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Psychosocial Intervention for a Case of Early Onset Schizophrenia

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Abstract

Background: Schizophrenia is a chronic and severe mental disorder characterized by distortions in thinking, perception, and emotions. This chronic mental illness causes significant difficulties for the individual as well as their family, including the difficulties that may arise as a result of the symptoms, disruption of family routine, interpersonal issues between couples, its effects on social and occupational functionality, and the stigma associated with the mental illness. This case report presents the role of psychosocial interventions in the non-pharmacological management of a patient diagnosed with early-onset schizophrenia. In this scenario, the role of a psychiatric social worker is essential to enhancing the quality of life of the person with mental illness.

Method: The present study was undertaken with the objective of evaluating the efficacy of establishing comprehensive psychosocial interventions for person with early-onset schizophrenia. The interventions carried out with the patient and family included psychoeducation, supportive psychotherapy, addressing the expressed emotions, enhancing the support system and supportive work with family.

Result: Significant improvement was observed after intervention at the individual and family level.

Conclusion: The case study helps us understand why and how psychiatric social work interventions are important in mental health care. Interventions from psychiatric social work can improve the quality of life and health of people with long-term mental illnesses. It also empathizes with the fact that a psychiatric social worker plays a key role in the treatment of early-onset schizophrenia.

Keywords: Schizophrenia; Psychiatric social work interventions; Early onset

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Introduction

In India, the majority of the people with schizophrenia stay with their families [1]. Persons with severe mental illness experience significant disability in self-care, interpersonal relationship and work. The onset of mental illness in the family can be stressful [2]. It can be crisis for the family members. They were experience high levels of burden in caring a person with severe mental illness [3,4]. Family experiencing high perceived stigma in the community which in turn can affect their relationship with the affected with family member, as well as neighbors the majority of the family members could not seek help from the community due to stigma and illness parse it affects the well-being of the family and patient. Expressed emotion found to be high among these families [2-5]. Expressed emotions are the strongest predictor of relapse in schizophrenia [6,7]. It is also observed that family who cares for a person with mental illness experience less social support and withdraw from their regular social contacts due to their high perceived stigma [2]. Psychoeducational and family interventions and reduce the rate of patient relapse. Interventions improve patient functioning and family well-being [8]. Evidence based Psychiatric Social Work interventions have been found to help to enhance the level of functioning of the patient and their family members and also it may reduce the risk of relapse and improve compliance with medication [6,7,9].

The present case report is of a person with early-onset schizophrenia who was struggling with various psychosocial problems with his family. It dealt with psychosocial intervention; a psychosocial formulation was made to accomplish with the patient and his family members. So, to demonstrate the scope, feasibility, and possible outcome of the psychosocial intervention in a case of a person with early onset of schizophrenia and associated psychosocial problems formed the background of this case report.

Case Presentation

Reason for psychiatric social work interventions

Psycho Social Assessment and Intervention

a) Assessment of awareness about Mental illness

b) Assessment of the impact of mental illness in the family

c) Assessment of the caregiver issues due to the illness

d) Assessment of intervention for Marital issues

e) Evaluation and planning of Rehabilitation and Vocational needs

Clinical history: The patient was apparently maintaining well until December 2016. In January 2017, a patient quarreled with the neighbor over a land issue. After a few days, the patient started telling caregivers that the neighbor was trying to harm him and was following him. Additionally, the patient also claimed that the co-workers at his workplace were talking badly about him and discussing him, which he used to cross-check with his friends. Despite the friends telling him that it was not true, the patient argued and believed that they were talking about him and plotting against him. Patient had a physical fight with them as well, following which he took leave from work and went to his hometown. After a few days, when parents inquired about his job, he got angry and assaulted them. Subsequently, when the patient went back to work, he fought again with co-workers for trying to harm him due to their suspicion, left the job, and went back home. When he was at home, he was abusive and quarreled with family upon enquiring about his job. The patient's father's friends informed the family that the sudden behavioral changes in the patient were probably the result of black magic by the neighbors, secondary to the land issues. Hence, it was advised to take him to the temple and the faith healer in the village. The patient's family took him to various faith healers, and he was less disturbing for a few days after such visits. Symptoms were reported to have worsened close to the full moon days. When the patient became unmanageable, his parents took him to different temples suggested by his relatives. They also involved him in religious ceremonies for a year. Though they spent around 1.5 lakhs, the patient's symptoms were fluctuating and unmanageable. During the symptomatic phase, the patient also demanded to get married because his friends got married. A few neighbors' families pushed this idea to get him married. After a few days of marriage in May 2019, the patient and his wife moved to Bengaluru for employment. Though marriage was consummated, after 3 months, there were frequent quarrels with his wife, including physical abuse. A few days later, the patient suspected his wife of having extramarital affairs. Accusing her of having extramarital affairs. Secondary to this, he used to be physically abusive to the wife. Due to this, the wife went back to her family of origin. Patient biological, social, and occupational functioning was also impaired. With these complaints, he was brought to the hospital and admitted on 8/26/2019.

