Case Vignettes
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Case I Paranoid schizophrenia

History of present illness

Index patient 23 years old unmarried male, studied up to 10th standard, belongs to middle socio-economic status comes from urban background. He was brought to the hospital in January 2011, with an 8 years history of insidious onset and continuous course, which was characterized by, hearing voices, thoughts are being known to others, aggressive behaviours, suspicious on others, bizarre behaviour and decreased sleep. Mental status examination suggestive of delusion of persecution, references, auditory hallucinations, thought broadcasting, with the history of poor drug compliance and was diagnosed to paranoid schizophrenia.

He was treated on inpatient bases. Patient was on regular follow up for 5 months and was reporting significant improvement. However, gradually he become off drugs, thinking that he became well and there is no need to take drugs, consequently which, resulted a relapse. Patient was again brought to hospital with same symptoms and treated on inpatient services.

Family History:

Patient comes from a nuclear family of middle socio-economic status and belongs to urban area. The patient is the third born child out of non consanguineous marriage. Patient currently resides with parents.

Father: He is 55 year old male, who have studied up to SSLC, and runs his own business. He is actively involved in family matters, performs adequate roles, takes active decisions and close intimate and healthy relationships with other family members. Father has some understanding about illness. He is found to be very supportive to all family members.

Mother: She is a 46 year old female who have studied up to 9th std. Due to illness, patient is less emotionally attached to his mother.
**First Sibling:** First sibling is sister who is 25 yrs old unmarried female. She have studied up to SSLC and presently looking after household work. She have healthy relationship with other family members.

**Second Sibling:** Index patient

**Family interactions**

Parents of patient in hail from urban background and were married at an young age. Parents exchange adequate marital intimacy, and actively involved in family dynamics. At premorbid level patient used to expressive his feelings. Later after the onset of illness, there were conflicts between parents and son. Patient gradually become aloof and become detached from parents. Gradually, patient was seen spending time to himself without doing any constructive work and stopped taking with other family members.

Patient was seen less cordial and had an informal relationship with sibling. His sister also does not pay much attention to patient. But however on need base they help each other mutually. Interaction appears more off hostile and critical towards each others.

**Family dynamics**

The subsystems were well maintained in the family before the onset of illness. The subsystems of patient-sibling were well established and patient had a healthy alliance with sister. Parents perform an instrumental role in the family system. It appears before the onset of illness family system had an adequate parental subsystem with open ended boundaries. The current family system has become enmeshed and boundaries were diffused. Father assumed the role of nominal and functional head of the family. Father is autocratic in decision making and which is accepted in the family system. But none the less family is seen to be poor in leadership as the patient is unable assume the responsibilities. Most of roles are performed by father but however other the family members are having prescribed roles and these are defined according to the needs of the family system. As because of illness the patient did not assumed adequate role in the family system. Consequentially this was imposing heavy burden on family and father is forced to assume multiplicity of roles. Patient
adopted a non verbal communication pattern and more often he communicates indirectly to parents. Premorbidly patient was found to be having traits of introvert personality, and which got worsened after the onset of illness. Verbal reinforcement is the main mode of reinforcement in the family system. Parents appropriately reinforce patients’ behaviour. Family system adaptive behaviour is found to be healthy and well recognised. It is found cohesiveness is unhealthy in the family. Family members are less attached among themselves. Family rituals are marginally celebrated. Before the onset of illness family used to celebrate the rituals now after the onset of illness all most they are absent in celebrating rituals. The family does not meet during problem solving process and they seem to have poor capacities in solving problems. Patient has inadequate primary support system. Moreover, he has very minimal secondary social support. However, family is having adequate tertiary support system at hospital.

