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How deinstitutionalisation and the current public mental health system affects individuals with schizophrenia:

Four case reports

Ms Lisa Hardman
BA. BSc(Hons)

A thesis submitted in partial fulfilment of the requirements of the degree of
Doctor of Psychology (Clinical)
School of Psychology
October, 2000
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OVERVIEW

The professional component of this thesis focuses on how deinstitutionalisation and the current public mental health system have affected individuals with schizophrenia. Chapter one discusses the process of deinstitutionalisation and the research that has examined the impact of this initiative. Chapter two concentrates on schizophrenia, specifically the symptoms, course, etiological theories and treatments of this illness. Four case studies are then provided in order to explore how deinstitutionalisation and the current mental health system have affected individuals with schizophrenia. The names and identifying characteristics of these clients and their families have been modified to ensure anonymity. Chapter three describes a 47 year old woman, AA, who was referred for a neuropsychological assessment. Chapter four outlines the second case study, a 23 year old male, BB, who was referred for a psychological assessment regarding diagnosis and treatment recommendations. Chapter five describes the third case study, a 54 year old woman, CC, who was referred for therapy and consultation regarding future treatment recommendations. Chapter six discusses the fourth case study, a 21 year old male, DD, who was seen for crisis intervention and treated in the community. Each of these case studies outlines the background history, formulation and treatment approaches. These case reports are used to illustrate how deinstitutionalisation and the present public mental health system affect individuals with schizophrenia. Chapter seven provides an overall discussion and conclusion to these case studies.
CHAPTER ONE
DEINSTITUTIONALISATION

Introduction

Deinstitutionalisation in the mental health context refers to a government initiative developed to decrease hospitalised care and increase community-supported living for clients with mental illnesses. This initiative emerged about 40 years ago during a period of dissatisfaction with the conditions and effects of public mental hospitals. This trend towards community-based management is evident throughout developed countries, but Australia, which currently uses less than 50 beds for people with mental illnesses per 100,000 population, is the leading nation in this regard (Sumich, Andrews & Hunt, 1995). This chapter outlines the philosophies underlying deinstitutionalisation and discusses the research that has examined the effects of this initiative on clients with mental illnesses, their families and the general community.

The deinstitutionalisation initiative was based on several assumptions. Firstly, it was assumed that mentally ill individuals fare better being treated in the community with brief hospital admissions as required. Secondly, it was thought that the longer a person was institutionalised, the more likely they would be permanently disabled (see Brown, 1985). Also, it was believed that people with mental illnesses should be integrated into typical neighbourhoods, work environments and community settings in order to create a more normalised living environment where they could experience opportunities for personal growth and fulfilment. The assumptions underlying deinstitutionalisation are reflected in the
current Australian *Mental Health Act* (1986), “wherever possible, people with a mental disorder should be treated in the community and that the provision of treatment and care should be designed to assist people with a mental disorder to live, work and participate in the community” (Mental Health Act, 1986, Section 6a).

In addition to these philosophical assumptions, there was also a financial rationale that precipitated the process of deinstitutionalisation. Several researchers revealed that the cost of alternative community care, such as community residential programs was less than state hospital costs, when measured in terms of the cost per hour of direct care staff time (see Brown, 1985; Conroy & Bradley, 1985; Kicsler & Sibulkin, 1987). These findings were based on the fact that amalgamating services saved on costs of administration, and that alternative carers were cheaper to employ than nurses. However, more recent research has found wide variations in the annual cost of facilities. For example, Korman and Glennerster (1990) noted that more humane, intensive care costs more, regardless of location. In order to accurately measure the financial benefits or losses of deinstitutionalisation, the number and variety of services that are involved to meet the needs of mentally ill individuals living in the community need to be considered.

Deinstitutionalisation also resulted from the effectiveness of anti-psychotic medications. Prior to the introduction of anti-psychotic medication, schizophrenia was seen as an irreversible, chronic, or progressive illness which lead to severe impairments in social and cognitive functioning (see Hegarty, Baldessarini, Tohen, Watermaux & Oepen, 1994). Anti-psychotic medications helped to change the way serious mental illness was viewed as they controlled and eliminated psychotic symptoms, enabling patients to be discharged from institutions and treated within the community for the first time.
Deinstitutionalisation brought about many changes in the way in which the public mental health system in Australia operates. As a consequence of deinstitutionalisation, psychiatric hospitals are currently used as short-term, acute-care facilities. Elements of the public adult mental health system in Victoria have broadened and include: crisis assessment and treatment services; mobile support and treatment services; community mental health centres, continuing care, clinical and consultancy services; acute inpatient services; residential and nonresidential rehabilitation services; and residential and nonresidential disability support services. In addition to these, other community services that assist individuals with a mental illness include housing, income support, general health care, emergency services, and family education/support.

Deinstitutionalisation has had a significant effect on individuals with mental illnesses, their families and caretakers, and the general community. The research literature that relates to each of these areas is discussed below.

The effects of deinstitutionalisation on individuals with mental illnesses

The majority of deinstitutionalisation research examined the effect of removing mentally ill individuals from large institutions to smaller, community-based, residential units. Overall, comprehensive, community-based treatment, which may involve brief hospital admissions for acute periods, have been shown to be at least equal to or more beneficial than long-term, hospital admissions for mentally-ill individuals (see Braun et al., 1981; Kopelowicz & Liberman, 1998; O'Donnell, 1991).

Kiesler and Sibulkin (1987) reviewed 14 studies that randomly assigned mentally ill individuals to either hospital or alternative (community) treatments. They concluded that alternative care was more effective than hospital treatment. Specifically, alternative care was
found to reduce individuals' degree of psychopathology and dependency, whilst increasing their level of social and behavioural skills, their prospects of subsequent employment, and their independent living skills.

Harding, Brooks, Takamaru, Strauss and Breier (1987) conducted a long-term, follow-up study of 118 patients from Vermont State Hospital who met DSM-III criteria for schizophrenia and were chronically disabled. These patients were provided with a comprehensive rehabilitation program and discharged to the community during the mid-to-late 1950s in a planned deinstitutionalisation program. Although the outcomes were variable, one-half to two-thirds of the sample had achieved considerable improvement or recovered after being discharged to the community.

In 1990, Korman and Glennerster examined the fate of the 800 former residents of Darenth Park, the first large long-stay hospital closure in Britain. Their findings suggested that community units were feasible alternatives to hospital care. Deinstitutionalisation increased skills such as feeding, washing, dressing and appropriate social behaviour.

The Team for the Assessment of Psychiatric Services (TAPS) project (see Leff, Trieman & Gooch, 1996; Leff & Trieman, 2000; Trieman, Leff & Glover, 1999) compared the quality of life of patients in two London hospitals that were closing with that in the community houses to which they were discharged. Five hundred and twenty three discharged patients were followed up after one year in the community and again at five years. The results indicated that the patients' clinical state and social-behavioural problems did not change. However, these patients gained domestic and community living skills. They also made more friends and confidants. The patients were living under much freer conditions and
the great majority (80%) wished to remain in their community homes. The authors noted that these results are only generalisable to well-planned and well-resourced discharge programs.

A parallel study in the field of intellectual disability (Dunt & Cummins, 1990) revealed that after relocation, individuals increased their capacity for self-care and positive social interactions. However, no changes were observed in their degree of negative social behaviour, idiosyncratic or stereotyped behaviour, or physical health. Relocation resulted in the residents experiencing a more varied life-routine, a more extensive range of social activities, as well as somewhat greater contact with their families and the general community (Cummins & Dunt, 1990). At four-year follow-up, a more normalised life-style continued, patients’ variation in daily routines increased, and more community interaction and greater parental involvement was observed (Cummins, Polzin & Theobald, 1990).

