



Case Report

Evaluation of Childhood Psychosis Negligence: Cultural Influences in Treatment Process: Case Report

Maria T¹, Royke Tony Kalalo¹,  Tiwik Koesdiningsih², Justina Evy Tyaswati^{3,4}

¹Department of Psychiatry, Faculty of Medicine, Universitas Airlangga, Surabaya, Indonesia

²Faculty of Medicine Wijaya Kusuma, Surabaya, Indonesia

³Department of Psychiatry, dr. Soebandi Hospital, Jember, Indonesia,

⁴Faculty of Medicine, Universitas Jember, Indonesia



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*) Corresponding Author :
drroykekalalo@gmail.com

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ABSTRACT

Introduction: Childhood psychosis is rare. In Indonesia, strong cultural influences on how people perceive mental disorders. Culture and knowledge interact dynamically in mental health in Indonesia. Lack of mental health knowledge, results in abandonment among psychosis patients, especially in their first episode. This negligence leads to no medical treatment associated with a worse disease course. **Aims:** To study childhood psychosis negligence and the challenges related to the psychosocial aspects faced, such as lack of knowledge, strong influences of cultural beliefs on the patient for the cause, and treatment-seeking for the illness. **Method:** Case Report. **Result:** 27 years old male with the third episode of psychosis, presented with schizoaffective disorder mixed type. The earliest suspected psychosis episode was at the age of 12 and was not treated medically. The patient was treated after his second episode of psychosis at the age of 26 but exhibited non-adherence to the treatment caused a relapse. After being discharged, the patient was currently in the stabilization phase for 5 months with oral antipsychotics and long-acting antipsychotic injections. The patient also sought spiritual treatment from psychics and religious treatment. **Conclusion:** Negligence of psychosis during childhood, could progress to worse episodes in later periods of life, but the protective factors influenced by culture are dynamism of belief related to the illness, endorsed multiple causations for the illness including natural and supernatural attribution, local wisdom to perceive a mental disorder, including in this case cultural-psychological concept.

INTRODUCTION

Childhood psychosis is a rare condition (less than 1 in 10,000) [1]. Diagnosing psychosis in children and adolescents is a difficult challenge because they're often unable to talk about their problems. The diagnosis process got harder by the denial of parents who do not believe in psychotic disorders that occur [2]. At the age of 3, average-intelligent children can normally distinguish fantasy from reality. Psychotic symptoms can be seen in the child's behavior, such as holding or shaking their heads, feeling afraid and insecure, expecting excessive protection and reassurance, and exhibiting impaired adaptation and aggressive behavior. Some diagnostic tools that can be used to help diagnose psychosis in children, such as drawing, playing, and telling dreams, can reveal logic and direction of speech, disturbances to thought flow, and processes in speaking [2].

Psychosis in children and adolescents whose caregivers have a strong belief in mystical culture; abandonment is common for psychosis patients, particularly during their first episode [3]. This negligence leads to less medical treatment, which is associated with a worse disease course and prognosis. In a prospective cohort study, a 15-year follow-up conducted in New Zealand, assessments were done at 11 years and 26 years, 42% diagnosed schizophreniform at age 26 interviews were associated with the presence of psychotic symptoms at the age of 11 [4]. The caregivers of patients' cultural knowledge of illness are critical [5]. Local cultural beliefs, including possession and forms of black magic, were among the most common initial concepts held by caregivers concerning psychosis in Indonesia and a lot of cultures around the world [6].

CASE

A case study from an inpatient, adult male patient, 27 years old, Javanese, Moslem. The family brought the patient to the

emergency room in August 2021, with the chief complaint being restlessness. The patient repeatedly went up and down the stairs, went around the house aimlessly, spoke slurred, and slept only 2-3 hours daily for 2 weeks before. He cried sometimes, at other times he talked a lot and appeared happy, claiming to hear a whisper in his ear ordering him to take responsibility for Indonesia. The patient also saw things and people that other people couldn't see. The patient's mind was often empty, confused, and blank. He felt that his mind could be possessed by thoughts that did not belong to him. The patient had complained of feeling empty and possessed like this before, twice, when the patient was 12 years old and a year ago.

