



Intensive Case Management on a Person with Treatment Resistant Paranoid Schizophrenia

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Abstract:

Multi-factorial contribution of bio-psychological and social constitution has been established as a maintaining factor for chronic illnesses like Schizophrenia. Current case study depicts how long term impairments can have considerable effects on a person's functioning, specifically in the absence of social support system. Intervention for social integration was done on a person with 15 years long history of schizophrenia, abandoned by family due to her paranoid delusions and decreased social functioning. Intervention on establishing networks with the community resource mobilizers, intensive Case Management Approach and illness management strategies have been used to provide a holistic mental health service and support.

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Keywords: Intensive Case Management, Schizophrenia, Rehabilitation

Introduction

This case report describes the long term course of treatment resistant paranoid schizophrenia characterized by ongoing negative life events and social stressors of a 31 year old lady and the outcome of intensive case management as a facilitating factor for her life-long survival. For reasons of confidentiality, the client will be referred to as Ms. V.D.

Brief Clinical history

Ms. V.D, a 31 years old single lady, educated up to Diploma in Commercial Practice; unemployed, with nil primary and secondary social support system; belonging to lower-middle socio-economic status; from urban Bangalore, India was under inpatient care of National Institute of Mental Health and Neurosciences (NIMHANS), Bangalore, India. She was diagnosed to be suffering from delusional disorder during the initial days of treatment in 2001. Later on the diagnosis changed to Paranoid Schizophrenia with gross social dysfunctioning. Her clinical history showed past history of seizure disorder, and family history of schizophrenia in 1st degree relative and 2nd degree, and consanguinity among parents. Pre morbid history was not available. Her parents had died at her early years of development leaving her with relatives to be taken care off. Consistent change in her behavior with special reference to her socialization with the external world and impaired occupational functioning over a period of about 12 years of continuous illness was prominent.

She was mainly treated with Clozapine and other supportive medications to manage the side effects, and Electro Convulsive Therapy (ECT). Patient was under clinical supervision of NIMHANS on both inpatient and outpatient basis throughout the course of her illness. Since her father's death in 2008 till 2012 the patient had multiple admissions in NIMHANS following which

patient continued to stay in the psychiatry closed ward in view of her safety under Reception Order of Indian Mental Health Act 1987.

Psychosocial Context of Patient's long term illness

Subsequent to the death of her brother in a road traffic accident in 2004, mother due to breast Carcinoma in 2006 and father due to stroke in 2008, she was found on street with florid psychotic symptoms and impaired bio-psychosocial functioning. Repeated police complaints against relatives claiming them responsible for her brother's death, and paranoid thoughts that people conspired against her because of which she lost her parents and property, also made her lose the extended family support system. After her family members' death her economic condition deteriorated and eventually she lost her rented house because she failed to pay for it. Patient was never on a continuous treatment as she lacked supervision and her secondary support system refused to provide her support. Eventually patient used to wander in different streets of Bangalore without the basic food, shelter and clothing. Lack of insight to her illness, deteriorated social functioning, and loss of government issued identity documents, prevented her from claiming any kind of benefit from community support systems. One of her cousins took responsibility after her discharge from NIMHANS in 2009; but in the latter half of the same year she stopped taking medications and refused to cooperate with her possibly because of the manifestation of her symptoms of paranoid delusion. She was found on road abusing her sister's family and was readmitted. Following this incident her cousin sister refused to take her back and on discharge, the patient was placed in rehabilitation home.

From 2010 till mid of 2011 she had been placed in three rehabilitation homes in her native place and in the meantime she was maintaining well except for occasional fleeting delusional ideas. Change of multiple organizations was primarily due to administrative issues with regard to keeping patient with mental illness, and partly due to her difficulty in adjusting with new

environments which led to another two more readmissions in NIMHANS till the year 2012.

The treating team (Psychiatrists, Clinical Psychologists, and Psychiatric Social Workers) in NIMHANS decided to keep patient in clinical supervision of closed ward in view of her safety under Reception Order and since then patient continued to stay there permanently.

Psychosocial conceptualization of the case:

Family history of schizophrenia in the first degree relative is a strong single indicator of individual schizophrenia risk. Early experience with a schizophrenic parent (mother) often played a very important role in the developmental dynamic that yielded pathology. Patient had been constantly influenced by the mother's social cognition about the external world which was certainly a reflection of neuro-pathological implications on the brain behavior correlates of information processing (Penn et al, 1997). Series of stressful life events, social adversity and trauma (Mary Richmond 1917; Arseneault et al., 2004; Bebbington et al., 2004; Moore et al., 2007), and lack of connections with a larger social support network had potentially been determined as a maintaining factor for her persistent maladaptation in the social world.