Overall, the above research findings generally support the process of deinstitutionalisation. However, there are a number of possible reasons why these improvements were observed. Dunt and Cummins (1990) suggested that the requirements of normalisation might have led to these adaptive responses. For example, patients living in the community were required and expected to care for themselves, whereas in hospital they were excused from these responsibilities, as part of their sick-role. While community units seem to facilitate appropriate changes in clients, it is not clear how much these changes should be attributed to the location of the treatment. Other factors, such as level of staff and physical resources, training and support, educative and rehabilitative services, commitment to philosophy of care, and client mix also need to be considered.

While the majority of studies have compared individuals pre- and post-discharge from institutions, few studies have directly examined the effects of deinstitutionalisation on
the individuals who remain in the hospitals being downsized. Stancliffe and Hayden (1998) addressed this issue and found that downsizing of institutions was not associated with most outcomes, including adaptive behaviour. Although per person expenditure increased substantially, the availability of therapy services fell over time and individuals experienced many residential and day program moves within the institution. Stancliffe and Hayden (1998) concluded that the combination of no change and rapidly rising expenditure provides strong support for deinstitutionalisation.

Several researchers have noted that deinstitutionalisation works best for patients who respond well to medication, and are able to return to homes, jobs and families, whereas long-term hospitalisation may remain the best treatment for chronically-ill patients (e.g., Bachrach & Lamb, 1989; Iodice & Wodarski, 1987; Mills & Cummins, 1982; Shadish, Lurigio & Lewis, 1989). The majority of chronically ill patients require a highly structured and controlled environment that provides basic needs, such as food, shelter, social contact and medical treatment.

As a result of deinstitutionalisation, most of the chronic mentally ill clients have simply moved from large state psychiatric hospitals to other institutions such as nursing homes, or to settings that are characterised by poverty, stigma and social isolation. A longitudinal study of 313 ex-state institutionalised mental patients in Chicago found that these individuals were predominantly poor, unemployed and on welfare (Lurigio & Lewis, 1989). Herman and Smith (1989) also interviewed 139 formerly institutionalised patients. Ninety three percent of the ex-patients noted that poverty was a problem, 89% of the respondents complained about the quality of care they received in aftercare facilities, especially in regard to food, space and general living conditions, and 78% stated that finding
a job was impossible. Belcher (1991) noted that mentally ill clients who have become homeless are frequently so thought-disordered and out of touch with reality that they are not aware of where they have been or where they are going. Their cognitive disturbances hinder their ability to collect social security payments and to manage money. It appears that more research is called for to gain a full understanding of the effects of deinstitutionalisation on mentally ill individuals and to determine which clients benefit from community treatment and which require institutionalised care.

**Effects of deinstitutionalisation on families and caretakers**

Prior to deinstitutionalisation, state mental hospitals provided care to most individuals with severe mental illnesses and families were largely relieved of the ongoing responsibility. However, with deinstitutionalisation, families have re-emerged as a major source of care giving. Gralnick (1985 p.8) noted that “all mentally ill, and particularly the severely so, are very difficult to manage even under the best of hospital conditions. They are difficult to treat even in a family that is loving and willing to try.”

Deinstitutionalisation has returned the burden of care for mentally ill individuals onto their families. Approximately 38% of mentally ill patients in the US are entirely financially dependent upon their families (Lurigio & Lewis, 1989; Thompson & Doll, 1982). Furthermore, there is considerable emotional and psychological stress placed on family members living with a mentally ill relative. Family members endure their own anxiety, anger, fear and frustration while caring for their mentally ill relative. Doll (1986) interviewed 125 families caring for a relative with a mental illness. He found that the patient’s presence, especially when severe psychotic symptoms persist, often placed a heavy emotional, financial, and social stress on these families. Anderson and Lynch (1984) also found that as
interaction increased between family members and the mentally ill relative, family opportunities were more limited, a greater negative attitude toward the mentally ill relative was observed, and the family experienced less social support.

Cummins and Dunt (1990), in a Melbourne study in the intellectual disability area, found that parental attitudes to community residential units were mainly positive. However, parental concerns included: concern that the community-based system was unstable and impermanent; concern that the quality of service in the community-based system would be diminished; that inadequate supervision may lead to their relative being exploited, or at least fail to protect their relative’s safety and health; doubts as to their ability to cope with their relative in the community or at home; and that their relative had no potential for further educational or psychological development. It is likely that carers of individuals with a mental illness have similar concerns.

Effects of deinstitutionalisation on the general community

The effects of deinstitutionalisation on the general community may be categorised into three broad areas: homelessness, criminalisation and the community’s responses. The research examining each of these areas is examined below.

Homelessness

Beginning in 1970s, there has been a significant increase in the number of homeless mentally ill individuals that has resulted, at least partially, from deinstitutionalisation (Bachrach, 1990; Benson, 1994). Johnson (1990) noted that when deinstitutionalisation first began, 65% of discharged mentally ill individuals had families and homes to go to. However, at least 20-25% wound up on their own. She stated that community based services were not
sufficiently in place at the time when the state hospitals began to discharge patients to the community. In addition, Belcher (1991) conducted a six-month follow-up study of 132 former patients of a state psychiatric hospital. He found that 36% of these 132 subjects became homeless during the six months following discharge.

Brown (1985) estimated that approximately 50% of homeless people in New York were ex-patients. Many individuals with mental illnesses have simply moved from mental health facilities to welfare facilities. Therefore, cost shifting occurred: the mental health services reduced their costs whilst the welfare system expenses increased. A Melbourne study of 382 homeless individuals revealed that over half the people interviewed were diagnosed as having a mental illness at the time of interview (Herrman et al., 1988). Additionally, a high proportion of these was diagnosed with more than one disorder, usually a combination of alcohol dependence/abuse and a psychotic or mood disorder. Herrman et al. (1988) concluded that the proportion of mentally ill individuals who were homeless was much higher in comparison to the general population.

In addition, homeless individuals are usually transient in pursuit of stable accommodation whereas mental health services are delivered according to geographical regions. Consequently, these clients may fall through the gaps in the system. Lurigio and Lewis (1989) found that 42% of ex-state patients with a mental illness had moved at least once during a six-month period. They also noted that over 30% of their sample “worried a great deal about a place to stay” (p. 85).
Criminalisation

Deinstitutionalisation has resulted in the criminalisation of a subgroup of mentally ill individuals. Kanter (1989) estimated that approximately 6-10% of people incarcerated in US state correctional facilities suffered from serious mental illness. Lurigio and Lewis (1989) noted that mentally ill individuals commit crimes for a variety of reasons. These include crimes that are direct consequences of their illness, crimes that are committed for survival purposes, and crimes in which the mental illness appeared to be secondary.

Community responses

Deinstitutionalisation has brought individuals with mental illnesses in closer proximity with the general public than ever before, thus increasing social fears and hostility towards these individuals. Brown (1985) noted that of twenty-one disability groups, mentally ill persons were the least preferred, even when compared with ex-convicts and alcoholics. Neighbourhood residents often feel that individuals with mental illnesses are intrusive, dangerous, that they make the neighbourhood less pleasant an environment, and that they diminish property values (Brown, 1985). Integrating individuals with a mental illness in the community may increase the community’s awareness and knowledge of mental illnesses, and in time, the stigma surrounding mental illness may diminish.

Summary

In summary, deinstitutionalisation has had an enormous impact on mentally ill individuals and their families. Clinical studies have revealed various beneficial outcomes for most patients with mental illnesses living in the community. However, several researchers suggest that an individual’s degree of chronicity, social skills, social support network, family
responses, and level of clinical, housing, and financial support must be considered when deciding whether or not community treatment will be beneficial for an individual with a mental illness. Deinstitutionalisation has also affected the wider community, by increasing the burden of care on families, and by influencing the rate of homelessness, criminal behaviour, and the ways in which the general community respond to individuals with mental illnesses. As this professional component addresses the effect of deinstitutionalisation on individuals with schizophrenia, the following chapter provides a brief overview of this illness.
CHAPTER TWO
SCHIZOPHRENIA

Prior to deinstitutionalisation, the great majority of mentally ill individuals who lived within institutionalised environments were diagnosed with schizophrenia. Schizophrenia is a serious mental illness that affects approximately one out of every hundred individuals (American Psychiatric Association, 1994). The following chapter provides a brief outline of the symptoms, course, etiological theories and treatments of schizophrenia.

