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A Case of Chronic Schizophrenia with Poor Social, Interpersonal and Work Functioning

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Abstract: *Schizophrenia is a chronic, episodic psychotic disease that affects a broad range of the patient's life. Several studies have been administered indicating general functional impairment as a component of severe mental illness, especially in schizophrenia. Psychiatric social workers deal with person with schizophrenia, their families and communities. It refers to a range of social work methods and technique beside , educational , behavioral, and cognitive interventions and vocational rehabilitation for increasing the role performance of persons with mental illness , enhancing their recovery process , involving the family and community.*
Keywords*: Schizophrenia. Psychiatric social worker, family, community, work functioning*

I. Introduction

Schizophrenia is a serious mental illness that afflicts about 1% of the population at some point in their lifetime. The schizophrenic disorders are characterized in general by fundamental and characteristic distortions of thinking and perception, and by inappropriate or blunted affect. Pratt & Mueser (2002) defines social and interpersonal functioning as an the ability to accurately perceive social cues, solve problems, evaluate behavioral alternatives in social situations, comprehend common social interactions, decode facial and vocal expressions of affect, engage in conversations, and maintain interpersonal relationships" .Further Bond, Drake, & Becker(1998) defined as "one's capacity to interact appropriately and communicate effectively with other individuals" Marsh et al. (2010) state, "impaired recognition of facial emotion in schizophrenia is associated with poor social functioning" . Kohler and Martin (2006) also reported that individuals with schizophrenia exhibit impaired recognition of facial emotions, which is associated with poor interpersonal communication skills and poor social functioning. Empirical evidence suggests that functional impairments exist in those diagnosed with severe mental illnesses especially in schizophrenia (Addington, Piskulic, & Marshall, 2010; Bond, Campbell, & Deluca, 2005). Psychiatric social workers deal with person with schizophrenia, families, groups and communities. It applies social work methods and technique for enhancing social, interpersonal and work functioning in person with schizophrenia.

Psychiatric Social Work Assessment
Brief Clinical History

Patient was apparently well 6 years back when family notices that patient showing duration irritability like he used to get irritated very fast at his family members even on small things, increase anger without any provoking, he beat up his elder brother and even breaking the house hold things, suspicious that his family member are against him and they have made him mad, wandering behavior like he will go out from the house without any reason. He had decrease sleep as he was facing difficulty in falling asleep during the night, he used to talk less and discontinue going to work , there was also decrease in his self care he usually take bath after a stretch of 1 month. Had decrease appetite as he was not able to eat like he was eating before the onset of his illness at time he eat inconsumable thing and vomit, he used to take and eat from the waste bin and poor drug complained. His symptoms have been increased for the past 1 month. Patient first hospitalize in 2011 in LGB Regional institute of mental illness(LGBRIMH) for 3 month was discharge and was maintaining well , due to poor drug compliance patient was relapse and again he was admitted in 2014 in LGBRIMH for 3 month. He was diagnosed as F 20(schizophrenia) according to ICD-10 Classification.

Social Milieu:

The patient belongs to a nuclear family of the middle socio-economic stratum from urban semi-urban background of Sibsagar district of Assam. The patient hails from a nuclear family; patient is the 3rd born among three siblings out of a non-consanguineous marriage. Currently he stays along with his brother and sister in law. There is family history of mental illness patient paternal uncle daughter has mental illness.

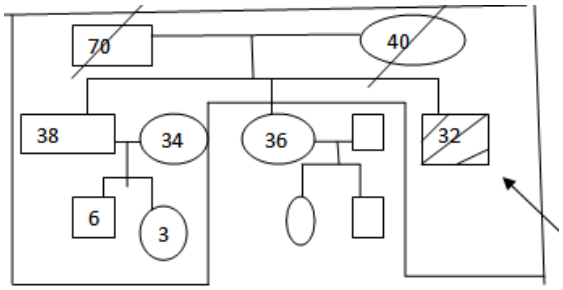

Fig 1: Family Genogram:

Father: Patient's father was 70 years old when he expired due to stroke, educated up to VIII, worked as contractor. He is informed to be extrovert by nature, responsible and a hard working person was emotionally close with the patient, described as a good, respected person in the community but his relationship. After patient's mother death brought a significant change in the dynamic, all major role and function had to be made by the father.

