



# A case report of schizophrenia with severe disability: the eclectic family therapy approach

## Abstract

Schizophrenia is one of the most common mental disorders affecting perception, emotion, cognition, thinking, and behaviour of the person. The onset is generally in the second decade. Its manifestation varies from patient to patient but its effects are usually severe and long lasting. It can manifest as 'positive symptoms' such as hallucinations (hearing voices and seeing things) and delusions (having strange beliefs). People with schizophrenia also suffer from disorganisation and 'negative symptoms' (such as tiredness, apathy, and loss of emotion). The patient becomes isolated socially and becomes a burden to the family due to lack of proper knowledge about the disease, frequent relapses due to poor drug compliance, side effects, high negative expressed emotions, poor coping skills, and disability. Due to the chronic nature of the disease, the family members and caregivers are also affected. This social casework report describes how a young adult girl with severe disability and dysfunctional family functioning has become hurdle in the treatment and management. Though pharmacotherapy is the mainstay of this disease, social casework based on structural family therapy approach undertaken along with family psychoeducation, behaviour modification techniques, social skills, and coping, and also supportive work with family members help. A home-based rehabilitation plan was worked to provide relief to the caregivers. It illustrates the positive outcome of individual as well as family intervention using structural, behavioural, psychoeducational, and rehabilitative approaches and techniques with an individual after completing 12 sessions and telephonic feedbacks. This resulted in adequate change of the family functioning as they were able to identify their problems, generate solutions, and apply them.

**Keywords:** Caregivers. Drug Therapy. Rehabilitation.

**Bornali Das<sup>1</sup>, Shamiul Akhtar Borbora<sup>2</sup>**

<sup>1</sup>Senior Lecturer, Psychiatric Social Work, Department of Psychiatry, Gauhati Medical College and Hospital, Guwahati, Assam, India, <sup>2</sup>Senior Resident, Department of Psychiatry, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, Assam, India

**Correspondence:** Dr. Bornali Das, MSW, MPhil, PhD, Senior Lecturer, Psychiatric Social Work, Department of Psychiatry, Gauhati Medical College and Hospital, Bhangagarh, Guwahati - 781 032, Assam, India. bornali.d@rediffmail.com

**Received:** 2 March 2016

**Revised:** 14 October 2016

**Accepted:** 25 November 2016

**Epub:** 29 November 2016

**DOI:** 10.5958/2394-2061.2016.00050.1

## Introduction

Severe mental illness such as schizophrenia, a debilitating disease and long course illness can be categorised into five domains of psychotic symptoms, negative symptoms, cognitive impairment, mood problems, and behavioural disturbances.[1] Not that all the domains are fulfilled by the clients but clients have some symptoms in each category, though no one has all of the symptoms within each. The cause of schizophrenia suggested as four different factors that are: biological vulnerability, stress, coping skills, and social support, together said as stress vulnerability model.[2] No two persons with schizophrenia have exactly the same symptoms; each person is unique. Understanding schizophrenia prepares collaborative work with consumers, caregivers, and treatment providers.[3] Systematic reviews elaborated that family intervention makes family life less burdensome and tensed, reduces re-hospitalisation along with necessitates of high quality service.[4]

## Case introduction

Here, the client is a 28 years old unmarried girl. She studied up to 12<sup>th</sup> standard. She hails from lower middle socioeconomic

status of rural background of Assam. As informed by her parents she was temperamentally slow to warm up child, she never was able to mingle with any friends. During her childhood, neither she had any friends nor involved in any indoor or outdoor games. She remained aloof, isolated with poor academic performance in school. Moreover, her understanding to new concepts and adaptability was poor.

## Presenting complaints

Presently, she complained of one episode of abnormal jerky movements of whole body followed by disturbed sleep, fearfulness, suspiciousness, hearing voices, irritability, restlessness with poor oral intake and poor self-care. These symptoms were present for last seven days.

## Sources of information and reason for referral

As per the sources of referral and the information about the case was collected from the client and her parents. The information was found to be reliable and adequate. The case

was referred for psychosocial assessment, psychoeducation to family members, and specific intervention for the client and family.