Symptoms of schizophrenia

Schizophrenia is characterised by symptoms such as delusions, hallucinations, disorganised speech, and grossly disorganised or catatonic behaviour (American Psychiatric Association, 1994). These are known as the positive symptoms of schizophrenia as they reflect excessive behaviours that are not found in normal situations. In addition, there are the negative symptoms of schizophrenia; the behaviours that are absent within normal populations. Examples of these include affective flattening, alogia or avolition (American Psychiatric Association, 1994). To be diagnosed with schizophrenia, two or more of these symptoms must be significantly present during a one-month period, continuous signs must persist for at least six months, and these symptoms must cause a marked disturbance in the individual's social relations, occupation, or self-care (American Psychiatric Association, 1994). Furthermore, these symptoms must not result from a mood disorder, a substance abuse disorder, a general medical condition, or another pervasive developmental disorder (American Psychiatric Association, 1994).
Course of schizophrenia

The age of onset for schizophrenia is typically between the late teens and mid-30s (American Psychiatric Association, 1994). It is equally common in men and women, and equally common in all races (Coleman & Gillberg, 1996; Thorton & Seeman, 1991). However, gender differences are observed in the course of schizophrenia. Men tend to develop this illness earlier than women, with a peak risk around 20 years of age, whereas women have a peak risk around 30 years. In addition, the positive symptoms occur more frequently in women, while the negative symptoms are more common in men (American Psychiatric Association, 1994; Coleman & Gillberg, 1996; Thorton & Seeman, 1991).

The majority of individuals with schizophrenia display acute exacerbations with residual impairment, whilst others remain chronically ill. Full remissions are rare. Herz, Keith and Docherty (1990) estimated that approximately 50% of patients with schizophrenia have favourable end states with little or no evidence of symptoms. However, approximately 10% of patients fail to respond to currently available treatments and continue to remain psychotic with moderate to severe personal and social disabilities through the duration of their illness. Kopelowicz and Liberman (1998) noted that the proportion of individuals who do not respond to treatment is gradually decreasing following the introduction of atypical anti-psychotic medication.

Etiology of schizophrenia

Genetics, the environment, structural brain abnormalities, functional changes in the activity of brain regions, viral infections, and the neurotransmitters dopamine and serotonin, have all been associated with schizophrenia. The following sections briefly discuss the role of each of these factors consequencefully.
Genetic factors

It is generally accepted that a biological predisposition to schizophrenia is necessary in order to develop this disorder. The likelihood that a person who has a first-degree biological relative with schizophrenia will develop schizophrenia is about 10%; this compares to a 1% risk of schizophrenia in the general population (American Psychiatric Association, 1994; Moises, 1995). Family, twin and adoption studies have shown that genetic factors significantly add to the risk of schizophrenia. It has been estimated that the concordance rates of schizophrenia are 44% if the twins are monozygotic and 9% if they are dizygotic (Gleitman, 1991). Adoption studies have revealed that biological relatives of individuals with schizophrenia have an increased risk for schizophrenia, whereas adoptive relatives have no increased risk (American Psychiatric Association, 1994; Moises, 1995). In addition, twins who are reared apart are equally at risk of developing schizophrenia as twins living together. Consequently, it appears to be the biological rather than the sociocultural heritage that determines an individual’s risk of developing schizophrenia (Thornton & Seeman, 1991).

Although the importance of a genetic predisposition has been established, the actual gene or genes responsible for schizophrenia is yet to be determined. It seems unlikely that schizophrenia is caused by a single major gene (Bebbington, Walsch & Murray, 1993; Straube & Oades, 1992). Rather, either several major genes may be involved (oligogenic model), or many minor genes may interact with environmental factors (polygenic multifactorial model) to produce this disorder (Bebbington et al., 1993; Coleman & Gillberg, 1996; Straube & Oades, 1992; Thornton & Seeman, 1991). Bebbington et al. (1993) suggested that genetic factors appear to be more important in female than male patients. They reported
that the relatives of female patients with schizophrenia have a higher risk of developing schizophrenia than the relatives of male patients, and that the concordance rates for monozygotic twins are higher for females than for males.

Structural changes

Abnormalities have been observed in the structure of various brain regions in some patients with schizophrenia. Consistent findings reveal enlargement of the lateral and third ventricle in schizophrenic patients' brains, thus reducing total brain volume (Syvalahti, 1994; Taylor, 1995). However, Syvalahti (1994) noted that the degree of ventricular enlargement is relatively small, only occurs in 6-40% of all patients, and has also been observed in healthy, non-psychotic individuals. A decreased number of neurons and abnormal gross configurations have also been observed in the temporal lobe of two-thirds of schizophrenic patients (Taylor, 1995). However, these abnormalities are not exclusive to this disorder. For example, ventricular enlargement and diminished temporal lobe size have also been observed in patients with mood disorders (Syvalahti, 1994).

Additionally, post-mortem, magnetic resonance imaging (MRI), positron emission tomography (PET), and single photon emission computerised tomography (SPECT) studies have revealed that patients with schizophrenia have reduced neuronal density in the frontal lobe and in limbic structures (particularly the hippocampus and the amygdala), and increased neuronal density in the basal ganglia and thalamus (Ebmeimer, 1995; Syvalahti, 1994; Talamini, Louwerens, Sloof & Korf, 1995; Taylor, 1995). There is also evidence to suggest that ventricular size is not bimodally distributed in schizophrenic patients (Ebmeimer, 1995). Left-sided abnormalities are present in the majority of patients with schizophrenia,
while more widespread abnormalities result in more severe negative symptoms (Talamini et al., 1995). In sum, although there is considerable evidence regarding structural abnormalities in the brains of schizophrenic patients, several inconsistencies remain.

Functional changes

Functional imaging techniques such as electroencephalograms (EEG), studies of evoked potentials (EP), magnetoencephalography (MEG), PET, SPECT and nuclear magnetic resonance (NMR) have produced findings that some individuals with schizophrenia display abnormal functioning in specific brain regions. As above, although a large number of studies have been conducted, few of these have yielded consistent results (see Liddle, 1995). These contradictory findings may be due to differences in patients' behaviour and thoughts rather than differences in the disorder per se. Nevertheless, studies have revealed low relative glucose metabolism in frontal brain regions in states of rest, particularly in chronic schizophrenics, and increased cerebral blood flow in the left temporal lobe, especially in patients who have chronic hallucinations (Liddle, 1995; Syvalahti, 1994).

Viral infections

There is some evidence to suggest that schizophrenia is caused by a viral infection that develops prenatally and remains dormant until adolescence. This hypothesis is based on observations that there are more individuals with schizophrenia born during the winter months or during periods of viral epidemics, that individuals with schizophrenia are more likely to have mothers who were exposed to the influenza virus during pregnancy, that some viruses have clinical symptoms similar to schizophrenia, and that anti-psychotic medications have some anti-viral effects (Berquier & Ashton, 1991; Torrey, Bowler, Taylor &
Gottesman, 1994). At present, immunological studies have used small sample sizes and have produced inconsistent findings. Consequently, a specific virus that can account for the heterogeneity of symptoms seen in schizophrenia has not been conclusively identified.

