The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 8, Issue 2, April- June, 2020
DIP: 18.01.088/20200802, DOI: 10.25215/0802.088
http://www.ijip.in

Research Paper

Establishing efficacy of CBT in elderly treatment resistant chronic schizophrenia: a case report

Swati Sharma[1]*, Susmita Halder[2]

ABSTRACT

Cognitive Behaviour Therapy (CBT) has been proved to be effective for numerous patients and conditions and thus has been widely used ever since its establishment. However, it has been seen that using CBT or techniques of CBT in certain conditions is difficult and causes interruption in the flow of treatment. Likewise, management of elderly patients, treatment resistant patients or chronic schizophrenia are such conditions where a therapist might face an obstruction. The present study highlights application of techniques of CBT, its adaptability and effectiveness in terms of the outcomes of treatment. It describes the use of process of CBT for client aged 66 years, treatment resistant, and was presented with paranoid schizophrenia with a long duration of 42 years. The study uses various techniques to CBT as per requirement of the patient such as Socratic Questioning, Thought Challenging, and Challenging Absolutes, and the therapy was continued for 9 weeks. The outcomes of the therapy indicated improvement in psychotic features and reduced problem behaviours suggesting that CBT is an effective treatment approach in management of paranoid schizophrenia.

Keywords: *CBT, Chronic Schizophrenia, Treatment Resistant, elderly patient*

Schizophrenia is characterised by fundamental and characteristic distortions of thinking and perception, and by inappropriate and blunted affect (ICD-10). Schizophrenia has been considered a chronic and progressively incapacitating illness, and previous studies have also suggested that course and outcome of schizophrenia is wide-ranging. Also, the outcome can be significantly influenced by medications and psychosocial interventions (Carpenter & Strauss, 1991; McGlashan, 1988). This is highly suggesting the importance of treatment in management of Schizophrenia.

It is often difficult to treat patients with schizophrenia due to the age of patient, chronicity of illness, poor insight, and resistance to treatment. Treatment resistance occurs in 34% of the patients (Damjaha et al, 1989; Meltzer et al, 1997; Lally et al, 2016). Therefore, it becomes more essential to introduce psychological intervention in the treatment module. CBT had been more prominently used for mood and anxiety disorders (Halder et al, 2005) but in the

[1]Research Scholar, Department of Clinical Psychology, Amity University, Kolkata, West Bengal, India
[2]Associate Professor, Department of Clinical Psychology, Amity University, Kolkata, West Bengal, India
*Responding Author

Received: May 19, 2020; Revision Received: June 12, 2020; Accepted: June 25, 2020

recent years, it has been a choice of treatment for more severe disorders like schizophrenia. However, there has been neglect in use of psychological intervention as a mode of treatment in Schizophrenia due to the dominance of pharmacological treatment (Gogin, 1993). Psychotherapeutic interventions are more individually designed and cater to the unique needs of each diagnostic group. There are limited studies suggesting efficacy of application of CBT in management of treatment resistant patient with chronic schizophrenia.

Thus, the present study highlights application of techniques of CBT, its adaptability and effectiveness in terms of the outcomes of treatment for an elderly treatment resistant patient with chronic schizophrenia.

Details of The Case

Index client D.R. 66 years old female, widow, Hindu, educated up to post-graduation was presented with complaints of irritability, suspiciousness, delusion of persecution, auditory hallucinations, with suspected history of epilepsy. The duration of her illness is 42 years, insidious, episodic and static in nature. The problems started when the client was 24 years old, and would context of time and become disoriented. History reveals two suicidal attempts. The client has also received ECT twice, and was under irregular psychiatric treatment since a long period but no adequate information could be obtained.

The content of her auditory hallucinations was malevolent and persecutory. Her affective functioning was affected too; she would often stay irritable, fearful due to the voices, and was often suspicious about most of the care-givers at the center. On the behavioural functioning, the client was active, took care of her own needs, however she would often respond to the voices by shouting out loud. The client was functioning well on the social domain and would involve in conversations with others, and participate in activities.

A detailed clinical assessment was conducted on the client and the findings on 'Positive and Negative Symptom Scale (PANSS)' were indicative of presence of positive symptoms, and inconsistency in thinking, problem solving, and decision-making behaviours. There is also presence of impairment in reality testing. The therapy was conducted at a private Mental Health Unit, Kolkata. The total sessions taken were 9 and the time per session was 45-50 minutes.

