

Psychotherapeutic report of a case of schizophrenia: A recovery-oriented approach

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ABSTRACT

Schizophrenia is a chronic, severe mental disorder affecting thoughts, actions, emotions, perception of reality, and relationships. Schizophrenia, affecting around one percent of the adult population, is not as common as other major mental illnesses, but it can be one of the most chronic and disabling conditions. Effective care options include medication, psychoeducation, family interventions, cognitive-behavioural therapy, and psychosocial rehabilitation (e.g., life skills training). This case study highlights the need for facilitating assisted living, supported housing, and employment for individuals with schizophrenia. A recovery-oriented approach, which empowers individuals in treatment decisions, is crucial for patients and their families.

Keywords: Schizophrenia, psychoeducation, interventions, psychological, cognitive behaviour therapy

INTRODUCTION

Schizophrenia is a chronic, severe mental disorder impacting thoughts, actions, emotions, perception, and relationships. Women exhibit more affective symptoms and fewer negative symptoms compared to men, leading to more diagnoses of schizoaffective disorder.^[1] Older women with schizophrenia often neglect psychiatric and other health needs due to lack of social support and low socioeconomic status.^[2] These factors necessitate further research and clinical attention.

Case Presentation

The index patient is a 60-year-old Hindu, widowed housewife, from middle socio-economic family of urban Raipur with a significant family history, had an episode suggestive of paranoid schizophrenia, after her elder brother came to her house and stayed for a month, and repeatedly threatened her for lending him money. This incident was remarkably stressful. Another incident occurred where she injured herself in the bathroom, which led her to feel helpless and depressed. With an insidious onset, continuous course, deteriorating progress of illness, characterized

by being suspicious towards family members, delusions and paranoid ideas, feeling depressed, poor self-care, increased somatic complains hyperactivity, and self-reproaches. In addition, she has also been hearing voices of her husband and believes that he is alive. She has increased fearfulness and crying spells, and also has decreased appetite and sleep. The Mental Status Examination (MSE) findings revealed depressed mood, increased psychomotor activity, rapid and tangential flight of ideas, irrelevant speech with decreased reaction time, irritability, crying spells, appropriate communicable affect, poor judgement and orientation were intact with grade-I Insight.

Brief Clinical History


Apparently, the patient was maintaining well until the last four months, where she was alone at home and fell in the bathroom, which kept her from walking and led to increased fearfulness and irritability. Post that incident, the patient would remain undressed and naked in the house throughout the day, neglecting her personal hygiene.

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How to Cite the Article:

Dixit A, Sahu S. Psychotherapeutic report of a case of schizophrenia: A recovery-oriented approach. Indian J Psychiatr Soc Work 2024;15(1):39-45.

Access the Article Online	
<p>DOI: 10.29120/IJPSW.2023.v15.i1.202</p>	<p>Quick Response Code</p> 
<p>Website: www.pswjournal.org</p>	



As reported by the informant (daughter), the patient was brought up by her eldest brother and his wife. It was shared by the family that she was getting suspicious towards family members and the maids. She has also been hearing voices of her husband and believes that he is still alive. She also reported an incident where she saw her late husband, and reported vivid hallucinations like animals engaging in coitus in her house. This has markedly impacted her relationship and day to day functioning. She reported not to have adjusted well with any of the family members, including her husband and had disputes and fights with them on a daily basis, thus leading to poor adjustment. The husband and the patient had physical and verbal exchanges very frequently, to a point where the patient used to leave the house and run away. Due to the disturbing home environment, the patient was fearful and had crying spells.

She has reported to have strong faith in “*jaadutona*” and is of the opinion that black magic and evil practices are being used against her. Over the course of the last one year, her symptom exaggeration increased and somatic complaints have drastically increased. She reported saying “*mera pair teda ho gaya hai ab kyuki doctor muje kuch galat dawa de di thi*”. She has significantly poor sleep quality and low appetite.

The patient has a chronic history of Paranoid Schizophrenia for a period of almost 20 years. Initially when her symptoms started showing up, she was taken to tertiary care institute, Ranchi; for her treatment. However, the symptoms did not subside. She was then shown to a psychiatrist on an outpatient basis in the year 2019. As significant improvement did not take place, she discontinued treatment and whenever the symptoms increase, she would self-medicate without any medical consultation. She was also taken to various faith-healers by her family members.

No history suggestive of head injury, high fever, epilepsy, and any other psychiatric illness.