The early loss of primary family support system which led her to destitution along with severe economic crisis had not drawn the attention of social welfare system in mobilizing the available resources in the community for her inclusion in the mainstream society primarily because of either negligence or stigma and taboo associated with mental illness. Incompetent welfare support system with their poor infrastructure and functioning which failed to provide sustained maintenance to the patient, and her own inability to access services due to her illness ultimately resulted in institutionalization. Though she remained in Closed Ward of NIMHANS under Reception Order for several years the patient was reported to have a joint bank account with her late mother and she was supposed to get some money in the form of a fixed deposit as compensation for her brother's death in 2004.

Psychosocial Treatment

Illness management strategies included supportive therapy, psycho education, intensive case management and vocational rehabilitation as a combined treatment approach along with the medical treatment. Initial sessions with the client were facilitated through active engagement and rapport building with an aim to develop a good therapeutic alliance. About twenty sessions on supportive therapy was initiated and the focus was mainly on understanding and accepting the importance of client's internal emotional world centered on lived experience of the person (McCabe and Priebe, 2004). Frequency and regularity of sessions were maintained with an emphasis on empathic listening and 'non-possessive warmth'.

Psycho-education sessions were conducted to develop insight into patient's psychiatric condition as the main cause of her dysfunctioning. Information regarding management strategies were imparted in about ten sessions. These sessions were aimed at empowering the patient with better information to enable a different quality of conversation with the psychiatric social worker (Darzi 2008).

Intensive case management strategy was used to address the social issues responsible for the maintenance of the patient's illness. The intervention aimed at providing external support and addressing the social economical condition. The team made a visit to the patient's community in Begur in Karnataka state, and identified the person who was the witness of the patient's brother's motor vehicle accident case hearing through Karnataka State Legal Services Authority (KSLSA). The Lawyer assisted in contacting the Insurance Company that has paid the compensation amount that has been deposited in form of a Fixed Deposit Bond in Bank in Bangalore. KSLSA advocate helped the psychiatric social worker to avail the High Court Order that said that patient is one of the petitioners who have been awarded a sum of Rs. 50,000 with an addition of 6% interest per annum matured on 30th August 2011. The team had been able to identify the bank and was able to get all

support from the bank employees to transfer the amount Rs. 1 Lakh and 27 Thousand (INR) to a bank of patient's choice.

Prevocational training and supported employment was given to the patient. Patient was trained on basic computer applications and MS office. Supported employment has been found to be effective which include services focused specifically on competitive employment, client choice, rapid job search, and individualized support (Anthony et al, 2004).

Outcome of the Psychosocial Interventions & its implication in Psychiatric Social Work practice and research

The multifaceted treatment approach of Intensive Case Management has provided monetary support and social security to the patient which has empowered her to utilize her personal resources.

Attempt of reintegrating the patient back to the community is happening through a family friend. Assertive community treatment (ACT) as a part of Intensive Case Management was done to help the patient remain in contact with services, reduce her hospital admissions and enable mainstreaming in the community (Marshall & Lockwood, 1998) although mainstreaming was not possible because of her frequent relapse pertaining to adjusting in new social situations.

Patient was helped to remain in contact with different community services through coordination of provision for treatment across services and between agencies. Enhancement of skills to cope with adversities helped to decrease the frequency of relapses. Currently patient is rehabilitated inside the hospital and is working as a clerk in the Medical Records Department of the hospital. Empowerment of the patient has been done in terms of availing and accessing the tertiary social support system and utilizing her personal resources.

Challenges & limitations

The main challenges were the patient's chronic and treatment resistant nature of illness, the fleeting psychotic symptoms she

acted out, and her lack of emotional insight which created hindrance in sustained rehabilitation and mainstreaming. The limitation of this case was also failure in de-institutionalization and mainstreaming of the patient even after initiating Assertive Community Treatment.

Conclusion

The Intensive Case Management approach has enabled a patient with treatment resistant Schizophrenia to avail and access the community resources and improve her quality of life which has been found to be more clinically effective intervention.

Declaration of Interest: The authors alone are responsible for the content and writing of the paper.

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