

## CASE REPORT : PSYCHOTHERAPEUTIC MANAGEMENT OF SCHIZOPHRENIA

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Recently, there has been a growing emphasis on the biological aspects of schizophrenia (Kovelman and Scheibel, 1986). Mental Health professionals conventionally have focussed on physical methods like antipsychotic drugs and ECT in the management of schizophrenia and psychological forms of treatment have received scant attention.

The following case history is presented mainly to highlight the fact that psychotherapeutic aspects of management may often constitute an important component in the treatment package of schizophrenia and may even outweigh the physical methods of treatment in their efficacy.

*Case history* : Mr F, a 33 year old single male belonging to an upper class christian family from the state of Goa, was brought to the National Institute of Mental Health & Neuro Sciences, (NIMHANS), Bangalore on 27th of Feb 1987. Mr. F had his schizophrenic breakdown at the age of 22 years while he was studying in the engineering course. He was treated by a psychiatrist at Goa with antipsychotic drugs with which he showed improvement and was even able to complete his engineering course.

From the age of 28, however, F's illness began to pursue a steady downhill

course despite regular and adequate medication. He became progressively withdrawn, suspicious and negligent of self care. He began to consume alcohol excessively and smoked heavily. He harboured persecutory delusions which were mainly targetted towards his family members. He even acted on his delusions by violent outbursts. The treating psychiatrist at Goa further supplemented F's treatment with electro convulsive therapy which also failed to produce any improvement. F's socialization further decreased and since one and half years prior to his referral to NIMHANS, F had not moved out of the house *even once*. From that time, he also refused all medication. All his day-to-day needs were looked after by his personal attendant. The intractable and deteriorating nature of his illness prompted the psychiatrist at Goa to refer him to NIMHANS.

Family history revealed that, F's father a retired mechanical engineer (who passed away recently (was a short tempered and dominating person who displayed little warmth towards his children. F's mother was described as a timid lady. There was a history of schizophrenic illness in F's paternal aunt.

Personal history did not reveal any problems in the developmental period.

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F's academic performance was above average through school and college until the onset of his illness. He also evinced interest in sports and in music (especially playing the piano). However, certain schizoid traits were evident in his premorbid personality : he was sensitive to criticisms ; had a limited number of friends ; and experienced marked heterosexual anxiety.

Following his admission to NIMHANS F's relatives returned to Goa. Initial evaluation revealed that he was suspicious and defensive. He would generally keep pacing the room in a preoccupied manner, displaying repetitive movements of the hands most of the time. Over the course of next few days, he became more communicative, permitting a more detailed evaluation of his mental state. His speech revealed formal thought disorder. He harboured persecutory delusions against his family and the psychiatrist who treated him at Goa. His affective responses were markedly restricted. He had second person auditory hallucinations of a commanding nature. He lacked insight into his condition. There was no evidence of any physical abnormality. Routine investigations were within normal limits. He was diagnosed to be suffering from paranoid schizophrenia with non dependent alcohol abuse as per the ICD-9 (WHO, 1977).

Following discussions within the treating team, it was decided to give an adequate trial of pharmacotherapy since he was off medication for the previous 18 months. It was also decided to ensure abstinence from alcohol since it was felt that this might also have significantly contributed to the exacerbation of his symptoms. He was treated on antipsychotic medication which was increased stepwise. It was also planned to psychosocially rehabilitate the patient by attempting to send him to the occupa-

tion therapy unit, but he was totally resistant for the same. By the end of two months not even a minimal change was noticed in his clinical state even though regular intake of medication was ensured and he was abstinent from alcohol.

After further discussions it was decided to institute a more intense form of therapy along psychotherapeutic lines. Though the nature and duration of illness were unfavourable prognostic factors, patients' educated status and presence of social supports encouraged the treating team to institute psychotherapeutic approach. For the next two months of patients' stay in hospital F was seen regularly by the first author in a one-to-one situation. Initially sessions were held with the patient daily, and in the later stages, about once in two to three days. No specific school of psychotherapy was followed, but rather, an eclectic approach was used, principally utilizing supportive, cognitive and behavioural strategies. The therapy that was employed could be described under the following broad categories

a. *Development of a therapeutic relationship* : This component received a major focus in the therapy. The therapist attempted to build up relationship with regular interaction with the patient. During the initial sessions, F's communication tended to be minimal and the therapist found it difficult to sustain the conversation. The absence of any meaningful communication left the therapist frustrated at the end of the sessions. The therapist then attempted to explore the possible areas that would stimulate F to sustain communication. It was soon evident that he took interest in talking about his own profession and his achievements at work. In response to the therapists display of interest, F began to demonstrate the working of different kinds of mechanical contraptions with diagrams.

