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A Case Report of Schizophrenia Client with Multiple Episodes: An Eclectic Family Therapy Approach

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Abstract

Eugen Bleuler was a Swiss psychiatrist who introduced the term schizophrenia, meaning "splitting of the mind. Schizophrenia is a severe form of psychological disorder that encompasses what most of us have come to know as "madness." It is also called cancer of mental illness. Although researchers are probing the psychological and biological foundations of this psychotic disorder, the disorder remains a mystery. Schizophrenia is the most common mental disorder affecting perception, cognition,

thinking, and behavior. Although the way it manifests varies from patient to patient, its effects are typically severe and persistent. As a result of the disease's chronic nature, family members and carers are also impacted. This social casework report details the difficulties in treating and managing a man with repeated episodes and disrupted family functioning. Although medication is the mainstay of treatment for this condition, social casework based on a structural family therapy approach, family psycho-education, behavior modification techniques, social skills, coping, and supportive work with family members can also be helpful. A home-based rehabilitation program was developed to relieve the burden on the carers. It shows the fruitful results of individual and family intervention with a person using structural, behavioral, psycho-educational, and rehabilitative approaches and methods after several sessions and telephone follow-ups. As a result, the family could recognize its issues, develop solutions, and put those answers into practice.

Keywords: Schizophrenia, Psychological Disorder, Caregivers, Drug Therapy, Rehabilitation.

Introduction

Schizophrenia is a complex psychotic disorder characterized by the fragmentation of rudimentary psychological functions such as attention, perception, thought, emotions, and behavior. The name schizophrenia (skit-so-FREE-nee-uh) was coined by the Swiss

psychiatrist Eugen Bleuler (pronounced "bloy-ler") from the Greek schizo, "split," and phren, "mind," which stands for an abnormal disintegration of mental functions (such as thoughts and feelings). Positive symptoms are excesses.

They are marked by the presence of abnormal or distorted cognitive processes, mental contents, or behaviors that are not evident in healthy people, such as delusions, hallucinations, disorganized thinking, and disorganized behavior are known as positive symptoms (Sass & Parnas, 2003). People showing positive symptoms are sometimes described as having Type I schizophrenia. Type I is similar to acute schizophrenia. Negative symptoms are deficits in functioning. They are noticeable by the absence or reduction of normal mental processes, mental contents, or behaviors that are usually evident in healthy people, such as good social skills, motivation, appropriate affect, and life skills are called negative symptoms of schizophrenia and persons showing negative symptoms are sometimes described as having Type 2 schizophrenia (Correll & Schooler, 2020).

A person can experience a break from reality in other psychotic disorders besides schizophrenia. We also consider other psychotic conditions, such as delusional disorder, short psychotic illness, schizoaffective disorder, and schizophreniform disorder. The DSM-5 categorizes these disorders as a spectrum of schizophrenia-related disorders called Schizophrenia Spectrum and Other Psychotic Disorders, including schizophrenia and schizotypal personality (Cohen et al., 2021).

Schizophrenia does not mean "split personality," as in dissociative identity disorder (multiple personality disorder). It is

also said that the "split" in the term schizophrenia denotes a split between the intellectual and emotional aspects of one personality and intellect and external reality. For instance, some people with schizophrenia may giggle while claiming to feel sad. Five areas of severe mental sickness, including schizophrenia, a crippling disease, and long-term sickness, include psychotic symptoms, negative symptoms, cognitive decline, mood issues, and behavioral disorders (**Schwarz, 2013**).

The brief history of schizophrenia is that John Haslam was the superintendent of a British hospital. In 1809, in his publication Observations on Madness and Melancholy, he outlined a description of the symptoms of schizophrenia. Philippe Pinel was a French physician who described cases of schizophrenia. Benedict Morel was a doctor at a French institution who used the term demence precoce (in Latin, dementia praecox), meaning early or premature (précoce) loss of mind (démence) to define schizophrenia. Emil Kraepelin was a German therapist who combined the distinct categories of schizophrenia (hebephrenic, catatonic, and paranoid) under dementia praecox (**Metzl, 2010**).