**Personal history**

The patient is born out of non consanguineous union and he is a second sibling. It was a normal full term home delivery. Patient achieved normal developmental milestones which were appropriate to the age level. He had the habit of nail biting during childhood. There is no evident history suggestive of negative feeling toward sister. Patient reported to be an easy going child. He started his schooling at the age of 5 years. He was found to be average in studies, had a cordial social relation with teacher and peer group. However later the patient lost interest in studies. With two attempts he could clear his SSLC exam. Patient developed illness at an early age. He was going for work along with his father in family business but unfortunately due to his illness he could not assumed the productive responsibilities in business. No significant factors could be elicited in sexual history. Fantasy sexual life appears to be culturally appropriate and within normal limit.

**Premorbid personality**

He had assumed very minimal responsibility at home and used to escape from activity. He appears introvert and had minimal social relations. His relationship with family members reported to be very minimal. Patient had a conduct feature of stealing, and lying. He did not much believed in god worship. Premorbidly his
mood appears to be more of irritable with frequent anger outbursts. Patient used to get angry over trivial matters and his anger was almost uncontrollable. He preferred isolated social life. Patient did not have many hobbies, most of the leisure time he used to spend in watching television and listing to music. He used to receive and accept others criticism and would make changes as per the need arises in social relations. However, it was reported that he would become very angry and would quarrel with family members for minor provocations.

**Social analysis and diagnosis**

Index B is 23 years, unmarried Hindu male, studied up to SSLC, comes from a middle socio-economic status. He was treated at in patient ward with insidious onset, continuous course of illness with no significant precipitating factor, with 5 years history of muttering to self, thought are being know to others, suspicious on others, irritability, aggressive behaviour, decreased sleep, and mental status examination revels delusion of reference, persecution, auditory hallucinations, thought broadcasting, bizarre delusions and poor drug and treatment adherence.

Family indicative of high family caregiver burden and it is adversely effecting on family system.

Father is the only main sources of income, and who assumed more responsibility in running the family. Family interaction is suggestive of more unhealthy and patient is cold, aloof and depends on parents.

Family dynamic were found to be disturbed after the onset of illness. Boundaries were diffused due to the illness. Father is autocratic and functional head of the family. Adaptive patterns seem to be poor. The family adopted healthy way of reinforcement techniques. Family possesses adequate primary and tertiary support, but lacks secondary social support.

Personal history is indicative of poor school performance and did not hold responsibility in fathers business. Childhood history reveals conduct features, of stealing, and lying, predominantly irritable, frequent quarrels with social group, being self centered and less involvement in group activities.
Other significant factors found during the case study were, poor knowledge about illness management, family burden on caregivers, social stigma, poor adaptive and coping skills. All these factors lead to poor treatment and drug compliance.

**Psychosocial interventions**

Following psychosocial interventions were posed

- To work on the social support system of the family
- To ensure treatment and drug adherence
- Vocational rehabilitation
- To bring healthy expressed emotions
- To build up healthy way alliance
- To work on overall family functioning
- To provide psychological support for father

**Intervention strategies**

- Education about the illness
- Supportive social case work
- Behaviour modification (Activity scheduling)
- Family interventions
- Vocational rehabilitation
- Pre discharge counseling

**The therapeutic process**

**Psycho education**

To reduce family care burden, to bring healthy way of expressed emotions and to become more treatment compliant patient and his family were educated about the nature of the illness, causes of illness, symptoms, course and prognosis. It was taught on biopsychosocial model. They were told about their role in the treatment and recovery.
Supportive social case work

The specific techniques used in supportive sessions were ventilation, reassurance. Then gradually family started understanding their roles and responsibilities in the treatment. The next step was to make the mother accept her son’s illness. The mother was very disturbed due to patients’ positive symptoms. Thereafter, during therapeutic process, she gradually accepted illness and adopted healthy way of coping skills.

Behaviour modification (Activity scheduling)

The goal of activity schedule was to make the patient to be more independent and to adopt healthy way out of socio-occupational functioning. This was introduced with differential reinforcement techniques and family member were taught how to reinforce behaviour in sequences. The prime target was his biological functions. Thereafter recreational activities were planned as per his interests. With this he was seen to be adaptive to the normal routine and gained the confidence that he could do the activities by himself. Then gradually he was exposed to ward work. During the time of discharge both the patient and family members were told that the techniques are to practice even at home regularly and record to be maintained.