ASSESSMENTS

Areas assessed included hallucinations, disorientation, hostility, attention, concentration, and cognitive functioning. Tests administered were:

1. *Eysenck's Digit Span Test (EDFT)*: Used to assess attention and concentration. The patient scored 4 on Digit Forward and 3 on Digit Backward, indicating an ability to arouse and sustain attention for a required period.
2. *Rorschach Inkblot Test*: Used to assess the global structure of personality. The patient gave 19 responses, indicating tendencies towards conservatism, caution, and difficulty in defining objectives. The results suggested an over-incorporative style ($Zd = -9.5$), impaired reality testing ($X-\% = 0.27$), a high concern for conventionality (13 popular responses), and perfectionism ($FQ+ = 1$). The patient displayed hyper-alertness ($HVI = 2$), paranoia, flawed judgment, an attraction to emotional stimulation ($Afr = 0.9$), and intellectualization (index = 1). The patient is avoidant-introverted, ideationally oriented, and vulnerable to emotional intrusions ($EB = 6:2.5$, $\Lambda = 1.375$, $EBPer = 2.4$).
3. *Millon Clinical Multi-axial Inventory-III (MCMI-III)*: Assessed personality pathology and specific psychiatric disorders.
 - *Clinical Personality Patterns*: The patient displayed narcissistic ($BR = 93$), negativistic ($BR = 85$), depressive ($BR = 79$), and antisocial ($BR = 75$) traits.
 - *Severe Personality Pathology*: High paranoia ($BR = 83$) with defensiveness, guardedness, grudge-bearing, and cognitive suspicion.
 - *Clinical Syndromes and Severe Clinical Syndromes*: High scores on Anxiety, Somatoform ($BR = 75$), Bipolar-Mania ($BR = 80$), PTSD ($BR = 79$), and Delusional Disorder ($BR = 85$). Major Depression ($BR = 85$) indicated difficulty managing daily affairs and persistent depression.
4. *Nahor Benson Test*: Assessed cognitive functioning. A dysfunction rating score of 2 suggested problems in the right parieto-occipital region but no disturbance in interhemispheric transfer of information.
5. *Human Figure Drawing Test (HFDT)*: Assessed cognitive deficits due to

psychopathology. Scores indicated severe cognitive impairment and organic deterioration. The patient showed depressive tendencies, withdrawal, paranoia, and emotional focus on past events.

6. *Positive and Negative Syndrome Scale (PANSS)*: Assessed symptom severity. The patient scored 38 on the positive scale (99th percentile), 28 on the negative scale (88th percentile), and 75 on the general psychopathology scale (99th percentile), indicating high levels of delusions, disorganization, suspicion, stereotyped thinking, somatic concerns, anxiety, depression, and poor impulse control.

Provisional Diagnosis: Based on behavioural observation, clinical history, and test findings, the patient is diagnosed with Paranoid Schizophrenia.

Behavioural Analysis

The patient exhibited excessive worry and low mood, resulting in behavioral deficits such as decreased motivation and fatigue. The problem began after a family conflict and a bathroom fall, leading to physical and mental stress. Personal life and self-care activities became difficult due to low motivation and concentration, exacerbated by leg pain and anxiety.

Motivational Analysis

The patient had poor motivation upon hospital admission by family without consent but gradually recognized the benefit of seeking help.

Developmental Analysis

Biological changes included decreased appetite and sleep. The patient spent most of her time feeling fearful and helpless, with minimal interaction with family, which further diminished.

Self-Control Analysis

The patient demonstrated significant self-control in refraining from verbal conflicts, particularly with her daughter.

Social Relationships Analysis

The patient's family environment hindered mental health recovery. Relationships with brothers were strained, while the relationship with her daughter was cordial. She faced her issues alone at home.

Socio-Cultural and Physical Environment Analysis

The patient had considerable freedom due to lack of care but found solace in religious activities with neighbours.

Critical Incident

Poor psychosocial environment and conflictive family relationships triggered maladaptive functioning.

Recent Triggers

Increased verbal exchanges with brothers and comparison with better-performing friends' families.

Relevant Personal History

Unattached relationships with parents, sibling rivalry, and conflictive interactions with her husband and other family members.

Core Beliefs

"I could have a better life if my family had supported me more." "People want to harm me; nobody is with me."

Conditional Assumptions

"If this body ache and uneasiness with my mind do not go away, I'll never live normally." "If my family does not trust me, I will be punished by God."