Clients do not necessarily fulfill all domains, but they do exhibit specific symptoms in each area, but not all of them. The stress vulnerability model proposes four variables as the root of schizophrenia: biological vulnerability, stress, coping mechanisms, and social support (**Zubin & Spring, 1977**). Each person with schizophrenia is different; no two people have precisely the same symptoms. Acquiring knowledge of schizophrenia prepares one for collaborative work with patients, carers, and healthcare professionals (**Torrey, 2001**). Systematic evaluations elaborated that family

intervention reduces the stress and hardship of family life, prevents readmission to the hospital, and calls for high-quality care (**Pharoah et al., 2010**).

1. Prevalence of Schizophrenia

Schizophrenia affects about 1% of the U.S. population and about 0.3% to 0.7% of the global population (**APA, 2013**). In developed countries, schizophrenia is one of the top five reasons for debility.

2. Onset of Schizophrenia

Around age 18 for men and age 25 for women, schizophrenia is characteristically diagnosed in early adulthood or late adolescence. Additionally, men appear to experience a more severe form of the disorder (**Newman et al., 1996**).

3. Comorbidity of Schizophrenia

90% of people with schizophrenia also have one or more additional disorders (**Lyketsos et al., 2001**).

4. Cultural Differences

Schizophrenia is extra prevalent in cities and among those of lower socioeconomic status. Black Americans are twice as likely to be given this diagnosis as White or Hispanic Americans are. This may result from the selective usage of particular diagnostic classes for various ethnic groups. People in non-Western nations have a better prognosis than those in Western nations because they can better function in their societies (Sharpley et al., 2001).

5. Etiology of schizophrenia

Psychological, social, and biological/neurological aspects have all been proven to have a role in schizophrenia. People are more

likely to acquire schizophrenia as a result of neuropsychological risk factors than as a result of psychosocial variables (Hosak & Hosakova, 2015).

Case Introduction

The client is a 27 years old unmarried male. He is the fifth born and has three sisters and four brothers. His father is a retired Professor, whereas his mother is a housewife. He belongs to a Sindhi-speaking Muslim family with middle socioeconomic status. He lives in a nuclear family setup. His parents said his temperament made him slow to warm up; therefore, he could never make friends. He did not play indoor or outdoor games or have pals during childhood. He continued to be alone and had subpar schoolwork. His capacity for adaptation and grasp of new ideas could have been improved.

Presenting Complaints

He currently complains of one episode of remarkably jerky movements of his entire body, which was followed by disturbed sleep, fear, suspicion, hearing voices, restlessness, stress, impulsivity, anxiety, crying spells, smoking, helplessness, irritable mood, and forgetfulness, along with poor oral intake and poor self-care. These symptoms were present for the last eight days.

Sources of Information and Reason for Referral

The client and his parents provided information regarding the situation under the referral sources and other sources of information. The data was determined to be accurate and sufficient. A psychosocial assessment, family psycho-education, and targeted

intervention for the client and family were requested in this situation.

Brief Clinical History of the Client

The client reported that his problems started when he was 19 years old. He was a very shy boy. When he was in intermediate, he had a problem with urine drops coming after every time he discharged urine. He used to offer prayers regularly, so it was a very big question for him whether his clothes were clean for prayers. He was very shy and did not ask anyone what to do. He could not find an answer. Class-fellows teased him. It started with decreased sleep and suspicion. Gradually his fear increased as he started to be sceptical about the boy's behavior, and he thought he might somehow harm him.

When he was admitted to a university, his father accompanied him on his first visit to advise him on traveling by train. At university, there was a trend of ragging first-year students (juniors) who had to obey seniors. The fooling (ragging) remained continuous for 1 year in the hostel. The seniors were always ordered to make fun of, sing songs, tell jokes, do sexy dances, use abusive language, cry like jungles, etc. There was also vulgarity, like watching nude magazines and telling class fellows to measure the size of the penis. They always laughed at his small penis. They said that you are unable to do sex with any girl. Therefore, he was very much puzzled. Everyone teased me because he was physically weak (slim). His waist was 26 inches. Over time, his suspiciousness spread to the wider sphere as he started suspecting and fearing that all the boys in his neighborhood and college had passed comments on him

He reported auditory hallucinations as he listened to the voices of his spiritual father, who guided him. He reported becoming aggressive when his family members criticized him for his failed life. Afterward, he thought about his failed life, and he felt inferior. He said that he felt helpless when he thought about his family because his brothers were well-settled abroad but did not support him, and he thought that his father was supporting him, but after his father's death, who will support him? Furthermore, he reported that he had forgotten all his memories and forgotten things due to the stress of his life because he was still jobless. He said he feels stressed whenever his family tells him he cannot leave home because he is under treatment. He reported feeling anxious when he thinks about past traumatic life events, such as his seniors bullying him at his university.

