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Research Paper

A case of schizophrenia with auditory hallucination-cognitive behavioral case work approach

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ABSTRACT

Cognitive behavioral therapy for psychosis (CBTp) has proven effectiveness in the treatment of a patient with auditory hallucinations. This case report describes a middle aged man whose auditory hallucination caused great distress and disruption in daily functioning. He was receiving treatment from OPD of LGBRIMH, Tezpur for schizophrenia. A single subject case study design was used; pre and post-assessment was done to see the effectiveness of cognitive behavioral case work intervention. The intervention reported changes in reduced distress, positive symptoms (auditory hallucination), anxiety and depression. The therapy outcome showed changes in decreased distress, anxiety, depression and positive symptoms. Cognitive behavioral case work approach is effective in dealing with people with schizophrenia (auditory hallucination).

Keywords: *Schizophrenia, Auditory Hallucination, Cognitive Behavioral therapy, Case Work*

Cognitive-behavioral therapy (CBT) has been making a stand as an adjunctive treatment to pharmacotherapy. The success of cognitive behavioral therapy for psychosis (CBTp) in randomized controlled trials from the early 90s and evidence of cost-effectiveness has meant that many healthcare services across the world include CBTp in their treatment regime. CBT is an effective treatment for patients with schizophrenia who have persistent psychotic symptoms (Gould et al., 2001, 2004; Tarrier et al. 2004). A study by Bechdolf along with his colleagues in 2004 revealed that a brief CBT intervention for inpatients with schizophrenia reduces re-hospitalization rates compared with psychoeducation. Auditory hallucination experienced in psychotic illness contributes significantly to distress and disability. In 2015 report from the International Consortium on Hallucinations Research regarding a Randomized Controlled Trial data for the use of CBTp in schizophrenia supports the idea that including psychological therapy in addition to routine care is more beneficial than routine care alone on participants' report of psychotic symptom severity, with very recent data

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suggesting that this extends to measures of overall voice severity. The effectiveness of CBT for hallucinations and other psychotic symptoms is well documented in several meta-analyses. Gaag, Valmaggia, and Smit (2014) in meta-analysis studies show that CBT is effective in treating auditory hallucination. The aim of the study was to provide cognitive behavioral case work intervention to decrease the patient's distress causes due to the positive symptoms (auditory hallucination), increased adaptive pattern of behavior, and provide coping and problem solving skills to the client.

METHODOLOGY

The therapist used single subject case study design which is not merely observational, but a true experiment in which pre and post intervention baseline data was assessed. Kazdin along with his colleague (2003) identify that single case designs are used to determine if a treatment or other manipulation had an effect on the participant. The case has been taken from the Out-Patient Department of LGBRIMH, Tezpur. The patient was explained about the purpose and need for intervention after which written informed consent was obtained prior to the assessment and intervention. The therapist used cognitive behavioral case work approach to deal with problems.

Assessment Tools

1. **Brief Psychiatric Rating Scales (BPRS expanded version 4.0)** The Brief Psychiatric Rating Scale (BPRS 4.0) is a comprehensive 24-item symptom scale by Ventura, Green, Shaner, and Liberman (1993). The BPRS is used to assess the positive symptoms through a clinical interview. The clinician should enter responses in a numbers ranging from 1 (not present) to 7 (extremely severe). When a particular item did not assess it is scored as zero.
2. **Psychotic Symptoms Rating Scales (PSYRATS)** The Psychotic Symptom Rating Scales (PSYRATS) is an instrument developed for quantification of the multidimensional features of the psychotic symptoms of hallucinations and delusions developed by Haddock, McCarron, Tarrier, and Faragher, (1999). The 17 items PSYRATS has 2 subscales: the auditory hallucinations subscale (AHS) consisting of 11 items, and the delusions subscale (DS) consisting of 6 items. The AHS domians are Frequency, Duration, Location, Loudness, Origin, Negativity (Amount/Degree), Distress (Amount/Intensity), Disruption, and Controllability of the hallucinatrions. Preoccupation (Amount/Duration), Conviction, Distress (Amount/Intensity), and Disruption are the DS items. Each item is rated from the range 0 (absent) to 4 (severe).
3. **Beck Anxiety Inventory (BAI)** BAI is created by Beck (1997) and other colleagues, it is a 21-question multiple-choice self-report inventory that is used for measuring the severity of anxiety. Individuals from the age of 17 years can use this scale and it takes minimum (5 to 10 minutes) time to complete. The BAI contains 21 questions, the answers recorded on a scale value of 0 (not at all) to 3 (severely). The increase in scores indicates severity of anxiety symptoms.
4. **The Calgary Depression Scale for Schizophrenia** The Calgary Depression Scale for Schizophrenia (CDSS) is a nine-item structured interview scale developed by Addington et al. (1993) to assess depression in schizophrenics. It is the only depression scale designed for the assessment of depression in schizophrenia and it differentiates between depression and the negative and positive symptoms of schizophrenia. It has been extensively evaluated in both relapsed and remitted patients and is sensitive to change. Ratings of the items are defined according to operational criteria from 0-3.