### Brief clinical history

According to the patient, her symptoms started when she was 20 years old studying in class XII. It started with decreased sleep and suspiciousness that her neighbour, a boy passed lewd comments on her. Gradually her fear increased as she started to be sceptical about the boy's behaviour and she thought that he might harm her somehow. With passage of time her suspiciousness spread to the wider sphere as she started suspecting and fearing that all the boys of her neighbourhood and college passed comments on her. She increasingly became withdrawn to self and communication with others decreased. She became very irritable and would pick up fights with her family members. Patient's self-care deteriorated and lacked initiative to do any personal nor household work. She began hearing voices commenting about her looks and those voices would command her not to take food or prevented her from taking bath.

For the initial two years her family members did not sought any psychiatric help and rather visited many faith healers. Finally when they realised that these pursuits are not leading to any kind of improvement, then they took treatment for the first time six years ago.

### Past history

Patient was first admitted in psychiatry ward of the Gauhati Medical College and Hospital (GMCH) six years ago with the symptoms explained above. She had two more repeated admissions in psychiatric hospital.

### Family history

As per informed by the referral the client was youngest among the two siblings. She hailed from low middle class nuclear family and her mother had a history of diabetes mellitus and her father had hypertension as reported (Figure 1).

### Family composition

Currently the patient has been living with her parents and her elder brother.

#### Father

The client's father was 62 years old. He worked as a small time businessman who was on transport business. He studied till class X. By nature he was a very suggestible man with firm stand on his own beliefs about things and did not pay much heed to what others had to say. He believed that the client, i.e. his daughter had some major mental illness and was very critical towards all her actions and behaviour.

#### Mother

The client's mother was 59 years of age and was educated up to class VII. She was a loving and caring mother, and she shared a cordial relationship with client. As reported she

had no history of psychiatric or systemic illness. She was a homemaker; by nature she was submissive and afraid of her husband. She also had medical complications like high blood pressure, diabetes, and cardiac problem and physically weak. She was very close to the client and the client confided in her. However, as reported her mother was overburdened as she had to devote a lot of time to her and took a lot of stress in handling her.

#### Elder brother

Her elder brother was unmarried and 33 years old. He ran a stationary shop, and was social and responsible by nature. He was educated up to class XII. He was protective and caring about his sister.

### Family interaction patterns

The family interaction pattern was assessed to find and develop an understanding of the communication style and pattern of the family; also to understand the relationship existing between the client, her parents, and sibling.

#### Interaction between parents

The interaction between the client's parents was restricted and cordial only in crisis. Her father partially took care of financial aspects earlier. Presently he sold off the transport business as it was in different town and in order to take care of his wife and daughter. Now there has been a financial difficulty in managing the needs. Therefore, the eldest son was managing the house and all their needs to be met were from the shop. As reported her symptoms starts exacerbating when she started to skip her medications. Her parents panicked and they blamed one another for the client's carelessness. The client's mother was instrumental in managing the client and she did most of the basic needs for the client. At times she reported to feel overburdened, thus there was a 'role strain' and she was also harbouring medical illness. On the other hand her father was poor in managing the crisis and finances. He had paucity in articulating the needs of the family members and was not able to manage the situations. As per observation, her mother passed critical comments when the client was unstable and in times of inabilities.

#### Interaction between siblings

The client's elder brother maintained a cordial relationship and was concerned about her illness; in fact her illness had taken centre stage in his life too but he failed to spend quality time in doing any joint activities. There was neither joy nor satisfaction amongst their interactions.

### Family dynamics

#### Boundaries

The client's external boundaries in the family were closed and rigid as the father, mother, and elder brother did not allow much interaction with friends and relatives. Even the internal boundaries were closed as parental subsystem and the parent-child subsystem had differences. There seemed to be an alliance between the client and mother.

## Subsystem

There were three types of subsystem found in the family. The parental subsystem was not well formed, and the parent-child subsystem where father and mother found difficulty in handling her. Her mother had withdrawn from social visits so that she could be indulged with the patient all the time. Her brother was still unmarried because he was worried that he was the only earning member in the family; moreover the patient's treatment might get compromised if he got married. However the sibling subsystem was well formed.