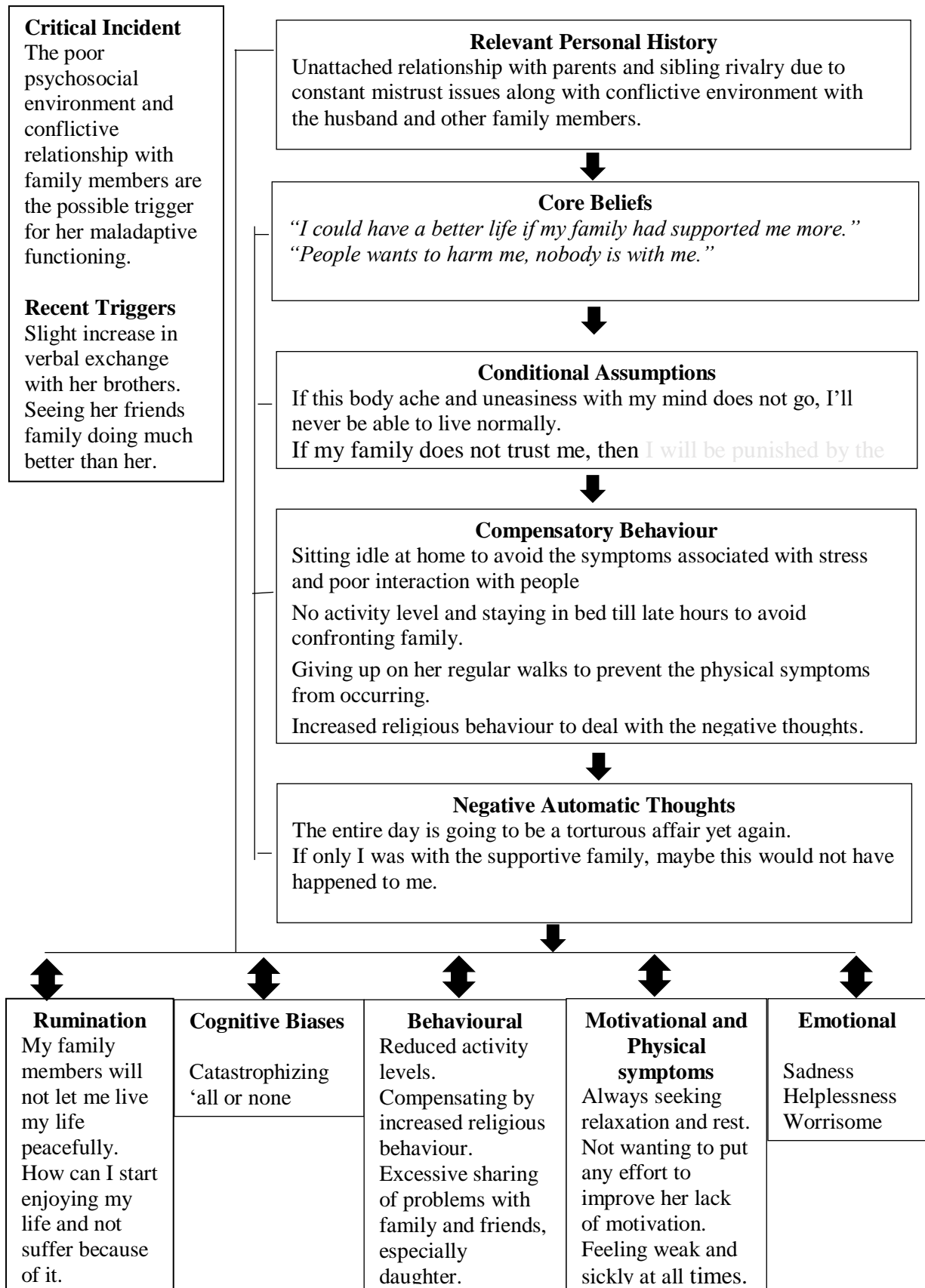
Compensatory Behaviour

Avoiding activities to prevent exacerbating symptoms.

PSYCHOTHERAPEUTIC FORMULATION

The patient's symptoms included suspiciousness, worry, low mood, physical complaints, and poor family support, contributing to a perpetually low mood and lack of motivation. Her poor social support and conflictive home environment hindered daily functioning. Coping mechanisms included listening to religious videos and reading the Bhagwad Gita.

Figure 1 Psychotherapeutic Formulation



MANAGEMENT

Target of Therapy

The short term goal of therapy provides information about the illness to the client via psychoeducation. It aims to reduce severity of the symptoms, and take the client's mind off her problems for a while. It helps the client make necessary adjustments in her routine. Therapy also motivates the client to slowly include some productivity in her daily routine.

The long term goals includes helping the client reduce the overall frequency and intensity of the anxiety response, in order that daily functioning is not impaired, helping her identify the major stressors that start the series of symptoms, help her learn and implement in therapy positive self-talk to be used to decrease the levels of depression and anxiety. Finally, help the client get back the will to put effort in her daily living and set a goal for herself so that she can move forward by having a definite target in life.