5. **Family Assessment Device (FAD)** FAD developed by Epstein, Baldwin, and Bishop in 1983 is based on the McMaster Model of Family Functioning (MMFF), FAD measures structural, organizational, and transactional characteristics of families. The measure is comprised of 60 statements about a family; respondents (typically, all family members ages 12+) are asked to rate how well each statement describes their own family. The FAD is scored by adding the responses (1-4) for each scale and dividing by the number of items in each scale (6-12). Problem solving, communications, roles, affective responsiveness, affective involvement, behavioral control, general family functioning are domains of FAD and cutoff score is used to see family dysfunction. The FAD has been extensively used in both research and clinical practice.

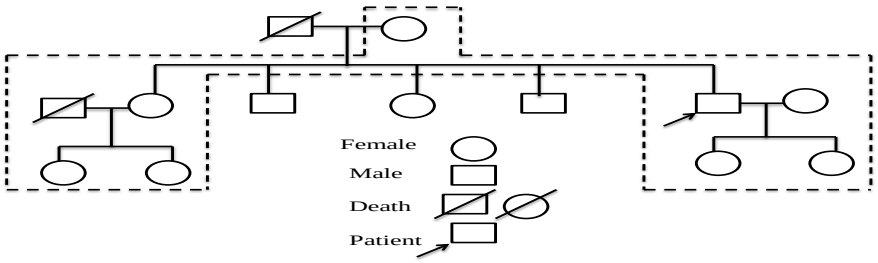
Case Introduction

Index patient Mr. M. B. a 36 year old middle aged male, Hindu, class ten passed, married, belonging from the lower middle-socio-economic background, hailing from Karbi Anglong, district of Assam. The patient visited Lokopriyo Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, Assam on OPD basis and he was diagnosed with schizophrenia.

Brief Clinical History

The patient came with the chief complaints of decreased social interaction, fearfulness, increased palpitation, suspiciousness, hearing of voice not heard by others, difficulty in maintaining daily activities, low mood, and decreased sleep with the gradual onset, continuous course and deteriorating progress of present illness with total of 2 years 3 months of illness. As reported by the family member patient was apparently well 2 years back, gradually they noticed the that he would remain silent most of the time, he would stay alone inside the room and did not initiate any conversation. On asking by the family member patient reported that he feels scared and that his heart beat is faster than usual. Gradually patient developed fearfulness and mentioned to the family members that people are coming to get him. Patient also heard voices which were unpleasant, calling his name and comments him to get up and come to them. Patient was unable to follow his regular schedule as he was disturbed and unable to concentrate due to hearing voices; family members also noticed that he was sad and stressed out. He was unable to fall asleep at night and used to lie down on the bed. At the beginning, patient was taken to a faith healer within the village, but there has been no improvement. After which they consulted a physician in Dimapur, on treatment symptoms were reduced; however at this period patient went off medication. Then when his symptoms increased form the last three months, patient's wife and brother brought him to LGBRIMH there has been regular follow up since then. In mental status examination patient was guarded, did not maintain eye contact, his speech was abnormally soft, auditory hallucination, ideas of persecution and ideas of reference were present, affect was found to be blunted, judgment was satisfactory. Insight was found to be in grade II. The case was diagnosed with schizophrenia (F 20).

