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Case Study

A Case Study of Person with Schizophrenia with Auditory Hallucinations (Voices) – A Cognitive Behavioral Case Work Approach

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ABSTRACT

Background: Effective psychosocial treatment like cognitive-behavioural therapy (CBT) is needed for quick recovery from schizophrenia. The applicability of CBT for schizophrenia has many applications to social work practice. ***Aim:*** The aim of the present study was to manage auditory hallucination using cognitive behavioural case work study approach. ***Methodology:*** It uses a single subject design and compares pre and post -intervention baseline data with that following intervention. Psychiatric social work assessment using - social history Performa, Brief Psychiatric Rating Scales (BPRS), Hamilton Anxiety Rating Scale (HAM-A), The Calgary Depression Scale for Schizophrenia, Psychotic Symptoms Rating Scales (PSYRATS), Family Assessment Device (FAD). Based on the assessment, psychiatric social work intervention was provided to patient and family members, which includes psycho education, Cognitive Behavior therapy and family intervention. ***Results:*** There was change in the pre and post score of psychotic symptoms, anxiety, depression and hallucinations (voices). Psychotic Symptoms were significantly reduced with treatment of client with cognitive behavior case work intervention and medication Patient understanding level of illness was improved, distorted beliefs about hallucination was modified, client was able to cope with distressing symptoms.

Keywords: *Schizophrenia, Psycho Education, CBT, Psychiatric Social Work Intervention.*

Schizophrenia is one of the severe mental illnesses affecting 1 percent of the population, irrespective of culture, class or race. It has an impact on individuals and family, causing

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distress, impoverished quality of life and poor social functioning. Cognitive behavior therapy (CBT) is one of the most widely used as an effective psychological treatment for psychotic disorders (Rector et al., 2010). The development of psychological therapies for voices has primarily involved the application of behavioral and cognitive-behavioral methods with persons with psychotic disorders (Jones et al., 2004). CBT aims at modifying the person's non-adaptive thoughts and beliefs in the context of a collaborative working alliance by teaching the link between perceptions, beliefs and emotional or behavioral reactions, questioning the apparent evidence supporting abnormal beliefs, encouraging self-monitoring of thoughts and, teaching effective coping strategies for dealing with distressing symptoms (Morrison & Barratt, 2009; Berry & Hayward, 2011). Cognitive behavior therapy (CBT), for schizophrenia is considered as an effective intervention on reducing the distress associated with psychotic experiences, controlling the overall severity of positive symptomsc (delusions and hallucinations) (Chadwick et al., 1996; Johns et el., 1999), enhancing relationships with family and friends and at work and increasing self-esteem in persons with schizophrenia (Garety et al., 2008; Maxwell et al., 2012; Buchanan, 2004). The effects of psychological therapies for voices have most frequently been evaluated by examining the efficacy of CBT, as an adjunct to routine care (pharmacotherapy), on the overall severity of positive symptoms (hallucinations and delusions combined) (Hagen et al., 2013).Psychiatric social worker can provide cognitive behavioral case work intervention in working with the person schizophrenia. Psychiatric Social Worker utilizes social work principle, techniques for the purpose of diagnosis and intervention. The current research is a case study of a client introduced to CBT while receiving treatment at LGBRIMH.

METHODOLOGY

It uses a single subject design and compares pre and post - intervention baseline data with that following intervention. It uses a single subject design and compares pre and post intervention baseline data with that following psychiatric social intervention based on cognitive behavior case work approach.

Aim & Objectives

- To assess the anxiety , depression and psychiatric symptoms in person with schizophrenia
- To measures dimensions of hallucinations in person with schizophrenia
- To assess the family functioning in person with schizophrenia
- To provide psychiatric social work intervention to manage auditory hallucination using cognitive behavioural case work approach.
- To see the effectiveness of psychiatric social work intervention in person with schizophrenia with auditory hallucination

Assessment

1. **Semi-structured clinical and socio demographic data sheet**: A relevant socio demographic and clinical detail was collected using this Performa.