Family environment before the onset of illness: Family routine usually starts at 6 a.m. in the morning. Mother did all household chores, including preparing meals. Father did outside household work - cleaning the ground and feeding the cattle - and after that he went to the field. All family members used to attend functions together. Every week, the family went to the temple and ate together. Father took the decisions in consultation with the rest of the family, and the family followed them. The interaction among them was cordial. The patient was contributing financially as well as in the day-to-day affairs of the family.

Family environment after the illness: The family routine was disrupted. Family stopped attending functions that used to happen in extended family. Routines were disrupted, and everyone appeared confused. The family environment became disorganized, with fights, disagreements, stress, and a high noise level. The brother stopped coming home regularly, the wife went back to her home, and communication within the family became need-based. The patient used to wake up late and did not engage in any family activities, except watching TV, eating, and sleeping. He also stopped going out and said nothing about his life.

Family dynamics

Boundaries: Since there were a lot of arguments, family members involved less as family. Relatives reduced visiting them. There were a lot of talks about his mental illness and that made the family to withdraw from social gatherings. However, there were a very few good neighbors and relatives who supported them. Family tried to keep the fights less and hence spoke less, and accommodated the demands of the patient. Father also started preferring to take support from extended relatives during the crisis and when the patient was unmanageable. Family had to listen to the influencing neighbors and relatives. The decision making was taken over by others. The family took all the suggestions given by others. Family got the patient married because of the influence of the neighbors and relatives.

Leadership and decision making-everybody took their own decisions: More confused and chaotic as the family environment kept changing with the symptoms of the patient. Majority of the decisions were taken by the younger brother and father supported it.

Role structure and functioning: Father performed the instrumental role while mother performed expressive role. Father and younger brother were the primary bread winners of the family. Father accompanied patient for the treatment everywhere and hence his role to contribute financially was affected. Nobody else took the charge of caregiving and he was tired of being with the patient. The younger brother took charge of the situation and started contributing more, mother continued to take care of the household affairs.

Communication: Conversation among the family members decreased. Patient communicated his needs through the mother to father. Brother and patient did not communicate at all. Patient spoke only to the mother. Both parents communicated to each other. The quarrels and arguments of the patient increased the noise level at home.

Reinforcement: The family exercised various forms of reinforcement when the family had young children. However, father used praise and support with patient to maintain self-care and hygiene. Though many times, appreciations were not said and given, acknowledgements of roles were evident.

Family rituals: Meeting together, talking to each other at home, visiting relatives together, eating together, celebrating festivals at home, and going for fair, were almost stopped. They also stopped visiting the temple as a family but they continued individually.

Cohesiveness: Wife separated from him. There were no efforts initiated to work with the marriage. Though the brother took charge of financially supporting the family, he reduced visiting them because of the fights.

Table 1: Psychiatric and psychosocial diagnosis.

F & Z Category	Diagnosis
F.20	Schizophrenia
Z65	Problem related to employment
Z60	Problem related to social environment
Z60.4	Social exclusion and rejection
Z63.0	Problems in relation spouse with partner

Family development stage six: Family with lunching young adults [10].

Adaptive patterns and coping strategies: The whole family was not able to deal with the crisis well. They though, sought help from others, it did not help them. They had difficulties to selecting the best care for the patient. They were carried away with the demands of the patient and encouragement of neighbors in getting the patient married. They did not disclose about the mental illness to the wife's family. Only during the admission of the patient, wife was contacted.

Social support system: Family had adequate primary and Tertiary support; however, secondary support was inadequate.