Figure: 1 Family Genogram



Family Dynamics

The internal and external boundaries of the family found to be open and clear. In the family, each and every member expressed their views and suggestions which are appreciated by everyone in the family. There are three subsystems present in the family i.e. parental subsystem, parent-child subsystem, and sibling subsystem. All the subsystem is well formed. Patient's father was the nominal and functional leader of the family. He takes decisions with the consultation of other family members. Decisions are taken in a democratic manner and followed by all the family members. Roles and responsibilities among the family members are well defined and each member adheres to their respective role. It is seen that each member of the family has been performing their own roles and assigned tasks adequately. There is no role conflict in the family however since the onset of illness patient was unable to carry out his role efficiently. The patterns of communication among the members are clear and direct. The verbal and non-verbal means of communication are used in the family. Communication patterns are direct with adequate clarity in the family. All the family members are given the freedom to communicate their needs and opinions. Noise level gets increase during the period of patient's increase symptoms. Since family members had poor knowledge regarding mental illness and were not aware of dealing with the patient problem. Positive reinforcement pattern is adequately present in the family. Positive reinforcement in the form of verbal appreciation was present. There is a healthy connectedness present in the family. They supported each other when required. We feeling and strong bonding relationships are present in the family. Family rituals like dining together, celebrating festivals together is present in the family occasionally. Problem solving and coping strategies have been found inadequate in the family in terms of patient illness. Family members also have inadequate knowledge about patient illness and the contributing factors associated with patient illness. Beside illness, family has well adaptive pattern. Support System was found to be adequate.

RESULTS

Table (1) highlights the family functions**,** it was seen that patient and family members problem solving ability is unhealthy with a score of 2.3, on the other hand communication pattern and roles is adequate with a score of 2 and 1.7, which depicts that the family follows a healthy communication and roles are equally distributed among family members. Affective responsiveness with a score of 2.3 depicts the unhealthy pattern in a family. Affective involvement with a score of 1.7, behavioral control with 1.9 and general family functioning with a score of 2 signifies that there is a healthy pattern in these domains within the family (Table 1). There was a change in on pre and post-test score in the domains of Psychotic Symptoms Rating Scales (PSYRATS), the maximum (4) to minimal or occasional (0) level of

frequency, amount of distress, intensity of distress and controllability of voice. Maximum severity (4) to no problem (0) in duration, location, amount of negative content and degree of negative content(4) to no problem (0) in the post-test. Minor (1) problem to no problem (0) in loudness disruption of life (Table 2).Table 3 depicts the pre and post assessment score of The Calgary Depression Scale for Schizophrenia that there is a moderate level of depression present in the patient, post-test reveal that there was no depression. The pre and post assessment of found to have positive changes in Brief Psychiatric Rating Scales (BPRS 4.0), The Calgary Depression Scale for Schizophrenia, Beck Anxiety Inventory and Rosenberg Self-esteem Scale (Figure 2).

Table 1: Family Functioning on the basis of Family assessment device

Domains	**Sore**	**Interpretation**
Problem solving	2.3	Unhealthy
Communication	2	Healthy
Roles	1.7	Healthy
Affective responsiveness	2.3	Unhealthy
Affective involvement	1.7	Healthy
Behavioral control	1.9	Healthy
General family Functioning	2	Healthy