2. **Family Assessment Device (FAD):** The interview was done with the client based on the family assessment device by Epstein, Baldwin, & Bishop (1983). Family assessment device consists of seven scales including a General Family Functioning, Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, and Behavioral Control.
3. **Brief Psychiatric Rating Scales (BPRS)** (Overall JE & Gorham DR. (1988): The scale is consist of 18 items, Somatic concern, Anxiety, Emotional Withdrawal, Conceptual disorganization, Guilt feelings, Tension, Mannerisms and Posturing, Grandiosity, Depressive mood, Hostility, Suspiciousness, Hallucinatory Behavior, Motor Retardation, Uncooperativeness, Unusual thought content, Blunted Affect, Excitement, Disorientation. Rate items 1-7 on the basis of the individual's self report.
4. **Hamilton Anxiety Rating Scale (HAM-A):** The HAM-A developed by Hamilton (1959) was used with the client to measure the severity of anxiety symptoms. The scale consist of 14 items, each define by a series of symptoms, and measure both psychic anxiety and somatic anxiety. The item scored on a scale of 0(not present) to 4(severe) with a total score range of 0-56, where <17 indicates mild severity, 18-24 mild to moderate severity and 25-30 moderate to severe.
5. **The Calgary Depression Scale for Schizophrenia**: The scale has developed by Addington (1990) at the University of Calory. To assess the level of depression in schizophrenia. The scale contains 9 items; Depression, Hopelessness, Self depreciation, Guilty Ideas or Reference, Pathological Guilt, Morning Depression, Early Wakening, Suicide, observed depression.
6. **Psychotic Symptoms Rating Scales (PSYRATS)**: The scales PSYRATS developed by Haddock, G., McCarron, Tarrier, & Faragher (1999) has been used to measures dimensions of hallucinations and delusion. The scales consist of 11 domains following Frequency, Duration, location, Loudness, Beliefs re origin of voice (s) Amount of negative content, Degree of negative content, Amount of Distress, Intensity of distress, Disruption to life and Controlled of voice.

Case Introduction

The index client was 41 years old male, Hindu, Unmarried from lower middle socio economic background, hailing from Dhemaji, District of Assam. The client was diagnosed as Paranoid schizophrenia and was admitted in Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur for psychiatric treatment.

Source Of Information

The information was gathered from the client himself, his sister and his father and the client case record file. The information which gathered was reliable and adequate.

The Reason For Referral

The case was referred for adequate psychosocial assessment and intervention.

Brief Clinical History

The index Client was brought to LGBRIMH for admission with the chief complaints of decreased interaction, wonder some behavior, increased in anger, self muttering, self smiling, over religiosity, decreased need for sleep with the gradual onset, continuous course and deteriorating progress of present illness with total 18 years of illness ,with nil precipitating factors, nil significant past history , with treatment history , no family history of mental illness, with nil contributory personal history, with well adjusted premorbid personality. Mental status examination revealing client was well groomed, maintained eye contact, cooperative, restless manner, increased productivity, intact cognitive functions, anxious affect, reactivity present, communicable, appropriateness. In perception, 3rd person auditory hallucination was present, with grade 4 Insight. On 9th of January, 2018 Client was admitted in LGBRIMH and diagnosed as Paranoid Schizophrenia (F20.0).

Family Genogram

The client family history (Figure1): Client's father 65 years of old, studied up to 6th standard. He is a cultivator. He is a responsible man and sociable in nature. He maintains cordial relationship with the Client. Client mother is 63 years of old, illiterate, homemaker and responsible towards the family members. She maintains cordial relationship with the Client. Client 1st sibling is sister 38 years of old, married, studied up to 10th standard. Client 2nd sibling is sister is 37 years of old, married. She studied up to 12th standard. Client 3rd sibling is sister, 36 years of old, married, studied up to B.A. Client 4th sibling is brother, 34 years of old, and married, studied up to 10th standard, unemployed. He maintains cordial relationship with the Client. The interaction pattern between parents was adequate; they were supportive to each other. They share a close and healthy relationship and both are equally responsible in terms of family matters. Client had cordial relationship with his father and mother. They shared a friendly and affectionate relationship. Client is close to both but more emotionally attached to his mother. The interaction between siblings was adequate. All his siblings are very approachable in regard to any issues to discuss; they are supportive to each other.