## Family developmental stage

The family was in the sixth developmental stage. i.e., the family was in launching stage. The client's father and mother stayed along with her. As reported, her elder brother ran his own business and had reached a marriageable age. Her brother was postponing his marriage as he was waiting for his sister's full recovery. Since it was the launching stage there had been a problem in launching of the daughter due to lack of education and the illness of daughter also deterring her launch.

## Leadership pattern

The client's father was the nominal leader and her mother was the functional leader. They preferred to discuss most of the family matters with their son. The leadership pattern in the family was democratic and participatory in nature. Although father had accepted with resistance.

## Decision making

The decision making pattern in the family was authoritative in nature from the client's brother. He usually dominated the other members with firmness and self-assurance. On the other hand the other family members were partially involved or they were not involved in the decision making process.

## Role structure and functioning

The client's elder brother played the instrumental role by being the leader and for the decision making he consulted his mother and managed the household. The mother played the 'expressive role' by being the 'comfortee' or 'consoler' with whom the client shared all her problems. The elder brother had multiplicity and complementarities of roles. Both the client and her mother reported over expectation from the father. However he was not pragmatic in many aspects like running the household and taking care of his wife and children or rendering support to his son. The client's brother too had delayed his marriage due to his sister's illness, contemplating that his sister would reach to a pre-morbid level. This had hindered the relationship between the parents and prematurely the elder brother of the patient had to take multiple roles in showing the role strain.

## Communication pattern

There had been direct communication existing between the father and mother, but the noise level was high; words like "incompetent father" was often mentioned during conversation. There was a minimal communication between

the client, father, and her brother. The client used switchboard communication to communicate with her father, while the mother being the communicator to both the children so as to avoid confrontation. The client's capacity to respond to emotional feelings of family members was diminished.

## Reinforcement pattern

The reinforcement strategies in the family were found to be inadequate as they scolded patient for her undesired behaviour and did not use praise to motivate the desired behaviour. The negative reinforcement in the family was presented in form of criticising and scolding the client for her activities, and behaviour was observed. She was not even encouraged to take up any activities. There had been no differential reinforcement pattern used by the parents.

## Cohesiveness

The bonding was good between the family members. There was a moderate "we feeling", although the bond with the patient was enmeshed as there was excessive sensitivity towards her acts. There seemed to be over involvement in the client's matters which were evident after the start of her illness behaviour.

## Family rituals

The family rituals were performed regularly in spite of the patient's illness but taking her out to family functioning was absent. She was mostly restricted to home.

## Adaptive pattern

The problem solving strategy and coping skills of family members seemed inadequate as they appeared helpless. Moreover in crisis situation they started blaming one another. The father blamed mother whenever the symptoms reappeared, and they preferred going to faith healers, then the client discontinued her medication. There had been an assumption that the mother was playing a non-participative role in solving the problem. The client also had difficulty in conflict resolution due to her disorientation in thoughts and cognition. She adopted unhealthy ways of dealing with stress like denial and escape. Her father had inadequate coping strategies and problem solving abilities for which her mother was taken by stress and burden leading to inadequate family functioning.

## Social support system

### Primary

Parents and elder brother.

### Secondary

The secondary support in terms of help from their relatives and friends was present but they never took initiative to utilise or maintain the relationship.

### Tertiary

The family had started receiving tertiary support from GMCH in the form of consultation and psychosocial interventions.

They were encouraged to try for home based task or other organisation from their native place which could be cost effective.

## Personal history

### Birth and early development

As per reported by referral there was spontaneous vaginal delivery at home by trained 'dai' (traditional birth attendant). Further there was no history of any illness during antenatal or infancy. Developmental milestones were achieved on time compared to her peers.

### Behaviour during childhood

She was an easy going child and had cordial relationship with all.

### Education

She started going to school at the age of five and was average in studies. She passed her exams till class XII; later due to onset of illness she could not continue her studies.

### Menstruation and sexual history

It was reported that she attained her menarche at the age of 12. Her menstrual cycle had been irregular for last four years. Further there was no history of masturbatory habits or sexual exposure.