He explained with drawings the

working of several devices like the candy floss machine, automatic washing machine etc. He mentioned how he himself had made some of the simpler mechanical devices like television stand, rack for storing gramophone records, and the like. As he spoke about these devices his affective responses improved. During the course of therapy he began to display affects like joy and surprise, something which had hardly been seen earlier. In the later sessions, the content of communication was further widened to include topics like sports, politics and music. The therapist also noticed that therapy sessions became meaningful by infusing an element of humour during the sessions.

#### b. *Increasing socialization*

Though F's communication began to improve during the therapy sessions, his socialization outside the therapy sessions remained low. Attempts were subsequently made to enhance F's socialization in a graded fashion. He was initially reluctant, but began to comply slowly with repeated persuasion. F's attendant was instructed to take F to the common hall everyday during a specified time so that he could watch the television. In the sessions that followed, the therapist persuaded F to talk about the programmes that he watched on the television. Later, F was instructed to go out of the hospital at least once everyday. It was possible to achieve this over the course of time. At this stage a student of psychiatric nursing who belonged to Goa and who had known F's family assisted in his socialization by taking him out frequently. Simultaneously F also began to pay more attention to his self care as this was a pre requisite to his going out.

#### c. *Focus on Psychopathology*

Along with attempts at increasing

socialization, attempts were made to reduce patients' psychopathology. As noted earlier, discussion of topics of patients' interest enabled the enhancement of his affective responses. With respect to delusions, instead of dynamic explorations, attempts were made to bring down patients' delusional belief using a cognitive approach. Logical inconsistencies in the patients' beliefs were pointed out firmly whenever patient spoke of them. Further patients' non-delusional communication was reinforced verbally as well as with appropriate gestures. This appeared to bring down the patient's preoccupation with this delusional beliefs. Reduction in the frequency of auditory hallucinations were also noted with the progress of therapy.

#### d. *Integration into the family*

The focus of therapy then shifted to extending F's improvement to the family situation. Following a specific request, his brother came over to the hospital from Goa and stayed with him for about 2 weeks. F's brother, having been satisfied with the improvement in his condition volunteered total co-operation to enhance and sustain his improvement. F's brother took him out frequently, and spent a lot more time interacting with him. It was further suggested to him that he could continue the same at home and also facilitate other family members to interact with F more frequently. F was discharged on 22nd June 1987, four months after his admission. Following the initiation of psychotherapeutic intervention, his medication was gradually reduced to half the earlier dosage and at time of discharge he was on an equivalent of 600 mg of chlorpromazine.

At home he continued to maintain improvement. He established contact with friends and often went out with them. He attended to his father who was

ailing at that time, and following his death, displayed appropriate grief. Though he had not taken up a job, he had registered his name in the employment exchange and had begun to apply for jobs. He came for follow up four months after his discharge. There was no evidence of delusions, hallucinations or formal thought disorder. His affective responses were adequate and appropriate. He continues to maintain by mail.

### Discussion :

The above case had been mainly presented to emphasize the beneficial role of psychotherapeutic strategies as an adjunct in the management of schizophrenia. Before making a strong point for the same, other factors that might have caused his improvement in this patient should be considered. (1) Patient's excessive alcohol intake was responsible for his continued symptomatic status and abstinence from alcohol was responsible for his remission. (2) The improvement noticed was chiefly mediated by antipsychotic drugs (3) The change observed was only temporary and not necessarily long lasting.