Mother: Mother was a home-maker, studied up to standard VI. She is responsible, extrovert by nature and had a close relationship with the patient and had expired when patient was 10 years old. Mother's death due to illness

1st Sibling: Patient's elder brother: Patient's eldest brother is a 38 years old person, married, educated up to Graduation, working as assistant manager in tea garden, residing with his wife and two children at Sibsagar District of Assam. He is the only brother of the patient who is also financially taking care of patient, patient is staying with his brother, he is the primary care for the patient. His wife is 34 years old, educated up to matriculation; she is a housewife and having cordial relationship among them and also with patient. He is extrovert and understanding person by nature. Patient is close to him.

2nd Sibling: The patient's Sister 36 years old got married at the age of 19 years, home maker, educated up to 10th class, stays with husband and two children. Extrovert by nature, after marriage she rarely comes to her parent's house but constantly keeps contacting.

3rd Sibling: the index patient.

At present the family composition is the patient, his elder brother his sister in law and his niece.

Family Interaction Pattern in Family of Origin

Interaction between parents: Patient's father and mother shared cordial and loving relationship when they were both alive. They had a love marriage they used to discuss most of the issues regarding family affairs and decisions were taken with mutual consent. Conflicts are rare, and mother used to obey the father in most of the matters.

Interaction between patient and parents: patient has a cordial relationship with the father when he was alive. Father was responsible towards his family members and gets involved in household matters. Patient is cared mostly by his father and devotes him considerable time. Patient was most communicative with his father and shared close ties in exchange and communication of thoughts and emotions. In case of mother - mother died when the patient was just 10 years old.

Interaction between Siblings: Interaction between the siblings has always been cordial relationship among themselves. There is healthy interaction between the patient and the first sibling. The patient stayed with him and his family. He used to help the patient in all matters like materials needs and emotional support. Interaction among the siblings is healthy but inadequate. There is no sibling rivalry present.

Interaction between patient and sister in law - There is healthy interaction between the patient and his sister in law. She is very supportive and helpful toward the patient. Patient also used to help in taking care of the child whenever he is at home.

Personal History

Birth order: Patient is the 3rd amongst 3 siblings. Patient had full term normal birth. The developmental milestones were age appropriate and achieved normally. No major health problems were reported during childhood. The patient had attained till higher secondary standard successfully, with an average scores. He had discontinued his studies due to least-interest. No behavioral and interpersonal issues were reported during his schooling. After discontinuing his studies, at the age of 20 patient started working as a bar manager at Guwahati for 15 days but he was not satisfied due to less salary so he left that job taking tuitions for the primary classes.

He was involved in that work for around 3 months after that he left doing that job. Then he started working in one of the grocery shop which was opened by the patient's father but there also he was not working properly but there also he worked for 2 month and then left that job also. He was reported to be unstable in any job for longer period of time due to low confident and low self. At present patient is not doing any work. Knowledge about sex and sexuality were first introduced to the patient by his friends at school. No adolescent sexual contact. No sexual deviation reported.

Socio-Economic Status: The family of origin of the patient is a nuclear family hailing from Sibasgar a semi-urban locality, belonging in the middle socio-economic class sustaining and supporting the family through the eldest brother's income. The present living condition is in a concrete Assam type house of their own with all basic facilities. All the family members have received some amount of formal education.

Family Dynamics of the Family of Origin:
Boundary and subsystem:
Internal Boundary: The internal boundary is open and clear, where each member is involved in doing their own work without interfering in others matter.
External Boundary: The external boundary is open and clear, where the family members were involved in taking the help of neighbors and relatives during crises and conflicts and able to get adequate help from them.
Leadership: Father was the nominal and the functional leader of the family which was accepted by all. The leadership style of the father was authoritarian. But since 2008 eldest son has been given the responsibilities and at present also he is the nominal and functional leader of the family.
Decision Making: Authoritarian decision making was present when father was alive. But presently decisions are made in a very democratic way, especially the decisions are made by the eldest son, each member of the family were asked their opinion for decision making for the welfare of the family but the patient is not involved in decision making process due to his illness.
Role structure and functioning: There are certain roles and responsibilities expected among the members of the family explicitly outlaid by the Father. Each member carries out their respective roles.
Communication: There were both verbal and non-verbal communication present in the family and we feeling are expressed among family members. Communication was mostly direct among members. Feelings were expressed by the family members in the communication process adequately.
Reinforcement: Both positive and negative reinforcement is present in the family. Members provide positive appraisal when the patient takes correct decision or does anything better for the family and scold and not given food when he does anything which is not appropriate.
Cohesiveness: 'We-feeling' present in the family especially it was seen when the members were in need. Family rituals have seen in the forms of dining together, going to temple and celebrating festivals and function together.
Adaptive pattern: Positive problem solving and coping patterns are found to be adequate in the family. Family members resolve their conflict by mutual understanding and discussions. The patients coping method in terms of his coping with work functioning is found to be poor.
Expressed emotion: The patient's brothers are involved in giving critical comments to the patient as he is not working and good for nothing, as well as they is also hostile towards the patient because sometimes they beat the patient when he demands for money from his father because he is not doing any job.
Social Support: Primary social support is found adequate and available to the patient from his family. Secondary social support is also found to be adequate from the friends and neighbors of the patient's family. Tertiary support found to be present from LGBRIMH.