Psychological Techniques

Approach for Psychotherapy: Cognitive Behaviour Therapy with family therapy approach to psycho-educate and counsel the family members, especially daughter (Eclectic Approach)

Psychoeducation, Cognitive Behaviour Therapy (CBT), Activity Scheduling, Guided Discovery, Cognitive Rehearsal, Thought Record Diary, Cognitive Restructuring, and Positive Self-Talk were used in this case.

Psycho education was used to provide information to the client about the nature of the problem, its symptomatology, onset, causes, prevalence, prognosis and relapse prevention.

Cognitive Behaviour Therapy (CBT) was used to help the client deal with negative automatic thoughts and improve her mood. Following techniques were used with the client:

Activity Scheduling was used as the client lacked motivation, this technique was used to set a routine, assess her mastery, pleasure and act as a motivator while accomplishing tasks in her daily life.

Guided Discovery was used to help the client reflect on the way she processes information. Through the processes of answering questions or reflecting on the thinking processes, a range

of alternating thinking could get opened up. It was beneficial in changing perceptions and behaviour

Cognitive rehearsal realistically and imaginably practising particular behaviours which allow the client to explore a range of possible responses and help him to select a response that is most conducive. It was used to make the client think of alternate behaviours rather than simply feeling distraught and lying down to escape her

Thought Record Diary was done for continuous monitoring of dysfunctional thoughts, emotions and ruminations to assess the frequency and nature of illness.

Cognitive Restructuring was used to restructure those thoughts related to that her family and friends want to harm her and building trust and rebuilding the effective relationship in a functional way.

Positive Self-Talk was done with the objective of the therapist to ask to explore in therapy her distorted cognitive messages. Some examples of those messages were "*I have no idea how I am going to get better*" or "*I will never be able to enjoy my life again*". The client was able to recognize how these negative statements increased her fears and made her more anxious. With statements such as "*I am going to make it through this*" the client will learn and apply in therapy deep breathing techniques to be used during times of stress and anxiety.

Therapeutic Sessions

In all the sessions the client was given homework assignments depending on the requirement of that session. Goals were set in two segments, i.e. from Session 1 to Session 4 the goal was to conduct initial clinical assessment and to psycho-educate her and the family members regarding her problems. Continuing from Session 5 to Session 7 the goal was to identify and develop insight into the nature of automatic thoughts and replace them with more adaptive thoughts. To help reduce the physiological symptoms which were associated with the thoughts. There were 8 Sessions in total which were accordingly proceeded by the therapist.

In the first session, the therapist greeted the patient and welcomed for taking detailed case history and mental status examination of the

client. Therapist was attentive, cooperative, and empathetic towards the client. Client was encouraged to talk freely about her problems and the therapist showed unconditional positive regard towards her. She actively listened to the client's problems and paraphrased to make sure that she correctly understood the client's problems. The goal of the session was to establish rapport and collect relevant information for case formulation. A detailed behavioural interview was initiated. Client was given a general introduction about structure and conditions for cognitive behaviour therapy.

The second session began by taking feedback about the client's previous week and mood check. A detailed behavioural interview was taken to assist in case of formulation. Baseline Assessment was conducted to know the severity of the symptoms experienced. Client was psycho-educated about the nature, course, causes and management of illness. Therapist then discussed and mutually agreed on goals of the therapy. Activity scheduling was done to help the client cope with the sleep problem.

In the third session, feedback of the client's past week activities and mood check were taken. Homework was reviewed. It was seen that after making some adjustments to her routine her sleep pattern had improved slightly but it was still not conducive for healthy living. Client was introduced and motivated to maintain a daily thought record diary. She was explained how to record her thoughts and the emotions associated with them as well the behaviours accompanying them. Client was educated about the cognitive model of anxiety. This was done to educate the client about how thoughts affect one's emotions and actions. Abdominal breathing technique was also taught to the client to help with relaxation.

In Session 4, the client had failed to do her homework. She said it was difficult to maintain the diary since she was unable to concentrate or pain in body and hands made her unable to maintain a diary. Upon further probation, it was discovered that the client found it difficult to cope with the fact that her family members were enjoying life without her and have left her to IPD admission with an attendee. The techniques of Cognitive Behavioural Therapy which included cognitive restructuring was applied here where she was taught that there are other ways of seeing a situation as well. With

the help of reframing, certain life situations of the client were modified, giving an additional perspective to the patient. Seeing the client's self-esteem extremely shaken she was asked to make a list of his daily activities to see mastery and pleasure.