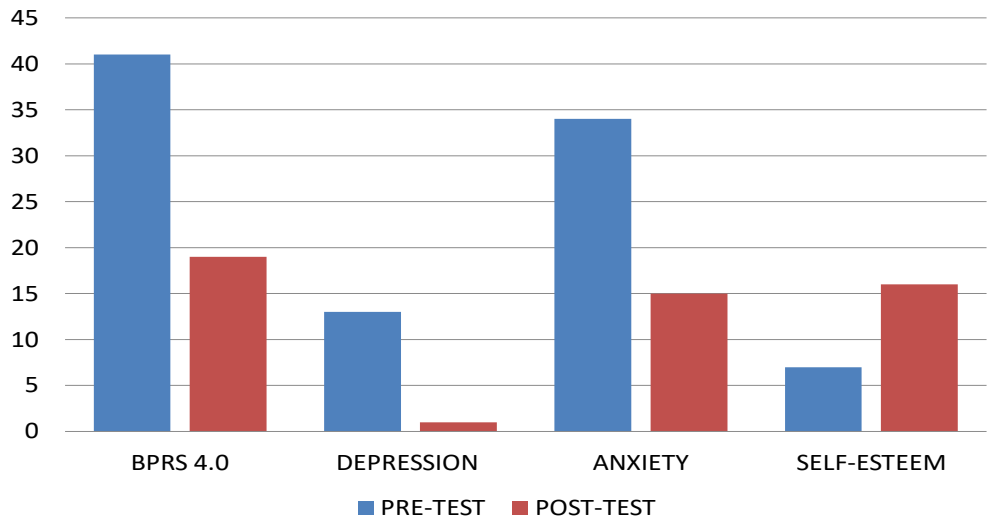
Table 2: Pre and Post test score of Psychotic Rating Scales (PSYRATS)

	Pre test score		**post test scores**	
Frequency	4	Maximum severity	1	Minimal or occasional
Duration	4	Maximum severity	0	No problem
Location	4	Maximum severity	0	No problem
Loudness	3	Minor to moderate	0	No problem
Belief of origin of voices	1	Minimal or occasional	0	No problem
Amount of negative content	4	Maximum severity	0	No problem
Degree of negative content	2	Minor to moderate	0	No problem
Amount of distress	4	Maximum severity	1	Minimal or occasional
Intensity of distress	4	Maximum severity	1	Minimal or occasional
Disruption to life	3	Minor to moderate	0	No problem
Controllability of voices	4	Maximum severity	1	Minimal or occasional

Table - 3 Pre and Post assessment on the basis of The Calgary Depression Scale for Schizophrenia

domains	**Pretest**	**Post test**
Depression	2	0
Hopelessness	2	0
Self-Depreciation	1	0
Guilty Ideas of references	1	0
Pathological Guilt	0	0
Morning depression	1	0
Early Wakening	1	0
Suicide	3	1
Observed depression	2	0
Total score	13	1

Figure 2: Pre and Post assessment on the basis of Brief Psychiatric Rating Scales (BPRS), Beck Anxiety Inventory, and Rosenberg Self Esteem Scale (RSS)



Psychosocial Formulation

Mr. M. B. is 36 years old, Hindu, Married, belongs to a middle socio-economic status hailing from Karbi-Anglong, Assam brought to LGBRIMH for treatment with complaints of decreased social interaction, fearfulness, increased palpitation, suspiciousness, hearing of voice not heard by others, difficulty in maintaining daily activities, low mood, and decreased sleep with the gradual onset, continuous course and deteriorating progress of present illness with total of 2 years 3 months. There was a family history of the sudden death of brother-in-law in accident and death of the father due to physical illness. Personal history reveals alcohol use on an occasional basis with an external locus of control. The psychosocial analysis revealed that role expectation was high towards the patient. The noise level gets increase during the period of patient's increase symptoms. Adaptive pattern showed coping and problem solving are inadequate in terms of dealing with a patient's illness. Apart from this support system was adequate from relatives and neighbors. There was increased positive symptoms (BPRS 4.0), increased hallucination (auditory) and distress ((PSYRATS), moderate level of depression and anxiety, the self-esteem was found to be at low level.

Psychiatric Social Work Intervention

Cognitive behavioral case work intervention was provided by the psychiatric social worker at OPD based sessions. A total of 18 sessions was conducted with the patient and family members. The duration for the intervention was from March 2018 to July 2018 and sessions were conducted on a weekly basis.

Rapport building and therapeutic alliance

The therapeutic relationship is an important aspect of effective outcome of the intervention. The therapeutic relationship in Cognitive Behavioral Therapy (CBT) has been argued to play an essential role in positive outcomes in therapy. The therapy session started with a formal introduction with the patient and care giver. The purpose of the intervention was to provide caring and empathetic relationship with the client for which the purpose of the session was

explained. Patient was further explained about the need for future sessions and the advantages he would gain, reassurance, positive attitude and confidentiality was maintained in order to make the session a meaningful and progressive one.

