Limitations in the Approach of a Residual Schizophrenia Case in the Romanian Mental Healthcare Environment

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Abstract

Over the past decade, major advances have been made in extending the principles and therapeutic strategies of cognitive therapy to the treatment of schizophrenia. What are the advantages of this approach and how can this type of therapy improve the patients’ state? What are its limits? What are the obstacles that the institutional environment – in which most of these patients live – rise in the path of the clinical psychologist? How can we surpass them? This case study aims to find answers to these questions, from a behavioral point of view.

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1. Introduction

“Over the past decade, major advances have been made in extending the principles and therapeutic strategies of cognitive therapy to the treatment of schizophrenia. In a number of large-scale outcome studies with cognitive therapy for schizophrenia, cognitive therapy has been shown to offer significant gains for those patients who have not been wholly helped with medications. It may even serve to prevent the consolidation of the illness, if delivered with those in the early stage of the illness” (Beck, Rector, 2000, p. 291).

Cognitive therapy may prevent or delay the progression to psychosis among individuals at high risk. Pharmacotherapy combined with psychotherapy are delaying the transition to psychosis in young people at ultra-high risk.

“Cognitive behavioral therapy improves the coping of patients with schizophrenia through improved adherence and symptom management. Cognitive behavioral therapy techniques include development of trust,
normalizing, coping strategy enhancement, reality testing, and work with dysfunctional affective and behavioral reactions to psychotic symptoms. An enhanced response to cognitive behavioral therapy would be expected when given with low dose cognitively enhancing atypical antipsychotic medication” (Kingdon, Turkington, 2005, p. 5).

This paper aims to be a presentation of a cognitive behavioral approach of a patient with residual schizophrenia. It will illustrate the advantages that this type of therapy may have for treating this kind of patients, but also the challenges that they may bring for the clinical psychologist and the limitations that the institutional environment can rise.

2. Case presentation

Lucia S. is a 31 years old woman, without a job, committed to a healthcare institution, by her brother. He admitted that Lucia’s father and sisters cannot care for her any longer and that her illness, which was triggered 10 years ago, was getting more and more severe. Lucia’s behavior was becoming increasingly violent and bizarre. She was diagnosed with schizophrenia and spastic paraparesis.

Family relationship: mother – about which Lucia affirms was taking good care of her – died 15 years ago. Lucia used to live in the home of her father, who was alcoholic. After the death of her mother, the father remarried. The second wife had a tensed and difficult relationship with Lucia. After the mother’s death, Lucia had been repeatedly raped and beaten by her father. She admits that her old man used to chase her through the courtyard and home, armed with an axe, while being drunk. Lucia also has a brother and two sisters, none mentally challenged, all of them married and away from the parent’s home. The only relative that visits Lucia is her brother, also the only one that has a pretty good relationship with her.

Lucia graduated an eight classes school at a state institution for mentally challenged people. She can read and write, can do calculations and can take care of personal hygiene.

In the first three years since her commitment to the mental health unit, Lucia manifested autistic behavior. She was sometimes quiet; sometimes she talked to herself, reproducing dialogue sequences she had heard, using a lot of dirty talk. Her symptoms were: psychomotor agitation, hallucinations and delirium, negativism, hypobulia, affective flattening, aggression towards others, insomnia, space-time disorientation, auto and allopsychic disorientation.

After receiving an intensive neuroleptics-based treatment, at a neuropsychiatric hospital, the positive symptoms of her schizophrenia had disappeared. The patient was amnesic regarding the active period of the psychosis, and temporally disoriented – she strongly sustained it was the year 2000.