Past History

Regarding his prior history, he reported that first of all, he visited a hospital in Karachi, and the client was admitted to the psychiatry ward seven years ago with the symptoms explained above. He reported that he approached ICP (Institute of Clinical Psychology) for psychological assessment and psychotherapy and was diagnosed with Phobia, Mania, and then Schizophrenia. He had two additional repeated admissions to the psychiatric clinic. Now he is in therapy at HLPS Islamabad.

Occupational History/Work History

The client reported that he felt unstable when he applied for any job. After joining the job, within 3 to 4 days, he thought this

environment was unsuitable for him, and he could not adjust there because these people were not according to his nature. He reported feeling stressed when he applied for a job; the organization called him for an interview, and at that time, he felt stressed about how he will manage the situation. He said that he felt impulsivity when he did any work. Regarding his work history, he said that he started work at different mills and suddenly broke down due to the high workload and stress. He said that when he joined Jubille textile mill in Karachi and left that job within 3 days due to sleep disturbance. Furthermore, he reported that the same procedure of joining and lifting continued. Now he was jobless.

Friendship History

Regarding his friendship, he reported that he had many friends before his problems, and he was very jolly with friends, but after his problems, he had no friends. Now he thought he was not able to continue his friendship. Nowadays, he has no friends.

Family History

Regarding his family history, he reported that he belongs to a middle socioeconomic family. The client was from a nuclear family; as stated, his father had hypertension, and his mother had a history of diabetes mellitus. The father of the client was 54 years old. He was a retired professor by profession. He had a good education. He had a strong opinion about things and was naturally quite suggestible, so he paid little attention to what others had to say. He was critical of all the client's activities and behavior and thought his son had a serious mental illness. His father had not any psychiatric illness.

The mother of the client was 56 years old. She was a housewife. She had a friendly relationship with the client and was a devoted mother. She had no history of psychological illness, as was reported. Additionally, she was physically frail and suffered from medical concerns like high blood pressure, diabetes. Because of their tight relationship, the client confided in her.

Personal History

Birth and Early Development

According to information provided by a referral, a skilled "dai" (traditional birth attendant) delivered a baby vaginally on his own at home. Additionally, there was no history of disease during the pregnancy or the baby's first year. Compared to his contemporaries, he met developmental milestones on schedule.

Behavior during Childhood

He was an easy-going child. His relationships with everyone were friendly because he was a laid-back youngster.

Education

He began attending school when he was five years old and had average academic performance. He did well in his exams until class XII, but he could not continue his education after the onset of mental illness.

Personality

He was a very shy, timid boy. He was not able to make friends easily.

Tests Administered

Bender Gestalt Test-Second Edition----------(BG-II)

Standard Progressive Matrices----------(SPM)

Human Figure Drawing----------(HFD)

Thematic Apperception Test----------(TAT)

Rorschach Inkblot Test----------(ROR)

Behavior during Assessment Sessions

Mr. X was very talkative and discussed his problem history in detail. He told the examiner that he wanted to change himself and confirmed 2 to 3 times that he might have changed himself. Overall, he cooperated and followed the instructions well, which were given by the examiner.

Psychological Evaluation

Scores on the neuropsychological screening test, "B.G," indicated that Mr. X's visual motor perceptual functioning falls within the "Superior" range. Furthermore, B.G.'s emotional indicators revealed that he has acting out behavior.

Scores on Standard Progressive Matrices (SPM), a type of intelligence test, indicated that Mr. X's abstract reasoning abilities fall within the "Superior" range.

Projective analysis revealed that Mr. X's self-respect is quite negative, and he felt clashed regarding his self-image. His prominent needs were related to affiliation achievement and sex. He perceived his environment as disapproving because he dealt with conflicts of affiliation versus isolation, approval rejection, and intimacy versus isolation. His anxieties were related to being punished, deprived, and disapproved. He often used the defense mechanisms of denial and reaction formation to overcome his anxieties and conflicts.