### Personality

She was very shy, timid girl. She was not able to make friendship easily, liked remaining aloof; however had two good friends with whom she used to share her feelings. She had a hobby of knitting handkerchief during her leisure time.

### Social analysis and diagnosis

Miss X, a 28 years old unmarried girl, she studied till 12th standard, hailing from lower middle socioeconomic status of rural background of Assam. Her personal history revealed that she was a temperamentally slow to warm up child and she never was able to mingle with any friends. She had no friends; she neither involved in any indoor nor outdoor games. As reported by referral she remained aloof and isolated with poor academic performance in school. Her understanding to new concepts and adaptability was considered to be poor. Further her past history revealed that she had been admitted twice in last six years and each time due to her poor adherence to medication. She had never received psychosocial intervention, although pharmacological intervention was going on and off for six years. The client's family history revealed that her mother had medical ailments such as high blood pressure and diabetes mellitus. She usually had frequent anger outbursts especially towards her father. A diagnosis of paranoid schizophrenia was made. The social analysis revealed that both external and internal boundaries in the family were closed and rigid, associated with autocratic decision making pattern for client. The client's father had high expectations from her in terms of academic

performance which she was not able to fulfil due to her breakdown while she was studying in 12<sup>th</sup> standard. The client was doing well when academic pressures were less. As she got promoted to higher classes, the academic load increased and this coupled with the various adolescent issues and conflicts overwhelmed the client. She became overly intense in her reactions which resulted in her anger outbursts and stubborn behaviour at times. Some of the major adolescent issues that bothered the client were interactions with people of opposite sex, her preoccupation with her appearance, and various infatuations played a major role in her maladaptive coping pattern by disengaging herself and leading to amotivation and avoidance. The client did not receive emotional support from her father and mother as they attributed her condition as "Matlobi"- self-doing or acting out. The main reason was that her father was not sensitive to her emotional needs and he never attended to it. He came to support his wife for the trouble taken for their daughter but never that he had been involved in initiating or caretaking. He would make several attempts to go to faith healers and discontinue medication. Though the client's mother attended to her emotional needs, it was inadequate as she abused the client verbally and critical comments were present. The client's father was inclined to catastrophise the client's behaviour and tried to label her as suffering from some major mental disorder and thus treated her in some afflicted manner. There seemed to exist a faulty interaction pattern of parents that made the client perplexed and showed in the form of anger outburst. The noise level was very high, which resulted in her withdrawn behaviour getting reinforced. There was absence of a role model at this period of her life which also made her more vulnerable. Negative reinforcement from the parents also acted as a maintaining factor for client's problem behaviour. The blaming attitudes and faulty decisions of the client's father worsened the family's climate which resulted in increased burden for the mother. The client did not have much creative outlet and not knowing how to engage in constructive activities, her behaviour was not understood by her parents and they interpreted it as abnormal and sought to faith healers and this time the faith healer also mentioned to take psychiatric consultation. The social analysis thus indicated that the case required a holistic outlook and called for a family based structural and behaviour modification approach of social case work. This needed to formulate a management to work with the client and family, to model empowerment and enable the family to meet the needs of its own member, i.e. building a natural social support network. There was also a need to increase skill levels and resources among client and family, so that they would function better after the intervention (Figure 2).

## Interventions

### Goal of interventions

- (1) Long duration of illness affecting her functional life,
- (2) Poor compliance to medication,
- (3) She was a young, early onset of chronic illness, unmarried girl with a long life ahead of her,
- (4) Patient was irritable, abusive, and violent and family members were unaware how to deal with it; parents concern and ignorance about the disease,
- (5) Patient's illness was taking a toll on mother's health as she was the primary

caregiver, (6) The family's maladaptive pattern of handling social interactions and communication among family members were grossly hampered, (6) Patient had poor role functioning and also did not maintain proper daily routine.