Family Composition

Family Genogram

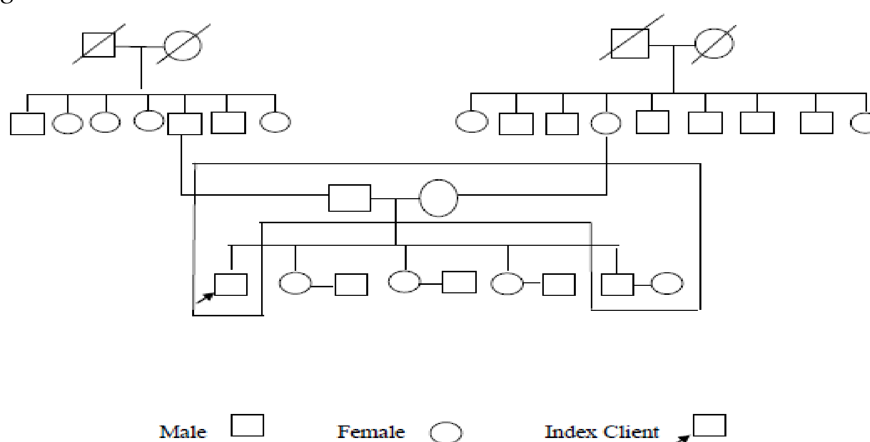

Figure: 1(Family Genogram)

Family Dynamics

The family internal and external boundary is 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. Client father is the nominal and functional leader of the family. He takes decision with consultation of other family members. Decisions are taken in a democratic manner and it followed by the entire family member. Roles and responsibilities among the family members are well defined and each member adheres to their respective role. There is clear and direct pattern of communication among the family members. The verbal and non-verbal means of communication are used in the family. All the family members are given freedom to communicate their needs and opinions. Noise level gets increase during the period of client's increase in symptoms. Since family members had poor knowledge regarding mental illness and were not aware how to deal with client's problem. Both positive and negative reinforcement pattern exist in the family, positive reinforcement in the manner of verbal appreciation by encouraging the client negative reinforcement in the manner of scolding to point out his wrong doings. There is a healthy connectedness present in the family. They support each other when required. They have been actively participating in all the treatment process and were enthusiastic about knowing the client condition. We feeling are present in the family where family rituals like dining together, celebrating festivals together is present in the family. Problem solving and coping strategies have been found inadequate in the family with regard to client's illness. The family members do not have adequate knowledge about the mental illness and contributing factors associated with the Client. However they are supportive in understanding each other. Primary social support is adequate from the family members. All requirements for Client's treatment are provided by his family member. Secondary social support system is adequate from the relatives and neighbor. Tertiary level of social support has been received adequately from LGBRIMH.

Personal History

In personal history, the birth order of the client was first among the four siblings. The client had normal birth and development milestone were achieved at appropriate age and no abnormality was reported. No major health complications were reported during the childhood. Client was reported to have good and normal health conditions during childhood. He studied up to B.A 2nd year, average in his studies. He had a healthy interaction with his peer group. He was working in a Sahara company for 5 years from 2000 to 2005. He couldn't maintain to go for the job due to his illness. Client gained sexual orientation from peers. No history of sexual deviation was reported.

Pre-Morbid Personality

Pre morbidly client has a well adjusted personality

Psychosocial Formulation:

Mr. P.S is 40 years of age, Hindu, unmarried belongs to lower socio economic background hailing from Dhemaji District, Assam brought to LGBRIMH for treatment. History reveals that client has poor knowledge regarding the mental illness; history of substance intake, no work functioning, poor drug compliance to treatment has contributed to the illness and gradually deteriorates the client symptoms. The psychosocial assessment reveals that family members had poor knowledge regarding mental illness and were not aware of dealing with client problems. Noise level gets increase during the period of client's increase in symptoms. Both positive and negative reinforcement pattern exist in the family, positive reinforcement in the manner of verbal appreciation by encouraging the client, negative reinforcement in the manner of scolding to point out his wrong doings. Problem solving and coping strategies have been found inadequate in the family with regard to client's illness. The distress level of client has been observed by family members as he used to get irritated over hearing voices sometimes he had showed aggression towards same voices and he was unable to perform any task due to hearing voices. On Mental Status Examination, client was well groomed, maintained eye contact, cooperative, restless manner, increased productivity, intact cognitive functions, anxious affect, reactivity present, communicable, appropriateness. In perception, 3rd person auditory hallucination was present, with grade 4 Insight.