The role of neurotransmitters

A number of neurotransmitters have been associated with the development of schizophrenia. At present, the Dopamine Hypothesis is one of the strongest etiological theories. This hypothesis suggests that an overactive dopaminergic system causes schizophrenia (Gleitman, 1991; Kahn & Davidson, 1995; Syvalahti, 1994). In particular, it proposes that disturbed function of central dopamine systems in the mesolimbic and mesocortical pathways are involved (Syvalahti, 1994). Adding to this basic hypothesis, Kahn and Davidson (1995) proposed that the negative symptoms and cognitive deficits apparent in patients with schizophrenia may be linked to decreased dopamine function in the prefrontal cortex, while positive symptoms may be related to increased dopamine in the striatum. Therefore, schizophrenia may result from both increased and decreased dopamine activity, possibly concurrently present in the same patient, albeit in distinct brain regions.

Most of the evidence supporting the dopamine hypothesis has come directly from pharmacological trials. For example, amphetamines increase dopamine activity and induce psychotic symptoms such as hallucinations and delusions (Syvalahti, 1994; Thorton & Sceman, 1991). Anti-psychotic drugs reduce the positive symptoms of schizophrenia by blocking the dopamine post-synaptic receptors. There is a positive correlation between the D2 dopamine receptor binding activity of anti-psychotic compounds and the observed therapeutic effect (Kahn & Davidson, 1995). This has been validated by PET studies
demonstrating that clinically effective anti-psychotic drugs occupy a significant share of D₂ receptors in the brain (Syvalahti, 1994). Furthermore, studies measuring plasma concentrations of dopamine’s metabolite HVA, have observed that anti-psychotics consistently decrease the amount of HVA in the brain (Kahn & Davidson, 1995). In sum, a decrease of dopamine activity appears to improve the symptoms of schizophrenia while an increase makes them worse.

The neurotransmitter serotonin has also been linked with schizophrenia. During the 1950s, the drug LSD (a serotonin antagonist) was found to have hallucinatory effects similar to that observed in schizophrenia (Iqbal & vanPragg, 1995). This led to the hypothesis that schizophrenia is related to an increase in serotonin levels. This hypothesis was supported by the therapeutic action of atypical anti-psychotics (e.g., Clozapine) on the negative symptoms of schizophrenia (Syvalahti, 1994). These drugs mainly affect the serotonin receptors, and to a lesser degree, the D₂ receptors (Meltzer, 1995).

However, the studies examining the role of serotonin in schizophrenia have provided mixed results (see Brown & vanPragg, 1991). Some studies established that neither increasing nor decreasing serotonin levels is therapeutic for individuals with schizophrenia (see Berquier & Ashton, 1991). Furthermore, drugs that solely affect serotonin levels do not significantly reduce the symptoms of schizophrenia (Syvalahti, 1994). The role of the dopaminergic system in the regulation of the serotonin system is unclear. A more sophisticated etiological hypothesis of schizophrenia needs to consider the role of dopamine and serotonin, and the complex interplay between these two neurotransmitter systems. In addition, the interactions between dopamine and serotonin with other neurotransmitters such
as noradrenaline, acetylcholine, GABA and glutamate, should provide a more integrated view of the etiology of schizophrenia (Syvalahti, 1994).

The two-syndrome hypothesis

Crow (1987) has proposed a two-syndrome hypothesis of schizophrenia (cited in Syvalahti, 1994). This hypothesis proposes that schizophrenia can be divided into two types of pathology: Type I and Type II. Type I consists primarily of the positive symptoms of schizophrenia and is thought to result from increased dopamine activities. This type should respond well to anti-psychotic medications. Type II is produced by structural brain abnormalities and leads to the negative symptoms of schizophrenia. These symptoms generally do not respond well to anti-psychotics and the course of this type of disorder is generally more chronic (Brown & van Praag, 1991). Patients with a predominant Type II syndrome also tend to display serotonin abnormalities and respond positively to drugs that primarily exert their influence on serotonin (Brown & van Praag, 1991). Therefore, dopamine seems to be associated with Type I schizophrenia, structural abnormalities and serotonin dysfunction appears to be more related to Type II schizophrenia.

Environmental factors

Although the above discussion highlights the importance of biological and neurological causes of schizophrenia, there is little doubt that environmental factors play an important role. The fact that there is less than 100% concordance between monozygotic twins suggests that the environment significantly affects the expression of this disorder. Certain factors may give rise to the symptoms of schizophrenia in individuals who are already biologically predisposed towards this disorder. These environmental factors may
include low socio-economic class, dysfunctional child-parent interactions, head injury, drugs, or poor nutrition (Berquier & Ashton, 1991; Goldstein, 1990; Thorton & Seeman, 1991). Other suggested factors may include a physical insult due to obstetric complication, and prenatal or perinatal difficulties (Bebbington et al., 1993; Thorton & Seeman, 1991). Future research is needed to investigate these factors and their causal relationship to schizophrenia.

**Treatment of schizophrenia**

In view of the many etiological hypotheses concerning schizophrenia and the heterogeneous symptoms of this disorder, it is not surprising that schizophrenia is one of the most complex disorders to treat. The following sections outline the pharmacological and psychological methods used in the treatment of schizophrenia. For specific treatment recommendations for individuals with schizophrenia the reader is referred to Lehman and Steinwachs (1998).

**Pharmacological treatment of schizophrenia**

Pharmacological treatment continues to be essential in the management of schizophrenia. Over 100 controlled studies have demonstrated that anti-psychotic medications are effective in decreasing the positive symptoms of schizophrenia in the majority of patients and may prevent relapse, symptom exacerbation and re-hospitalisations in remitted patients (see Kane, 1995; Sheitman, Kinon, Ridgeway & Lieberman, 1998). In many situations, these drugs are required to enable patients to participate in and benefit from other forms of treatment.
Pharmacological treatment of schizophrenia is essentially based on the dopamine hypothesis, in which a decrease of dopamine activity improves the symptoms of schizophrenia. Clinical improvements correlate strongly with the ability of anti-psychotics to block dopamine’s post-synaptic receptors. This dopamine blockade is more pronounced in some drugs than others and studies have shown that the stronger the blockade, the more therapeutic the drug (Syvalahti, 1994).

While the positive symptoms of schizophrenia usually respond well to anti-psychotic medications, the negative symptoms are generally less responsive to drug treatments (Kane, 1995). This has important implications relating to the gender differences in schizophrenia. Men usually present with the negative symptoms of schizophrenia that are less responsive to anti-psychotic medications. Consequently, men tend to have a poorer prognosis than women, and men’s symptoms are generally more difficult to treat (American Psychiatric Association, 1994; Coleman & Gillberg, 1996; Thorton & Seeman, 1991).

While the persistent negative symptoms of schizophrenia are generally unresponsive to anti-psychotic drug treatment, atypical anti-psychotic drugs that mainly affect the serotonin receptors tend to have a therapeutic effect on these negative symptoms. For example, Clozapine has superior effects over other drugs in treating patients who were previously unresponsive to anti-psychotic medications (DenBoer & Westenberg, 1995). In addition, Kahn and Davidson (1995) have suggested that simultaneously increased and decreased dopamine activity in various brain areas is involved. They proposed that increasing dopamine activity (in the prefrontal cortex) would also be effective in treating the negative symptoms of schizophrenia. Research is still needed to confirm this proposal.
Although we know how anti-psychotic drugs work, the regions of the brain that are most affected have not been established. Receptor studies suggest that anti-psychotics affect the D₃ and D₄ dopamine receptors, which are generally located in the limbic striatum and the prefrontal cortex, respectively (Talamini et al., 1995). Pharmacological studies reveal that atypical anti-psychotics affect the mesolimbic, but not the nigrostriatal dopaminergic systems (Talamini et al., 1995).

Currently, the drugs available to treat schizophrenia appear to be equal in terms of efficacy but are distinguished in terms of their side-effects (Schooler & Keith, 1990). Anti-psychotics may accentuate some symptoms of schizophrenia. For example, low-concentrated anti-psychotics tend to act like a sedative and so reinforce apathy, which already poses a problem for the patient (Thornton & Seeman, 1991). Some drugs that affect the noradrenaline and serotonin systems lead to sedation, anxiety reduction and decreased anger. Other side-effects include blurred vision, muscle stiffness, tremor, dystonias, akinesia and akatisias. These result from an interference with the balance of acetylcholine and dopamine. Careful control of the dose of anti-psychotics and the addition of other medications may prevent or reverse the appearance of these side-effects (Thornton & Seeman, 1991).