In the fifth session the client's pleasure and mastery list was seen. It was certain that the client did have some difficulty doing her daily tasks and her low mood played a huge role in lowering pleasure from the tasks. She was encouraged to actively participate in the ongoing yoga sessions that happened in IPD or initiate regular walks for healthy functioning. Her fear of failing to deliver the above tasks was addressed by using the technique of guided discovery. She was asked to perceive the task differently and use it as a means to improve her condition. Her concerns regarding falling during her walks were addressed. She was again asked to identify her negative automatic thoughts and the associated behaviours and emotions.

In Session 6, the client was able to identify some of her negative thoughts as well as the associated behaviours and emotions. Having a couple of successful walks with assisted support and attendee supervision had significantly improved her mood and her physical symptoms had reduced significantly. Adherence to medication prescribed by the psychiatrist played a big role as well. It was however seen that the client found it difficult to come to terms with her thoughts regarding her failed relationship with husband and significant family members which would prevent her from forming new relationships with others and as a result that would start her physical symptoms which in turn maintained the perpetual low mood. The client was made to understand this cycle. She was also taught cognitive restructuring so that she could stop feeling that she was being punished for all her conflicts with the family members. For homework the client was asked to make a list of all her achievements that she has had over the years despite not so conducive conditions.

In the seventh session the client had successfully expressed a list of all her achievements which included her ability to stay alone and not being dependent on anyone, healthy religious activity on a regular basis, ability to remember all events of life with good

precision. The client was made to see how her achievements were not so less despite her discipline faltering and her ways meandering. She was asked to ponder over how much more she could have achieved so far and there is always something positive in life to look back on. For the next session, she was asked to set a list of goals and how she thought she would achieve them post discharge of her IPD admission.

Finally the eighth session took place. In this session, the patient was motivated to share about her future plan. As one after the other, they were sharing about her future plan and fears about her future, daughter's family and personal relations with significant others. Informants, especially the daughter, were supporting her by giving positive feedback, sharing her own views, and by having an optimistic way of looking at life. Further, the session was summarised by the discussion of the whole therapy sessions. Thereafter, spoke about the importance of medication and motivated her not to stop taking medication by herself. The relevance of taking medication only through a proper consultation was also done in order to prevent the possibility of relapse. At the end the therapist shared in the nutshell all the sessions held and stressed the need to follow up with available options.

OUTCOME

Patient was able to understand the cause, nature, the need of therapeutic interventions. In eight sessions the client had significantly overcome her incessant low mood and her lack of motivation to do anything for work or pleasure. She was able to think more rationally and her sorrow that her life was not going to be enjoyable was quite much over. Her somatic complaints associated with her negative thoughts were also brought under control. The patient was able to get back to a healthy daily living functioning and with increased positive interaction with the family.

Future Plan

In future plan, it was decided to include the family members of the patient for a better understanding of the nature of the illness and its

management, to maintain the therapeutic alliance and to prevent relapse. The patient was advised to have a follow-up to assess the nature and extent of her recovery. Family Counselling aimed at improving outcomes by directly incorporating family members to address family disruption, dysfunction, or symptom accommodation.

DISCUSSION

The generic schizophrenia literature underlies for keys processes surrounding recovery; which are finding hope, re-establishing identity, finding meaning in life, and taking responsibility. However, as one ages, it becomes harder to adapt to new ways of life. One of the major issues that aging women with schizophrenia face is trying to reach certain goals or live as comfortably and independence from family members who care for them.^[3]

CBT was originally developed to treat acute symptoms. However, various recent studies show that it can also be used to treat persistent positive and negative symptoms in patients with incomplete remission who are on antipsychotics. It is now used as a standard treatment practice and is gaining more interest and acceptance as an adjunctive practice for people with schizophrenia.^[4]

REFERENCES

1. Dickerson FB. Women, aging, and schizophrenia. *J Women Aging*. 2007;19(1-2):49-61. doi: 10.1300/j074v19n01_04
2. Rosenberg I, Woo D, Roane D. The aging patient with chronic schizophrenia. *Ann Longterm Care*. 2009;17(5):20-4.
3. Seeman MV, Gupta R. Selective review of age-related needs of women with schizophrenia. *Clin Schizophr Relat Psychoses*. 2015;9(1):21-9.
4. Morrison AK. Cognitive behavior therapy for people with schizophrenia. *Psychiatry (Edgmont)*. 2009;6(12):32-9.

Submitted on: 06-01-2023

Revised on: 27-06-2024

Accepted on: 18-07-2024

Published on: 19-07-2024