### Course of treatment and assessment of progress

The social analysis thus indicated that the case required a holistic outlook and called for a family based structural and behaviour modification approach. The intervention was done in individual level and family level. The interventions done at the individual level were: self-care management skills, supportive work with the client, teaching coping skills, social skills training. The interventions done at the family level were: psychoeducation, supportive work with client's mother, dealing with expressed emotions and high expectations, information regarding alternative career options, improving interactions between parents and the client and their social support. Family management and skills development in families containing a mentally ill member does have a profoundly beneficial impact on relapse, family burden, and social adjustment.

### Individual level

The individual sessions with the client initially concentrated on establishing rapport and reassuring the client about help and finally moving towards more directive intervention. A total of five individual sessions were held. In the assessment session earlier there were behavioural excesses and deficits. Her behavioural excesses were identified as spending too much time alone – withdrawn and isolated, had difficulty in getting sleep, fatigued most of the time, fantasised strange thoughts, and had hallucinatory with deprecatory content. Behavioural deficits were identified as poorly sustained concentration, not completing task, unable to maintain friendship, not eating, diminished self-help skills, lack of social and instrumental activities, lack of affect, unresponsive to questions, poverty of speech. By working on the client's positive assets, rehabilitation can be strengthened to promote better adaptive behaviour; thereby displacing problematic deficits and excesses. In this client conscientious and reliable in meeting commitments, family members were concerned and willing to be involved in treatment. Client was encouraged to talk about the various issues bothering her thoughts and perceptual disturbances. Her concerns were validated through active and empathetic listening. She was encouraged to make a plan by scheduling her routine daily activities with work and hobbies which she avoided earlier and encouraged her about effective interpersonal relationships. She was encouraged to engage in activities which interested her. She was encouraged to engage in creative work like pottery, home based tasks like doing kitchen work or watering the pots; as they had kitchen garden, she was asked to plant vegetables and look after them. She was from Goalpara district; Goalpara is known for skilled weaves and there are lot of weavers. Client was suggested to look out weaving as career option. She was trained on affiliative skills, self-care management, efforts on upgrading the individual's conversational, peer and friendship and family relationship skills.

She was then helped to list down her reactions to those situations and the final outcome of it. Each of the situations was tackled individually and the client was helped to modify her behaviour accordingly through assignments and homework tasks. Successful completion of the task was reinforced through encouragement and praise.

### Social skills training

Client was explained about the concept of social skills, those being communication, problem solving, decision making, coping with stress, self-management, and peer relation abilities that allowed one to initiate and maintain positive social relationships with others. Client was taught how to establish and maintain friendships, understanding the feelings of others, dealing with bullies, etc. It was helpful to break down the skills into smaller pieces and demonstrate each part individually. In addition, she was given an explanation for why a particular skill is necessary. She was advised to be vocal about her feelings and come forward to seek emotional support from family members. She was also encouraged to be assertive at times when it was necessary.

### Communication enhancement training

In a conjoint session of the family members, it was explained how countering aroused irritability and led to non-cooperation as a part of client's symptom. Family was educated about the client's inability to comprehend their position due to her disturbed thought processes. Following this explanation of the caseworker to model the communication style to be adopted while dealing with the client, the following aspects of the modelled communication in management of the client were emphasised: the importance of supportive listening; helping the client to calm down and identify his emotional exacerbation by himself and then asking non-offending questions; gaining support and cooperation of the client; involving the client in a discussion regarding present needs; negotiating with the client possible solutions; provide one time clear instruction regarding any thing and wait for her response rather than repetitive instructions; give her responsibilities regarding small daily activities or household and encourage her to complete, on completion appreciate her. Client had developed very good communication with her father so he could motivate her regarding above mentioned aspects.

### Family level

The sessions with the family were mainly focused on psychoeducation and improving family interaction patterns. A total of seven family intervention sessions were required for the same.

### Psychoeducation

The client's family was given information about the client's disorder. They were explained about both the diagnosis with emphasis on young adult with schizophrenia. Parents were also given information about the disease and the process. The queries regarding the disease schizophrenia and its course

and prognosis were clarified. Her parents were also oriented to the various conflicts and issues that was part of a launching adult stage and were encouraged to identify such issues with respect to the client. The client's father was also given information about the major mental disorders in order to help him distinguish client's behaviour from psychotic disorders and early warning signs. The need for family support and psychosocial intervention was focused upon. The client's father was also psychoeducated about his necessity to get involved and the need for medication was impressed upon him.

