Basic Symptoms During Acute Schizophrenia: A Case Report

Aurora Bonifazi, MD;¹ Chiara Chetoni, MD;¹ Edoardo Spinazzola, MD;¹ Daniela Polese, MD;² Georgios D. Kotzalidis, MD, PhD³

¹Psychiatric Training School at Sapienza University – Rome; ²Psychiatry Department, Sant’Andrea University Hospital, Rome; ³NESMOS Department, Sapienza University – Rome, Italy

Basic Symptoms (BSs) are persistent subjective abnormalities preceding psychotic onset, waxing and waning across the phases of the psychosis, and identifiable with appropriate interviews or self-rated questionnaires. BSs are not focused upon in current practice and might go undetected, at the expense of timely diagnosis and treatment. However, the utility of considering BSs is witnessed by the fact that when they are considered conjointly with ultra-high risk criteria enhance the predictivity of transition to frank psychosis.¹ We here report on a case that had already converted to psychosis and presented residual BSs.

CASE REPORT: A 28-year-old man who was living with his mother, developed *serious symptoms* after his father’s death 13 years ago. He manifested progressive social withdrawal and weight loss (he weighs 48 kg, being 180 cm tall). He was followed up for three years at a local Child Psychiatry service and improved on low-dose risperidone. He developed stereotypies and nonadherence; thereafter he became suspicious about his neighbours. During the last five years he increasingly developed reference ideas, paralleled by steadily increasing stereotypies (Fig. 1). His global functioning deteriorated and he was diagnosed with schizophrenia. His major complaint focused on BSs (Table 1), which the patient blamed for rendering him unable to initiate sleep. When seen, he displayed cognitive BSs, especially anomalies of cognitive, perceptual, and motor experience. We diagnosed them after subjecting the patient to the Schizophrenia Proneness Instrument, Adult version (SPI-A).² The patient attributed to a hypothetical brain damage his urge to act as if commanded by his thoughts (he characteristically stated that “every thought corresponds to an action”). Brain imaging was negative. He appeared very anguished, so we decided to prescribe him 10 mg/day aripiprazole, 2 mg/day risperidone, and 1.5 mg/day clonazepam. He improved and promised to maintain his treatment.

DISCUSSION: Our patient reported BSs when properly questioned. Using an appropriate structured interview allowed us to identify them. BSs are not elicited in current everyday psychiatric practice. This prevents clinicians from identifying psychotic symptoms that may unravel undiscovered psychopathology, thus enforcing timely interventions.³ Despite BSs do not always herald transition, they should be considered very seriously in a young person showing reduced social function. In our case, attention should have been focused soon after the patient lost his father on reduced self-presence in experience, which might pave the way to altered cognitive, perceptual and motor experience and lead to early social withdrawal. Furthermore, they may predict outcome even in cases of already occurred onset.⁴ We believe that BS assessment should be included in evaluating patients suspected for or affected by psychosis, no matter how long they have been diagnosed.

CONCLUSION: BSs should be probed in cases of suspected or frank psychosis, as they may allow clinicians to monitor patient outcome.

Table 1. Basic Symptoms reported by our patient	
Symptom	Patient's expression
C.1.4 thought blockages	Sometimes I feel like my thoughts block, and I cannot restart talking and finish some sentences
C.1.7 disturbance of expressive language function	Sometimes I feel that I cannot articulate my words
C.1.6.1 disturbance of receptive language – visual	During this period I cannot translate what a person says to me or what I read in imagines
C.1.13 disturbance of thought initiative or thought intentionality	For almost every thought there corresponds a movement
C.2.3.9 disturbances in estimation of distances or size	I feel like I cannot measure the distances properly, sometimes I cannot open the door since I cannot reach the handle
C.2.1.1 unclear sight – phasic	Sometimes I cannot see well the objects in front of me, like this table, I see it clouded
C.2.3.2 changes in size	Sometimes I can't focus on the objects' shape, they appear changing
C.2.3.3 changes in form	
C, Anomalies of cognitive, perceptual and motor experience; C1, Anomalies of cognitive experience; C2, Anomalies of perceptual experience	

References

¹Schultze-Lutter F, Michel C, Schmidt SJ, et al. EPA guidance on the early detection of clinical high risk states of psychoses. Eur Psychiatry 2015;30:388-404

²Schultze-Lutter F, Koch E. Strumento di valutazione per la propensione alla schizofrenia, versione per bambini e adolescent (SPI-CY). Giovanni Fioriti Editore, Roma, 2010

³Fusar-Poli P, Yung AR, McGorry P, van Os J. Lessons learned from the psychosis high-risk state: towards a general staging model of prodromal intervention. Psychol Med 2014; 44:17-24

⁴Polese D, Bonifazi A, Gebhardt E, et al. Basic symptoms: differences between schizophrenia, schizoaffective disorder, and bipolar I and II disorders. A systematic review. PROSPERO registration N° CRD42018115183