with prominent confirmed symptoms of schizophrenia, including persistent auditory hallucinations, disorganized speech, and paranoid delusions. These symptoms were accompanied by negative symptoms such as flat affect, social withdrawal, and significant cognitive impairment. His paranoia and suspiciousness intensified over time, leading to interpersonal conflicts with family members and a complete detachment from social obligations.

Clinical Examination

During the clinical examination, the patient was found to be appropriately dressed for the weather but exhibited poor speech output, limited to one-word answers, and noticeable muffling with reduced volume. When asked how he was, he responded with "theek" (a Kashmiri word meaning "okay") in a low voice. His affect was blunt and incongruent, reflecting emotional flatness. Cognitive deficits were evident in areas of attention, memory, and verbal communication, which significantly impaired his social and occupational functioning. The patient demonstrated limited insight into his illness, and his judgment was impaired, leading to troubled behaviors such as wandering and violent outbursts.

Treatment History

The patient's treatment journey began with haloperidol, a first-generation antipsychotic, which led to severe extrapyramidal side effects (EPS), including rigidity and tremors. Due to these adverse effects, he was switched to risperidone and later olanzapine, both of which showed minimal improvement in managing his symptoms. Despite multiple hospitalizations for acute exacerbations of his condition, non-adherence to prescribed medications remained a significant challenge, further complicating his treatment.

Given the lack of response to standard antipsychotics, the patient was started on clozapine, the gold standard for treatment-resistant schizophrenia (TRS). While clozapine alone did not yield significant improvement, its combination with modified electroconvulsive therapy (MECT) provided temporary stabilization. However, the patient continued to experience fluctuations in symptom severity, particularly during periods of non-adherence or absence from hospital care.

Psychosocial Impact and Patient Perspective

The patient's illness has had a profound impact on his psychosocial functioning. Over the past seven years, his condition has remained largely unchanged, with periods of temporary stabilization followed by relapses. Despite these challenges, the patient acknowledges that his current state is an improvement compared to his earlier condition. After returning from MECT, he spoke softly about how the hospital environment and the presence of his caretakers provide a sense of stability and safety. He expressed gratitude for their understanding and ability to manage his illness, stating, "I feel okay here."

DISCUSSION

Manifestation and Progression of the Disorder

The disorder manifested in early adulthood, consuming the patient's youth and transforming minor behavioral outbursts into violent acts. Initially, these symptoms were attributed to supernatural causes, such as the presence of bad spirits, delaying appropriate psychiatric intervention. This lack of awareness and understanding of the illness allowed the aggression and psychotic symptoms to worsen, ultimately consuming the patient's sense of self and identity. The progression of schizophrenia, if left untreated or mismanaged, often leads to severe functional impairment and a diminished quality of life [1].

The patient's treatment history reflects a series of trials and errors with various antipsychotic medications. In 2021, he was prescribed olanzapine, which showed partial improvement over three months. By 2023, the dosage was increased, but the benefits remained limited. In 2024, risperidone was introduced, with dosage adjustments made over two months, but no significant improvement was observed. The subsequent use of haloperidol, a first-generation antipsychotic, led to neuroleptic malignant syndrome (NMS), a life-threatening side effect, necessitating its discontinuation. Finally, clozapine was introduced, but its efficacy was limited when used alone. The combination of clozapine and electroconvulsive therapy (ECT) provided temporary stabilization, but the patient's condition continued to deteriorate over time [13,15].

The patient's deteriorating condition cannot be solely attributed to the late initiation of treatment. A significant contributing factor is the lack of awareness about mental health disorders, which delayed the recognition and management of his illness. This case highlights a broader issue in many regions, where mental health literacy is low, and psychiatric disorders are often misunderstood or stigmatized. The patient's family initially believed his symptoms were a divine test, reflecting the cultural and societal barriers to mental health care [16]. Such misconceptions delay treatment and exacerbate the severity of the disorder.

Non-adherence to medication has been a persistent challenge in this case. The patient's reluctance to take prescribed medications, coupled with his tendency to wander away from home, has hindered long-term management. While the patient has shown some improvement in adhering to treatment over the past year, his condition remains unstable, particularly during periods of discharge. This pattern underscores the importance of continuous monitoring and support for individuals with treatment-resistant schizophrenia (TRS). Studies have shown that early intervention and consistent treatment adherence can significantly improve outcomes in schizophrenia, whereas delays and non-adherence often lead to chronic impairment and poor prognosis [17].

The family's belief that the patient's suffering was a divine test highlights the pervasive stigma and lack of awareness surrounding mental health in many communities. This case underscores the need for widespread mental health education and culturally sensitive interventions to address misconceptions and encourage timely treatment. Without addressing these sociocultural barriers, the burden of untreated or poorly managed schizophrenia will continue to grow, affecting not only individuals but also their families and communities [16,18,19].