**Psychological treatment of schizophrenia**

Follow-up studies indicate that psychotherapy alone has little impact on the course of schizophrenia. Most psychotherapists use a mixture of anti-psychotic drugs, at least intermittently, and psychosocial management. The psychosocial management of patients with schizophrenia has included case-management, psychoanalytic interventions, behavioural skills training, family therapy, and group therapy.
Community facilities for people with schizophrenia are not always easy to coordinate, as these individuals make up a diverse and complex patient population. Chronic mentally ill patients differ in their diagnoses, their symptoms, their treatment histories, their residential histories and their levels of functioning (Bachrach, 1990). Therefore, a wide variety of community interventions, such as psychiatric, medical, social, rehabilitative, and vocational need to be coordinated. Ideally the objective of case management of these severely ill patients is to link them to an array of services, and to coordinate and integrate these services (Benson, 1994). In practice, however, case management includes a wide variety of responsibilities, which are based on the patient's needs. Assertive community case-management has been found to reduce psychiatric hospital use, to increase independent living, and to moderately improve symptoms and subjective quality of life (see Mueser & Bond, 2000).

The psychoanalytic approach suggests that the symptoms of schizophrenia arise from patient's early conflicts, which when unresolved, block normal psychological development (Katz & Gunderson, 1990). It is established that psychoanalytic therapy given to randomly assigned patients with schizophrenia is not preferred over other forms of treatment (Thornton & Seeman, 1991). Katz and Gunderson (1990) emphasised that when using psychoanalytic treatments the therapist should focus on certain aspects of the patient's psychopathology being addressed and the timing of the intervention during the course of the illness.

Behavioural skills training, based on modelling skills over a long period of time, may be useful to improve patient's executive behaviours, such as decision making, planning, emotional regulation and learning (Roder, Eckman, Brenner, Kienzle & Liberman, 1990). Several models of skills training and cognitive treatment have been designed and evaluated,
each of which have proved to be effective in elevating the patient’s social competence, helping patients gain insight into his/her problems and acquiring appropriate coping strategies (see Kopelowicz & Liberman, 1998; Roder et al., 1990). Most involve role-playing and problem-solving techniques. These provide the patient with general strategies for dealing with a variety of social situations and help to strengthen the patient’s abilities to perceive and process incoming social cues. These treatments improve social functioning in medication-responsive patients who are receiving medication. However, they are not useful in reducing the need for medication in these patients (Schooler & Keith, 1990), and have little effect on symptoms or relapses (Lehman, Carpenter, Goldman & Steinwachs, 1995; Mueser & Bond, 2000).

Cognitive rehabilitation and therapy for positive symptoms (i.e. hallucinations and delusions) have recently been used in the treatment of individuals with schizophrenia (e.g., Chadwick, Birchwood & Trower, 1996). There are many different cognitive techniques, each based on the premises that altering an individual’s thoughts, attitudes, perceptions, self-efficacy and information processing will have beneficial outcomes on symptoms and general degree of functioning. Kopelowicz and Liberman (1998) reviewed 15 studies that utilised procedures for uncovering and changing irrational, automatic thought patterns, negative self-appraisals and delusions. They concluded that the evidence is scanty due to methodological limitations, and consequently more research is called for.

Family Therapy is a highly promising approach to the community management of schizophrenia. It is based on a self-help model of stress management, which includes education about the disorder and behavioural rehabilitation strategies (Falloon, 1990). Results have consistently shown that family intervention has a significant impact on reducing
relapse rates and rehospitalisation of these patients, while simultaneously increasing benefits for care-givers (see Kopelowicz & Liberman, 1998; Lehman et al., 1995; Mueser, 1997; Mueser & Bond, 2000). Furthermore, some studies report that family therapy improves treatment outcome with lower doses of medication (see Schooler & Keith, 1990).

Malm (1990) provided support for using group therapy to improve verbal and emotional communication and to aid the development of adaptive social skills for patients with schizophrenia. Group therapy is most effective when used in combination with medication and when it is focused on social planning, practical problem solving, and social relations. Group therapy has been found to assist the transition from psychiatric care to independent living (Malm, 1990).

It is essential that any form of psychosocial treatment used to treat patients with schizophrenia is embedded in a comprehensive program of rehabilitation that features continuity of care, supportive community services, therapeutic relationships and prescription of anti-psychotic medications (Roder et al., 1990). It is also essential that the treatments used be appropriately linked to the phase of the person’s illness. For example, commencing social skills training during an acute phase of schizophrenia is likely to merely overwhelm clients whose cognition is impaired by psychotic phenomena. The aim of this rehabilitation is not to cure the patient of schizophrenia, but to enhance the patient’s functioning, level of adaptation and quality of life. With social, vocational, family and independent living skills, some patients with schizophrenia can obtain a reasonable quality of life in their community.

Summary

In summary, schizophrenia is a serious mental illness that affects individuals’ thought processes and behaviour. None of the proposed etiological hypotheses for schizophrenia
have gained general acceptance. A genetic vulnerability is probably necessary to develop schizophrenia, however, this vulnerability alone does not necessarily lead to the illness. Something more is required and at present it is unknown what these factors are. To successfully treat schizophrenia, anti-psychotic medications is a necessary component of treatment, however, it is not sufficient. If we are to improve the overall functioning, coping skills, and quality of life for individuals with schizophrenia, psychosocial treatment interventions are essential. Individuals with schizophrenia require an integrated service approach to treatment.

This argument is made all the more important since the advent of deinstitutionalisation. Prior to deinstitutionalisation, individuals with schizophrenia were treated in the one location. Within the institutions, pharmacological and various psychological treatments were provided. Currently, the majority of individuals with schizophrenia live in the community and attend community mental health clinics, general practitioners, private psychiatrists and / or psychologists. Additionally, they may require home-based care, for example, crisis management or continuing rehabilitation. Various aspects of the private and public mental health systems, and general community services need to work in a collaborative way to ensure continuity and consistency of care, and best possible practice. In the following four chapters, case studies of individuals with schizophrenia are provided to explore the ways in which deinstitutionalisation has affected their treatment.
CHAPTER THREE
CASE STUDY ONE

Background

Ms AA is a 47 year old woman with a long history of schizophrenia who is currently residing at the Continuing Care Units (CCU). The CCU is comprised of several units where clients with severe mental illnesses live and are rehabilitated. It provides staffing of psychiatric registrars, psychologists, psychiatric nurses, occupational therapists and social workers 24 hours a day. Her case manager referred AA for a neuro-psychological assessment to provide information relevant to her rehabilitation and future residential plans. AA’s case manager was in the process of arranging AA’s discharge from the CCU to an independent unit in the community with support from the Mobile Support and Treatment Team (MSTT). This team provides further rehabilitation and long-term support for individuals with chronic mental illnesses. They are able to see their clients in their own homes several times each week and operate between business hours from Monday to Saturday.

Relevant personal history

AA migrated to Australia from Italy at four years of age. Information regarding AA’s birth and development is unclear as AA’s father migrated to Australia prior to AA’s birth and AA’s mother died in 1976. AA attended Catholic primary and secondary schools in the inner-Melbourne area. During a telephone interview in June 1999, her older brother described AA as an intelligent child who learnt new skills, such as playing the piano faster than most children her age. He also reported that AA was popular with her peers and used to
socialise on weekends. Her brother stated that AA has always been a very compliant person, eager to please others and to avoid conflicts. AA reported that she both enjoyed and was good at the language subjects at school and that she was “average at maths.”