Psychopathological Formulation and Therapeutic Intervention

The client was presented fearfulness and suspiciousness (emotional responses), and shouting at the door, self-muttering (behavioural responses). Her emotional and behavioral responses could have developed due to the event of being sent to a residential set-up for treatment and maintained by the misinterpretation of situations. The client also exhibits poor responses indication maladaptive beliefs. Overall, her symptoms might have been maintained by the poor or unpleasant life experiences.

The therapeutic intervention was formulated to restructure the faulty beliefs and reduce cognitive distortions. Therefore, techniques from the supportive therapy perspective, and cognitive and behavioural perspectives were adopted.

Psycho -Therapeutic goals

Enhancing insight
Organizing daily activities
Reduce associated distress
Improve coping skills

Reducing Auditory Hallucination
Reducing frequency and strength of voices
Modifying response to voices
Weakening the belief

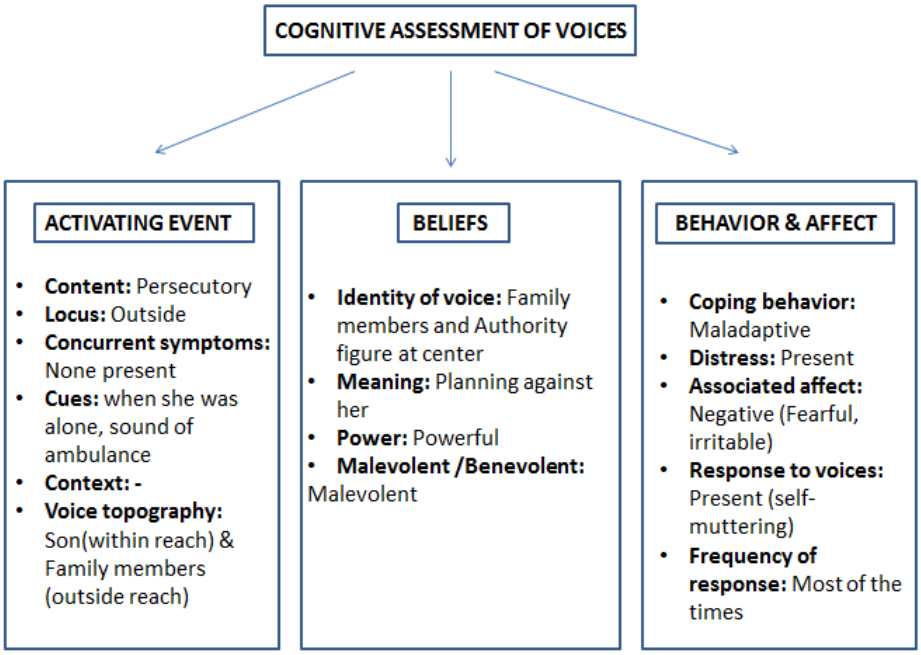
Modus of therapy
Supportive Psychotherapy
Cognitive Behavioural Therapy

Techniques specific to Auditory Hallucination
Cognitive Assessment of voices
Socratic Questioning
Thought Challenging
Challenging Absolutes

Details of Psychotherapy process
The goal was to provide information to the client regarding the symptoms to understand the illness better. Also, to develop the therapeutic alliance regarding the rationale of treatment, to facilitate the client's understanding of the process of cognitive-behavioural treatment and to establish agreement about treatment goals. The therapist took an active role educating the client about schizophrenia and the process of treatment. She was attentive and responded well to all required information. She responded poorly to efforts to increase her insight regarding her present symptoms. Client's understanding of her psychotic symptoms was enhanced and the need for psychotherapeutic intervention was explained. The client accepted to be greatly affected by the hallucinations and delusions and was readily motivated to follow the activity plan. Although, she denied the symptoms presented as being a part of the illness.

Cognitive Assessment of voices
A cognitive assessment of the voices was conducted assessing the activating event, beliefs and coping behavior. Issues from the client's daily life were used to highlight the cognitive components of feeling and behavior. The therapist and client would label the A (activating event) and C (the emotional consequence) of an emotional episode and the therapist would help the client figure out possible self- statements (B) that could have led to the emotional consequence or that would lead to other emotional responses.