### **Supportive work with client's mother**

The client's mother was focused on to her (client), and neglected duties toward husband and elder brother who was of marriageable age. She ventilated her frustration by passing critical comments on the client. So she was explained that due to stress she had developed 'wrong coping'. Her mother herself was physically unwell which added on to the stress. She was encouraged to talk about her problems and ventilate her frustration. She was provided support by active listening and empathetic reaction. She was motivated to do some relaxing activity whenever she found time and engage in recreational activities, visiting Naamghar (place for congregational worship). She was also taught some effective copings skills like when stressed, to practice taking long, deep breaths; taking regular breaks from her work; getting regular exercise and eating a balanced diet; learning time management and organisation skills; seeking to find the positive in every situation; viewing adversity as an opportunity for learning and growth; learning to really listen to what others were saying rather than getting upset because she disagreed and to seek to find areas of common ground and work for a compromise.

### **Dealing with expressed emotions and high expectations**

Family interventions, i.e., family psychoeducation and components of structural and behavioural family therapy approach were effective for reducing family's expressed emotions, especially criticality towards the client. Focus on improving interactions between the parents was also made, along with changing decision making pattern in the family. Various resource institutions' addresses were also provided. Moreover positive reinforcement patterns were explained to the parents in order to encourage client's creative abilities. The client's mother was taught how to channelise client's energy in constructive activities which improved interactions between parents and the client.

### **Social support**

Parents were guided to realise that primary social support is very important for the client at this stage and her parents needed to encourage the client to identify relatives, friends, and community resources that could provide support to her. The tertiary social support for the family was also strengthened by providing information about various resource organisations near client's hometown.

### **Specific modules/approaches and tools-techniques followed**

The case worker had employed the framework of behaviour modification model of social casework in dealing with the case. At the outset of intervention, a contract was formed and goals selected. The case worker developed a treatment plan, explained its rationale, and managed the highly structured therapeutic interchange. Further, behaviour assessment of stimuli and responses were done through direct relevant and observable behaviour of the client. The caseworker used learning principles and behavioural management techniques to alter the environment and/or client's and family member's responses to stimuli. The family was understood as intertwined part of 'person-situation configuration'. In this case, problems were viewed as arising out of role conflicts and poor knowledge of the parents about their daughter's condition. Techniques of behaviour principles, family therapy principles, anger management techniques, social skills training were used by the worker with the client while psychoeducation and communication enhancement techniques were used with the family members.

### **Outcome of interventions**

#### **Individual level**

The client started verbalising more and her withdrawn attitude diminished. Her preoccupation, disturbed sleep, fearfulness, suspiciousness, hearing voices, irritability, restlessness with poor oral intake and poor self-care contributing to disturbances have decreased. She was able to manage herself in communication in a better way and she could identify the stressors and was better equipped to deal with her adolescent crisis.

#### **Family level**

The family's understanding about client's problem improved. Her father became amenable towards accepting a psychosocial viewpoint regarding client's illness. Family's concern regarding client's future was addressed and the interaction between father and mother improved to some extent. The mother-daughter relationship was enhanced and a therapeutic alliance was established. Further, the brother was too altruistic that he blocked his marriage proposals thinking for permanent solution for his sister's illness like 'cure'. His involvement in the therapeutic process had also removed various misconceptions he had regarding the illness.

### **Complicating factors**

There were some challenges throughout the course of the intervention. The primary challenge in this case was the client's father's insistence on medical management of the case. It was quite difficult to engage him in the non-pharmacological intervention as he wanted some 'medicines' to be prescribed. However, this aspect became manageable after few sessions of family psychoeducation. The other challenge for the social worker was the fact that the client had borderline intelligence

and hence a lot of the interventions had to be simplified or modelled by the therapist and the sessions had to be continued for longer duration of time than usual.