Family interventions

In family intervention unhealthy family interaction pattern was removed and they were taught healthy way of communicating and during the session they themselves noticed its importance. They were told that once a day they should meet on their choice and should discuss the family matters in details. This will bound the emotional attachment among family members and which may help in resolving family conflicts.

Vocational rehabilitation

In the beginning patient was told its importance in the process of recovery and moreover, it gives psychological satisfaction. Then gradually he was exposed to ward work. Thereafter he was counseled that he need to assume constructive work in his father’s business which will help him financially and may reduce burden on family.
Predischarge counseling

At the time of discharge both the patient and family members were counseled for regular follow-up, early symptoms recognition and its management.

A total of seven sessions were held to meet goals of psychosocial intervention.

Outcome

- Family gained insight about the illness and adopted healthy way of coping
- Reduction in expressed emotions and family care burden
- Enriched family social support system
- Good treatment and drug compliance
- Patient adapted to daily routine activities
- Improvement in family dynamics

Case II Undifferentiated Schizophrenia

Client A is a 41 year old separated female, studied up to 8th std, belongs to a lower socio economic status and hailing from urban background.

The patient was brought by her family members on March 2011. She was found wandering without any apparent reasons, with poor personal care. On asking, patient reported that her family members were abusive and assaultive without any provocation. Hence, she broke relationship with her husband.

She found in an apathetic condition, inappropriate affect, poor insight and judgment, and cognitive deficits. Her speech sample was incoherent. On examination patient was conscious and alert.

On examination patient found to have delusions of persecution, formal thought disorder, disorganized behaviour, auditory hallucinations. Onset was insidious, continuous course and illness started without precipitating factor.
Family history

Patient belongs to nuclear family with lower socio economic status in hails from urban area. The patient is born out of non consanguineous union, places second order of birth. Currently resides with her cousin sister.

Family composition

Husband is a 51-year-old, uneducated and doing framing work. He had an extramarital affair. He is not providing adequate care to the patient. He was an alcoholic.

Patient is a 41-year-old female a housewife. She has diffused, enmeshed relationship with her husband and family origin.

Son is 19 years old, attending 12th standard and he is staying with elder brother of patient.

Elder brother is the first sibling of the patient, 43 year old, studied up to PUC II and currently he is a government employee. He appears to be rude and does not maintain contact with patient. He is non supportive in patients interpersonal and intrapersonal matters. Second sibling is index patient.

Younger brother is in third order and he is 39 years old married male. He secured graduation in science and is employed in private sector. He has one female child. This person is much attached to patient.

Family interaction patterns

Patient husband belongs to rural area and was married at the young age. This was his second marriage, as he was divorced to first wife. Couples had a cordial relationship and they used to share house hold activities. Their role performances were appropriate to the role expectations and were complementary to each other. Husband was a head of the family, and used to take democratic decisions. Due to illness and extramarital affairs of husband the family interaction was worsened. Interaction among patient and sibling was need based. Due to her illness patients
children were scared of her. Hence, he does not have cordial relationship with patient.

**Family dynamics**

It is broken/separated family hence; family dynamics could not be assessed.

**Social support system**

Patient has inadequate primary support system. However, patient has minimal secondary social support system with whom now patient is residing (Paternal cousin). Hospital is providing tertiary support system.

**Personal history**

The patient is born out of non consanguineous union and hold second order of birth among three siblings. It was a full term normal hospital delivery. She attended normal developmental milestones and which were appropriate to age. Patient did not have a major health problem during childhood. There was no history indicative of sibling rivalry. In school she was an average student, studied up to 8 the standard. It is reported she wanted to peruse higher education but due to family problem she has to discontinue her education. Menstrual history could not be collected. Patient reported to be easy going child. Her relationship with teacher and peer group was cordial and had few selective friends.

