"The one" Annoying Patient

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Schizophrenia – a mind torn asunder – is a difficult illness to live with, both for the patient as well as for the caregiver; thus, it is not an uncommon sight to see the authorities bring such patients to our psychiatric practice, whether abandoned or simply lost. What was unusual in this case is that this patient was handed over to us by 2 dour "agents" as they introduced themselves. It was assumed that they were from the FBI, though we never got a chance to see their credentials.

Background

Mr Anderson was a young heterosexual Caucasian male working as a programmer in a large computing firm. He lived alone in a small apartment and was currently not in any meaningful relationships. He was generally reclusive and introverted. He went by the alias "neo" on the Internet and was a computer programmer of a renowned association in the underground software community.

Recently, however, he has developed certain behavioural traits that his friends have become concerned about. He believed that he was being constantly watched by some police force or there were spies eyeing on his programmes and he had overheard conversations about him when there was no one around. He was notably more socially withdrawn.

His employer found him to be a bright young man with great aptitude for his vocation but without the discipline and attitude to go far. He was constantly late for work and always appeared looking as if he had not slept much the night before. Recently, he had a sudden loss of his usual interests, a lack of productivity at work, and a loss of drive to the point where he often failed to show up to work (He was in short starting to behave somewhat like a houseman).

History

Mr Anderson had no history of mental illness in his family. His childhood and developmental history showed no abnormalities. He was a heavy smoker but otherwise had no previous medical history of note.

Mr Anderson has started to hear voices giving him instructions via the telephone and from his computer screen. These voices encouraged him to indulge in various risk-taking behaviours. In the latest incident, he was found on the 30th floor outside his office building along the window ledge, apparently trying to escape from the authorities. He claimed that the voices from his mobile phone bade him to do so, but a quick check of the phone log confirmed that there were no incoming calls received at that time. These auditory hallucinations were at times male, other times female, and appeared to originate from various different personalities. He had no previous suicide attempts.

The same hallucinations had also caused him to partake in some instances of high-risk behaviour. Apparently after taking orders from his computer screen to "follow the white rabbit", he then latched onto the first rabbit imagery he saw, which in this case was a tattoo of a rabbit (being a tattoo it was probably a bluish-green rabbit rather than a white one) on the shoulder of a fetching female punk and accompanied a group of total strangers to an all-night rave party. He then met a lady "trinity" who introduced him to her drug dealer.

From the history elicited, it can be surmised that Mr Anderson has certain attitudes towards "recreational medication" that could only be described as cavalier. When offered 2 pills to choose between by the drug dealer, who is aptly enough called "Morpheous", with only vague allusions mentioned to their effects and side effects: "Take the red pill and I'll show you how deep the rabbit hole goes", Mr Anderson chose based on the colour of the pill. He subsequently swallowed the pill in the presence of the aforementioned dealer and started seeing solid objects attain liquid characteristics and take on a metallic sheen. This spectrum of effects hints that the pill may contain a hallucinogen, possibly lysergic acid diethylamide (LSD).

Incidentally, Mr Anderson had spent an inordinately large amount of time in front of his computer looking for this "Morpheous" character. It must be said that we have advised him that it is not a recommended practice to trawl

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the Internet for prescription medication.

Mr Anderson suffered from delusional symptoms of an impressive magnitude. He had a preoccupation with a world called the "matrix" which he believed mankind was currently trapped in. The current reality was an illusion into which we were all bound and there was a sinister plot by a machine overlord to take over our existence and change us into human batteries. The schizophrenic nature of his delusions was further reinforced by this loose, disconnected incoherent discourse.

In this same "matrix", it seemed Mr Anderson saw himself as a central figure in this world and was currently the only person who could save mankind from the aforementioned machine overlords. We looked for other symptoms of mania but they were not evident. When we asked Mr Anderson to prove his omnipotence, he attempted to bend a teaspoon with the power of his mind, making odd movements and whispering a mantra that sounded like: "*there is no spoon, there is no spoon*". An attending staff nurse waited 15 minutes before losing patience and bent the spoon with the power of his supinator muscles.