Psychosocial Analysis

- Z56. Problem related to employment and unemployment
- Z72.2 Problems related to drug use
- Z91.1 personal history of noncompliance with medical treatment and regimen

RESULTS

Table: 1 Family dynamics of the client's family on the basis of Mc Master Family assessment device

Family Assessment Device (FAD)	Scores	Findings
Problem solving	2.3	Unhealthy
Communication	2	Healthy
Roles	2.25	Healthy
Affective responsiveness	2.33	Healthy
Affective involvement	2.1	Healthy
Behavioral control	2.2	Unhealthy

Table: 2 Pre and Post assessment scores of Brief Psychiatric Rating Scales (BPRS), Hamilton Anxiety Rating Scale (HAM-A), The Calgary Depression Scale for Schizophrenia and Psychotic Symptoms Rating Scales (PSYRATS)

Tools	Pre test scores	Findings	Post test scores	Findings
Brief Psychiatric Rating Scales (BPRS) expanded version (4.0)	38	Mild	22	Mild

Tools	Pre test scores	Findings	Post test scores	Findings
Hamilton Anxiety Rating Scale (HAM-A)	14	Mild Severity	4	Mild Severity
The Calgary Depression Scale for Schizophrenia,	8	Mild Depression	2	Mild Depression

Psychotic Symptoms Rating Scales (PSYRATS):

	Hallucination rating scale	Pre-test	Post-test
1	Frequency	4	1
2	Duration	1	0
3	Location	4	0
4	Loudness	1	0
5	Beliefs of origin of voices	3	0
6	Amount of negative content	3	0
7	Amount of distress	1	0
8	Intensity of distress	4	0
9	Disruption of life	4	0
10	Controllability of voices	4	0
	Total score	33	1

The Table1 shows family assessment scores. In the domain of problem solving the scores was s 2.3; it shows that family has difficulties solving problems. In communication the scores was 2 and it shows the better communication style among the family member. In Roles the score was 2.25 and it shows the family member has organized pattern of roles. In affective responsiveness the score was 2.33 and it shows appropriate affect in the range of stimuli. In the affective involvement the score was 2.1 and it shows no stress. In the behavioral control the scoring was 2.2 and it shows high stress.

The Table 2 shows that in the pre test the scoring of the BPRS scale was 38 (mild level of psychiatric symptoms), while in the post test the score come down to 22 suggestive of (mild level of psychiatric symptoms). In the Hamilton Anxiety rating scale, the pre score was 14 suggestive of mild level of severity and in the post test client scored 4 suggestive of no anxiety symptoms. In the Calary Depression scale for Schizophrenia the pre test score was 8 suggestive of mild level of depression while in the post test the score was reduced to 0, suggestive of absence of depression. Under the Psychotic Symptoms Rating Scales (PSYRATS) the score of hallucination rating scale was seen on a frequency in pre-test 4 and post-test come down to 1 while duration 1 and 0, location 4 and 0, loudness 1 and 0, belief of origin of voices 3 and 0, amount of negative content 3 and 0, amount of distress 1 and 0, intensity of distress 4 and 0, disruption of life 4 and 0, Controllability of voices 4 and 0 score was observed in pre-test and post-test respectively (Table 3).

PSYCHIATRIC SOCIAL WORK INTERVENTION

For this case study, the Psychiatric Intervention mostly focuses on Cognitive Behavioral Therapy (CBT). Some of the brief intervention has been conducted include, Psycho education, vocational Rehabilitation, Family Intervention and Pre-discharge counseling was provided to the client and the family members. The total number of the session took place was 17.

PROCESS OF INTERVENTION

1. RAPPORT ESTABLISHMENT

Building rapport is a critical component of successful client-therapist relationships, as this process promotes open communication, develops trust, and fosters the client's desire to participate in the therapy program. During the discussion the client was informed about the therapy and the benefit that he would get. Reassurance, positive attitude and confidentiality were maintained in order to make the sessions a meaningful and progressive one.