### Follow-up

As the client's family was from a state very far from the hospital, regular follow-ups were not possible. However, the therapeutic relationship was continued through telephonic conversations. The client's family had been coming for follow-up to psychiatry department, GMCH every two months. The client was maintaining well, stability towards father was still present. They were planning for the client to take up a course in weaving.

### Discussion and conclusion

Relatively simple, long-term psychoeducational family therapy should be available to the majority of persons suffering from schizophrenia. Patients with schizophrenia can clearly improve their social competence with social skills training, which may translate into a more adaptive functioning in the community.[4] Assertive community training programmes ought to be offered to patients with frequent relapses and hospitalisations, especially if they have limited family support. For patients interested in working, rapid placement with ongoing support offers the best opportunity for maintaining a regular job in the community. Cognitive behaviour therapy (CBT) may benefit the large number of patients who continue to experience disabling psychotic symptoms despite optimal pharmacological treatment.

### Efficacy with regard to secondary outcomes

Along with promising benefits from antipsychotic medications, non-pharmacological treatment have emerged a steep vertical growth. Going back four decades, the role of expressed emotions (EE) by Brown and Rutter[5] suggests reduction of EE within family or other environment decreases relapse rates.[6] More recent studies suggest intensive work in psychoeducation, family support, teaching the recognition of early warning signs, improvement in such factors as family burden, coping, and medication adherence show enduring effect.[7,8]

Moreover, Garety *et al.*[9] studied efficacy of CBT in controlled trials and showed effective reduction of symptoms in schizophrenia and sustained benefit. Further mentioned about reduction in relapse rates and ameliorate factors in psychosocial management plans.

### Treatment implications of the case

The case provided a very vivid picture of psychosocial management of schizophrenia, especially in the case of young adult. Because of poor adherence to treatment and repeated admissions, the case was given to the psychiatric social worker for exclusive psychosocial management.

### Recommendations

Therapy can restore self-esteem, build emotional coping strategies, and help return the child or teenager to their previous level of functioning.