Projective analysis revealed that Mr. X got overwhelmed by interpersonal demands, which leads him toward social ineptness. He had low emotional control, so he got impulsive when things were out of his control. He felt withdrawn from the environment. which lead him toward conflicted interpersonal relationships. Mr. X considered himself inferior to others, leading to mood fluctuations and dysfunctional behaviors.

Tentative Diagnosis

295.90 (F20.9) Schizophrenia with multiple episodes, currently in the acute episode.

Prognosis

Psychological tests and clinical observation indicate that the client is motivated and has good insight. Hence, his prognosis was good.

Interventions

Goal of interventions

Long illness duration upsetting functional lifecycle; Poor medication compliance; men with early onset of chronic illness; Patient was irritable, abusive, and violent; parents' apprehension and unawareness about the ailment; Patient's sickness was harming mother's health as he was the chief carer; The family's maladaptive pattern of behavior.

The Course of treatment and assessment of progress

Four treatment steps for schizophrenia were used, each targeting specific symptoms. The steps are:

STEP I: Decrease the positive symptoms.

STEP 2: Reduce the negative signs.

STEP 3: Improve neurocognitive functioning.

STEP 4: Reduce problems with daily work.

Targeting Neurological Factors in Treating Schizophrenia

Currently, most treatments focus on Steps 1 and 2 (reducing the positive and negative symptoms), although some treatments do focus on improving cognitive function.

Medication

Traditional Antipsychotics/Typical Antipsychotics.

Atypical Antipsychotics.

Other Therapies

Shock therapy: Shock therapies have been used for years to stimulate the depressed cases of schizophrenia.

Psychosurgery: It was used for acute emotional disorders by disconnecting the prefrontal lobe from the hypothalamus. There was mixed support for transcranial magnetic stimulation (TMS) to decrease hallucinations.

Targeting Psychological Factors in Treating Schizophrenia

1. Cognitive behavior therapy (CBT)

Cognitive behavior therapy (CBT) was also used to help the client with schizophrenia to cope with symptoms, such as helping them to modify their thoughts about hallucinations or delusions (Fowler et al., 1995).

Cognitive-behavioral treatment following steps:

a. **Engagement:** The therapist enlightens the therapy and works to foster a harmless and combined method of looking at causes of

suffering, drawing out the client's understanding of stressors and ways of handling them.

b. **Assessment:** The client was invigorated to converse about his fears and anxieties; the psychotherapist shares information about how symptoms were fashioned and maintained.

c. **Identification of negative beliefs**: The therapist explained to the client the link between personal beliefs and emotional distress and the ways that beliefs such as "Nobody will like me if I tell them about my voices" can be disputed and changed to "I can't demand that everyone like me. Some people will and some won't". This reinterpretation often leads to less sadness and isolation.

d. **Normalization:** The therapist worked with the client to normalize and catastrophize the psychotic experiences. Information that many people could have unusual experiences can reduce a client's sense of isolation.

e. **Collaborative analysis of symptoms:** Once a strong therapeutic alliance had been established, the therapist begins critical discussions of the client's symptoms, such as "If voices come from your head, why can't others hear them?" Evidence for and against the maladaptive beliefs was discussed, combined with information about how beliefs were maintained through cognitive distortions or inferences.

f. **Development of alternative explanations:** The therapist helped the client develop alternatives to previous maladaptive assumptions, using the client's ideas whenever possible.

2. Milieu Therapy and Token Economy

Milieu treatment and token economy were two psychological strategies used in inpatient psychiatric facilities for clients with severe psychotic symptoms. Milieu's treatment entails creating a setting that promotes pro-social and self-care behaviors. The client with psychotic symptoms was constantly praised and encouraged to dress, eat, groom, attend treatment sessions, interact correctly with others, and engage in other good behaviors by mental health professionals, doctors, nurses, and other employees. Milieu treatment was occasionally associated with a "token economy" in which pro-social and self-care behaviors are concretely rewarded with points (or other things) that can be exchanged for benefits like out-of-hospital days. Rewards for brushing your teeth and having supper with others could be part of a token economy (Heap et al., 1970)

3. Cognitive remediation

Cognitive remediation addresses the cognitive deficits associated with schizophrenia (e.g., impaired executive functioning). Cognitive remediation might include practice with cognitive tasks, compensatory strategies (e.g., posting notes), and learning with positive reinforcement (Medalia & Choi, 2009).