Cognitive behavioral therapy

The therapist used the Cognitive behavioral therapy for psychotic symptoms: A therapist manual (Smith, Nathan, Juniper, Kingsep, & Lim, 2003). The manual consist of 10 structured modules. The goal was to increase understanding about symptoms, insight into the psychotic experience, improve coping, reduction in distress associated with auditory hallucination, and prevention of relapse.

Early treatment Engagement

The session emphasized the range of already used coping strategies from the part of the patient repertoire, the therapist covey the patient that he is already actively coping with his symptoms and difficulties. Patient way of coping the voices is by distracting himself through interaction with his wife, and trying to be around people. The therapist discusses each strategy with the patient in detail in order to develop an understanding of the effectiveness of each strategy. Motivations for psychological treatment were also provided.

Psychoeducation

These sessions focus on helping the patient to understand psychosis and psychotic symptoms. The aim is to develop a shared understanding with the patient about the nature and context of his difficulties and not to teach a standard set of facts about psychosis. The information regarding his psychosis through a stress vulnerability model was provided. Past experiences, treatment initiatives, risk factors and life stressors were discussed. Also protective factors present were discussed.

Cognitive Therapy for Voices

Therapist worked to make patient understand about his thoughts, beliefs in relation to the voices and how it affects his feelings, mood and coping. The therapist used the A- Activating events, B- Belief, C- Consequences model, in which the patient was helped to describe a recent situations where he had listened those voices and experiences related to those voices and how thought, emotions and feelings. Focus was also laid on the automatic thought which runs on his mind at the moment. After discussion, the therapist draws a three column and explains the patient with his own example, on how his belief and thoughts in relation to the voices influence his feeling and mood. An assignment was given to the patient and was asked to keep a thought diary, to record the specific content of the thought. Next was to challenge his beliefs related to his voice. Therapist also encouraged the patient to try out some different techniques for controlling his voice. After a review on the most helpful strategies for coping with his voices, 'coping cards' were made and the patient can be encouraged to use these when he is troubled by voices.

Behavioral Skills Training

This session focuses on teaching the appropriate behavioral skills including problem solving, relaxation, activity scheduling, and the use of behavioral hierarchies for graded exposure and task assignment. The associated distress was also addressed. Calming techniques involve management of anxiety and its arousal state, via controlled breathing which was demonstrated, the patient was also asked to focus on his breathing through the relaxation via letting go, when he breathes in and out, and during the process he is to scan his body for any areas that he feels particularly tense, and to let go with each breath. He is to relax from head

to toe and tries to set times throughout the day or whenever the patient feels stress building and also to combine deep breathing with meditation for even greater relaxation and stress relief. And the key for relaxation approaches is a regular practice which has been conveyed to the patient. Other than these the coping strategy which he used are being encouraged to continue with besides keeping in mind the thought diary and the coping cards whereby his coping strategies are laid down.

Cognitive Therapy for Secondary Problems

This session concentrate on patient awareness of unhelpful thinking styles that are linked to the experience of secondary difficulties. And to apply cognitive therapy techniques to beliefs and thoughts associated with secondary problems (low self-esteem, depression, and anxiety). Patient was encouraged on ways to increase healthy thinking. Talking back to his own thoughts using the A-B-C-D method (A- Activating event, B - belief or thought he has, C - consequence and D- dispute or talk back to the thought). Decreasing thoughts that make him feel bad by using distraction technique or thought stop. Schedule worry time each day so he can concentrate completely on necessary thinking and leave the rest of the day free of worry.

Self-Management Planning

In this session patient was helped in the identification of early warning signs, and how he himself can actively manage his symptoms. Few steps that are to be taken are assessing social support or asking family members for help, another is to remind himself about the coping strategies. During this session a review on all the topics of discussion were covered. The importance and benefits of compliance was discussed. Further engagement in purposeful activity was discussed.