2. FAMILY ASSESSMENT AND INTERVENTION

The family assessment was done with the client sister and father to address the psychosocial issues of the family. Throughout the assessment it was found that the family member have inadequate knowledge regarding mental illness, family psycho education was provided focusing on signs and symptoms, treatment modality, medication adherence, role of primary care giver and importance to engage in productive activities. Besides, the family members were also counseled to develop adequate coping skills and problem solving ability to reduce emotional and physical burden in the family by resolving the problems. Family psycho education is a method based on clinical findings for training families to work together with mental health professional as part of an overall clinical treatment plan for their family member. Family psycho education has been shown to improve patient outcomes for person with schizophrenia (Dixon et al., 2000; Lam, 1991; Berkowitz et al., 1984).

3. COGNITIVE BEHAVIORAL THERAPY

Cognitive behavioral therapy for psychosis (CBTp) is the most well-known and widely researched psychological intervention for psychosis (McCarthy &Jones, 2011). CBTp typically aims to reduce the distress associated with psychotic experiences, rather than attempting to reduce the frequency of those experiences (Morrison and Barratt, 2010). Cognitive behavioral therapy (CBTp) Beck and colleagues (2011) which focus on alleviating the distress associated with hearing voices (auditory hallucination) is achieved through the normalization of psychotic experiences, the use of behavioral experiments to test unhelpful beliefs about voices, the development of better coping strategies, the adoption of more effective emotion regulation strategies in place of unhelpful strategies (such as safety behaviors), and the revision of negative beliefs about the self

3.1 General Assessment & introduction to therapy

The session was conducted with an objective of building therapeutic relationship with the client, to assess the client's explanation of the disorder and attitude towards the psychosis and mental illness in general and to introduce the therapy. Following scales was administered Brief Psychiatric Rating Scales (BPRS), Hamilton Anxiety Rating Scale (HAM-A), The

Calgary Depression Scale for Schizophrenia, Psychotic Symptoms Rating Scales (PSYRATS). As the therapist introduced about the therapy the client was welcoming and ready to go forward. The therapy aim to treat individuals with hallucinations and to reduce the level of distress associated with psychotic symptoms. Further to educate the patients and family members about the illness.

3.2 Symptom Specific Assessment

The session was conducted with an objective of assessing the psychotic symptoms that the client had been experiencing and their explanatory model of these symptoms and to provide feedback on the assessment. The session focuses on the explanation of the client regarding the voices that he heard. The client had started hearing voices during difficult period in his job, where he was visiting frequently to the temples in search of right path; from there gradually he started to hear voices of god calling him. The client believed that God has selected some people those who can hear voices and they were philosopher and only they can hear the voices. He explained himself that he was one of them. The client had heard the voices almost all the time until and unless he starts communicating with others. Client also explained that the voices are distressing. The therapist also discussed about the symptoms that his family members reported during the time of admission. During the following sessions, the therapist understood the mechanism in which the patient perceived psychosis through his experiences, and how he interpreted his own symptoms.

3.3 Early treatment Engagement

The session was conducted with an objective of reinforcing client's existing use of coping strategies. The client was assessed about the coping skills that he used when he heard voices. It was found that when the client started talking to other people he heard no voice. The client had been motivated to maintain the coping strategies of talking to other people when voices occur. The client also motivated about the psycho social treatment that he would go through.

3.4 Psycho education

The session was conducted with an objective of providing the client with information about psychosis and psychotic symptoms suited to level of his insight and attitude to illness and to provide clients with a normalizing stress vulnerability model of psychotic symptoms. The session focuses on helping the client understanding about the psychosis, its positive symptom and negative symptoms and the types of psychosis. The causes of the psychosis were explained to the client and how all the predisposing, precipitating, perpetuating factors come together to trigger the onset of the illness. The discussion took place in a four session. Information was also provided about the nature and causes of the mental illness, myths and misconceptions, early warning signs and symptoms, its treatment modality, importance of medication adherence, side effects of medication, regular exercise and its advantages were explained to the client.