According to the DSM-IV-TR (2003), the residual schizophrenia is a type of schizophrenia in which the following criteria are met:

A. Absence of prominent delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.

B. There is continuing evidence of the disturbance, as indicated by the presence of negative symptoms or two or more symptoms listed in Criterion A for schizophrenia, present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences). The diagnostic is as follows:

- Axis I: Residual schizophrenia
- Axis II: Borderline intellectual functioning
- Axis III: Spastic paraparesis
- Axis IV: * Primary support group issues: physical abuse, childhood neglect.
  * Social environment issues: inadequate social support, insufficient accommodation and acceptance of the patient status.
- Axis V: Global assessment functioning, according to the Global assessment of functioning scale, DSM-IV-TR: GAF=25 (current) (behavior influenced by delirious ideas; dysfunctional in almost all areas).
3. Therapeutical approach

“People with critical and abusive auditory hallucinations with linked depression and low self-esteem often disclose during therapy that they have been the victim of childhood sexual abuse or adolescent trauma, including bullying. Early trauma has been linked to hallucinations in schizophrenia and specifically to diagnostic symptoms of schizophrenia. In such cases it may be a further negative life event that triggers abusive voices” (Kingdon, Turkington, 2005, p. 7).

The psychotherapy started during the residual phase of the illness. The patient had the almost complete amnesia regarding the active period of the psychosis, lack of consciousness of present mental disorder, temporal and allopsychic disorientation, associated with delusional misrecognition (thinking that some of the employees of the institution were her relatives, friends or neighbours); Lucia was also manifesting tangential thinking, dysphoria, apathy, anxiety and attention disorder. Sometimes she was hostile with the other patients and with the staff members.

3.1. Objectives of the psychotherapy

The objectives of the psychotherapy are: anxiety level decrease, ameliorate the social behavior – by improving the relationship with the other patients in the healthcare unit and maintaining family connections.

The psychotherapy process will be briefly presented. It took which 16 sessions to complete. The patient received support also after the end of the short-term therapy, but the frequency of the meetings progressively decreased.

3.2. Methods and techniques used in therapy

The cognitive behavioral approach “targets distressing psychotic symptoms and maladaptative understandings of mental illness, using a collaborative empirical framework. The therapist explores the distressing conditions with the person, attempting to reframe them as beliefs rather than facts, empathically discussing how one might arrive at such beliefs (but also recognizing the emotional costs), reviewing evidence for and against the beliefs, and trying to find less distressing alternative interpretations” (Beck, Rector, 2000, p. 318).

In this case, the process began at Lucia’s initiative. The first sessions were dedicated to the analysis of her condition, investigating her thoughts and her beliefs. Her concerns regarded two major aspects: her status as a patient in a mental health institution and her relationship with her family. She was wavering between enjoying her relative security in the institution and getting back to her family.

In the first three sessions, the pros and cons (costs and benefits) of both the options were analysed and verified. In order to clarify, she was also counselled to realize a behavioral experiment: visiting her family during winter holydays. Thus, she would activate her feelings towards her relatives and also detect and correct some unrealistic expectations. Coming back, Lucia had kept her ambivalent feelings about the healthcare unit and her institutionalized status, but she inclined towards staying here, rather than going back into a family environment where she had been hurt.

In order to decrease anxiety, relaxation techniques, ego strengthening suggestions, healing suggestions, relaxation music and rhythmic breathing exercises were used (Holdevici, 2003). She was also helped to adopt more positive expectations towards the present environment.

Ways and strategies for her to adapt to the institutional environment were searched during the next five therapy sessions, with focus on the problems she had mentioned. After the first eight sessions, she was able to be included in the group activities. The client was encouraged to participate in occupational therapy and interact with the other patients. This improved the relations with the others, by rehearsing the cooperation and by
applying assertiveness techniques (Holdevici, 2003). Visits to a small general store close-by also helped establishing a contact with the outside world.

In order to ameliorate the social behavior, the patient was also trained to create positive representations and expectations from others.

Strategies of coping with stressful situations that appeared during therapy were analysed. Most of the stress generators regarded situations within the institution. Examples were discussed, both from personal and institutional perspectives. Her initiatives and successes were every time recompensed.

After ten sessions, Lucia became more confident, but she began to expose unsustainable projects and views about her autonomy outside the center, that she had created. She was helped to correct them, when possible, and establish a stronger grip on reality.

The client was encouraged to maintain the connection with the family members. She also became more sympathetic with them, trying to empathize with each other.

The last sessions were destined to test and to fixate the acquisitions made during the therapy.

