CASE STUDY: PARANOID SCHIZOPHRENIA

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Abstract

Ms. S.G. is 29 yrs old unmarried female educated up to B.A. II yr. came with the complaints of aggression, violence, intolerance, withdrawal, disobedience, laziness and increased self muttering. The patient was well till about 12 years back. In 1996 for the first time she complained that someone is taking her photographs and whistling on her. That time she also became very suspicious and reported some unclear fears also. When the problem increased, her parents took her to the psychiatrist who prescribed some medicines that she took for a period of 3 years and after that she made some manipulations by herself and the symptoms were relapsed. After that she again made manipulations in her medicine because of the side effects like- laziness and increased appetite. Since 2002 she is taking medicine with no manipulations. On MSE she showed less cooperation with the examiner. Her psychomotor activities were decreased with inappropriate social manner and non-verbal behaviour. Eye to eye contact was inadequate. Her tone of speech was decreased with rapid rate and verbigeration. Reaction time was decreased and mood was subjectively reported sad and objectively observed irritable. Second person auditory hallucinations were present. The patient was not oriented towards time and place but oriented towards person. Attention and concentration could be less sustained. Immediate, recent and remote memory was impaired. Abstract thinking was inappropriate with poor judgment.

Grade 1 insight was present.

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Introduction

Schizophrenia is a group of psychotic disorders characterized by major disturbances in thought, emotion, and behavior- disordered thinking in which ideas are not logically related; faulty perception and attention; bizarre disturbances in motor activity; in motor activity; and flat or inappropriate affect. It causes a patient to withdraw from people and reality, often into a fantasy life of delusions and hallucinations.

Two major figures in psychiatry and neurology who studied the disorder were Emil Kraepelin (1856-1926) and Eugene Bleuler (1857-1939). Earlier, Benedict Morel (1809-1873), a French psychiatrist, had used the term *demence precoce* to describe deteriorated patients whose illness began in adolescence. Kraepelin translated Morel's *demence precoce* into *dementia precox,* a term that emphasized the change in cognition (dementia) and early onset (precox) of the disorder.

For a diagnosis of schizophrenic disorder to be given, there must be a significant period of time in which a person shows changes to a markedly less satisfactory level of functioning in one or more major areas of life; for instance, work, social relations, or self care. There must also be a period of at least one month when the person is actively psychotic, as shown by bizarre delusions, prominent hallucinations or other clear signs of disorganized and strange behavior.

Identification Data

Ms S.G. was 29 years old unmarried female educated up to B.A. 2nd year belongs to a Hindu, higher middle class family. The information was gathered through the parents and seems to be reliable. The total duration of illness was 12 years, the onset was gradual, the course of illness was continuous and the progression is increasing. Some major disputes in the family served as the precipitating factors and the misbehaviors by her grandmother and her aunt served as the aggravating factors in the illness.

Presenting Complaints

At the time of history taking the patient was showing the symptoms like aggression, violence, social withdrawal, lack of interest in the social activities, intolerance, laziness and increased self muttering for about two months.

History of present illness

The patient, resident of Bareilly, was well till about 12 years back. Then she started to report that someone was whistling on her and taking her photographs. She started showing suspiciousness at a high level. At some of times she reported the fears also which were not clearly defined by her. One day when she came back from tuition she reported that her neighbor had fitted a camera in her bathroom, though it was nothing like that. These symptoms continued for about 3.5 months. So her parents took her to the doctor and then she started taking the medication for the first time. She took this medication continuously for about 3 years and then she herself made some manipulations in the dose after which the symptoms were relapsed. She again started showing suspiciousness and this time she alone used to sit in her room and started talking to self and whenever she was asked whom she was talking to, she always replied that she was talking to her friend but she never reported any other person involved in this discussion. Her parents reported

that her friend whom she was talking to did not live in Bareilly. Then again her parents took her to the psychiatrist who prescribed some medications but as a side effect of this medication, she became lethargic and started feeling more hungry. So again she made some manipulations in the medication and this time she became very aggressive. Such kind of manipulations continued for about two years. After that she has been taking her medicines regularly without manipulations. But for about 2 months the patient has been showing complaints like aggression, violence, intolerance, disobedience, laziness, self-muttering and less participation in the activities of day care rehabilitation center.

