The case of MF

Name:	MF
Age:	56 years old
Gender:	Male
Race:	Malay
Religion:	Islam
Marital status:	Single
Occupation:	Unemployed
Address:	Bercham, Perak, Malaysia.
Source of information:	1) Patient 2) Family members (siblings) 3) Ex-colleagues 4) Hospital record of patient

(Owing to the fact that MF has a long history of mental disorder for more than 30 years, it will be more coherent and appropriate to present his case beginning from his first contact with Psychiatric Health Care, rather than to start off with his current condition and working retrospectively later.)

HISTORY OF PRESENTING ILLNESS:

MF is a 56 year old Malay gentleman who is still single and unemployed, he has been diagnosed as suffering from Schizophrenia at the age of 21.
The chronicity of his illness and unfavorable social environment pose a challenge to his treatment. As a result, he has been admitted to Hospital Bahagia for 17 times.

On the 12th of September, 1967, at the age of 21, MF was brought by his father to consult Dr. KSN of Hospital Batu Gajah, Perak who subsequently referred him to the Central Mental Hospital (former name of Hospital Bahagia) with the following symptoms:

1) hallucinations
2) delusions

Patient was unable to remember the duration of his symptoms prior to admission, but he said he had been hearing voices for almost a year.
He heard many voices of both males and females.
He had auditory hallucination in 2nd person; he heard the voices talking to him and scolding him, e.g., “You are stupid, useless!”
He also experienced 3rd person auditory hallucination when he heard the voices making derogatory remarks about him, e.g., “He is a dirty fool! He never showers.”

He claimed to see ‘small people’ and feeling flies and spiders crawling all over his body. He denied abusing substance such as alcohol or drugs which might give rise to these visual and tactile hallucinations.
Patient said he was afraid to see his image in the mirror as he could see a

tiger instead. He had bizarre delusion as he believed he was half man and half tiger. He had delusion of control and passivity phenomenon.
He believed his thoughts were read by others and they knew all his secrets although he could not tell exactly who those people were.

On the first few days of admission, he was noted to talk irrelevantly such as "I don't want to be James Bond" and "If they cut the pine tree, I will die!"
Most of the time patient was uncommunicative and kept to himself.
He appeared preoccupied and sometimes smile to himself for no apparent reason. He chose to sit alone for long periods of time and disinterested in his surrounding.

Mental state examination also showed flattening of affect and appearing confused. The other aspects of higher cognitive function could not be accurately examined although he might probably have poor insight as he was caught trying to scale the fence to abscond 2 weeks later on the 26.9.1967.
He was treated with Trifluoperazine 5mg thrice a day and a short course of electroconvulsive therapy (ECT) on the 12th, 14th and 16th of October, 1967.
He was reported to be improving and was discharged on the 31st of October, 1967.
On the 19th of February, 1969, he was brought to the hospital for the 2nd time for being withdrawn, preoccupied and indifferent to his clerical job in the army.

He admitted to hearing the same voices again and the bizarre delusion that he was half man and half tiger.

He also complained of finding life difficult in the army.

6 weeks later, on the 1st of April, 1969, he was discharged by the psychiatrist with the following recommendation;

- Diagnosis: schizophrenia- reactive type of Adolf Meyer.
- Improved socially.
- Not retained in the army.

He was treated with oral Chlorpromazine 150mg twice a day.

Patient's 3rd admission was from 4th of June to 28th of July, 1971.

It was a voluntary admission with the complaint of insomnia, talking and laughing to himself.

The following table is a summary of his subsequent admissions.

Some of the details are unavailable due to non-standardized recording.

Number of admissions	Date of admission	Date of discharge	Remarks
4	5.5.1973	29.6.1973	Patient hearing voices talking to him over the radio. Father said he was disturbing and 'acting mad'. Found to be talking irrelevantly.
5	25.2.1977	14.4.1977	Brother complained that patient was breaking door and windows. Unmanageable at home.
6	30.5.1986	(N.A)	Father passed away some time between 1977 and 1986. Patient asked to stay in an empty building near brother's house. Patient said he was rejected by his family. Brother lodged police report complaining about patient's disturbance and 'may be dangerous' to others.
7	22.7.1986	27.8.1986	Brother reported that patient destroyed property and posed a danger to others.
Number of	Date of	Date of	Remarks

admissions	admission	discharge	
8	15.10.1991	(N.A)	Brother complained that patient had been acting abnormally by breaking his shop windows and refused to get treatment.
9	27.8.1993	(N.A)	Brother complained that patient was irritable and threatened to beat him.
10	(N.A)	(N.A)	(N.A)
11	8.4.1994	5.5.1994	(N.A)
12	28.12.1994	14.2.1995	Similar complaints of disturbing and threatening to harm family, and destroying property.
13	(N.A)	5.2.2000	
14	7.2.2000	1.6.2000	
15	4.6.2001	14.12.2001	
16	18.12.2001	31.12.2001	
17	1.1.2002		Awaiting discharge

Footnote:

1) (N.A) refers to information 'not available'.
2) From the 14th admission onwards, the close proximity between the dates of admission with the previous dates of discharge, is due to 'home leave/ holiday' given to patient.