When the patient was about 12 years old, he experienced episodes of illness in the form of slurred speech, talking to himself, being angry at home and school, and didn't want to do activities. From the patient's point of view, the patient narrated this complaint with a feeling of "possession", and he remembered being followed by a genie named "Walhan" who lived in his house and started doing things outside of his control. This complaint was associated with his family moving to a new house that was thought to be haunted. At that time, the patient was treated spiritually with the help of his religious teacher at school until he was taken for non-medical treatment, but it was not known exactly what kind of treatment he got because the patient's mother, who accompanied him at that time, had died. The patient only remembered that his spiritual teacher said that the genie that followed him had been expelled and gone. The episode of illness happened for approximately 6 months. After that, the patient was able to return to normal as before, finishing up at the high school level. The patient's sister also thought that the patient was sick because of being scolded by his father and threatened not to be recognized as a child.

In April 2020, the patient was first brought for treatment by his wife because of a burst of anger. The patient was experiencing economic problems; the patient's business was experiencing difficulties due to the COVID-19 pandemic and the social restriction regulation. He confirmed that he thought that the world was about to end, called his elder brother, Dajjal (devil), and beat him. The patient was inpatient for about two weeks with Risperidone and continued outpatient treatment for approximately four months then stopped treatment on his own because he felt he had fully recovered. He was able to return to work and run his trucking business, interacting normally.

In August 2021, the patient was admitted to the hospital, the assessment of the PANSS Score was 86 (P21 N23 G42), the Young Mania Rating Scale 17, and the Calgary Depression Scale for Schizophrenia 6. The patient was discharged after 40 days of treatment. The pharmacotherapy received was Trifluoperazine 5 mg twice daily, Divalproex Sodium ER 500 mg twice daily, Quetiapine XR 400 mg, and Lorazepam 2 mg once at night. The patient also got Fluphenazine 25 mg IM for long-acting antipsychotics. The patient is currently in the stabilization phase at 5 months with this therapy. Besides getting medical treatment, after being discharged this patient also sought spiritual treatment from psychics and got an amulet. In addition, patients also seek religious treatment by getting directions from religious leaders. From the patient's family and wife's perspective, the patient illness was caused by psychological and economic stressors, but it was also believed that the patient was being cursed by black magic by a jealous person.

DISCUSSION

The difficulties faced in this case were the lack of patient's and caregiver's knowledge, strong influences of cultural belief on the patient for the cause and treatment-seeking for the illness, and multiple under-

standings of it. However, cultural aspects were found as protective factors related to the illness, including multiple beliefs about illness causation, including natural and supernatural attributions, which can be used as an entry point for the medical treatment of the patient. Local wisdom, in this case, Javanese psychology, perceives a mental disorder as caused by disruption of the "peace" (tentrem). Holding this traditional understanding did not prevent them from pursuing psychiatric treatment. Experience of frustration (kagol), stress (tertekan), and especially agitation or feeling shocked (kaget) can threaten the peace of mind [3, 6]. The idea that mental illness can be caused by shock is also found in other local cultures, such as in Bali, and other areas [7, 8]. The idea of sarap (injured nerves), is the most popular physiological explanation for mental disease in Java. Javanese people think that an electrical current runs through the brain nerves, and when an electrical short circuit (in Dutch word korslet) occurs inside the nerves, mental disease emerges [6].

The culture-psychiatry preserves the essential correlation of its two component entities; culture act as a repository of individual and collective expressions of identity, and psychiatry/mental health as a clinical effort to protect and care for both individual and collective sense of well-being, order, and stability [9]. Culture has to do with a collective identity, a group of people that can be distinguished from another based on historical lineage, language, religion, gender, or ethnicity which may include membership in a community, regional group, nation, or other historical people. Culture also corresponds to its current use in anthropology as a way of life: the values, customs, beliefs, and practices that form a complex system that encompasses all the humanly constructed and transmitted aspects of the material and social world [10]. Cultural variables influence culture-bound syndromes and are also relevant to the common mental disorders in societies [11].