Treatment History

In December 2002, she started taking medication for the first time. In 2005, her previous medicine was changed which showed its side effects. In May 2007 she changed the hospital and started taking another medication and in reaction to heavy dose of these medicines she got body rashes. But at that time her parents' financial condition was not good so they could not go for better treatment for her. From 16th October 2008 to 2nd November 2008 she was hospitalized for the first time where she was given Electro Convulsive Therapy for the first time. This proved to be very effective but just for a month. After one month her condition again started deteriorating.

Negative History

No obsessive-compulsive symptoms, no depression, no somatic symptoms like- headache, weakness, back and muscle pain or digestion problem, no history of seizures, no history of alcohol or drug dependence or abuse and no motor dysfunctions were identified.

Psychiatric History

There was no history of any other psychiatric illness other than the present one.

Medical history

There was no history of any medical illness.

Family history

Earlier the patient was living in a joint family where she faced misbehaviors from her grandmother's and aunt's side. Presently she was living in a nuclear family with parents and 2 brothers. Head of the family was her mother. Initially the parents were keeping a cursing attitude towards themselves that they were paying for their sins. The attitude of the parents towards the patient was very supporting and caring but her elder brother does not pay much attention to her. There was less communication in the family members. She was more attached to her mother before the illness. There was a no history of any significant medical and mental illness in her family. But the patient's mother reported that one of her uncle was suffering from some mental illness, which was not diagnosed.

Personal history

She was a full term normal vaginal delivery with immediate birth cry and no birth defects. Developmental milestones were achieved delayed, specifically walking and speech. Neurotic traits like tamper-tantrums were present. She was a pampered child since childhood. Health during the childhood was normal except tonsils for which she had gone through an operation.

Her education was started at the age of 3 years. There was no history of any school phobia. She had very less friends since childhood and she was also introvert from the beginning. In her childhood she met an accident in which some of her teeth were broken. After this accident she became more introvert. There is no history of any maternal deprivation. She had no male friends since her childhood and there is no history of attraction towards opposite sex. She did not very frequently play with her friends. She was a very bright student in her childhood. For this reason

her teachers also liked her but for some reason she could not excel in 10th standard, so was not able to remain in the same school, which adversely effected her and she was disturbed a lot. Her menses was started at the age of 12 plus. Her reaction to it was normal and it was regular before the illness. The length of the periods was 5 days.

Pre-morbid Personality

She was a less interactive child since childhood. She was very fond of being properly dressed up. She was also very much fond of books and new dresses. She liked singing and dancing in her leisure time. She did not properly entertain any responsibility assigned to her. She never used to take part in household activities. Her attitude towards self and others was positive except towards her grandmother and aunt.

Mental Status Examination

On general appearance and behaviour the patient appeared to be kempt and groomed. Her attitude towards the therapist was not cooperative. Her comprehension was found to be intact. She was leaning towards the right while sitting and walking. Psychomotor activity was decreased. Social manner and non-verbal behaviour was inappropriate. Eye to eye contact was inappropriate as sometimes the patient was staring vacantly and sometimes she was staring at the examiner. Rapport could not be established with the patient. Rate of the speech was rapid and volume and tone of the speech were decreased. Verbigeration was present in the speech and the reaction time was increased. Subjectively the mood was reported sad and objectively the mood was appeared irritable. Tengentiality was present in thoughts. Second Person auditory hallucinations were present. No illusions or misinterpretations were present. No depersonalizations or derealizations were present. No somatic passivity phenomenon was present. The patient was conscious at the time of MSE. She was not oriented towards the time

and place but she was oriented towards person. Attention and concentration could be less sustained. Immediate, recent and remote memory was impaired. In the assessment of intelligence it was found that abstract thinking was inappropriate and social and test judgment was poor. There was a complete denial of illness, hence the insight was present at level 1.