4. Targeting Social Factors in Treating Schizophrenia

Hospitalizing those unable to care for themselves and educating families about the warning indications. By practicing social skills, you can lessen some undesirable symptoms. Community-based initiatives enhance performance and lifestyle quality (Li et al., 2016).

a. Family Education and Therapy

Families were taught about the condition through psycho-education, including recognizing its symptoms, warning signals of relapse, drug side effects, and handling emergencies. This

information may lessen the likelihood of relapse. Family-based therapy can obtain emotional sustenance and more flexible family collaboration patterns. Family treatment can also lessen strong EE patterns, which lowers the recurrence rate from 75% to 40%; nevertheless, as mentioned, high EE is advantageous for some cultures' families (Doherty, 1995).

b. Social skills training

Social skills training was intended to clarify for people with schizophrenia in what way to be successful in an extensive range of interactive situations, such as ordering food at restaurants, filling out job submissions, learning how to conduct job interviews (it is also known as vocational rehabilitation), and declining offers to buy drugs on the street (Smith et al., 1996).

c. Inpatient treatment

It could be required to stabilize the patient with a shorter stay in the hospital. The patient will be released once the risk has decreased. The nature of the condition may prevent people from realizing they need care, even though laws make it challenging to hospitalize people without their choice (Schwartz et al., 1997).

d. Minimizing hospitalizations: Community-based interventions

Before antipsychotic drugs were developed in the 1960s, many people with schizophrenia were institutionalized. Deinstitutionalization subsequently became a social policy to assist people with mental illness to live in the community instead of a hospital; many were released without sufficient resources and are currently homeless. Several communities have developed programs to aid persons with severe problems. Assertive community treatment is another name for programs that enable mental health professionals to visit patients at any time of the day or night in their homes. These patients express higher levels of satisfaction.

Treatments, nevertheless, might not always produce better results (Guo et al., 2001).

e. Individual level

The focus of the client's sessions was initially on building rapport and ensuring the client that aid was available before shifting to a more directive intervention. There were multiple individual sessions. There were behavioral deficiencies and excesses during the earlier evaluation session. His excessively withdrawn and solitary behavior, inability to fall asleep, general exhaustion, weird fantasies, and hallucinations with derogatory content were all noted as behavioral excesses. Poorly maintained concentration, failure to complete tasks, inability to establish friendships, failure to eat, inability to respond to inquiries, and bad speaking are examples of behavioral deficiencies. Rehabilitation can be reinforced to encourage greater adaptive behavior and replace harmful deficits and excesses by focusing on the client's positive attributes. Family associates were concerned and ready to participate in dealing with this reliable and conscientious client about keeping promises. The client was urged to discuss the numerous problems causing him trouble with his thoughts and perceptions.

His worries were taken seriously because of his attentive and involved listening. He was urged to establish a plan by aligning his daily routine with his career and hobbies, which he had previously ignored, and he was also advised on building strong interpersonal relationships. He was urged to take part in pursuits that he found interesting. He was encouraged to work on household chores like cooking or watering the plants. The client was advised to consider weaving as a career. He received training in affiliative abilities, self-

care management, and efforts to improve the person's verbal, peer, and familial relationship skills. Then he received assistance in writing down his responses to those circumstances and the result of them. Each circumstance was addressed separately, and the client received assistance in changing his behavior through assignments and homework chores. The task's successful completion was reinforced with words of encouragement and appreciation.

f. Communication enhancement training

In a joint session with the family, it was described how the client's symptom of countering resulted in impatience and non-cooperation. The family was made aware of the client's distorted cognitive processes and how they prevented him from understanding their stance. The following facets of the modeled statement in client management were highlighted after this explanation of the caseworker's responsibility to model the communication style to be used when dealing with the client: the significance of supportive listening, helping the client to regain composure and recognizing his emotional exacerbation before asking him non-offensive questions; securing the client's support and teamwork; engaging the client in a discussion. In addition, you should assign the client tasks in any situation and offer him a clear command about anything before waiting for his response. For his father to encourage him regarding the abovementioned characteristics, the client and his father established good communication (Park & Han, 2018).