Many studies of psychiatric care have included cultural concepts, but there are few clinical examples of the actual integration of therapeutic procedures. Cultural factors, notably supernatural and spiritually sanctioned traditional healers, are extremely important in the etiology, course, treatment, and prevention of mental problems in Indonesian areas [6, 12]. In Bali, spiritual healers called Balian will do spiritual therapy, such as the Malukat ritual, by using a mantra to purify all contamination, so then the disease will disappear and the person could return to their original state [7]. Strong cultural influence makes the treatment process of mental illness in people who are still bound by tradition and religion impossible to do entirely by medical means [7, 13]. Even though Balian, became the first and main choice for society or Balinese families, Muryani found in her study that 76% of patients would continue treatment with a psychiatrist, then also return to Balian after visiting a psychiatrist [8]. In Java, Javanese often seek treatment from traditional, religious, and alternative resources. There are many popular Javanese healing traditions such as Islamic healers called Kyai, Javanese healers popularly called "Paranormal", "jamu" or traditional medicine sellers [6].

On another hand, a study conducted in Nigeria with caregivers of patients diagnosed with schizophrenia who had been on treatment for at least two years dominantly pointed out supernatural causes as the etiology of schizophrenia. This study found that the most frequently endorsed causation was Satan's work which was mainly endorsed by participants without formal education [14]. The patient's family tended to embrace multiple causal attributions for schizophrenia, suggesting that endorsing natural causes did not exclude supernatural attributions. Belief in supernatural causation might result in a tendency to disregard orthodox treatment due to the belief that the treatment would be ineffectual. Nigerians also believed in tradi-

tional and spiritual treatment, fortunately, they believed conventional psychiatric treatment to be as useful as the westerner saw it to be [14]. Biological and psychosocial factors are more widely accepted in Western countries than supernatural causes which are popular in non-western civilizations [14].

Cultural factors are just one of many that influence treatment-seeking behavior and the patient's and family's way of thinking about the cause of psychosis and how to deal with it. Complex and interrelated factors influence Indonesians' choice of health providers, including sociodemographic characteristics, the influence of significant others, sociocultural beliefs, perceptions of diseases and their causality, and conceptions of medical services, including accessibility and availability, and also their associated costs [15]. People usually first went to any alternative treatments for illness attributed to supernatural causes, when they perceived it as ineffective then switched to formal health care [15].

Non-medical treatment-seeking is one of the popular ways families cope with mental illness around the world, especially in areas inhabited by people who lack education and have strong cultural influences [12]. In our case, the family believed in supernatural causes, this view was shown in the treatment chosen by the patient's family which was non-medical treatment. The patient's caregiver during his first psychosis episode was his parent who was low-educated. The patient himself explained the treatment result as the genie being expelled from his body. He described that genie as following him, and he did things outside of his control. Genie is said to affect human thoughts and conduct by unseen speech or action rather than "possessing" them [16]. Genie can influence vulnerable persons, during big transformations or certain life events, as well as when struggling with confidence, identity, or social acceptance [16]. Psychosis complaints in the patient were associated with the patient family

moving to a new house that was thought to be haunted. Ceremonies aiming at banishing the genie (Zar), reciting prayer over the ailing individual (Ruqyah), or fostering peaceful cohabitation with the genie are examples of traditional healing procedures [16]. At that time, the patient was helped to be treated spiritually by his religious teacher at school and was taken to more rural areas for non-medical treatment. Unfortunately, in our case, there was no specific data on what treatment was performed on the patient. Both genie and mental illness are stigmatized and seen as spiritual afflictions; this “double stigma” can make patients and their families hesitant to reveal symptoms and seek medical treatment [16]. The stigma could lead the patient and his family to only seek traditional or religious healers, this was what happened in our case during the first episode of psychosis. Lack of knowledge, low social-economic status, and scarcity of mental health services at that time were proposed as the cause of seeking non-medical treatment, besides the cultural influences. It is important to distinguish between culture and religion, even if these two factors are sometimes fused [16, 17]. Overemphasis on culture and religion might make oblivious inclination and fortify negative stereotypes, which can create a false myth and influence the physician’s approach to diagnosing and creating a treatment plan. Cultural formulation is important in every single case, but it must be perceived with caution and individualized [16].

