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# A SOCIAL CASEWORK OF PARANOID SCHIZOPHRENIA WITH CAREGIVER BURN OUT AND REHABILITATION ISSUES

**Ms. Buli Nag Daimari**
*Psychiatric Social Worker, Department of Psychiatric Social Work, L.G.B. Regional Institute of Mental Health, Tezpur, Assam.,India.*

**Abstract**
*Schizophrenia is a severe and chronic psychiatric disorder, which has multiple challenges in its management for both patients and their caregivers. Burnout is a common issue in caregivers of patients with schizophrenia. However, several aspects of this issue have not been clearly understood. The present case illustration tries to understand the characteristics of burnout and the need for social rehabilitation for patients to address caregivers concerns of health and emotional well being.*

***Key Words: Schizophrenia, Caregiver's Burnout, Social Rehabilitation.***

## INTRODUCTION

Caring for a person with mental illness like that of schizophrenia can be overwhelming tasks with challenges involved during the care giving. The stress experienced by caregiver can be particularly damaging, to one's own health or, as well leaves one vulnerable to a wide range of physical and emotional problems like depression. Caregiving in itself bring with it the many stressors of changes in the family dynamic, household disruption, financial pressure, and the added workload. Several studies emphasized negative symptoms of the patients and inadequate social support of the caregivers as major factors for burnout [1](Dyck 1999, Gulseren 2010). Caregivers can experience psychological problems, such as anxiety and depression [2](Gibbons et al., 1984, [3]Olridge and Hughes, 1992; [1]Dyck et al., 1999; [4]Pitschel-Walz et al., 2001). Additionally, some researchers investigated family problems, and the emotions and needs of caregivers in schizophrenia, and conducted supportive and psychoeducational group studies [5](Sayıl et al., 1984; Unluo lu, 1994; Soygur et al., 1998; Gulseren et al., 1999b).

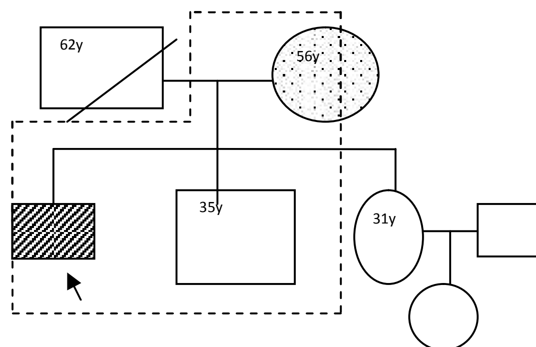
The chronic stress and burnout can be addressed through social rehabilitation of the patient as well addressing the needs of the family. Rehabilitation efforts that aim at helping the individual a)acquire skills and living and working environments that are compensatory and b) adjust to the level of functioning that is realistically attainable can be successful in dealing with the stress experienced by the caregivers. The loss of social and role functioning as a result of illness can be sustained through the goals of rehabilitation. The assumption of clinical rehabilitation is that by changing psychiatrically disabled person's skills and or support in their immediate environment, they will be more able to perform those activities necessary to function in specific roles of their choice.

## BRIEF CLINICAL HISTORY

Mr. A is a 38 years old unmarried male from a Hindu background who has completed his graduation and is currently unemployed. He comes from low socioeconomic status and lives in Bangalore. He was under treatment in NIMHANS since 15 years and was maintaining well with medications with fluctuating course. However, he had relapse despite being on treatment and was admitted in NIMHANS with complaints of delusion of persecution, delusion of reference, grandiose delusions and disturbed sleep. He had stopped going for his work since six months from the date of admission.
The patient was referred for psychosocial intervention and rehabilitation.

**Family History:**Patient comes from a nuclear family consisting of three members presently. He was born of a non-consanguineous union and there is significant family history of psychiatric disorder in mother.

**Family Composition**



**Father:** He was 62 years old when he died.
**Mother:** She is 56 years old, a housewife who is having psychiatric illness and is currently undergoing treatment in NIMHANS. She is maintaining well.
**First sibling:** Patient himself.
**Second sibling:** He is 35 years old and educated up to XIIth standard. He is working in a company and earns around 2000 rupees per month. He is introvert in nature and is taking the whole responsibility of the family. He feels providing care for the patient and mother was his exclusive responsibility.
**Third sibling:** She is 31years old and has not completed her matriculation. She is married and supportive to the patient and family. She is not involved much in caregiving of the patient and mother.