II. Premorbid Personality

Social relationship and attachments: The patient was sociable in nature; would socialize well with people before the onset of his illness. The patient was introvert in nature, as well as shy person from the beginning onwards and less involvement in talking to the people. Patient followed the common religious beliefs and practices all rituals according to family beliefs and morally has adequate standards. Predominant mood of the patient was not involved in talking to the people, not working etc .Leisure hours were usually spent in watching TV and singing. Patient's diet consists of non-vegetarian orientation. Sleep habits were regular and followed a nocturnal pattern.

Social analysis:

Index patient 32 years old male educated up to higher secondary with an average performance scores, unemployed, hailing from Sibsagar ,Assam was presented at LGBRIMH with 6 years duration of illness and increases for past 1 month of irritability, aggressive, wandering behavior, suspicious, eating food from waste

bin, poor self care, poor work functioning and with poor drug complain. Patient pre morbidly was extroverted by nature, very sociable and has a number of friends and maintains good social relations. Social history and family dynamic assessment reveals open and clear boundaries between the parent-sibling subsystems, authoritative decision making, indirect communication between the parent sibling subsystems, expressed emotions in terms of critical comment and hostility by the siblings. Role performance is also adequate in eldest brother, he is the eldest of the family responsibility and family decision is taken by him. Reinforcement pattern is seen in both negative and positive form. In the present case study we found that patient was having negative symptoms, he was maintaining poor self care, poor social and occupational functioning. With the death of mother in the early age and father has to play both the parental role in the family. Hails from a family with good social support from the family members, which is the great support for the patient at the time of crisis. The lack of knowledge regarding illness and lack of rehabilitation services and long duration of illness have deprived the patient from holistic growth and improvement in functioning.

Psycho-social Diagnosis (ICD-10-Axis-III)
Z 56: Problems related to employment and unemployment.
Z 61.0 Loss of love relationship in childhood.
Z 62.0: Inadequate parental supervision and control.
Psycho-social factors
Individual factors:

- Poor Insight regarding illness
- Poor knowledge regarding illness
- Poor social functioning
- Poor work functioning.
- Poor drug compliance

Family factors:

- Indirect communication
- Expressed emotions.

Types of intervention

- Therapeutic casework
- Social group work
- Supportive therapy.
- Psycho education
- Family intervention
- Discharge counseling
- Psycho social Rehabilitation

Specific objective of the therapies

- To develop and enhance insight in patient.
- To enhance social and occupational functioning
- To enhance motivation regarding work
- To improve drug compliance of the patient.
- To educate family and patient about mental illness.
- To reduce expressed emotion.
- To help relieve stress in the patient's brother.

Number of sessions
Session with patient: 9
Session with family members: 4
Group sessions: 4
Total number of sessions: 17

Intervention at individual level
Rapport establishment

Rapport establishment aims to maintain a good relationship with the patient and to assess the level of cooperation and participation of the patient. About 40-45 minutes was taken for session with the patient. During the discussion the patient were informed about the importance of therapy and benefit he would gain from the therapy. Repeated reassurance and positive attitude towards the patient however had developed some rapport and basic trust of non-harm and well-being made the session successful. Further these sessions were also utilized for the patient to work on his insight about his illness state without imposing diagnostic labels it on him.

Motivation Enhancement for Work Functioning:

The patient was assisted to realize his need to undertake his daily activities, to be responsible to take care of himself. In the further sessions, the patient was discussed with his responsibilities as the son in his family and to assist his aging mother at home with the daily chores. Repeated assessments were conducted about the motivational levels at regular intervals to mark progress/decline. Along with the above sessions were coupled with some tasks and associated rewards for successful completion of each task. A tasks schedule was developed where successful completion of each task was coupled with a reward in form of verbal appreciation. The tasks were scheduled around computer learning, statue making, working in gardening section in rehabilitation center and seek medication on time. Initial results were irregular, but later he progressed to some consistency.