Activity scheduling

The session was conducted with a patient the aim of providing some minimal tasks to help him in daily activities and make him engage in some work. Activity scheduling can be extremely useful in gradually increasing the patient's activity level and in encouraging patients to interact socially. Patient was interviewed to understand his interests and likes to include in the list of activities which will help in making the Activity Daily Living (ADL). Based on the findings as well as the patient's consent the ADL was made for which the patient was motivated and advised to follow the same. Therapist also took help of family members and involving the patient's family network in therapy in some way can be helpful. They may assist in activity scheduling strategies and may welcome advice and information on the nature and management. Care giver was also explained about the importance of following the Activity Daily Living (ADL) and keeping the patient always engaged which will in turn help the patient leaving his mind always occupied.

Problem solving skills

Problem solving technique is a core strategy in controlling the life stress experienced by people with psychosis. This strategy is particularly helpful because it is a straightforward and easily taught technique that can be easily applicable to the patient. The therapist teaches the patient a step by step process for addressing psychosocial problems. Therapist asked patient to follow some steps to make her easy to solve the problem, they are as follows- identify problems, come up with a list of possible solutions, consider various approaches like brainstorming, changing her point of view or reference, adopting a solution that has worked before, select the most promising solution, create action plan and evaluate the effectiveness of implementation (Falloon, 1882; Barbieri et al., 2006). During the session Therapist allowed the patient to list down the problems that currently face by the patient. Then pick out

one problem or particular environmental circumstance that is contributing to or causing the problem that the patient think he can tackle in the next couple of weeks so that therapy will help patient to develop strategies to resolve those problems. Therapist helped the patient to develop coping skills to manage upsetting life experiences as is the atient unable to adapt to the environment due to his stressful event and lacking behind to cope up with the problems.

Family psychoeducation

The sessions mainly focus on the nature of illness, symptoms, course, prognosis, early warning signs, importance of medication, and management of the patient need for regular follow up, the burden due to the illness, needs and ensuring availability of social support. At the end of the session, doubts were clarified. Family was given time to discuss the difficulties that they face in dealing with the patient and their concerns were addressed. A family was also helped to identify ways on how to cope with difficult situations and to develop adequate problem solving ability.

DISCUSSION

This case report describes a 32 years old man referred for psychoeducation after diagnosed with a psychiatric disorder. After completing a thorough interview it was found out that the patient's duration of illness was for the last 2 years 3 months. The interview revealed that the patient had auditory hallucination which is causing distress to him and his daily functioning. The objective was to reduce the emotional distress associated with auditory hallucinations and develop new coping strategies also helping the patient recognize and change his negative pattern of thinking as well as cognition through the use of Cognitive Behavioral Therapy. After the intervention it was found out that there was a difference in the pretest and post test score. Similar result was found by Peter Trower and Max Birchwood in 2004 when they conducted a study on the efficacy of cognitive therapy for auditory hallucination. Large and significant reductions in compliance behavior were obtained favoring the cognitive therapy group and improvements were also observed. Thomas with his friend (2011) conducted a similar study and there was a significant improvement in post-treatment on the PSYRATS and PANSS Positive and General Scales. CBTp reduce the frequency, intensity, loudness, associated distress, perceived degree of controllability of, and interference from Ahs (Gottlieb et. al., 2013; Dannahy et. al., 2011; Hutton & Morrison 2012). Thus, CBT teaches the patient to ignore the voices and focus on future plans and aims that will increase their quality of life. Tammie and Arthur (2006) CBT and Social Work practice shares common components such as individualism, understanding of thinking, emotions and behaviors of patient, assessment, evaluation, and interventions planning, developing skills for behavior change and empowerment – to solve problems using skills. For social work practitioners who use CBT to treat persons with schizophrenia, perhaps the biggest clinical advantage to patients is the social worker's ability to substantively influence both intrapersonal and environmental factors.

Outcome of Intervention

1. Patient's knowledge and insight regarding illness has been improved.
2. Patient's distress about auditory hallucination has been decreased.
3. Increased in mood state of the patient and enhancement of coping strategies.
4. Increased in work and social functioning.

CONCLUSION

Psychiatric social work intervention based on cognitive behavioral approach is effective to deal with cases of schizophrenia with auditory hallucinations. The improvement in insight

about the illness, enhancement of positive thought and new pattern of thought, his self-esteem were enhanced, there was also a positive effect of treatment on psychosocial functioning, coping and problem-solving skills were also improved.

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Conflict of Interest

The author declared no conflict of interests.

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