

PERSONALISED APPROACH IN TREATMENT OF A PREPSYCHOTIC ADOLESCENT

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SUMMARY

In clinical practice with adolescents we often come across with prepsychotic and psychotic disorders. When an adolescent patient has a positive hereditary burden for psychiatric illnesses in both parents, then the qualification of adolescent's mental disorder seems closer to psychotic. We must have in mind that hereditary burden is only one of many etiological factors that contribute to mental decompensations in adolescent age, that can, but don't have to be the prodrome of psychosis in the future. Whether is characterised as psychotic or not, the treatment of an adolescent in critical situation must be personalised, considering biological, social and individual factors of a patient. We believe that clinician's experience in treating psychotic adolescent patients and personalised and integrative approach to a patient is of great importance.

In this article we will present the therapeutical process of a 19-year old female adolescent, with psychotic symptoms, whose both parents are psychiatric patients. A personalised and integrative approach in treatment of this patient made possible the overcome of crisis, termination of high school education and an employment. These achievements, no matter what the future can bring to this patient, create better conditions for her functioning in life.

Key words: adolescence – heredity - personalised treatment

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INTRODUCTION

Psychotic disorders in adolescents appear often in middle and late adolescence as Brief psychotic episodes. These episodes can be transient or can lead to a chronic, long-lasting illness with bad prognosis and long-term treatment.

In order to evaluate and classify psychotic disorders in adolescence, besides diagnostic criteria of actual classifications, developmental processes must also be included and considered, as well as the family context where the child or an adolescent comes from (Nikolić et al. 2004).

When a child is raised by parents who are mentally ill, then the child's psychological development is negatively influenced by numerous risk factors (like dysfunctional family dynamics, lack of feeling of safety, traumatic childhood experiences, being different from children of the same age, disturbed process of separation, lack of positive identification figures, low self-esteem, etc) that can contribute in appearance of psychiatric symptoms (Manjula, 2009).

Children's and adolescent's behavioural adjustment and parent-child interaction operate through bidirectional family processes, some of which have genetic roots (Kuczynski et al. 1997).

A large body of literature describes how specific psychiatric conditions may influence parenting styles and how children who live with "disordered" parents fare in their overall development (Cox et al. 1987, Deater-Deckard 2000).

However, many studies tend to ignore that association between parental behaviour and child

disorders is not unidirectional, and it is necessary to evaluate possible contributions of genetic or other factors within the child in each case (Lewis 2002).

Interaction of many factors mentioned above, demonstrates the importance of an individualised, personalised approach in psychiatric evaluation of every child or adolescent. Also, a similar approach is necessary in therapeutical interventions in children and adolescents, which often includes psychopharmacotherapy, psychotherapy and sociotherapy.

CASE REPORT

A 19-year old female adolescent comes alone to the Ward of psychiatry due to intensive fears, nonsystematised ideas of relation, sleeping and eating disturbances, and an overwhelming feeling of inadequacy; all of these symptoms first appeared twenty days ago.

Her symptoms were estimated as prepsychotic and she was admitted for in-hospital treatment.

Our patient is a nurse, had just finished high school, and began her internship, during which she started experiencing psychiatric symptoms. In the same time her emotional relationship ended. She says that she always has difficulties adjusting to new situations, and has a hard time when faced with stressful events. Because of the symptoms that appeared during her nurse internship, she wants to end that internship and maybe start some other school, less demanding, that would prepare her to become a hairdresser, because she doesn't feel capable for anything else.

Her parents divorced when she was 7 years old. She lives with her mother, who is treated for schizoaffective

psychosis. Her father lives in another town, and is diagnosed as paranoid schizophrenia; the patient often contacts him. Mother is employed, and father is in invalid retirement. She is an only child. She never had any serious physical illnesses, except rather often respiratory inflammations in childhood. She was never too close to her mother. She always had hard time coping with her parents' mental illnesses, especially her mother's illness and her absences from home, when a neighbour looked after her. Growing up, she became very ashamed because of her parents.

Until early adolescent age she didn't have any significant psychological or mental difficulties. She was a good student, but had few relations with children of the same age. In sixth and seventh class of elementary school she began to feel bigger pressure, everything had to be perfect; she had to have only excellent school marks. She wanted to continue with professional high school, but her mother insisted on medical high school, that would prepare her to become a nurse, even though she didn't feel capable enough for that kind of work. In high school she also had good marks, but she experienced overall process of education (programme, other students, and teachers) as very stressful.

At the end of second class of high school, summer vacations were ending, and she was treated on psychiatry for state of crisis, evaluated as Brief psychotic episode (F 23.8). Hospitalisation occurred after summer seasonal work and termination of an emotional relationship. She complained that she was exhausted, couldn't sleep, began to feel strange, and became sad and forgetful. She had an impression that people at work were criticizing her, that she wasn't working good enough, that they were making jokes about her parents. After two weeks of treatment her symptoms disappeared. Medication was recommended – risperidone 2 mg and diazepam 10 mg in the evening.

In the period between two hospitalisations she was in outhospital psychiatric ambulatory treatment. Due to galactorrhea that appeared after one year of pharmacotherapy, medication with risperidone was stopped; she continued taking antidepressants (fluoxetine, tianeptine) for several months. She was feeling good, and psychopharmacotherapy was interrupted. She successfully graduated high school (medical school).

During second hospitalisation examination was conducted; laboratory values and EEG were normal.