**Family Interaction Patterns**
The interaction between family members was cordial and each member was supportive to each other. However, after the illness of the patient the interaction with the brother was strained. Since mother is also suffering from mental illness there is very minimal interaction with the patient and other siblings.
**Family Dynamic**
**Boundary**: Boundaries are closed and rigid.
**Allignment:** No alignments are seen in the family.
**Family developmental Stage**: The family is in the seventh stage of the family life cycle (Duvall 1977) –middle aged parents.
**Leadership patterns and decision making**: - Father was the nominal and functional leader of the family initially. But after the death of the father and patient's illness, the brother has the sole responsibility towards the family and decisions are taken individually by him.

**Role Structure and Functioning**
Mother does the household chores for the family as there is no female member in the family. Though she is ill she is maintaining well with medications and is functioning well. Patient's brother has the multiple roles to fulfill. He has the responsibility to look after the family having two sick persons and also to help them financially. He has a role strain as he is only the healthy member in the family. The burden of caregiving was expressed by the brother and as the family has lack of control over resources and support, alternate care for treatment was needed to support the patient.

**Communication**
Communications between family members were poor before and after the onset of patient's illness. Communication of feelings was lacking and there was no sharing of opinion between the members..

**Reinforcement**
There was lack of reinforcement followed in the family.
**Cohesiveness**
The development of cohesiveness in the family seems to be unhealthy due to early onset of illness in mother and patient.
**Family rituals**: Family rituals are absent.
**Social Support System**: Primary social support is inadequate in terms of emotional support. Secondary support is not available to the family from friends or relatives. Tertiary support from NIMHANS is being extended through treatment and other facilities.
**Adaptive Pattern:** Maladaptive coping pattern is adapted by the brother. He used to suppress his emotions within himself as both members of the family are not approachable.

**Personal History**
The patient had a full term normal delivery in hospital. His milestone development was normal with good health during childhood. Patient started schooling at the age of 5yrs and was an average student. He has completed his graduation. His relationships with peers and teachers were cordial. He was working in different companies as in none of the companies he was able to give his full effort. He did not have the ability to take up gainful employment and fulfill the responsibilities expected from him.

**Premorbid Personality**
Premorbidly, patient was well adjusted and was calm and easygoing in nature. He was ambitious to take up a good job. He had few circle of friends and was able to make and sustain relationships with others. Patient was moderately god fearing and morally has adequate standards. Patient was not much interested in any activities except his reading books.

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**Social Diagnosis**

Mr. A 38 years old male, educated up to BA first among the three siblings born of an non-consanguineous union hailing from a nuclear family of low socio economic status with significant family history of psychiatric illness in mother (paranoid schizophrenia) having a nil significant personal history with well adjusted premorbid personality presented with a history of 15 yrs duration characterized by auditory hallucinations, delusion of persecution, delusion of reference, grandiose delusions, reduced interest in work and disturbances in sleep. He was diagnosed with Paranoid Schizophrenia in NIMHANS.

A social analysis reveals that the patient was well adjusted premorbidly and was responsible person. His interpersonal relationships were good because of his calm nature. He was ambitious and even after the onset of illness he was interested to do job. He continued doing small jobs as he was unable to maintain the demands required by the company.

In the patient's case the genetic loading of psychiatric illness was a risk factor to the illness. The progressive deterioration of the illness may be the fact that ongoing stresses of poverty in the family with its day to day demands of adjustment to one's illness as well as mother's illness pose a challenge for the patient as well his family. Brother's occupation was the only source of income for the family. The burden of physical care bestowed upon him is overwhelming to the extent he has to compromise with his own needs and priorities. Though medications were continued by the patient with a good understanding about the illness, still high amount of criticality seemed to be present from the brother. This may be because he was overwhelmed with the amount of caregiving responsibilities demanded by the family. These expressed emotions of criticality and hostility were major maintaining factors of the patient's illness.

**PSYCHOSOCIAL FACTORS**

- Mother's mental illness
- Role confusion and role strain in brother
- Family burden
- Poor support system
- Caregivers burnout
- Unemployment of patient

**GOALS OF INTERVENTIONS**

**At individual level**

- To enhance social skills
- To build motivation for work

**At family level**

- To give supportive counseling to brother
- To address caregivers burnout
- To develop knowledge about patient illness
- To facilitate future rehabilitation, if required

**Types of Interventions**

- Pyschoeducation
- Social skill training
- Vocational guidance and rehabilitation
- Supportive counseling to the brother

**COURSE OF THERAPY**

The patient was brought to NIMHANS when he was symptomatic. He was treated with medication and when symptoms were improving he was referred for psychosocial interventions. The first step initiated in intervention was establishing and building rapport with the patient. Initially patient's brother was reluctant to come and see the patient in the ward. He was with fear and was over burdened to take the patient back at home. However, the therapist succeeded remarkably in her attempt to make him visit the hospital and help in the treatment process which ultimately made interventions possible.