Cognitive Therapy for Voices

The session was conducted with an objective of facilitating client's understanding how his beliefs and thought in relation to voices influence his feelings, mood and coping. The session was focused on how the thoughts influence the feelings following the ABC model (A-Activating event, B-Belief, C-Consequences). During the sessions patient reported that the

voices occurred all the time but he couldn't remember all the thing what they says, after hearing the voices it make him anxious and distress. The triggering event that the client identified was that when he stays alone he started hearing voices. Client was asked to concentrate on his experiences in order to make him understand the automatic thoughts and feeling associated with it. Further he was explained regarding how the hearing voices are affecting his thoughts and feelings and how he is losing touch with reality. The client was asked to make relation between belief and consequences. Client was encourage to have balanced thinking to reduces the distress level by giving positive explanations alternate thoughts after voices. Some of the positive feeling and negative feeling that the person had was elicited to the client. The discussion took place in three sessions. He was asked to maintain thought diary and record the voices and thoughts he experience. He was told to keep note of the time or event that he heard voices, the belief or the thought at the time of the event and the consequences that what his feeling was.

3.5 Behavioral Skills Training

The session was conducted with an objective of client's existing coping repertoire to improve management of current problems, increased self efficacy and reduced associated distress. As the client had coping strategy that he had been using was communicating with the people, he was motivated to maintain his habits. Calming techniques which manages the anxiety level of the client by following the two core relaxation techniques which was controlled breathing and relaxation via letting go. Some of the other calming technique using destruction, narrowing attention, self-instruction, increase in social interaction, increased sensory stimulation that was discussed with the client. The client was also referred to the Rehabilitation center where he could engage himself into productive activities. The distraction, calming and relaxation techniques helped client and he could understand the voices used to hear when he was not engaged when he became busy in activities he did not het hearing voices. Client could accept that those hearing voices were part of mental illness and he should not pay attention towards them. The discussion took place in three sessions.

3.6 Self Management Planning

The session was conducted with an objective of to facilitate client's identification of early warning signs of psychotic disorders and also to develop the client's self management plan to be activated when they begin to experience early warning signs and symptoms. The session was focus on the detecting of the early warning signs & symptoms, the client was assigned to keep note about the early warning signs and symptoms also letting others to inform if they noticed the symptoms.

4. DISCHARGE COUNSELLING

Pre discharge counseling has been imparted to client for the maintenance of treatment and drug compliance of illness after discharge. The following areas were focused:

- The nature of the mental illness
- The importance of taking medication
- Side effects of the medications
- The importance of engaging into productive activities

- Follow up
- Dealing with stigma

5. FOLLOW UP

After the discharge, follow up was done through telephonic conversations and it was found that client was following the instructions provided to him. He is maintaining well currently.

DISCUSSION

The case study with the objective of managing the auditory hallucination (AH) using cognitive behavioural case work study approach and to enhance coping strategies to reduce distress in person with schizophrenia with auditory hallucination was found that after psychiatric social work intervention there was difference in pre and post test scores. Cognitive behavioral therapy) is the most well-known and widely researched psychological intervention for psychosis (McCarthy & Jones, 2011; Morrison et al., 2011; Hutton et al., 2012). In the present case study psychotic Symptoms were significantly reduced with management of patient with cognitive behavior case work intervention, medication and other intervention. Client understanding level of illness was improved, distorted beliefs about hallucination was modified, patients was able to cope with distressing symptoms and significant improvement was noticed in terms of social functioning. Cognitive behaviour therapy has shown to be effectiveness in treating persons with schizophrenia (Turkington & Kingdon, 2000; Kuller et al., 2009; Rector & Beck, 2001). Psychiatric social worker effectively can work both at interpersonal and environmental factors and can enhance individual functioning in the social environments. Kingdon & Tarkington (2004) sated that clients with schizophrenia may benefit from social workers who simultaneously provide CBT along with other social work intervention.

CONCLUSION

The study based on the psychiatric social work assessment and intervention to the client, focused on enhancing coping strategies and changing unhelpful patterns in cognition, behavior and emotions based on cognitive behavioral approach. A brief psychosocial intervention along with the pharmacological treatment can contribute positive impact towards person with schizophrenia.

REFERENCES

Morrison, A. P., & Barratt, S. (2009). What are the components of CBT for psychosis? A Delphi study. *Schizophrenia Bulletin*, *36*(1), 136-142.

Chadwick, P. D., Birchwood, M. J., & Trower, P. (1996). *Cognitive therapy for delusions, voices and paranoia*. Oxford, England: John Wiley & Sons.

Johns, L. C., & McGuire, P. K. (1999). Verbal self-monitoring and auditory hallucinations in schizophrenia. *The Lancet*, *353*(9151), 469-470.