3.3. Results of the therapy:

There were also some problematic aspects that interfered with the therapeutic approach: the deterioration of cognitive functions, the anxiety generated by the mental patient status, labels applied by staff and other patients (“crazy”, “fool”), hostility manifested from and towards other patients. She also manifested resistance towards change and therapeutic tasks.

In spite of all these obstacles and of the fact that residual symptoms persisted, the objectives were accomplished. During the therapy, the anxiety level of the client decreased. The personal initiatives started appearing and the patient’s involvement in activities increased. Lucia became more self-caring, her looks improved and the way others saw her became more important.

She had made progress, especially in the area of interpersonal relationship, she acquired assertiveness and communication skills, managed to take part at the activities organized by the institution, although her reclusion tendency is still present.

After the first five therapy sessions, she became more organised, desirous to help others, communicative and initiated to be spontaneous.

The desire to leave the institution and the fantasies about acquiring a house periodically reappeared, in spite of reasonable arguments.

Lucia kept her connections with the family and maintained an open attitude towards their members.

Psychotherapy and prescribed medication will still help decrease the chances of a new psychotic episode. The possibility of new episodes remains, though.

4. Conclusions and proposed solutions

Some authors (Turkington et al., 2004; Corrigan, Calabrese, 2004) described the advantages that the cognitive behavioral therapy has in treating the patients with schizophrenia. It can help them check the reality of their experiences and tune out the intrusive voices. It can also help them with paranoid ideation and negative self-talk. In the institutional environment also, the caregivers can help the patients with homework exercises.

Cognitive behavioral therapy can be combined with family therapy and assertive community treatment programs targeted to reduce relapse. Cognitive-behavioral therapy has a proven role as an adjunct to antipsychotic medication and remediative approaches such as social skills training in the management of residual symptoms of chronic schizophrenia. Positive symptoms, depression, and overall symptoms appear to be viable treatment targets for cognitive behavioral therapy with a less pronounced effect on negative symptoms. The effect size at end of therapy is strong, with durability at short-term follow up.
There are also other means and lines of action that should be taken into consideration, for the schizophrenics: the assisted employment, the inclusion in support groups, providing more accessibility to appropriate treatment, the association of the psychopharmaceutical and psychotherapeutic measures, the use of the religion in medical rehabilitation (Imola, 2010; Iamandescu, 2005; Ionescu, 1995).

4.1. Limits of the therapeutic approach in Romanian institutional environment

Other types of limitations or obstacles, specific to the institutional environment, were encountered:

1. Inadequate collaboration between members of the staff and between the staff and the patients, and negative attitude – indifference and hostility - towards clients;
2. Rejection and blaming attitude between clients;
3. Lack of involvement and passive attitude of members of the family and close members of the community in the treatment of the patient; low support towards her/him.

1. The barriers related to the stigmatization of the mental disorder patients – by the other patients and by the staff members – consist in discriminative behaviors and misconceptions. The lack of cooperation or the difficult cooperation of some staff members with the patients and with the psychologist made Lucia’s fitting in the institutional environment a very difficult endeavor. Their negative attitude and even some hostile behaviors had contributed to the increase of the patient difficulty in the accomplishment of the therapeutical tasks.

2. Some of the other patients manifested physical and verbal aggressiveness. That leaded, sometimes, to the increase of her anxiety and the highlighting of her persecutory ideas. Some of them blamed her and labeled her “crazy”. That augmented her isolation tendency.

3. The implication of the family members in the recovery of the patient was reduced. In the period when Lucia was institutionalized, she received only a few visits from her brother, and only after the remission of the symptoms. The family showed low interest in cooperating with the institution staff regarding the way of caring and the recovery method being used.

“Existing cognitive therapy and cognitive rehabilitation programs are inadequate for addressing the full range of deficit which characterize the disorder of schizophrenia. A broader conceptual paradigm, which incorporates strategies for reducing stereotype threat, may prove useful in addressing the social cognitive deficits of schizophrenia” (Corrigan, Calabrese, 2004, p. 326).

References