CONCLUSION

The case study highlights the critical need for widespread mental health education and culturally sensitive interventions to address misconceptions and encourage timely treatment for individuals with schizophrenia, particularly in regions with limited mental health resources. The patient's journey from early symptoms to treatment-resistant schizophrenia (TRS) underscores the devastating consequences of delayed intervention, lack of awareness, and societal stigma surrounding mental health. The progression of the patient's illness, exacerbated by cultural beliefs and non-adherence to treatment, illustrates the importance of early diagnosis and consistent care. The case also emphasizes the challenges faced by individuals in remote areas, where access to mental health services is often limited, and mental health literacy is low.

To improve outcomes for individuals with schizophrenia, especially those at risk of developing TRS, it is essential to:

1. Promote Mental Health Awareness: Increase public understanding of schizophrenia and other mental health disorders to reduce stigma and encourage early intervention.
2. Provide Culturally Sensitive Care: Develop interventions that respect and incorporate cultural beliefs while educating communities about the importance of psychiatric treatment.
3. Ensure Access to Treatment: Expand mental health services in underserved areas to ensure that individuals have access to timely and effective care.
4. Support Treatment Adherence: Implement strategies to improve medication adherence, such as patient education, family involvement, and continuous monitoring.

By addressing these barriers, we can improve the quality of life for individuals with schizophrenia and reduce the burden of treatment-resistant cases. This case serves as a reminder of the importance of a holistic approach to mental health care, combining medical treatment with psychosocial support and community education.

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CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest.

REFERENCES

1. American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Publishing.
2. van Os J, Kapur S. (2009). Schizophrenia. Lancet. 374(9690):635-645.
3. Sass LA, Parnas J. (2003). Schizophrenia, consciousness, and the self. Schizophr Bull. 29(3):427-444.
4. Kirkpatrick B, Fenton WS, Carpenter WT, Marder SR. (2006). The NIMH-MATRICS consensus statement on negative symptoms. Schizophr Bull. 32(2):214-219.
5. Howes OD, McCutcheon R, Agid O, de Bartolomeis A, van Beveren NJ, Birnbaum ML, et al. Treatment-resistant schizophrenia: Treatment Response and Resistance in Psychosis (TRRIP) Working Group consensus guidelines on diagnosis and terminology. Am J Psychiatry. 2017;174(3):216-229.

6. Kennedy JL, Altar CA, Taylor DL, Degtiar I, Hornberger JC. (2014). The social and economic burden of treatment-resistant schizophrenia: A systematic literature review. Int Clin Psychopharmacol. 29(2):63-76.

7. Meltzer HY. (2012). Clozapine: Balancing safety with superior antipsychotic efficacy. Clin Schizophr Relat Psychoses. 6(3):134-144.

8. Kahn RS, Sommer IE, Murray RM, Meyer-Lindenberg A, Weinberger DR, Cannon TD, et al. (2015). Schizophrenia. Nat Rev Dis Primers. 1:15067.

9. Shorter E. (1997). A history of psychiatry: From the era of the asylum to the age of Prozac. New York: Wiley.

10. Valenstein ES. (1986). Great and desperate cures: The rise and decline of psychosurgery and other radical treatments for mental illness. New York: Basic Books.

11. Leucht S, Cipriani A, Spineli L, Mavridis D, Orey D, Richter F, et al. (2013). Comparative efficacy and tolerability of 15 antipsychotic drugs in schizophrenia: a multiple-treatments meta-analysis. Lancet. 382(9896):951-962.

12. Kane J, Honigfeld G, Singer J, Meltzer H. (1988). Clozapine for the treatment-resistant schizophrenic: A double-blind comparison with chlorpromazine. Arch Gen Psychiatry. 45(9):789-796.

13. Siskind D, Siskind V, Kisely S. (2020). Clozapine response rates among people with treatment-resistant schizophrenia: Data from a systematic review and meta-analysis. CNS Drugs. 34(4):367-382.

14. Correll CU, Rubio JM, Kane JM. (2018). What is the risk-benefit ratio of long-term antipsychotic treatment in people with schizophrenia? World Psychiatry. 17(2):149-160.

15. Grover S, Sahoo S, Rabha A, Koirala R. (2019). ECT in schizophrenia: a review of the evidence. Acta Neuropsychiatr. 31(3):115-127.

16. Thara R, Srinivasan TN. (2000). How stigmatising is schizophrenia in India? Int J Soc Psychiatry. 46(2):135-141.

17. Kane JM, Robinson DG, Schooler NR, Mueser KT, Penn DL, Rosenheck RA, et al. (2016). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. Am J Psychiatry. 173(4):362-372.

18. Bleuler E. (1950). Dementia praecox or the group of schizophrenias. New York: International Universities Press.

19. Smith RC, Lindenmayer JP, Davis JM. (2016). Smoking and schizophrenia: Evidence for self-medication. Schizophr Res. 176(2-3):123-129.