From Good’s study, family members play an important role in the treatment-seeking process, including in Indonesia, traditional and religious healers, as well as general medicine doctors and psychiatrists [3]. Care-seeking is often most intense during acute episodes and when medical care seems to fail but continues as a complimentary service along with medical care [3, 6]. The quality of traditional healer services ranges from extremely insightful and supportive to abusive and injurious, includ-

ing some religious residential services that keep individuals in chains and abuse human rights. Mental health specialists often blame resorting to traditional healers for delays in care-seeking [3, 5]. The patient’s family endorsed supernatural attributions that need years after the onset of the illness, but the family with a belief that the causes were medical sought a psychiatric consultation early [14]. Having ever gone to a non-medical specialist is hypothetically related to the Duration of Untreated Psychosis (DUP), but an intervention project carried out by Marchira, showed that two-thirds of families consulted alternative healers before contact with a psychiatrist [5]. Persons with protracted prodrome and slow progression of psychosis have longer DUP, while those with very sudden, acute onset tend to seek psychiatric services rapidly. This does not mean families do not also seek to find the cause of illness and secure treatment from several healers, if the acute psychosis continues after only a few days, families often go directly to a mental health facility [3]. Another problem faced in Indonesia because the existing health system is unable to maintain contact and continuity of services with psychiatric patients [3].

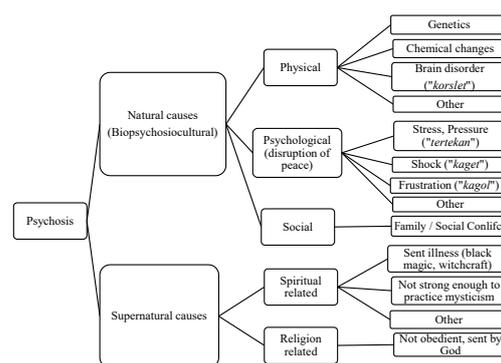


Figure 1. Caregiver’s cultural framework about causes of psychosis (Modified from [5, 6].)

Family members usually also use explanations from local psychology for mental illness, including, frustration, disappoint-

ment, and stress. Despite the contradictory nature of explanations, diverse explanations are often integrated within family caregivers' cultural frameworks. Underlying these is the idea of "peace" (*tentrem*), or loss of it. The feeling of peacefulness (*tentrem*), restored by active 'effort' (*usaha*), and *rukun*, the process of integration with family and community, results in *bangkit*, which concludes the recovery process [6]. Seeking medical attention could be included in this psychological view, as one of the active endeavors in this perspective. In our case, the family had treated the patient gentler after the psychosis episode, he was seldom scolded by his father. A metaphor for regaining the previous self (*bangkit*), the active effort (*usaha*), and the process of integration with family and community (*rukun*) [6]. This is captured in the idea of revitalizing oneself and coming alive again [6]. In Indonesian culture, holding traditional understandings did not prevent all patients and their family pursuing psychiatric treatment [6]. The dynamism of caregivers' explanations of psychotic illness exists and changes significantly over time. This may result from attempts to understand changes in the illness or chronicity, as well as negotiation between family caregivers and healers, mental health care providers, and neighbors who provide alternative information [3]. In our case, the role of the caregiver shifted from the patient's mother during childhood period to the patient's wife after the second and third episodes of psychosis. This difference in knowledge caused different treatment-seeking and plans to be done. Having multiple explanations of the etiology of mental illness could be complementary and satisfy the family and patient. Paying respect to the family and patient's perception of the illness can help the therapist build rapport for better collaboration between the therapist, patients, his family, and even the traditional healer if needed.

Psychotic experiences differ from brief psychotic disorders by examining whether there is any distress and functional impair-

ment caused by it [18]. In this case, the patient had significant impairment in his daily life, his symptoms in childhood could be considered psychosis episodes. The traditional treatment performed on our patient brought the wanted result, the patient was able to socialize and live normally as before. It was unclear whether the patient's recovery was the result of non-medical treatment or because the nature of the disease was a brief psychotic disorder.