Berry, C., & Hayward, M. (2011). What can qualitative research tell us about service user perspectives of CBT for psychosis? A synthesis of current evidence. *Behavioural and Cognitive Psychotherapy*, *39*(4), 487-494.

Rector, N. A., Stolar, N., & Grant, P. (2011). *Schizophrenia: Cognitive theory, research, and therapy*. Guilford Press.

Jones, C., Cormac, I., Silveira da Mota Neto, J. I., & Campbell, C. (2004). Cognitive behaviour therapy for schizophrenia. *Cochrane Database Syst Rev*, *4*, Art.

Garety, P. A., Fowler, D. G., Freeman, D., Bebbington, P., Dunn, G., & Kuipers, E. (2008). Cognitive–behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: randomised controlled trial. *The British Journal of Psychiatry*, *192*(6), 412-423.

Maxwell, J., Farhall, J., & Matyas, T. (2012). Translating CBT for Voices into a Program for Carers: a pilot study. *Behavioural and cognitive psychotherapy*, *40*(1), 117-123.

Buchanan, R. W. (2006). Persistent negative symptoms in schizophrenia: an overview. *Schizophrenia bulletin*, *33*(4), 1013-1022.

Hagen, R., Turkington, D., Berge, T., & Gråwe, R. W. (2013). *CBT for psychosis: A symptom-based approach*. Routledge.

Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster family assessment device. *Journal of marital and family therapy*, *9*(2), 171-180.

Overall, J. E., & Gorham, D. R. (1988). The Brief Psychiatric Rating Scale (BPRS): recent developments in ascertainment and scaling. *Psychopharmacology bulletin*.

Hamilton, M. A. X. (1959). The assessment of anxiety states by rating. *Psychology and Psychotherapy: Theory, Research and Practice*, *32*(1), 50-55.

Addington D, Addington J, Schissel B. A (1990). Depression rating scale for schizophrenics. Schizophrenia research.247-51

Haddock, G., McCarron, J., Tarrier, N., & Faragher, E. B. (1999). Scales to measure dimensions of hallucinations and delusions: the psychotic symptom rating scales (PSYRATS). *Psychological medicine*, *29*(4), 879-889.

McCarthy-Jones, S. (2011). Voices from the storm: a critical review of quantitative studies of auditory verbal hallucinations and childhood sexual abuse. *Clinical psychology review*, *31*(6), 983-992.

Dixon, L., Adams, C., & Lucksted, A. (2000). Update on family psychoeducation for schizophrenia. *Schizophrenia Bulletin*, *26*(1), 5.

Lam, D. H. (1991). Psychosocial family intervention in schizophrenia: A review of empirical studies. *Psychological medicine*, *21*(2), 423-441.

Berkowitz, R., Eberlein-Fries, R., Kuipers, L., & Leff, J. (1984). Educating relatives about schizophrenia. *Schizophrenia bulletin*, *10*(3), 418-429.

Morrison, Anthony, Julia Renton, Hazel Dunn, Steve Williams, and Richard Bentall. (2004). *Cognitive therapy for psychosis: A formulation-based approach*. Routledge.

Hutton, P., Morrison, A. P., & Taylor, H. (2012). Brief cognitive behavioural therapy for hallucinations: can it help people who decide not to take antipsychotic medication? A case report. *Behavioural and cognitive psychotherapy*, *40*(1), 111-116.

Turkington, D., & Kingdon, D. (2000). Cognitive-behavioural techniques for general psychiatrists in the management of patients with psychoses. *The British Journal of Psychiatry*, *177*(2), 101-106.

Kuller, A. M., Ott, B. D., Goisman, R. M., Wainwright, L. D., & Rabin, R. J. (2010). Cognitive behavioral therapy and schizophrenia: A survey of clinical practices and views on efficacy in the United States and United Kingdom. *Community mental health journal*, *46*(1), 2-9.

Rector, N. A., & Beck, A. T. (2012). Cognitive Behavioral Therapy for Schizophrenia: An Empirical Review Neil A. Rector, PhD and Aaron T. Beck, MD (2001). Reprinted from the J Nerv Ment Dis 189: 278–287. *The Journal of nervous and mental disease*, *200*(10), 832-839.

Kingdon, D. G., & Turkington, D. (2004). *Cognitive therapy of schizophrenia*. Guilford Press.

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