**Premorbid personality**

Premorbidly she was moderately adjusted person. She did not assume much responsibility at home and she was to force to take part in household activities. She appears introvert and had selective reserved social milieu. Her relationship with family member was cold and aloof. She believed in god, and worship daily. She was more attached to mother and used to share her feeling without any hesitation. It was reported that her pervasive mood was apathetic. Patient leisure time was spend in watching television and stitching. Patient had fewer thresholds to stressful life events and become neurotic to other critics.
Social analysis and diagnosis

Index patient B is a 41 separated female, studies up to 9th standard, belongs to lower socio economic status comes from urban background. Suggestive history of bizarre behaviour, delusion of reference, auditory hallucinations, and illness stated with insidious onset and course being continuous.

Psychosocial interventions

The flowing intervention were posed

- Psychoeducation to family members
- To make daily activity schedule.
- Supportive social case work with patient.

The therapeutic process

Supportive social case work

Supportive social case work aimed to solve patients’ practical problems. In therapy patient was provided foster and positive feelings and provided a chance to express her inner feelings. The strategies used in the therapy were, reassurance, explanations, clarification, guidance and suggestions. Initially therapist was an active listener with empathy. This process helped the patient markedly and then patient was gradually engaged in treatment and rehabilitation.

Psycho education

Family knowledge about the illness was assessed in detail and it was noticed family has lack of knowledge about illness. To make active participant in the treatment and recovery, the family was educated about illness. All the symptoms were explained in details. They were also explained about coping skills.

Activity scheduling

As found out in assessment, patient did not have any daily activity schedule. Hence, to make patient active, patient’s daily schedule was structured through activity scheduling. Initially it was quite difficult to introduce her to activity schedule.
However, within a day or two patient gradually become acquainted with daily schedule. Main objective of the activity schedule was to increase the activity level of the patient. So activities like, waking up in the morning, bathing, cleaning, bed making, combing, and helping the staff in the ward activities were incorporated in activity schedule. Later step patient was gradually introduced to stitching work with the help of staff nurse.

**Pre discharge counseling**

At the time of discharge patient and key care givers were provided pre discharge counseling.

A total of 8 sessions were held to meet the goals of interventions

**Out comes**

- Patient became acquainted to daily routine activity
- Patient started working in tailor shop
- Good treatment and drug compliance was noticed in follow-up sessions
- Social support was improved her cousin started looking after her.

**Case III Undifferentiated schizophrenia**

Index patient X, 30 years unmarried male, studied up to 11th standard, resides in joint family, belongs to lower socio economic status, comes for rural background.

Patient was brought to hospital with six years history of insidious onset, and continuous course, characterized by talking to self, poor self care, social withdrawal, abuse and assaultive, not doing any work, thought are being know to others, decreased sleep and mental status examination suggestive of delusion of persecution, auditory hallucinations, thought broad casting, and with a prominent history of poor drug compliance diagnosed with undifferentiated schizophrenia.

**Family history**

Patient born out of non consanguineous union, he is being the last born, hailing from joint family of lower socio economic status from rural area. Currently patient resides with his parents, brother and sister in law.
Family composition

Father is 58 years old, studied up to 7th standard, agriculturist by occupation and nominal head of the family. He is highly distressed about patient symptoms.

Mother is 55 years old housewife, assumed the responsibility in household activities and assists in agricultural work. She accepts her husband leadership. She is affectionate person in the family she provides appropriate care to the patient and other family members.

Elder sister is 32 years old married resides in her husband’s house along with children and in laws.

Elder Brother is 34 years old unmarried male, completed his graduation and he assists his father in agriculture work. He is minimally involved in family matters.

Sister in law is 23 years old married female studies up to 10th std she has cordial relationship in the family system.

Family interaction pattern

It was a mutual consented arrange marriage. They hold cordial relationship with each other. Father is a domineering kind of person which is accepted by mother. It is reported that children are less interactive with father as he is very strict and domineering. Children are more comfortable with mother and express their views freely. The onset of illness disturbed the relationship with brother.