**PSYCHO EDUCATION**

Patient's brother though had knowledge about patients illness he was still critical and hostile towards him. It was explained how such emotions can be triggering factors for the patient's illness. His expectations were addressed and suggested that they

should reduce their expectations to some extent and be supportive with whatever amount he was able to be productive. The course and prognosis of the illness were also discussed. An insight into the patient's behavior was also given and importance of family support explained.

**SOCIAL SKILLS TRAINING**

**Importance of Social Skill Training for Chronic Mental Patients**

Research data has suggested that social skills training might help to remediate deficits in areas of functioning that are important for successful tenure in the community. Moreover, since tension and stress within family has been found to be powerfully predict relapse in schizophrenia and depressed patients (Hooley,1985), it would appear reasonable to try to improve the communication and problem solving skills of patients and their relatives.

As the patient had difficulty in maintaining a job for a long time and had poor communications with other members of the family deficits in social skills are evident. This inability to communicate their feelings in it is a prognostic factor for relapse and rehospitalisation for the chronically mentally ill patient. As improvement in social skills will allow pursuing their interest effectively and living a more rewarding life, the therapist planned to give social skills training within the ward. He was asked to do routine activities in the ward and help the staff. He was encouraged to communicate his feelings and interests to the staff and interact with others. This helped the patient to remediate his deficits in areas of functioning.

**Vocational Guidance and Social Rehabilitation**

Based on the previous vocational history from the patient and the family, the patient was initially engage in an activity schedule as part of behavioral management for routine work activity. He was constantly motivated while engaging into daily activity during his stay in the hospital. His interpersonal and social skills were developed through role plays and communication skills training. Besides this, the most important need for people suffering from schizophrenia is that of rehabilitation. On explaining the importance of rehabilitation, the patient was willing to go in for rehabilitation if required in the future. Hence, brother was provided with address of Richmond fellowship society and MIND center. For this, the Psychiatric Social Worker contacted the authorities from the centers and future hope was given to the patient and the family.

**Supportive Counseling to the Brother**

Patient's brother was overwhelmed with the patient's illness and also in the care giving of the mother. Being the single healthy person in the family he was going through care givers burn out as he had to play multiple roles complementary to the roles expected from the other family members. He was allowed to ventilate his pent up feelings and emotions. He was also sharing his inner feelings about his responsibility towards his family. The unrealistic expectation over caregiving was revised to an extent that was less critical to his guilt feeling. Further suggestions were given to share the responsibilities with sister and express his needs over the concerns of his family. Since he was overwhelmed by the amount of care giving he was expressing himself to place the patient for rehabilitation. As patient's current conditions seemed to be better it was suggested that patient would be placed back to the family and in the meanwhile, the Psychiatric social Worker tried to look for his further rehabilitation needs and placement. He was empathized and reassured of the patient's improvement in terms of his productivity if sufficient family and community support is extended to him.

**Pre-Discharge Counseling**

Prior to discharge, both patient and brother were counseled about patient's illness, need for supportive family environment, the chronic nature of patient's disorder, emphasis on medication adherence and regular follow up to Out Patient Department was advised. At the time of discharge patient's brother was willing to keep the patient at home and if still there was no improvement in his functioning, to place him in rehabilitation center during the next follow up.

**OUTCOME**

**At individual level:** Patient's confidence and self esteem was built**.** He had better understanding of his symptoms and illness and was able to perceive things in a more realistic way. He was motivated to engage in gainful employment.

**At family level:** Family had a better understanding about the patient's illness and was less critical and hostile towards the patient. Family was more supportive to the patient and caregiving stress was reduced to an extent with the support provided by the psychiatric Social Worker.

The patient was having regular follow ups and there was improvement in him. After discharge he was working as sales person in a small company. He was highly appreciated by the therapist and further motivated to continue with his job.

**Future plan:** To continue with vocational guidance and support to the patient. To help in rehabilitation if required. To continue with the therapeutic relationship with the caregiver and patient and to engage other primary support system (sister) for the family.

## CONCLUSION

In order to decrease the burden of care in schizophrenia it is recommended that effective management of patient symptoms, enhancement of patient social functioning, interventions that target caregivers with high levels anxiety and depression, and social support should be provided by healthcare professionals. Professional support and building social support network with relatives and other agency support can be crucial in enhancing the emotional well being of caregivers of persons with schizophrenia.

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