Diagnostic Formulation

Ms. S.G. was 29 years old brought with the complaints of aggression, violence, intolerance, withdrawal, disobedience, laziness and increased self-muttering. Total duration of illness is 12yrs., onset is gradual, course is continuous and the progression is increasing.

In 2001, some major family disputes worked as the precipitating factor for the illness and the behaviour of her grandmother and her aunt worked as aggravating factor. During the whole course of illness the patient made some manipulations in the medication, which caused the relapses with increased symptoms. On MSE she showed less cooperation with the examiner. Her psychomotor activities were decreased with inappropriate social manner and non-verbal behaviour. Eye to eye contact was inadequate. Her tone of speech was decreased with rapid rate and verbigeration. Reaction time was decreased and mood was subjectively reported sad and objectively observed irritable.

Second person auditory hallucinations were present. The patient was not oriented towards time and place but oriented towards person. Attention and concentration could be less sustained. Immediate, recent and remote memory was impaired. Abstract thinking was inappropriate with poor judgment. Insight was present at the level 1.

Provisional Diagnosis

Paranoid Schizophrenia (ICD-10: F20)

Significance and findings of psychometric assessments

Some tests from NIMHANS Battery (2004) and Brief Psychiatric-Rating Scale were administered for the purpose of assessment. The significance and findings are given below:

1. ***Brief Psychiatric-Rating Scale (BPRS):*** To confirm the observed psychotic features. She scored high which is suggestive of psychoticism.
2. ***Digit Symbol Substitution Test (DSST):*** To assess the mental speed. The patient took 218 seconds to complete the test, which lies under 13th percentile that is suggestive of deficiency in this particular area.
3. ***Digit Vigilance Test (DVT):*** To measure the sustained attention. The patient took 765 seconds to complete the test, which lies under 3rd percentile that is suggestive of deficiency in this particular area.
4. ***Controlled Oral Word Association Test (COWA):*** To measure the phonemic fluency. The average of new words i.e. ANW created by the patient is 1.66, which lies under 5th percentile that is suggestive of deficiency in the related area.
5. ***Animal Names Test (ANT):*** To measure the category fluency. The total of new words i.e. TNW created by the patient is 7 that come under 5th percentile that is suggestive of deficiency in the related area.
6. ***Auditory Verbal Learning Test (AVLT):*** To measure the learning and memory for word lists. the patient scored 26 on the first 5 trials, 4 on list B, 2 on immediate recall i.e. IR, 4 on delayed recall i.e. DR, 66.66 on long term percent retention i.e. LTPR. All these scores lie under 5th percentile that is suggestive of deficiencies in these particular areas.

7. ***Complex Figure Design Test:*** To measure the visuo-constructive ability. The patient scored 30 in copy trial, 0 in immediate recall and 0 in delayed recall. It shows that the immediate and delayed response is deficient.
8. ***Mini Mental Status Examination (MMSE):*** To assess the mental status of the patient. The patient scored 12 out of 30 in which she showed total disorientation towards time, higher level of disorientation towards place whereas her attention and concentration was found to be intact. The patient also showed impairment in language and recall. In total the scores are suggestive of higher level of impairment in her mental status.

Behavioural observation during the test administration

The patient was obediently doing the work when asked to. She showed no distractions during the testing. She was silently and sincerely doing the work.

Assessment summary With case history, mental status examination, psychological assessments and neuropsychological assessments Ms. S.G. meets the criteria of Paranoid Schizophrenia.