Social analysis and diagnosis

Patient is hailing from a family that is rooted in religious beliefs, rural background and healthy parental and sibling subsystems. Members had healthy interaction among them; they were supportive to each other, shared healthy communication and was a cohesive unit. Family had adequate rituals to be together. However, changes started seen after the patient became mentally ill. History reveals that, the interaction of family members affected, family members involved less as family and withdrawal from socializing. Family followed magico-religious beliefs and practices its hindered early treatment of the patient it's impacted the family functioning. Father started preferring to take support from extended relatives. During the crisis and when the patient was unmanageable, the family system started changing especially, the boundary system becoming diffused, leadership changing, communication pattern becoming need based, and involvement of several others in the family affairs. Family environment became, more confused, stressful, conflictual and chaotic. Illness also affected the decision-making role of the patient and the younger brother became more powerful in decision making. Father had Care giver burden role in the family. Patient also went through a marriage without disclosing about his illness that has also contributed in aggravating his condition as well as affecting the wife and marriage. The whole family was not able to deal with the crisis well, and they did not receive adequate guidance which prolonged the psychiatric consultation, impact of mental illness of the patient. The pathological family situations or disorganizations could be attributed to the impact of mental illness (Table 1).

Psychosocial interventions

Goals and interventions:

- To establish rapport with the patient and family
- Psychoeducation
- Supportive psychotherapy
- Family Intervention
- Normalizing the family routine
- Expressed Emotions
- Addressed Caregiver burden
- Pre discharge counselling
- Intervention Offered

Psychoeducation: Assessed the knowledge of the patient and caregivers about etiology, treatment, and prognosis and provided information about etiology, symptoms of schizophrenia, the importance of medication, and treatment compliance. Discussed relapse and early signs of relapse. Dealing with stress today while managing a person with schizophrenia improving insight into illness handling expressed emotions and improving communication enhancing adaptive coping to deal with persistent or residual symptoms.

Supportive psychotherapy

Supportive psychotherapeutic work initiated with father who was the primary care giver.

Allowed ventilation enhanced his psychological strength by addressing his worries and concerns. Guidance is given about the available treatments and the patient's recovery process. Provided a strong foundation for him. The therapist appreciated his efforts in accompanying the patient. Validated his emotional experiences brought other family members for therapy and made their roles clear in caregiving. Gave him time away from caregiving. Discussed his need for his space and routines to be normalized.

Family interventions

Normalize the family routine: discussed with and facilitated insights with the family about the disadvantages of focusing on the patient's illness as the center of their lives. The long duration of illness and its potential effect on members potential stress-related issues in family's potential perception by the patient as a burden to his family encouraged them to resume the daily routines that were present before the illness; helped them to make a daily routine that included time for leisure; celebration of festivals; birthdays; marriage ceremonies; family time and advised them to attend to the needs of other family members.

Addressed expressed emotions: identified criticality from the brother and father [11].

Explained the effect of expressed emotions on mental illness. There was discussion about the father's and brothers emotional reactions to the patient's symptoms. Validated their emotional responses and educated them about the role they play in relapses. Helped them understand these reactions as normal for such experiences. However, they needed handling because it speeds the recovery. Once they were able to relate to the patient as a person with illness, their attitude and behavior changed. We appreciated their understanding and changes.

Addressing the family caregiver burden: As the family belongs to a lower socioeconomic class and faces lots of financial issues, it adds to the family's caregiver burden issues, which adds to the family's burden. They followed the magico-religious practices and spent more than one lakh rupees on these practices. The patient's father was staying with the patient in the hospital, while other family members were less involved due to other commitments. The caregiver burden was addressed with the father, and the therapist encouraged the other family members to get involved in the patient's treatment, which reduced the caregiver burden in the family.

Pre-discharge counselling: The emphasis was given to improving

the client's treatment adherence. Previous sessions were summarized. Points on identifying signs of relapse and seeking immediate help were discussed. Support was assured to the patient and wife from the hospital through follow-up sessions. Emergency care locations were given locally. Refers to DMHP Tumkur Karnataka. Questions related to discharge were addressed.

Follow up (Telephonic)

- On regular medication under supervision.
- Patient is helping father in agriculture work
- family is very supportive and no expressed emotions reported
- Wife is living with him and in laws. Communication improved and relationship improving

Outcome

Individual level: The patient showed significant improvement in the illness, communication, and relationships with his wife and brother at the time of discharge.

Better understanding of illness.

Planned to join her father in farming.

Family Level: Psychoeducation improved the family's awareness, acceptance of the patient and his illness, and their role in supporting the patient.

Challenges while treating as an IP Care

- Had difficulties psycho-educating the family because it frequently clashed with magico-religious beliefs and practices with psychiatric treatment.
- The patient's father's receptivity was too low, and therefore the intervention went at a very slow pace in the beginning. The patient's father was not ready to include the patient's wife during the hospitalization as she was pregnant.

Conclusion

Chronic mental illnesses have a devastating impact on the individuals as well as their families. The present case report demonstrated that psychosocial intervention could be effective in reducing the family burden, enhancing the well-being of patients as well as their families, and improving their quality of life and social functioning.

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