PAST PSYCHIATRIC HISTORY:

MF had no other psychiatric illness prior to his 1st admission.

PAST MEDICAL/ SURGICAL HISTORY:

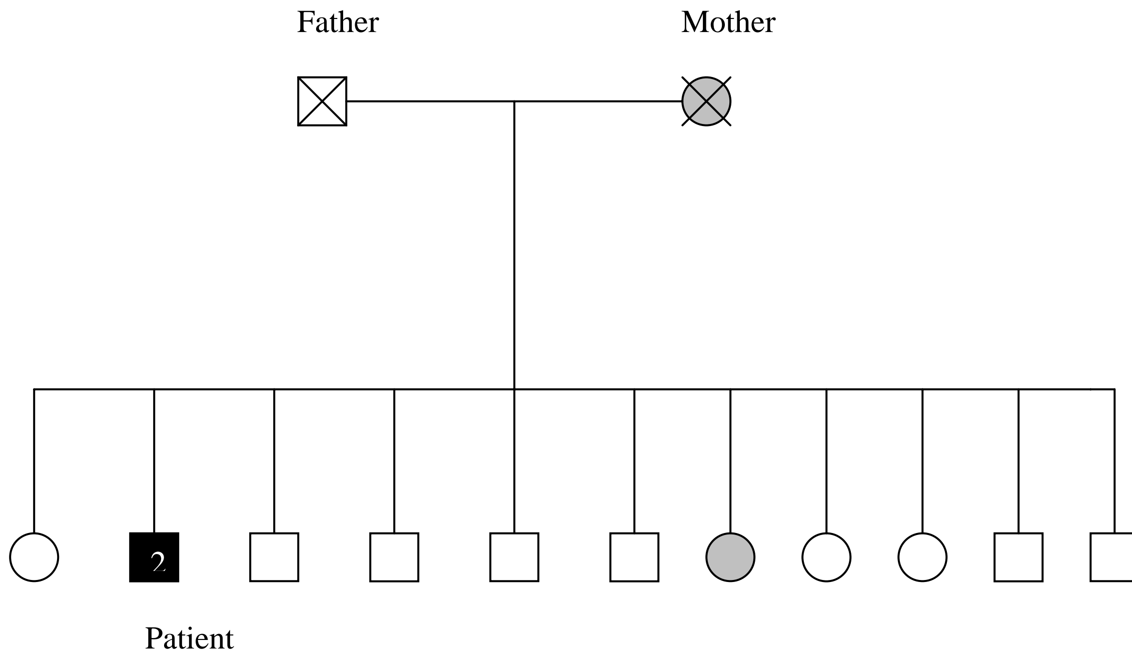
Patient did not have any significant medical or surgical problems prior to his 1st admission although he developed a few episodes of asthmatic attacks in 2001 for which he was treated with oral Ventorlin and Neulin.

FAMILY HISTORY:

MF was the 2nd child in a family of 11 children.

Both his parents had passed away.

There was strong family history of mental illness, both his mother and his younger sister (Salmiah) was diagnosed with Schizophrenia.



Father:

Father was a government officer in the Land Office. Patient described him as a strict and authoritative figure. Nevertheless, he was a loving and responsible man. He passed away around 70 years old, most likely as a complication of hepatitis.

Mother:

Mother was a housewife. She was a loving and caring person. Patient was closer to mother than to father even though he did not confide his problems to her.

Patient could not remember when his mother became ill, but remembered vaguely he was very young when people said his mother was "*gila*" (mad). She had a medical record in Hospital Bahagia which showed she was suffering from Schizophrenia since the 1940s.

After her husband passed away, she moved to Kuala Lumpur to stay with

her eldest daughter until her demise in 2001 at the age of 80.

Siblings:

1) Sister:

   She is about 60 years old now. She is married and lives with her own family in Kuala Lumpur. She is a housewife and took care of her mother when she was alive.

   She is supportive of patient and rallies her siblings together to set up a fund for him.

2) Patient.

3) Brother:

   He is 53 years old and lives with his family in Bercham, Perak. He works as an officer in the "Land and Irrigation Department".

   When patient's father died, he was the one who took in patient into his house and tried to care for him.

4) Brother:

   Works with 'Telekom Malaysia' in the service department. He lives in Kuala Lumpur with his own family. Financially quite supportive of patient.