New-onset psychosis in children must be carefully examined because presenting complaints can be attributable to multiple factors and etiologies. The onset of psychosis is an important diagnostic clue. An acute onset is commonly associated with an underlying medical bipolar disorder and schizophrenia, as well as neurologic conditions such as central nervous system infections, autoimmune encephalitis (e.g., related to antibodies to N-methyl-D-aspartate receptor (NMDAR), alpha-amino-3-hydroxy-5-methyl-4-isoxazole propionic acid (AMPA), or Gamma-aminobutyric acid B (GABAB), and toxic/substance-induced encephalopathy could

People can recover after the first episode of psychosis [20]. Identification of factors that may impede recovery is critical to recovery. The duration of untreated psychosis (DUP), which is the time between the onset of any positive psychotic symptom and the initiation of sufficient antipsychotic treatment, is one factor involved in recovery. A recent prospective study with 10 years of follow-up periods gave uncertainty on whether longer DUP was associated with poorer outcomes. The duration of untreated illness (DUI), which is the time between the beginning of any mental symptom and the initiation of effective antipsychotic treatment, is another potential risk factor for poor outcomes. DUI has been proven to be more strongly related to a poor outcome than DUP [20]. The family's awareness plays important role in the treatment-seeking process, so they need more knowledge of mental illness [21].

In general, younger individuals have a higher risk of developing symptoms of anxiety and depression. Individuals who experience a decline in economic ability are more vulnerable to the emergence of mental disorders, especially in people with comorbidities or a history of it [22]. The COVID-19 pandemic can reduce the quality of mental health in general, including children and adolescents who previously had susceptibility, due to a combination of public health crises, social isolation, and economic recession [23]. Declining economic well-being is related to an increase in mental health problems, especially because of an increase in unemployment rates in adults, which leads to an increase in mental health problems. The mental health risk is not only for adults but also for children and adolescents, especially those with certain special needs conditions [23]. The stressful events related to COVID and non-adherence to the treatment made the patient in this case relapse. Non-adherence in treatment problems can be handled by long-acting antipsychotics which have been established the efficacy in preventing relapse, but might not prevent subsequent exacerbations for a proportion of individuals who are stabilized and are on continuous antipsychotic treatment [24].

Preventive approaches in psychiatry are included within primary prevention, targeting antecedents/clinical high-risk syndromes. WHO classifies the management of mental disorders as a continuum encompassing prevention, treatment (secondary prevention and early/standard treatment), and rehabilitation (tertiary prevention and long-term care) [25]. NICE recommended a maximum wait of two weeks from referral to start of treatment, for better outcomes, people who receive the right treatment at the right time can have productive lives. Family intervention has been shown to improve outcomes significantly, predominantly through supporting the family to understand the experience of psychosis and to respond appropriately, reducing re-

lapse rates by 40% [26].

Psychiatrists and traditional healers have different theories, methods, techniques, and modalities of treatment to manage mental illness. Openness to patients' explanatory models is essential to negotiating a shared model of illness and providing care [17]. Integrated care by the psychiatrist and traditional healer is ideal when working with the same patient in an informal agreement, each providing treatment appropriate to their abilities, knowledge, and theory. For the psychiatrist, this is termed clinical acculturation. Disagreeing with each other's diagnoses and treatment plans and attempting to influence each other between medical personnel and traditional healers would be counterproductive. The psychiatrist and the traditional healer need not be in direct contact nor necessary to communicate with each other regarding their treatments. Each should not attempt to influence or change the other's methods and treatments, for an ideal treatment atmosphere [11, 13, 17]. This situation was attained in the present case, the patient visited spiritual and religious healers who didn't interfere with medical treatment and vice versa.

A culturally competent psychiatrist's role as a bridge between diverse explanatory models of illness is needed. Be forthright about the differing epistemologies of Western biomedicine and the religious and cultural beliefs of the family, emphasizing respect for the family's belief system and integrating their perspectives into the care plan [17]. A family meeting can help to clarify the family's priorities and to establish shared therapeutic targets. Clear communication between those involved in the patient's care is essential. When possible, exceptions can be made to standard protocols, to facilitate important cultural and religious practices [17].

CONCLUSION

Culture can be a challenging factor related to the treatment process. Culture can support the treatment-seeking process but

also on the other hand cause resistance. Negligence of psychosis, especially during childhood is not rare to happen in Indonesia. The dynamism of belief related to the illness endorsed multiple causes for the illness including, local wisdom to perceive a mental disorder, that psychosis could be related to physical (brain) abnormalities could be a potential benefit that leads the patient's caregiver to medically treat the mental illness. Escalate patients, caregivers, and traditional healers' knowledge about mental illness, a collaboration between medical personnel, families, and if needed spiritual or traditional healers need to be done for the sake of providing comprehensive services in a spiritual bio-psycho-socio-cultural manner.

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