Final Diagnosis

Paranoid Schizophrenia (ICD-10: F20)

Treatment Plan

Objectives of the Therapy

Short-term goals –

1. To reduce the level of aggression and violence.
2. To encourage the patient to participate in the activities of day care rehabilitation center.
3. To reduce the level of intolerance.
4. To reduce the level of disobedience.
5. To reduce the level of laziness

Long-term goals –

To enhance the following cognitive functions:

1. To enhance the attention and concentration
2. To enhance the mental speed
3. To enhance the phonemic and category fluency
4. To enhance the memory and learning through repetitive tasks
5. To enhance the social skills

Therapeutic Process

- Cognitive Exercises
- Behaviour Therapy
- Music Therapy

Session Summary

Session 1,2,3,4 (Diagnostic Interview, Rapport Establishment and Psychometry)

Diagnostic Interview continued from session 1to 4. Patient's parents were inquired about the nature and development of the illness. In these 4 sessions rapport formation also started taking place gradually, as the patient was uncooperative in the beginning. In the later sessions psychometry was also started.

Session 5,6,7 (Rapport Establishment, Observation and Psychometry)

In session 5 and 6 rapport was established through interaction and playing games with the patient. Behavioral observation was also done in these sessions to find out the targeted areas for interventions. Psychometry was also done in these sessions.

Session 8, 9, 10,11,12,13,14,15,16 & 17 (Psychometry, Behavior Therapy: Shaping Through Rewarding Successive Approximations & Social Skills Training

In these sessions psychometry was done and the patient was provided positive reinforcements in which successive approximations were rewarded. Social skills training were also provided simultaneously. For example— if the patient was not interested in participating in the day care group activities, every time she was motivated to participate. And when she participated even unwillingly she was praised every time and each and every patient and other members of day care rehabilitation center were made to clap for her. The patient was also asked to respond to the other patients and the members who clapped for her. For example, she was asked to say thanks to them. Through this technique the patient was reinforced to behave in a desirable manner.

Session 18,19,20,21,22, 23,24,25,26,27,28 (Positive Reinforcements & cognitive Interventions)

In these sessions the patient was provided positive reinforcements and cognitive interventions.

For example -- if the patient participated in the games, she was appreciated and if she performed better then the earlier she was announced to be a good player in front of all the patients and members of the day care rehabilitation center. Sometimes the patient was given small gifts as a positive reinforcement like attractive pencils, erasers etc.

In cognitive interventions the patient was involved in the mental exercises like simple mathematics, which included sums of addition, subtraction, division and multiplication, letter cancellation for enhancing attention and concentration, one-minute games to enhance mental speed, informative games, like Name-Place-Animal-Thing to enhance the phonemic and category fluency. Some other games were also created to enhance the learning and memory. For example one patient was asked to tell a number of some fruits, flowers etc. and this patient was

asked to repeat in the same manner. The grades were also provided to the patients to make the game interesting. In board activities an object was drawn on the board and the patients were asked to copy it in the same manner. This activity helped her in enhancing the visuo-constructive ability. Such kinds of other board activities were also included to enhance the cognitive abilities of the patient.

Follow-ups (Cognitive Interventions and Positive Reinforcements)

The follow-ups were continued for about 5 months in which the patient was provided positive reinforcements along with the cognitive interventions and social skills training.

Results (Outcome of the therapeutic sessions)

A case of Paranoid Schizophrenia had been receiving daily sessions, each lasting from 2:30 P.M. to 5:00 P.M. The patient was dealt with the help of the techniques like shaping, positive reinforcements, social skills training and cognitive interventions that included mental exercises. The patient was regularly coming for the sessions. She was sincerely doing all the work assigned and responding well to the therapies. The patient is showing improvement over a number of sessions and her parents reported that she had been benefited from the therapy.

Discussion

On the basis of the tests administered on the patient, it can be concluded that schizophrenic patients have deficiencies in the different cognitive functions like, mental speed, sustained attention, visuo-spatial construct, phonemic and category fluency and auditory verbal learning. These deficiencies can be recovered to some extent through the techniques like, behavior therapy, cognitive interventions, positive reinforcements etc. Thus the patient of schizophrenia can be taken into the mainstream through these psychotherapeutic interventions.

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