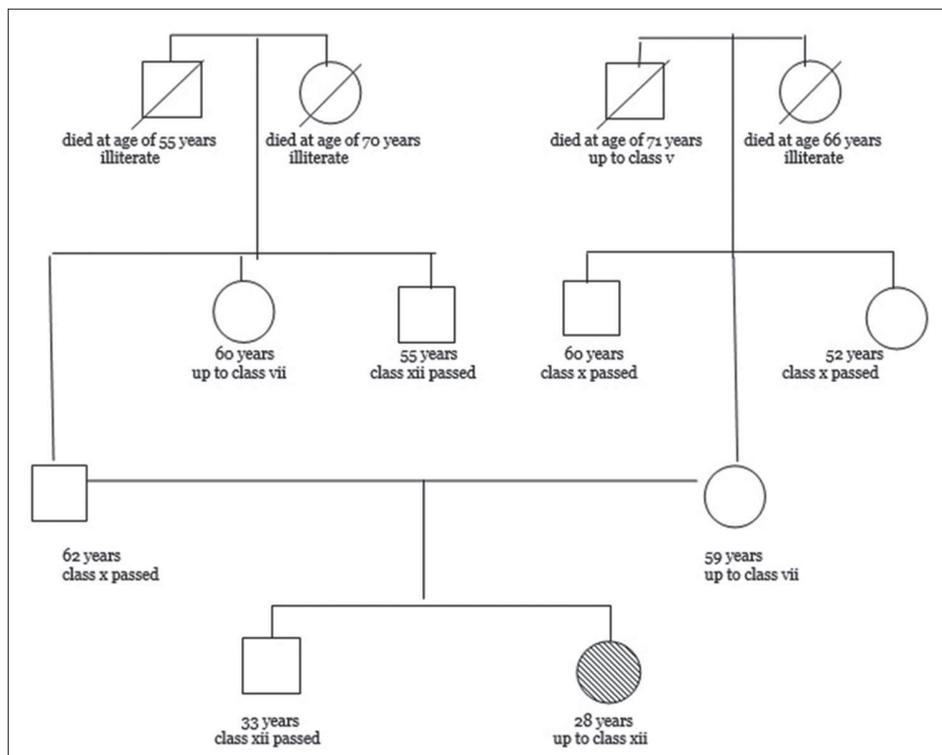


Figure 1: Family history

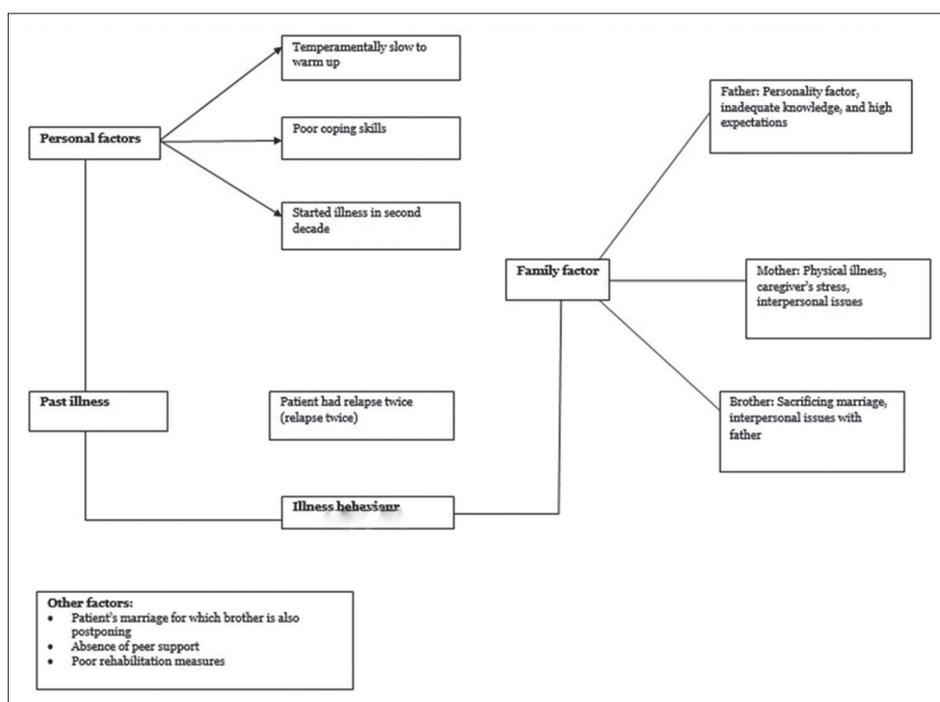


Figure 2: Social analysis

## References

1. Andreasen NC. Brave new brain: conquering mental illness in the era of the genome. New York: Oxford University Press; 2001.
2. Zubin J, Spring B. Vulnerability--a new view of schizophrenia. *J Abnorm Psychol.* 1977;86:103-26.
3. Torrey EF. *Surviving schizophrenia: a manual for families, consumers and providers.* 4<sup>th</sup> ed. New York: HarperTrade; 2001.
4. Pharoah F, Mari J, Rathbone J, Wong W. Family intervention for schizophrenia. *Cochrane Database Syst Rev.* 2010;(12):CD000088.
5. Brown GW, Rutter M. The measurement of family activities and relationships: a methodological study. *Hum Relations.* 1966;19:241-58.
6. Penn DL, Mueser KT. Research update on the psychosocial treatment of schizophrenia. *Am J Psychiatry.* 1996;153:607-17.
7. Lauriello J, Lenroot R, Bustillo JR. Maximizing the synergy between pharmacotherapy and psychosocial therapies for schizophrenia. *Psychiatr Clin North Am.* 2003;26:191-211.
8. Miller R, Mason S. *Diagnosis: schizophrenia.* New York: Columbia University Press; 2002.
9. Garety PA, Fowler D, Kuipers E. Cognitive-behavioral therapy for medication-resistant symptoms. *Schizophr Bull.* 2000;26:73-86.

Das B, Borbora SA. A case report of schizophrenia with severe disability: the eclectic family therapy approach. *Open J Psychiatry Allied Sci.* 2017;8:91-8. doi: 10.5958/2394-2061.2016.00050.1. Epub 2016 Nov 29.

Source of support: Nil. Declaration of interest: None.