From the client, the contextual evidence to examine power, beliefs, fears, and meaning underlying voices was elicited.



Externalisation of interest

The daily activities of the client were explored to know the routine client follows. The daily activities of the client were organized due to increased frequency of voices during free time and thus to reduce the distress a weekly plan was custom made for the client considering her level of activity, her interest. Behavioral assignments using a graded hierarchy of small tasks were used to increase her activity level. Initial focus was on activities of her interest and further exploration of previous interests was helpful in stimulating her interests and expanding the range of her activities. The client's previous assignments were reviewed every week and new assignment was for the next week was given to the client. The benefits of following the plan were also discussed.

Reducing distress

Skills for reducing distress were developed and breathing exercise was demonstrated to the client. The distress caused due to the auditory hallucinations was discussed and assessed based on the SUD, and its impact on daily functioning. On a scale of 1-10, the client gave a score of 10, stating she was more bothered by the voices.

Client was asked to do breathing exercises when she would feel distressed due to the voices. The therapist taught her deep breathing and it was practised meditation for short periods in each session. She gradually established a regular practice twice daily for 15 minutes. She was given evidences where this had helped others. Second, she was assisted to identify her personal signs of stress. The client was asked what she would often do to cope with the voices, and then a list of helpful strategies was made for coping adaptively to the voices. An understanding of use of these strategies and their effectiveness in reducing distress was discussed with the client.

Reducing response to voices & Improve coping skills

Client was asked to utilize her interests in creating new diversion from the voices. The client was asked what she would often do to cope with the voices, and then a list of helpful strategies was made for coping adaptively to the voices. An understanding of use of these strategies and their effectiveness in reducing distress was discussed with the client. The

helpful coping strategies were discussed with the client and how using these will help client in reducing distress and will also reduce the frequency of responding to the voices. The client had followed activities to reduce the voices and also had made efforts to reduce responses to voice. Following the CBT model, a home-task was given to the client of maintaining a record monitoring self for frequency of responding to voices. The client had completed her home-task and mentioned to have responded less to the voices. Each week a new home task was given and reviewed at the end of the week. This was corroborated with the care-givers at the center. The client was given a chart to maintain the frequency of responding to voices each day per hour. Initially the client would respond each time she would hear a voice, estimating to around 10-12 times a day. Client used the coping strategies discussed previously for reducing response to voices.

The client was given situations and asked for possible solutions to the problem. She was further explained the importance of generating potential solutions instead of responding to voices. This helped her cope with situations better than before.

Weakening the belief

The client was asked to detail out the places where her family members live, and then the distance between the places and the center was discussed. The client had difficulty accepting that these people whose voices she was hearing didn't live in the vicinity.

The client also mentioned to have hearing the voices during the session. She was then challenged regarding this and a behavioral experiment was conducted where she asked two other members of the center whether they could hear anything. The client was disturbed when others mentioned about not listening anything. She immediately requested a break from the session and came back after 2 minutes to resume the session. Client mentioned to have feeling irritable due to restriction on responding to the voices.

Client was asked to list out things that were disturbing her. She mentioned 2 things- her son leaving her and staying with her in-laws, and the other family members wanting to send her away. It was then discussed with the client, the probability of these being true. The client was then given evidences of her son staying in England along with his family. And it was also discussed with her that the probability of her being sent away to "bad places". The client was asked to list all places that she believed that she was being sent to. These places were often referred by client as "bad places" and viewed them in negative light. After making a list, the client was shown pictures of each place in all its scenic beauty.

She was then asked to put '✓', '×' or '?' on places if she thought of them as 'good', 'bad' or 'confused'. After completing this activity, her thoughts regarding the places were challenged making the client to change her belief.

Termination

Two major tasks were addressed: dealing with thoughts and feelings regarding ending treatment and developing plans to maintain treatment gains. Several techniques were used to facilitate maintenance of change. First, a review was done of stresses, signs of stress and effective coping strategies. Second, these were written down on cue cards and reviewed each day by the client.

OUTCOME OF THERAPY

Table 1: depicted scores on PANSS on Week 1 and Week 9 has been given below.