Activity Scheduling:

An activity schedule was prepared to the best interest of the patient. As he had a very low work functioning and motivation towards work and. He was given activities which will reflect his work functioning and builds his motivation as well. Through each activity he was given a positive feedback and this increased his behavior. He was facilitated with some of the positive strength that he had and motivation was built on those strengths. His capability to hold some responsibilities at home were emphasized through the structured activities.

Insight oriented therapy

This helps the individual understand how patterns that are repeated in adult life actually have a genesis in their formative years. It works out with the assumptions that better one knows about oneself, the better one will function. The patient was told that the problems, symptoms that he has been experiencing is because of the poor work functioning and lack of motivation towards work can be triggering factor for his illness. This may come as a result of failure to be appreciated by others or when he has not measured up to his standards or self-expectations. Patient's brother being critical and hostile towards him led to his illness, schizophrenia. Therapy was focused by uncovering these unconscious conflicts and bringing them under conscious control of the patient.

Psycho-education

.Psycho education is a process in which the therapist imparts knowledge of illness and imparts it's related its aspects to the patient on a continuous manner. It would provide assistance to the patient in implementing better coping skills and enhance the interaction with others. Therapist enlisted and provided knowledge regarding his illness and symptoms and the maintaining factors for it. The importance of medication compliance and follow up was explained.

Social Group Work

The patient was involved in weekly group interaction sessions. The patient attended group interactions session is for patient to learn more, to learn and understand from the other members of the group and to improve his interaction and communication skills. The patient was given a heads-up on his assigned task at the session as to share what he had been psycho-educated on about mental illness with other patients. After, initial hesitation amongst other patients, the client had participated adequately with the given opportunities to express and interact. His quality and level of participation was seen to improve and so does the confidence during the latter group sessions.

Pre-discharge counseling

It was to strengthen the patient to resume his activities with appropriate medication and coping strategies. During this session patient clarified many of his doubts on medication, family involvement and follow-up of the treatment. His awareness and judgment was found to be appropriate which showed that he had gained some insight of his illness. The worker again described the nature of mental illness, the need of regular medication and follow up, the harms of taking any kind of substances and the need to engage in productive work and activity. Therapist provided assurance for follow up help during and after discharge.

Interventions at the family level

Family Assessment and Intervention:

The session were conducted to assess the family functioning of the patient, the constituent dynamics, the nature of interactions, family support and discuss plans for the patient about the future. The family was psycho-educated about mental illness after recognizing the need. Patient's brothers though had knowledge about

patients illness he was still critical and hostile towards him. It was explained how such emotions can be triggering factors for the patient's illness. His expectations were addressed and suggested that they should reduce their expectations to some extent and be supportive with whatever amount he was able to be productive. The course and prognosis of the illness were also discussed. An insight into the patient's behavior was also given and importance of family support explained.

Discharge Counseling

Patient and his brother attended the session. The session contained detailed information on the illness and treatment modalities, importance of regular follow up, importance of regularity of medicines, causes of relapse, and family involvement in motivating patient. Importance of involvement of patient in productive work activity was once again stressed upon. The therapist assured the patient to be available for help anytime he required.

Follow up

On follow up in OPD basis the patient was found to be maintaining well with medication. He is reported that he feels weakness and tremor. The possible side effects of the medication were explained to the patient. The need for maintaining a daily routine was discussed. The patient was encouraged to go to work at regularly.

Outcome of the intervention

- The family members were educated about the patient's illness and their acceptance and adjustment with the patient.
- Drug adherence is maintained by the patient.
- There is regular follow up
- Patients is engaged in purpose work activity, he has started running his own grocery shop
- There is reduction in the negative symptoms
- Patient has enhanced his social and occupational skill
- Patients self esteem has been enhanced

III. Conclusion

The present case study it was found that patient was having negative symptoms, he was maintaining poor self care, poor social and occupational functioning. He was having poor knowledge regarding mental illness. Beside, Social history and family dynamic assessment reveals open and clear boundaries between the parent-sibling subsystems, authoritative decision making, indirect communication between the parent sibling subsystems, expressed emotions in terms of critical comment and hostility by the siblings. Patients was provided with psycho social intervention in the inpatient department and was referred to rehabilitation center for vocational training and skill enhancement , further the patients was involve in group work session to enhance his social skill .Family intervention was done to reduced high expressed emotion and family psycho education was provided to educate the family regarding mental illness . Psychiatric social worker intervention can help in enhancing social and occupational functioning of persons with mental illness and enhancing their recovery process.

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