5) Brother:

   Married and lives in Alor Setar, Kedah. Not much correspondence with patient.

6) Brother:

Married and lives in Tanjong Malim, Perak. Not close to patient.

7) Sister:

She is a mental patient treated in Hospital Bahagia as a case of Schizophrenia. She is married and currently lives with her daughter and son-in-law in Bercham, Perak.

8) Sister:

She is a practicing medical doctor who lives in Kuala Lumpur.

9) Sister:

She lives in Banting, Kedah with her family. Not close with patient.

10)Brother:

He lives in Kampar, Perak. Not close with patient.

11)Brother:

He is 32 years old, married and lives with family in Kuala Lumpur. Not close with patient.

PERSONAL HISTORY:

Childhood:

Patient was born full term, normal delivery.

There was no known perinatal complication.

He had a normal milestone and no childhood neurosis.

He had many childhood friends from his neighborhood and did not exhibit any unusual personality traits.

Academic and Occupation:

His academic performance had not been satisfactory, he often failed in his school examination.

He studied until Form 3 and obtained Grade 3 in his Lower Certificate of Education.

His father told him to join the Trade School in Ipoh which he did for about a year.

When he was about 19 years old, his father secured a job for him as an assistant clerk in a government office.

He was disinterested in the job and sometimes slept in the office. He was dismissed from the job for being irresponsible.

He joined the army on 9.1.1967 at the age of 21 as a clerk.

He did not have a good track record, more over, his mental illness which was diagnosed in September 1967 compounded his work performance.

He was medically boarded up a few years later.

Since then, he did not have permanent employment although he did lend a hand in his brother's business.

Relationship:

He admitted to having a steady girl friend when he was serving in the army. She did not know of his mental illness until she was informed by one of his colleagues.

Initially she corresponded with him, but after a year or two, he did not get any news from her anymore. He did not pursue the relationship because he felt he was both financially poor and mentally sick.

He did not have other special girl friend after that.

History of substance abuse:

Patient admitted to smoking 'ganja' when he was in the army. He claimed he was using it rarely as a recreational drug.

He denied continuing smoking 'ganja' after discharge from the army.

He had been smoking cigarettes for many years since adolescent, averaging 10 sticks per day.

He denied drinking alcohol or consuming other illicit drugs.

PREMORBID PERSONALITY:

Patient was described by his brother as a friendly man.

He easily mixed and made new friends. He was deemed helpful and did not hesitate to lend friends money. He was care-free and 'happy go lucky' in nature.

He was not a loner nor one who entertained odd magical believes, but he never shared his problems with anyone else.

MENTAL STATE EXAMINATION:
(As on 27.6.2002)

General appearance and Behavior:

An elderly looking Malay man who was neat and tidy. He was of average built. He was cooperative and well-mannered.

No abnormal movement such as tardive dyskinesia detected.

Speech:

Patient was forthcoming and cooperative. He was talking relevantly and coherently although he repeatedly apologized for not being able to recall details of his past. There was no looseness of association.

Affect and Mood:

There was some slight flattening of affect.

Otherwise, he was euthymic and his mood was congruent with thoughts.

Thought:

He denied anymore hallucination and delusion, he had been free from abnormality of thought for many years.

Orientation:

Patient was orientated to time, place and person.

Memory:

Patient had good immediate, recent and remote memories.

He was able to do the 5-minute memory test.

Attention and Concentration:

Good.

Judgment:

Good. He was able to say, "Call the fire brigade" when asked what he would do if his house was on fire.

Insight:

He had good insight.

He knew he had mental illness that required prolonged medication. He was receptive to the idea of community psychiatric nursing care.

PHYSICAL EXAMINATION:

Patient did not have pallor, icterus, clubbing, pedal edema or cervical lymphadenopathy.

He had poor oral hygiene.

He had normal vital sign; pulse: 78/minute, regular.

blood pressure: 136/ 88 mmHg.

afebrile.

Examination of cardiovascular, respiratory, abdominal and central nervous systems did not reveal any abnormality.

INVESTIGATIONS:

1) Biological investigations:

Baseline investigations were done, the results were within normal, acceptable range:

Full blood count: normal

Renal function test: normal

Liver function test: normal

Random blood sugar: normal

Electrocardiogram: normal

2) ***Social investigation:;***

These include:

a) patient's work report from his superior while serving in the army during the early phase of his illness.

b) his subsequent assessment of functioning level while in the ward.

c) interview with family members.

Work Report.

Dated: 12.2.1969.

(Excerpt of work report from patient's immediate superior in the army. Patient joined the army as a clerk on 9.1.1967.)

"…at times he is (in) no way to execute his duties in a soldierly manner and find (it) hard to assimilate or absorb any training instructions given, as he always prefers to stay alone and quiet."