AA’s brother reported that AA discontinued school during her final year of high school due to a medical problem that related to her appendix, for which she spent 51 days in hospital. Her school granted her special exemption from sitting her final exams and certified that she passed matriculation. Following school, AA completed a secretarial course. She also attempted several office jobs, however, her family reported that she would often return home from work crying and then would not return to work. AA has been involved in a number of relationships including one that lasted between 1 and 2 years. However, she stated that she has not been in a relationship for the past 15 years.

Psychiatric history

There is no family psychiatric history reported. AA’s brother stated that AA began seeing doctors “for nerves” when she was 13 years old, however he could not elaborate on the nature or frequency of these visits. AA was diagnosed with Schizophrenia in 1978, at 25 years of age. Her brother first noticed significant changes in AA’s behaviour following their mother’s death in a motor car accident in 1976, in which AA had been a passenger. According to her brother, AA was unconscious following this accident for approximately two days and remained in hospital for about nine days. AA received no formal grief support or counselling after the accident. Initially, it was thought that AA was experiencing a prolonged grief episode as social withdrawal and depression was evident, however schizophrenia was later diagnosed.
Between January 1978 and October 1985, AA was hospitalised as a voluntary patient on 15 separate occasions in large institutions. During these times she presented with auditory hallucinations, delusions, bizarre behaviour, social withdrawal, and would be observed staring blankly into space. Although she denied hearing voices, she often appeared to be responding to internal stimuli. Her delusions would revolve around themes of devils and fire. Since 1985 she has had three further admissions presenting with residual symptoms, such as self-neglect, social withdrawal, giggling for no apparent reason and some disorganised behaviour. Between 1988 and 1994, AA was managed in the community while attending a local Community Mental Health Clinic. She was readmitted to a large institution in December 1994 for rehabilitation in view of her marked dependency on her family. She remained there until her relocation to the Community Care Unit in mid-1996.

**Current functioning**

Currently, AA resides at the Community Care Units and returns to her father and brother’s home on Saturdays for approximately five hours each week. AA’s father and brother are both very supportive of AA and are willing to provide assistance as required. AA’s brother reported that over the past five years, following treatment with Clozapine, AA has been gradually improving emotionally and mentally. Specifically, he stated that she is “quieter, more mellow, able to concentrate for longer periods of time, not as anxious, able to initiate conversation when making requests, and is able to immediately respond to questions.” He stated that AA’s main problem is her “lack of motivation,” and that “she has decided that life is not worth living.” AA’s brother also noted that while AA is home she usually spends the time alone relaxing, cooking and listening to music. Furthermore, he reported that although AA is able to care for herself adequately and without supervision, she
needs to be prompted to clean up after activities such as cooking. Her brother currently manages AA’s finances. He is unsure whether AA could handle her own financial affairs and stated that she is comfortable with the present financial arrangements.

AA’s case manager reported that generally AA can remember and initiate most things, such as housework, shopping, cooking, banking etc. without prompting. However, when AA is asked to do something new, out of her routine, or to stop doing something within her routine she needs to be reminded several times and despite this, she still often forgets. For example, AA began using a diary about six weeks ago and she still needs to be prompted to write appointments in her diary and to check her diary on most days. Her case manager is unsure whether this problem is related to AA’s motivation or memory.

AA’s case manager also reported that physically, AA is receiving treatment for urinary incontinence, iron deficiency and asthma. She is also on the waiting list for her gall bladder to be removed surgically due to Common Bile Duct Stones. AA has been taking Clozapine (150mg mane’ and 250mg nocte’) for the past five years. AA self-manages her medication and is usually compliant with her prescribed medication regime.

Clinical presentation

AA is a moderately obese woman whose weight has remained generally stable over the last three months. She presented as an extremely pleasant, polite, co-operative and compliant lady with whom rapport was readily established. She appeared oriented to time, person and place, seemed reasonably at ease, and did not appear anxious. AA stated that she spoke both English and Italian fluently and equally well. However, AA did not initiate conversation, generally spoke very little and tended not to elaborate on her answers to questions. Thus, it was difficult to obtain information regarding AA’s history directly from
her. Her affect appeared restricted and at times, she was observed to be laughing/smiling inappropriately in response to questions. It is unclear as to whether this was a response to internal stimuli or a reaction to the stress of the testing environment.

AA generally attended well to the given tasks and worked conscientiously. However, she tended to fatigue and her level of concentration appeared to decrease after approximately 45 minutes of formal testing. Although AA seemed motivated during the testing sessions, she needed prompting on several occasions to continue tasks. She also needed to be prompted to use her corrective reading glasses at the beginning of each testing session. When instructions became complex, AA would display some difficulty in remembering/following them and would again need prompting to initiate the tasks. AA tended to use appropriate cognitive strategies, such as speaking out loud and talking herself through problem solving tasks.

**Tests administered**

The following neuropsychological tests were used: Subtests of the Wechsler Intelligence Scale - III, Subtests of the Wechsler Memory Scale - I and Wechsler Memory Scale - III, Rey Auditory Verbal Learning Test (RAVLT), Rey Complex Figure, Controlled Oral Word Association Test, Trail Making Test, Clock Drawing Test, Subtests of the Wide Range Achievement Test - Revision 3, Neale Analysis of Reading Ability - Revised.

**Neuropsychological findings**

Neuropsychological assessment in June 1999 revealed that although AA attended well to routine tasks, significant impairments were noted in her executive functioning. These included difficulties with planning and organising complex information, initiating and monitoring her behaviour, difficulty in switching attention between different types of
information, and reduced ability to hold and manipulate information mentally in her working memory. Her speed of information processing was also significantly slowed.

Overall, AA's performances on intellectual measures fell within the borderline range. Her cognitive strength was her problem solving ability at visual, hands-on tasks, which fell within the low average range. She was concrete in her thinking style and she displayed difficulties with mathematical reasoning. AA demonstrated mild difficulties on a word generation task that appeared to be related to her executive dysfunction, such as her lowered ability to form appropriate word-finding strategies.

On tests of her memory functioning, AA's immediate recall of verbal (spoken) information was poor and she demonstrated considerable difficulty learning and retaining new information even when it was repeated several times. When presented with a list of simple words, AA found it easier to recall the first and last words on the list. Her retention of verbal information following a period of delay was also below the expected level. However, AA was able to recognise more verbal information than she could spontaneously recall. AA's acquisition of simple and complex visual information on single presentation was also relatively poor.

On screening of AA's educational skills, her reading of simple words fell at the upper- to post-high school level, and it was observed that she usually used appropriate decoding strategies to sound out words she did not know. However, when the reading tasks became more complex requiring her to read more than 3-4 sentences, her comprehension and ability to answer abstract questions about the reading passages was notably impaired. On written arithmetic tasks, she performed at a level expected of a student in Grade Three. AA was able to add and subtract one- and two-digit numbers, however impairments were noted
when the problems became more complex and when she was required to hold and manipulate numbers in her working memory.

**Provisional diagnoses**

**AXIS I:** 295.20 Schizophrenia Residual Type – Episodic with inter-episodic residual symptoms.

**AXIS II:** None

**AXIS III:** obesity, urinary incontinence, iron deficiency, asthma, and common bile duct stones

**AXIS IV:** death of a family member, inadequate social support, intellectual difficulties, change in living conditions.

**AXIS V:** GAF = 45 (on assessment).

**Summary and opinion**

Ms AA is a 47 year old woman with a 22 year history of schizophrenia. The onset of her illness appears to have been precipitated by a motor car accident in 1976, in which her mother died and AA incurred a head injury with possible loss of consciousness of two days duration. She has been taking Cloraril over the past five years during which time a gradual improvement in everyday functioning has been observed. She currently resides at a CCU.