Positive and Negative Symptom Scale (PANSS)	WEEK 1	WEEK 9
Positive	30	22
Negative	12	11
General	46	40

The client's frequency of responding to voices had reduced significantly from 10-12 times a day to 2-3 times a day. The self-monitoring records of frequency of responding to voices had even given her feedback regarding her behaviour in turn reducing it. Client mentioned to have feeling irritable due to restriction on responding to the voices. She also attempted do to deep breathing and felt better.

There was a reduction in the psychotic symptoms (delusions) of the client. The client mentioned that she had never imagined the places to be beautiful as might as well be open to the idea of shifting there in future, and also indicated that maybe her family members wanted to send her good places suggesting they don't want to harm her. She was quite for most part of the session indicating that her belief was shaken.

DISCUSSION

The case of an elderly treatment resistant schizophrenia (paranoid type) patient was given treatment using CBT module. It was found that there major improvement in domain of psychosocial functioning, attainment of treatment goals, reduction of symptomatology. This suggests the potential effectiveness of CBT interventions in treatment of above mentioned case and the multidimensional nature of problems facing individuals with schizophrenia. The model presented expands the use of CBT with persons with schizophrenia from the focus on brief treatment of delusions and hallucinations to the multiple problems experienced by clients over the long course of the disorder.

The model can thus be proved to be effective as an attempt to identify problems in the disorder and apply specific interventions to stages of treatment in schizophrenia. Literature suggests the potential usefulness of CBT with schizophrenic clients. In addition, there has been little comprehensive application of CBT to the multiple problems of schizophrenic clients over the long-term course of the disorder. The present study however gives an adequate elaboration on the effectiveness of treatment on chronic schizophrenia. This case study describes a model of CBT that is responsive to the unique issues of persons with schizophrenia, and delineates the use of CBT strategies in treatment resistant elderly patient with chronic schizophrenia.

REFERENCES

Beck, A. T. (2009). Schizophrenia: cognitive theory, research, and therapy. New York: Guilford Press.

Beck, J. S. (1964) Cognitive Therapy: Basics and Beyond, New York: Guildford Press.

Bradshaw, W.R. (1998). Cognitive-Behavioral Treatment of Schizophrenia: A Case Study. Journal of Cognitive Psychotherapy, 12(1), 13-25.

Chadwick, P., Birchwood, M., & Trower, P. (1996). Cognitive therapy of delusions, voices, and paranoia. New York: J. Wiley & Sons.

Halder, S., Singh, A. R., & Prakash, J. (2005) Efficacy of Cognitive Behavior Therapy for the treatment of OCD- A Case Report. Indian Journal of Clinical Psychology. 32 (2), 133- 136

Kingdon, D. & Turkington, D. (2005). Cognitive therapy of schizophrenia. New York: Guilford Press.

Kuller, A. M., & Björgvinsson, T. (2010). Cognitive Behavioral Therapy with a Paranoid Schizophrenic Patient. Clinical Case Studies, 9(5), 311–327.

McQuaid, J. R., Granholm, E., McClure, F. S., Roepke, S., Pedrelli, P., Patterson, T. L., & Jeste, D. V. practice and research, 9(3), 149. (2000).

Morrison A.K. (2009). Cognitive behavior therapy for people with schizophrenia. Psychiatry (Edgmont(Pa Township)), 6(12), 32-39.

Perris, C., & Goggin, W.C. (1995). Cognitive Therapy with Schizophrenic Patients

Sensky, T., Turkington, D., Kingdon, D., Scott, J. L., Scott, J., Siddle, R., . . . Barnes, T. R. (2000). A randomized controlled trial of cognitive-behavioral therapy for persistent symptoms in schizophrenia resistant to medication. Archives of General Psychiatry, 57(2), 165-172.

Svensson, B.E., Hansson, L., & Nyman, K. (2000). Stability of outcome in a comprehensive, cognitive therapy-based treatment programme for long-term mentally ill patients. A 2-year follow-up study

Acknowledgements

The author appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author declared no conflict of interest.

How to cite this article: S Sharma & S Halder (2020). Establishing efficacy of CBT in elderly treatment resistant chronic schizophrenia: a case report. *International Journal of Indian Psychology*, *8*(2), 733-739. DIP:18.01.088/20200802, DOI:10.25215/0802.088