Family dynamics

The boundaries appear to be diffused. There are very a minimal alignments and coalitions formed in the family system. Father is autocratic person, he takes decision which stands final, and other family members are expected to follow the same. Power struggle between father and elder son exists. The roles in family were abruptly defined in the family. Father is burdened with multiple roles. Role conflict exits in the family, in terms of fulfilling role obligations. Instrumental role is assumed by father and expressive role is performed by the mother. Communication appears to be direct among family members. But however, inner feelings are not
communicated properly among family members. Family system adopted more of negative reinforcement techniques to sequence the behaviour. Despite of differences of opinion with regard to patient illness affective involvement of family system is regular. Family related rituals are celebrated at family level and even at village level. Family adaptive pattern is enmeshed they find their own way of resolving problems which distress each other. Due, to his symptoms patient has lost the primary and secondary support system.

**Personal history**

Patient born out of consanguineous union and stands third in order of birth. It was a full term normal hospital delivery. He attended normal developmental millstones, which were appropriate to the age level. There were no complications during prenatal and post natal period. No suggestive history of health and behavioral problems during childhood. Patient started schooling at the age of six years. He was an average student and could complete his education up to 11th standard. There after there were some behavioural changes and later the developed mental illness. Due to illness, he has not procreated his own family of origin. Before the onset of illness patient had a cordial relationship with brother, but however, after onset of illness relationship with brother is disturbed.

**Premorbid personality**

It is reported that patient relationship with family member was healthy and cordial. He used to accept the responsibility at house as when required and used to show interest in house hold work. His social relationship in the village appears to be minimal, and made a few selective friends. He is the person who believes in god and worship god on daily bases. His mood appears to be euthamic. He did not much preferred social life, leisure time he used spend at house only. Patient has poor coping skills. With this, thus it appears that patient has introvert personality and moderately well adjusted.
Social analysis and diagnosis

Client A, a 30-year-old unmarried male, studied up to 11th standard, comes from a low socio-economic status background, resides in a joint family, and was brought to the hospital with a 6-year history of undifferentiated schizophrenia.

Patient stands 3rd in order of birth. His father is the nominal and functional head of the family. Currently, patient is unemployed and more emotionally attached with his mother.

After the onset of illness, the family dynamics were disturbed. Internal boundaries were diffused. Father is a domineering and autocratic person, leading to role conflict between father and brother. Father makes decisions without considering other opinion or view and expects family members to abide. The adaptive pattern seems to be inadequate. The family system is not open to changes. The family system holds adequate cohesiveness. Family rituals appear to be marginal. Impairment was observed in the social support system. Patient is unemployed, and premorbidly introvert person.

Due to illness, the family is experiencing a significant high level of family care burden. Patients' bizarre behavior is almost disturbing village people, due to which, family is isolated from village people.

The therapeutic process

Intervention was begun with empathy and rapport could establish and family members were briefed about the sessions.

Supportive social case work

As the father was more burnout, he was allowed to ventilate his feelings and later on, he was reassured about the treatment available. It was noticed that father was using unhealthy denial defense mechanism about his son's illness, hence, it was been told to him try to accept the son's illness which will reduce burden. In the next step, the father's guilt feeling were removed as he was feeling he is the cause of his son's illness. With this father become much comfortable.
Psycho education

The assessment reveals that family has inadequate knowledge about illness, high expectations from patient, high level burden and poor social support. To address all these issues psycho education was given.

In the initial phase family misconception was removed. They were explained about normal and abnormal behaviour. Later they were told about symptoms and nature of illness. The causes of illness were explained on bio-psycho-social model. There after family was taught about treatment modalities like, pharmacological and psycho social management which would help in recovery. More importantly they were told about medication and regular follow up, which would help to improve patients’ condition.

Pre discharge counseling

At the time of discharge family members explained about importance of regular medication and follow up.

A total number of 6 sessions were held

Outcome

• Family members gained the knowledge about the illness
• Healthy way of coping defence mechanism
• Regular Follow- ups