The first and second possibilities are unlikely. For the initial two months following admission, patient was abstinent from alcohol. He was maintained on adequate doses of antipsychotic drugs, equivalent to 1200 mg of chlorpromazine. Yet there was no discernible change in his clinical status. Additionally following the initiation of psychotherapeutic management, it was possible to reduce his medication to 600 mg of chlorpromazine. The third possibility, that the improvement was only 'temporary' is unlikely. Patients' improvement was sustained in his home setting despite the absence of a direct contact with the therapist. Thus the benefits of psychotherapeutic intervention are clear in this

case and appear to have even outweighed the benefits of pharmacotherapy. Interestingly the former approach has been efficacious despite the long duration of his illness.

Opinion regarding the psychotherapy of schizophrenia are divergent. Authors like Schulz (1975) and Arieti (1980) have advocated the use of psychotherapy in schizophrenia and have delineated the different therapeutic techniques. Other authors like Will (1980) have been more cautious in their opinion. Infact, Will (1980), while citing 4 reasons for the use of psychotherapy in schizophrenia, cites atleast 15 reasons against the same. An earlier review by Feinsilver and Gunderson (1972) noted that evidence with respect to the utility of psychotherapy in schizophrenia was inconclusive. The authors highlighted the need for more systematic research in this area. Dyrud and Holzman (1973) in their discussion have emphasized the need for considering issues related to the definition of 'Psychotherapy' 'schizophrenia' and 'Outcome'. In another discussion Gunderson (1973) has noted the controversies in the psychotherapy of schizophrenia with respect to the focus of therapy, the theoretical framework and the technique employed. He has further highlighted the need for systematic studies to measure the effect of specific variables in the psychotherapeutic interaction in relation to outcome. Regardless of these different controversial issues, opinion has generally favoured the combined use of pharmacotherapy and psychotherapy to produce optimum benefits in schizophrenics (Will, 1980; Marder and May, 1986).

With respect to empirical studies, the recently completed study by Gunderson *et al.* (1984) is noteworthy. The authors compared the efficacy of exploratory insight therapy versus reality adap-

tive supportive therapy on a sample of 95 schizophrenic patients. Both the therapies were found to be effective though minor differences were noticed with respect to the improvement in different domains of psychopathology. There have been no such studies from India. While there is an obvious need for systematic enquiries with respect to the various aspects of psychotherapy in schizophrenia, it can be said in conclusion that mental health professionals need to employ psychotherapeutic techniques more frequently in the routine clinical care of patients.

## REFERENCES

- Arieti, S. (1980) Psychotherapy of schizophrenia: new and revised procedures. *American Journal of Psychotherapy*, 34, 464-476.
- Dyrud, J. E. and Holzman, P. S. (1973). The psychotherapy of schizophrenia: does it work. *American Journal of Psychiatry*, 130, 670-673.
- Feinsilver, D. B. and Gunderson, J. G. (1972) Psychotherapy of schizophrenia: Is it indicated? A review of the relevant literature. *Schizophrenia Bulletin*, 6, 11-23.
- Gunderson, J. G. (1973). Controversies about the psychotherapy of schizophrenia. *American Journal of Psychiatry*, 130, 677-681.
- Gunderson, J. G.; Frank, A. F.; Katz, H. M.; Vannicelli, M.; Frosch, J. and Knapp, P. H. (1984). Effects of Psychotherapy in Schizophrenia: II Comparative outcome of two forms of treatment. *Schizophrenia Bulletin*, 10, 564-598
- Kovelman, J. A. and Scheibel, A. B. (1986). Biological substrates of schizophrenia. *Acta Neurological Scandinavica*, 73, 1-32.
- Marder, S. R. & May, R. A. (1986) Benefits and limitations of neuroleptics and other forms of treatment in schizophrenia. *American Journal of Psychotherapy*, 40, 357-369.
- Schulz, C. (1975) An individualized psychotherapeutic approach with the schizophrenic patient. *Schizophrenia Bulletin*, 13, 46-49.
- Will, O. A. (1980). Schizophrenia: Psychological treatment. In: *Comprehensive Textbook of Psychiatry*, Vol. 2, Third edition, (Eds.) Kaplan, H. I.; Freedman, A. M. and Sadock, R. J. Baltimore; Williams and Wilkins.
- World Health Organisation (1977) *International Classification of Diseases*. 9th revision. Geneva: WHO.