He further claimed that he could escape to his alternate reality through the telephone. When we attempted to verify if he meant that he was attempting to contact his "Morpheous" for another hit of recreational medication, he became frustrated and tried to explain that he could physically travel through the phone wire if he could only contact his "operator". We decided to test this delusion of control (e.g. call his bluff) and put him in touch with a telephone operator. He was naturally unable to move through the telephone wire and put this down to the "machines" blocking his exit, much to the bewilderment of the telephone operator on the other end.

Mr Anderson exhibited poor insight and did not appreciate our attempts to help him. He had paranoid ideation towards the medical staff. He sat there chain-smoking while claiming we were serving the cause of the machines but did not know it.

He displayed a very limited, almost catatonic, emotional range during our interview with him and demonstrated a great poverty of speech with a largely blunted affect. He also showed thought blocking in which long pauses were made before answers to questions or odd pauses occur in the middle of answers. (The views expressed here are the writers own, any mention of psycho-motor retardation in reference to the wooden acting ability of certain part-Hawaiian actor celebrities are purely coincidental.)

Certain phrases, however, caused Mr Anderson to become very agitated. One of our staff in passing mentioned that he experienced an episode of "déjà vu" This sparked off a panic episode during which he attempted to break down the door and flee the room, claiming the same machines were coming. It was only with the help of our custodians that we managed to overpower and sedate him. This ended our session with him, just another schizophrenic-affective patient on a long night shift. We left him for the daytime staff to sort out, but somehow we have an illogical yet pervasive feeling that we have condemned the human race.

Mental State Examination

Appearance: A quick examination shows that Mr Anderson was dressed oddly wearing a black trench coat and sunglasses. He was neat and tidy, though apathetic and self-absorbed.

Behaviour: He was retarded and withdrawn, only becoming agitated when certain key phrases were mentioned. He appeared unduly suspicious of the examiner and endorsed a variety of odd beliefs or delusion. He had a flat affect.

Conversation: There appeared to be a formal thought disorder, and his speech was slow and laced with stoppages. There was a vagueness of speech and he often answered questions with pseudo-existential statements that did not relate to the question (e.g. "am I really here, or is the matrix making me think I am here?").

Emotion: He had a depressed mood, but denied any suicidal ideation.

As described previously Mr Anderson suffered from severe auditory hallucinations. It originated from the telephone and his computer and occurred at all hours. There was no evidence of olfactory or visual hallucination.

Mr Anderson's orientation to time, place and person was intact. His attention was normal and he was able to perform serial 7s. His ultra-short, short and long term memory were intact

He had poor insight into his condition and poor judgment.

The patient did not report any other signs of alcohol withdrawal, such as sweating, hand tremor, nausea, or vomiting.

There were no obvious movement disorders, stereotypic movements or mannerisms.

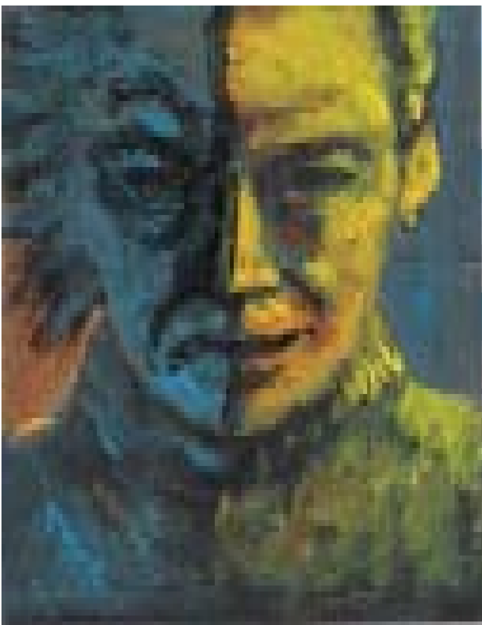
His vital signs are stable.

Gross examination of the heart, lungs and abdomen were essentially normal. There were no skin lesions or rashes.