5. Family level

The family sessions were primarily concerned with enhancing family interaction patterns and psycho-education. For the same, multiple family intervention sessions were necessary.

a. Psycho-education

The disorder of the client was disclosed to the client's family. They were informed of diagnoses focusing on young adults who have schizophrenia. Information on the illness and the procedure was also supplied to the parents. Questions about the course and prognosis of the illness schizophrenia were answered. Additionally, his parents were warned about the numerous conflicts and issues that came with becoming an adult and urged him to look out for these issues concerning the client. The client's father received mental health education about the importance of getting involved, as well as the importance of taking medication (**Doherty, 1995**).

b. Dealing with expressed emotions and high expectations

Family therapies, such as family psycho-education and structural and behavioral family therapy elements, successfully lowered family members' reported emotions, particularly criticalness towards the client. Along with altering family decision-making patterns, emphasis was placed on enhancing parent-child interactions. The addresses of various resource organizations were also given. To support the client's creativity, parents also explained positive reinforcement patterns. The mother of the client was taught how to direct the client's energy into positive endeavors, enhancing interactions between parents and the client (**Kuipers & Bebbington, 1988**).

c. Social support

Parents were instructed to understand that the client's primary social support is crucial at this point and that they should assist him in finding family, friends, and community services. By giving the family information about numerous resource organizations close to the client's hometown, the tertiary social sustenance for the family was also bolstered (**Beels, 1981**).

Discussion and Conclusion

Most individuals with schizophrenia should have access to relatively forthright, long-term psycho-educational family treatment. Training in social skills can help patients with schizophrenia become more socially adept, which could lead to more adaptable functioning in society (**Pharoah et al., 2010**). Patients who experience recurrent hospitalizations and relapses should be offered assertive community training initiatives, specifically if they have little family care. Early placement with continued support is the best chance for patients interested in working to keep regular employment in the community. Most patients experiencing incapacitating psychotic symptoms while receiving the best medical care may benefit from cognitive behavior therapy (CBT) (**Lynch et al., 2010**).

For persons with schizophrenia, medical, psychological, and social interventions are all important (**Read et al., 2004**). Social interventions may be more effective when neurological and psychological aspects are altered. Psychologically based therapies lessen symptoms and enhance overall functioning. Social influences prioritize enhancing family relationships, which may impact the nervous system's functions. Although some symptoms can be reduced by medication, psychosocial interventions are crucial.

Efficacy of Secondary Outcomes

Antipsychotic drugs have shown encouraging results, but non-pharmacological treatments have also shown a fast vertical growth. Four decades ago, Brown and Rutter's role of expressed emotions (EE) was first discussed (**Brown & Rutter, 1966**), suggesting reduction of EE within a family or other environment declines

relapse rates (**Penn & Mueser, 1996**). Recent research indicates that rigorous efforts to address aspects like family stress, coping, medication adherence, family support, early warning sign detection, and psycho-education have an ongoing impact (**Lauriello et al., 2003**).

Furthermore, controlled studies on the effectiveness of CBT demonstrated sustained benefits and an efficient reduction of schizophrenia symptoms. Additional information was provided regarding factors that improve psychosocial management plans and lower relapse rates (**Garety et al., 2000**).

Treatment implications of the case

The example clearly shows how schizophrenia is managed psychosocially, especially at this age. The case was given to the communal psychiatric worker for sole administration of the psychosocial aspects due to poor adherence to treatment and frequent hospitalizations.

Recommendations

Therapy can help kids, adolescents, or men regain their self-worth, develop emotional coping mechanisms, and return to where they were before. Cognitive Behavior Therapy is recommended to modify his rigidity of negative thinking into rational thinking.

- Providing a sustained emotional atmosphere where he can experience affection, support, and acceptance is recommended.
- Emotion regulation and social skill training are necessary to improve his emotional problem, social interactions with others, and how to deal with a specific stressful situation.

- Assertive training is recommended to help him deal with his communication styles, which will help him to regulate his interpersonal relationships effectively.

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