On neuropsychological assessment in June, 1999, AA demonstrated significant impairments in executive functioning, working memory and processing speed. She performed within the borderline range of intellectual functioning, displaying a concrete thinking style and difficulties with mathematics. AA also demonstrated significant impairments in recent memory recall and learning new information, however her recognition of verbal information was better than her spontaneous recall. This means that she is able to
take in and store information presented to her, but she struggles to retrieve the information without prompting. As a result of this, she is likely to remember more information when prompted. Educationally, AA was able to read simple sentences, however, impairments in her reading and comprehension were noted when the reading passages became more complex and abstract. Her performance on written arithmetic tasks was at a Grade Three level.

These deficits are consistent with those associated with chronic schizophrenia. In addition, AA's prescribed medications may be contributing to her slowed processing speed. It does not appear likely that AA's head injury in 1976 had a significant impact on her cognition. However, it remains possible that she may have experienced some mild cognitive problems in the immediate period following the head injury. While AA has demonstrated specific cognitive and memory deficits relative to her apparent premorbid abilities, there is no evidence, at this stage, that her difficulties are related to a progressive neurological disorder, such as dementia.

AA can be assisted to manage her problems with her short-term memory by: reducing the amount of information provided at one time, keeping distractions to a minimum when having a conversation, discussing one issue at a time, frequent repetition of information and prompting, writing down important information and checking her recall of information. AA needs to be prompted over several weeks/months to incorporate new information into her routine. In view of her executive dysfunction, it is likely that AA will find it difficult to adapt to change and take on new routines. It is for these reasons that careful planning of AA's discharge is warranted. AA should begin learning new tasks/skills that will assist her in other forms of accommodation several months prior to being discharged from the CCU. For
example, AA will need to be taught skills such as safety procedures, new budgeting plans, and other general changes over a period of several months. This could be done with a large amount of repetition and role-playing. It is likely that AA will find it difficult to generalise these skills and therefore, she will need assistance in implementing her new routine while living in her new accommodation. Given AA’s problems with executive functioning and arithmetic, she will continue to require assistance with financial matters.

AA was observed to be highly compliant during the testing sessions. Her brother expressed concerns that this level of compliance may increase AA’s vulnerability when she is living in the general community, and therefore, potentially place her at risk of personal harm. AA’s brother and case manager indicated that she does not directly jeopardise her safety, for example, by leaving the gas on, but rather have expressed concerns that she may open the door and befriend strangers to avoid any form of conflict. She may also be financially at risk, as her brother reported that AA is an overly generous woman. As previously mentioned, the issue of AA’s safety needs to be explored and it is likely that she will require assistance to establish a safety routine.

Reflection

AA is an example of a client with a long history of psychiatric treatment for schizophrenia. She has spent the majority of her adult life living in institutions. These institutions were home to AA. They provided a structured environment where there were few surprises. The CCU also provided AA with a highly structured environment. For example, her daily activities, such as exercise and shopping were planned for her in a routine manner. Additionally, like the large institutions, the CCU facilitated social contact among the patients. AA shared her unit with another woman with schizophrenia. The CCU also
provided some level of protection from individuals who may take advantage of AA. Therefore, AA’s family were not as concerned about her level of vulnerability while she lived in the CCU.

The philosophy of deinstitutionalisation and the laws governing the present mental health care system suggest that AA should be treated in the least restrictive environment, preferably in the community. Therefore, the CCU staff’s goal was to rehabilitate AA in order for her to live in the community with supportive case management. Although this goal was legally appropriate, there may have been some discrepancy between AA’s goals and those of the staff. Due to AA’s eagerness to please others and reluctance to communicate her own opinions, AA’s goals were never entirely clear.

There are several factors that need to be considered when deciding whether or not an individual with schizophrenia is capable of living in the community and the level of care required for that particular individual. Decisions of this sort should always be assessed on an individual basis rather than administrative convenience. However, in the present system this is not always possible. Research has found that the psychology of the attending physician has a greater effect on a decision to hospitalise or release someone with a mental disorder than patient variables such as the severity of the disorder, the specific diagnosis, and the demographic characteristics of the patient (Kiesler & Sibulkin, 1987).

Salokangas (1991) suggested that a key factor in the decision to discharge mentally ill patients is their level of social capacity. If community placement is to benefit mentally ill individuals, they must possess a minimum level of social skills, be able to tolerate pressure, meet reasonable demands and have a comprehensive social system. Unfortunately, the majority of clients with chronic schizophrenia do not meet these criteria. One of the
unfortunate effects of institutionalisation is the constriction of social and interpersonal responses. As Kopelowicz and Liberman (1998) stated “the “good” patient in a custodial setting was quiet and unobtrusive” (p. 193). Through many years of institutionalised care, AA learned to be compliant and submissive. In order for AA to successfully live in the community, AA must have some social skills and assertiveness training. On discharge from the CCU, AA should feel confident in conducting basic tasks, such as catching public transport, asking for directions, shopping, and social conversations.

Secondly, discharge from institutions should not cause unreasonable inconvenience and stress to the relatives of the client. Whilst AA was living in the psychiatric institutions, her family were relieved of their caring duties. Being transferred from the CCU into the community, it is likely that AA’s family will take a more active role in her care. As AA has few relatives living in Australia, AA’s brother will have to provide care for AA and his father. This will increase AA’s brother’s burden of care, and appropriate supports for AA’s brother should be in place upon AA’s discharge from the CCU. AA’s family should be involved in AA’s discharge planning and be fully informed during this process.

Thirdly, the level at which those clients are able to generalise adaptive behaviours to different social environments needs to be considered when making clinical decisions regarding an individual’s capacity to live in the community. Many individuals with mental illnesses find it difficult to adapt learned skills and behaviour to new situations. The neuropsychological assessment noted that AA displayed significant difficulties with her executive functioning. The recommendations made in the neuropsychological report need to be incorporated into AA’s discharge plan.
In sum, if AA’s discharge from the CCU is carefully planned and implemented, it should be possible for AA to live in the community with the support of active case-management. Prior to her discharge, the treating team should attempt to meet the needs of both AA and her family. In terms of AA’s quality of life pre- and post-discharge, this is likely to be difficult to predict and measure, due to AA’s poverty of speech and level of compliance. The institution provided AA with a structured, safe and supported environment. In contrast, community-based care will give AA a more “normalised” life-style, with greater freedom and responsibility. Furthermore, AA will need to take more responsibility in managing her illness, both pharmacologically and psychologically. Financially, it would cost the government more to care for AA within the institutions and the CCU, as compared with the cost of living in the community. Upon discharge, AA’s family will need to take a more active role in AA’s financial and emotional well-being, which is likely to increase AA’s brother’s level of stress.

In conclusion, the case of AA demonstrates that there are many facets to consider when determining whether or not an individual with schizophrenia should be community or institutionally managed. Although clinical research and legal guidelines support the notion of community-based care, all clinical decisions should be based on an individual level, paying particular attention to the needs and wants of the client.
CHAPTER FOUR
CASE STUDY TWO

Background

BB is a 23 year old male who was referred in January 1999 by his psychiatrist from a public hospital inpatient service. His psychiatrist requested a psychological assessment to clarify BB's diagnosis and obtain recommendations regarding treatment strategies and management. Past differential diagnoses have included chronic paranoid schizophrenia, borderline personality traits, dependent personality traits, antisocial personality traits, and depressive mood.

The following account of BB's presenting problems and personal history was obtained through interviews with BB, his mother and his private clinical psychologist.

History of presenting problems

Over the past 6 to 8 months BB has been variously managed by the Crisis Assessment and Treatment Team (CATT), Community Mental Health Clinic (CMHC), and the Hospital In-patient Unit. His psychologist reported that over this time BB has been out of touch with reality, believing he was Jesus and that the world would end on 9/9/99. He reported to staff that he was experiencing auditory and visual hallucinations, including visions of Ghandi. His delusions were grandiose and religious. For example, he believed he was the prophet BB, and that he needed to fulfil a biblical event to rid the world of paedophiles, rapists, and killers. According to staff reports, no formal thought disorder was observed.
BB stated that he was hospitalised because he "was on a downer" and "felt shit". He noted that he was depressed because his relationship with his girlfriend had ended, and because he has Hepatitis C. He stated that he attempted suicide by heroin overdose twice. On one occasion he absconded from the hospital, went into the Melbourne CBD and tried to overdose using heroin. BB denied any current plans or intent to self-harm or suicide. He stated that he feels "lucky" that the attempted suicide was unsuccessful. BB also stated that if he ever had future thoughts about suicide he would not tell anyone about it.

