

# Balancing Treatment and Ethics: Addressing Schizoaffective Disorder and Catatonia in Children

Tanvi Gupta D.O., Mark Mazer M.D., Janet Karanja M.D.,  
Katrina Escuro M.D., Sarah Edwards D.O., and Jacqueline Clauss, M.D., Ph.D

Division of Child and Adolescent Psychiatry, Department of Psychiatry, University of Maryland School of Medicine, Baltimore, MD



## BACKGROUND

- Prevalence of childhood-onset schizophrenia is estimated to be 0.04% in the United States<sup>1</sup>
- Mortality/morbidity associated with untreated schizophrenia disorder include a higher risk of suicide and cognitive impairment.<sup>2</sup>
- Risks associated with untreated excited catatonia include impaired ADLs, dehydration, malnutrition, and risk of conversion to malignant catatonia, especially in the setting of antipsychotic use<sup>3</sup>

## CASE TIMELINE

- Our case discusses a 12-year-old girl with childhood-onset schizoaffective disorder who was admitted 6 times in 3 years (collective length of stay 7+months) for symptoms of erotomanic delusions, aggression, and mood lability, resulting in persistent school refusal and poor self-care:
- Summer 2022- 1st inpatient admission for aggression, elopement, bizarre behavior, severe insomnia, discharged Zoloft + Zyprexa
- Summer 2023- 2nd admission for similar presentation + severe school truancy. Had not been taking medication for several months. Inpatient, treated with risperidone, then Abilify, diagnosed with catatonia. Treated with Ativan. Referred to PACT team.
- Spring 2024- 3rd admission + ECT sessions following decompensation. Prior to admission, PACT team observed persistent truancy, poor treatment compliance and medication non-adherence from family despite wrap-around services and interventions. Parents declined further services (TBS, PRP, family preservations)
- Summer 2024- 4th admission due to medication non-compliance, treated with Zyprexa + Ativan. Family requested discharge from PACT team and UMMC system
- Fall 2024- 5th admission, presented with police to ER and was secondary to medication non-compliance
- Spring 2025- 6th admission, similar presentation



## METHODS

Reviewed the electronic medical health records of patient and talked to psychiatric mental health providers who cared for the patient during her treatment period at the University of Maryland Medical Center

## RESULTS

- For treatment of schizoaffective disorder, patient was trialed on various antipsychotics and mood stabilizers. Several meetings with family and experts about clozapine occurred, but concern about adherence and monitoring prevented its initiation
- For treatment of agitated catatonia, patient was trialed on benzodiazepines and several rounds of ECT.
- She was stabilized inpatient with each admission with improvements in her Busch Francis Rating Scores, mood, and overall self-care
- Following discharge, patient would quickly decompensate in her clinical symptoms and functioning
- The treatment team became concerned that the family's actions constituted medical neglect, and a report was made to CPS.
- Despite hospitalizations and PACT team engagement, family dynamics and chronic treatment non-adherence led to additional ER visits, hospitalizations and decompensation.

## DISCUSSION

- In situations where treatment goals do not align between providers, patient, and family, advance determination of what constitutes medical neglect and having an established protocol for reporting may prevent delays in care and further decompensation.
- Maryland medical neglect is defined as the failure or refusal of a caregiver to provide necessary medical care to a dependent person, resulting in harm or potential harm to their health.
- CPS determines medical neglect
- In Maryland, parental rights are based on “best interest of the child”<sup>4</sup>
- In considering what is in the “best interest” of a child, we propose including assessment of objective components including the safety, health, and emotional/functional stability of the child.

## FUTURE DIRECTIONS

Development of a standard hospital-wide protocol that includes early interdisciplinary communication, clear criteria for reporting suspected neglect, and connecting families with resources that will likely reduce the risk of delayed treatment and subsequent decompensation<sup>8</sup>

## REFERENCES



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