Neurological examination was normal as well and the cranial nerves were intact, he was ambulatory and he was moving all 4 limbs.

Discussion

Due to his current mental state, Mr Anderson has experienced an overall deterioration and change in his



quality of life with neglect of his personal hygiene and an apathetic outlook to the social aspects of his life.

Incidentally, he has not shown any overt symptoms of depression despite his suicide attempts.

His rambling speeches about post-apocalyptic machine controlled worlds and his obsession with him being the saviour of humanity lent some weight to a diagnosis of mania, but the rest of his history and examination were incongruent with such a diagnosis

According to the DSM-IV American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders[1] for the patient to be diagnosed with schizophrenia, he must have experienced at least 2 of the following symptoms: delusions, hallucinations, disorganised speech (e.g. frequent derailment or incoherence), grossly disorganised or catatonic behaviour, or negative symptoms like affective flattening, alogia or avolition. The patient must experience at least 1 month of symptoms (or less if successfully treated) during a 6-month period, and social or occupational deterioration problems occur over a significant amount of time. These problems must not be attributable to another condition for the diagnosis of schizophrenia to be made.

Whilst the length of symptoms that Mr Anderson has suffered from these symptoms was debatable, he obviously had persistent delusions and hallucinations. His blunted affect and unusual reaction towards typical phrases ("déjà vu") also is sympathomimetic of schizophrenia. Other alternative differentials would be of paranoid schizophrenia, or possibly even drug-induced psychosis, taking into account his predilection towards recreational drug use.

The onset of his symptoms was during his early adulthood, which is typical of schizophrenia. Mr Anderson, like most patients with schizophrenia (and teen idols), smoked. Smoking may also be related to the boredom associated with hospitalisations, the peer pressure from other patients to smoke, or the boredom associated with unemployment. In any case, the health risks from smoking are well known, and patients who are schizophrenic should be encouraged to stop smoking.

His prognosis was fair for he did not have the poor prognostic factors of early onset of illness, or a family history of schizophrenia. He did exhibit prominent negative symptoms, which were known to be associated with poorer outcomes. His drug usage may point in his favour as paradoxically, a history of substance abuse may also be associated with better prognosis. However, his suicide risk was also higher as a result of such behaviour. There was also an association with increased hostility, crime, violence, non-compliance with medication, homelessness, poor nutrition and poverty. The deleterious effects of substance abuse cannot be overestimated, not to mention the risk of contracting transmitted diseases from intravenous use, Hollywood lifestyle not-withstanding.

REFERENCE

1. Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). 4th ed. Washington D.C.: American Psychiatric Association, 1994

Robert's Surgical Practice

Dear Colleagues and friends

I am pleased to inform you that I have started my practice in Mao E Medical Centre since Feb 2006, upon leaving a renowned tertiary hospital in Singapore, where I slogged for 15 years. I am no stranger to long hours of surgery, having assisted many surgeon-teachers who trained me to hold retractors and gave me an opportunity to perfect my wound closures.

My current practice is robot-based and revolves around the management of challenging unresectable tumours of the abdomen. I am particularly known for my work in pancreatic cancers, especially those that have invaded the vertebra and aorta. My other areas of interest include:

- **Screening for microsopic pancreatic cancers with the Da Vinci Robotic System**
- **Robotic liver transplantation**
- **Robotic excision of sebaceous cysts of the skin**
- **Robotic gastro-oesophagoscopy**
- **Robotic consultation (I am usually away on the golf course)**

For more information please contact my nurse, a medically trained robot Ms Tan Vin Chee SRN, Tel 1101101 or e-mail: hey@youcannotbeserious.com.sg

DR ROBERT TAN
MBBS, FRUST, FAMISHED, Da Vinci Certified, MBA, E.R.A. Certified
Consultant Pancreatic (Difficult Cases) Surgeon

Featured in Channel News Asia (21 Nov 2004 7.30 pm), Zao Ann Ni Hao, and Tatler Singapore (Sept 2004, page 76, upper left picture, standing beside our Prime Minister)

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