Psychological evaluation confirmed increased anxiety and depressive mood. Tolerance threshold for frustration was decreased, self-control weakened, self-esteem low. Further more, confidence in her own capacities was diminished and interfered considerably in "becoming a grown up". Anticipation of future generated anxiety. Fears of illnesses and social situations were increased, and fear control was diminished. Family situation represented an important field of conflicts (the way she saw her parents, their interpersonal relations).

During in-hospital treatment, anxiolytic doses of quetiapine and hypnotics were used. She was included in group psychotherapeutic work adjusted for adolescents on our ward (sociotherapy, educative therapy, art therapy, therapeutical community). Gradually, her symptoms were reduced, her mood became better, her sleep and eating was also regulated, and the patient was discharged, with recommendation of Daily hospital programme.

The following three months, she came regularly to recommended Daily hospital program, that included sociotherapy, educative group therapy, psycho-drama and analytic therapy. In the process of therapy many therapists of different profiles participated (psychiatrist, psychologist, social pedagogue, resident in psychiatry, head nurse). Through estimation of therapeutical procedures, clinical evaluation and psychological retesting, we concluded that psychical condition of the patient was rather improved. In group interactions she became more open, active; she opened and worked through family interpersonal relations and her feelings and reactions to them. Her mood was better, as well as her self-esteem. Functioning within group setting became more effective, which made possible an improvement outside group frame.

Diagnosis at discharge: Brief psychotic episode (F 23.8); Adolescent crisis.

She decided to give up prequalification and to continue her nurse internship. We contacted head nurse of the hospital who was responsible for organising nurse internships. We asked for and received her understanding and cooperation. The patient gradually continued internship; she started of with "less stressful and less demanding wards", and because she functioned well there she transferred to "more stressful and more demanding wards". This way earlier negative experiences and stress effects were reduced.

She successfully terminated internship. She was employed as a nurse.

She was a very regular patient during outhospital treatment controls, anxiolytic doses of quetiapine were reduced and two years after she didn't have quetiapine in therapy. She comes for support psychotherapy every few months. She's now feeling well and is working.

DISCUSSION

Empirical studies that examine the effects of specific parental disorders on the development of children go back to the early part of 20th century. Janet (1925.) concluded that mental disorders of parents had a negative effect on their children because of their impact on the social life in the family (Janet 1925).

Later studies, involving general population samples (Rutter et al. 1975) and case control comparisons on children and parents with a mental disorder (Cytryn et al. 1984, Beardslee & Poderesfsky 1988) further extend our knowledge and permit us to ask some specific question about the linkage between parental and child

psychiatric disorder: How close is the demonstrated link between psychiatric disorder in parents and children? The answer is „significant but not very close“. Large sample of studies indicates that poor parenting is just one of many other risk factors for later mental health (Lewis 2002).

Our clinical case report demonstrates that in diagnostic evaluation we were led by actual diagnostic criteria, developmental processes and family surrounding, according to principles of personalised and individualised psychiatry.

Integrative psychiatry originates from the principle of harmony of human's body and soul, and it is built on the premise that human beings in health and disease are complex systems of dynamically interacting biological, psychological, social, energetic, informational and spiritual processes (Jakovljević 2008).

Patient's clinical symptoms were analysed in the context of all mentioned factors, always having in mind her hereditary psychiatric burden, but also respecting her individual characteristics.

Symptomatology that our young patient presented in period before both hospitalisations occurred, satisfied criteria for the diagnosis Brief psychotic episode (F 23.8) according to diagnostic criteria ICD-10 classification of illnesses (International Statistical Classification of Diseases and Related Health Problems 1992).

In the process of treatment of mental disorders in children and adolescents personalised and integrative approach is necessary. It requires good knowledge of psychopathology, psychopharmacotherapy, developmental processes and relations in family, which interaction in every child or adolescent is expressed in a specific and unique mode. When a patient is a child or an adolescent growing up, then the presence of different profiles of therapists that take care of the patient is inevitable (Došen 2007).

Our clinical case report shows that despite strong hereditary mental burden and prepsychotic disturbances in two periods in time, a personalised psychiatric approach can bring good results. Our interventions were based on individual evaluation of all aspects of the patient. Psychiatric treatment started as in hospital care, and then continued with treatment in Daily hospital, with presence of many different profile therapists. Pharmacotherapy, psychotherapy and social interventions were organised on personalised level. In this way, we achieved the overcome of psychotic episode, reduction in symptoms, remission, as well as education and employment of our patient.

Integrative psychiatry may have a role in reducing other modifiable risk factors, including reduction of stress level, stress management strategies, family consultation/education, education against street drugs use, treatment of prodromal symptoms and developmental social skills (Šagud et al. 2008).

It would be very hard to estimate future psychic deteriorations of the patient in some new life stressful

events or crisis. We believe that achieved education and employment are a good foundation for her better life, no matter what temptations in mental health may come in future.

CONCLUSION

Diagnostic evaluation of psychotic disorders in adolescence is a complex process that includes consideration of psychic symptoms, developmental processes and interactions in the family where the child was raised.

Even in situations of strong hereditary psychiatric burden, disorders of parenting are not static single variables and are best understood within the context of developmental psychopathology. Thus is, they reflect interactions between internal representation within parents and outside stresses and support, as well as a range of child related variables (6).

In treatment of Brief psychotic episode of our adolescent girl patient we used psychopharmacotherapy, psychotherapy and sociotherapy in all three stages of treatment – inpatient, daily hospital and ambulatory (outpatient). We were guided by principles of integrative and personalised psychiatry that are necessary in treatment of psychiatric disorders in children and adolescents.

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