"…unstable minded. He comes late, he is always improperly dressed. Very

quiet and offers no violence…when pressed on him, he will go on absent and leave the place without consent of his superior officer.

AWOL (absence without leave): 4.9.67 – 13.9.67, 17.1.69 – 20.1.69 and 28.1.69 – 9.2.69."

Occupational therapy assessment/ treatment plan.

Dated: 12.8.1997.

Summary of patient's assessment:

Patient is independent in activities of daily living such as dressing, grooming, hygiene, eating and community skills.

He has good conversation skills and appropriate social behavior.

He is orientated to place, time and person.

In terms of task operation, he is able to pay attention for more than 30 minutes. He is able to solve minor problem independently. He can make decision with intermittent assistance. His memory functioning is good and can learn a new/ simple task without difficulty. He can follow verbal/ complex instructions but prompting is still needed.

Comments: patient is having poor insight, he needs to be educated.

Aims/ treatment plan:

1) send to 'Penilaian Kefungsian Kerja' ('job functioning assessment') for assessment of work habit and work concept for 2 weeks.
2) send to 'Bengkel' ('workshop') 2 for job training.
3) job placement (need further discussion with family and patient).

Report from 'Bengkel Pemulihan Industri 2' ('industrial rehabilitation workshop 2').

Dated: 14.1.1998.

(translated into English. Kindly refer appendix 2 for the original report in Bahasa Malaysia version.)

Period covered by report: 20.8.97 – 15.1.98.

Type of occupation during this period: Assembling electrical connectors.

a) Personal hygiene; satisfactory, able to take care for self hygiene.

b) Work habit; punctual. Lately, patient only come in the afternoon due to shortage of staff in 'Workshop 2', as patient is not allowed to come out by himself (without escort).

c) Work performance; patient is able to work fast and with quality.

d) Social interaction; good. No problem.

e) Community skills; not implemented as yet.

f) Recommendations/ comments; patient can be brought out to work because he did not have any problem while working here (in Workshop 2).

Interview with patient's brother.

Patient's younger brother, Patel, was chosen to be interviewed because he is the closest to patient in terms of social contact and logistic reasons as he lives in the nearby town of Bercham, within 10 kilometers of Hospital Bahagia.

The brother becomes the main caretaker of patient since the demise of their father.

He emphasized that patient was behaving normally until he joined the army.

Patient initially became irritable and acting abnormally like talking to self and frightened about something. Although he was brought for treatment in the hospital, he frequently defaulted taking his medication.

The brother noticed recurrence of patient's illness with worsening social and occupational functioning levels.

Patient became 'lazy' and 'irresponsible'.

After demise of their father, the brother took the patient in and tried to care for him.

The brother lamented that patient was uncontrollable as he would go out late at night, refused to obey advice and rather destructive.

The brother complained that patient would break the things in his house and intimidate his family.

The siblings came to the decision of allowing patient to stay alone in their late father's house, but he purportedly broke down the wooden house piece by piece and sold them to other people! He even sold off the furniture in the house.

The brother tried to help patient to be self sufficient by offering him a job in his welding shop but, alas, patient stealthily sold off his machinery little by little.

There were few occasions when patient broke the windows in the shop for no apparent reason.

Owing to these factors, the brother requested the help of their sister Jamaiyah, who is a medical doctor, to commit patient into Hospital Bahagia

for long-stay. At the moment, he is still hesitant to bring home patient to stay with him, but amenable to the idea of renting a house for patient to stay by himself. The brother said the siblings are setting up a fund to assist patient financially.

SUMMARY:

MF is a 56 year old Malay man who is single and unemployed. He is suffering from Schizophrenia from the age of 21, presenting with auditory hallucinations in 2nd and 3rd persons, visual hallucination, tactile hallucination, bizarre delusion and negative symptoms of the illness. Owing to his poor insight and lack of supervision from family, he frequently defaults his antipsychotic medication, resulting in relapses characterized by violent behavior which warranted multiple admissions. He has a strong family history as both his mother and sister were suffering from Schizophrenia. Mental state examination only showed mild flattening of affect and normal physical examination. However, patient never recovers to his premorbid functioning level. Hence, his prolonged stay in this hospital aims at optimizing his treatment and for psychosocial rehabilitation.

PROVISIONAL DIAGNOSIS:

AXIS I:	295.60 Schizophrenia, Residual type, Episodic with interepisodic residual symptoms.
AXIS II:	No diagnosis.
AXIS III:	Bronchial asthma.
AXIS IV:	Problems with primary support group – some amount of family rejection is present. Problems related to the social environment – inadequate social support from relatives and friends. No formal employment, inadequate finances and inadequate housing.
AXIS V:	GAF = 80 (current)