BB stated that three months ago he had a "heroin-induced psychosis" in which he "lost the plot bad". He also stated that during this time he was smoking "pot" everyday. He began reading a book entitled "Heavens breath - Super Nature". He believed that this book was talking about him and making predictions about his life.

Currently, BB states that he gets messages from the television, which he finds difficult to understand. He believes that the TV channels change on their own. He stated that he has never heard voices, except that once, following drug use, he heard a deep laugh. BB believes he is a wizard and that he can communicate with the spiritual world. He talks about goannas and snakes visiting him. His mother stated that she found BB lying in the garden at night and that BB maintained that he was communicating with nature.

According to his mother, BB's personality changed at age 14 after he was involved in an accident in which he hit the back of his head and was unconscious for a period of time. She stated that his temper became more aggravated, and that he became more antisocial and rebellious.
Family history

BB last saw his father when he was 11 years old. According to his mother, BB's father has Schizophrenia and leads an itinerant lifestyle. She also reported that BB's paternal grandmother had schizophrenia and spent the majority of her life in psychiatric institutions. BB stated that he currently has no contact with his father's side of the family. BB also reported that his father was incarcerated for raping two or three women.

BB's mother stated that as an infant, she was given up by her mother, made a ward of the state, and grew up in foster care homes. BB described his mother as a "drama queen." BB reported that he had witnessed his father violently raping his mother at gunpoint in 1986. BB also stated that he had tried to hold the door to prevent his father from entering the premises. BB's mother stated that after the rape, BB and his brother were placed in foster care for appropriately six months.

BB's mother reported that her ex-husband (BB's stepfather) was intermittently physically violent towards her, BB and BB's brother between 1987 and 1992. She believes that there is currently a significant amount of conflict between her ex-husband and the boys. According to his mother, BB has a "heart of gold" and was the "protector of the family". She stated that during the domestic violence, BB did not want to leave home to attend school because he was scared the ex-husband would hurt her. Additionally, she reported that when her ex-husband was violent towards her, BB would climb out of the window at night and run to the police station to get help.

BB currently lives with his aunt, her partner, and their two children. He sees his mother every few days. BB feels closest to his sister who is a dental nurse. He describes her as "having her life together." BB believes that he does not resemble any of his family
members. However, his psychologist reported that BB and his brother are almost identical in every way. His mother also stated that BB sometimes says that he thinks he is like his father.

**Developmental history**

BB’s mother stated that when she was 8 months, 3 weeks pregnant with BB, she was in a motor car accident. Following the accident, the doctor thought that BB was dead as they were having difficulty finding a heart beat. BB was induced 3 weeks later during a 3 hour labour. BB was breast fed for 2 days and switched to formulas as his mother had Mastitis. BB’s mother stated that BB was a warm and cuddly baby, "always in her arms." She reported that BB crawled and walked at the appropriate developmental stages. There were no problems with toilet training. She also stated that BB’s speech was delayed and that he began reading sentences in Grade 3. BB’s mother reported that he was placed in foster care at three and a half years of age for approximately six months because his father was putting pressure on her to get the children adopted and she felt she could not cope. She believes that this time in foster care had negative effects on BB’s development. According to his mother, BB did not show any signs of separation anxiety during his early primary school years.

**Educational history**

BB completed his formal education at approximately 15 years of age. He enjoyed art, graphics and English subjects. However, he believes that he struggled with all of his classes. He stated that he realised that he was "dumb" in about Grade 4. His mother reported that BB "never had the ability to learn" and "struggled with school". BB attended 3 different primary schools due to changes in address. In Grade 6 he became involved in many physical fights with his peers. According to his mother, his teacher physically assaulted BB during that year. During Year 8 he attended a special school for learning difficulties and behavioural problems
for about six months. The nature of these learning difficulties is unclear and BB stated that he was never formally tested. BB reported that he had to repeat Year 9 because he "couldn't keep up with the work."

**Employment history**

After completing his formal education, BB stated that he worked as a panel beater for about 3 months and was fired because he had a "bad attitude". He then worked as an auto electrician for a few months and quit after he was accused of stealing. He later worked as a plasterer for one and a half to two years but had to stop due to a heroin habit. BB is currently receiving sickness benefits and working part-time as a builder's labourer.

**Social history**

BB reported that he had no friends during primary school and that he became involved in many physical fights. His mother reported that in Grade 6 BB's best friend moved overseas and was killed in a motor car accident. She stated that this friend was the only person at BB's school who did not laugh at him and tease him. During high school, BB mainly associated with people who used marijuana and "magic mushrooms." He does not regard these people as "true friends." BB stated that presently he has about 3-4 friends who he sees every few weeks.

BB has had two serious relationships. At age 21, BB was involved with a girl for about a year. She died of a heroin overdose. He also lived with another woman and her daughter for about 2 years. BB described his ex-defacto as a heroin abuser who has a "borderline personality disorder" and "evil souls." He stated that they argued a lot during their relationship.
**Psychiatric history**

BB has been seeing a Clinical Psychologist since he was 17 years old. He reported that he sees her for counselling to deal with the domestic violence issues. The psychologist stated that she became involved with BB’s family whilst conducting psychological assessments for crimes compensation (for witnessing the rape). She reported that her involvement with BB has generally been sporadic, crisis intervention.

BB stated that he has been managed by his GP who has tried him on two anti-depressants for low mood. BB and his mother reported that these medications did not help BB.

BB is currently case-managed at his local Community Mental Health Clinic.

**Substance abuse history**

BB started to use marijuana and "magic mushrooms" occasionally at 14 years of age. After finishing school he began using marijuana around every second night. He commenced drinking alcohol heavily at approximately 15 years of age. Between the ages of 20 and 22 years, BB used speed and developed a heroin habit. BB stated that he successfully completed a methadone program after a court order for a six month urine screen.

Currently, BB states that he drinks about 3-4 beers a couple of times per week. He also reported that he had stopped using marijuana two months ago because it made him paranoid. He acknowledged that he uses LSD on an infrequent basis. BB also smokes cigarettes. His mother described BB as an "emotional user" of drugs.
**Medical history**

BB stated that he had a six hour operation when he was young due to mastoiditis, which resulted in a severe hearing problem. He has lost most of his hearing ability in one ear. This problem was not discovered until BB was 14 years of age.

BB has Hepatitis C. His psychologist and mother stated that BB was aware that his ex-girlfriend had Hepatitis C and deliberately shared a needle with her. However, BB denied this.

**Forensic history**

BB stated that at age 19, he spent one month in prison for stealing two cars. He acknowledged that he has stolen about 3-4 cars for "fun" and only got caught for two. When BB was addicted to heroin, he stole from private houses, and stole food, clothes, Sony games and videos from shopping centres. He also stated that he had been arrested and fined for minor driving and train offences.

**Current medications**

Olanzapine 10mg nocte (anti-psychotic)

Clonazepam 0.5mg BD (benzodiazapine)

Sertraline 100mg mane (anti-depressant)

PRN Clonazepam 1mg TDS (benzodiazapine)

Tacazepam 20mg nocte (benzodiazapine)

**Behavioural observations**

BB readily agreed to the psychological assessment, despite stating he couldn't see how this might benefit him. He was generally inappropriate and overfamiliar (e.g., asking the therapist out on a date). He was a poor historian, as he experienced difficulty remembering
approximate dates of important events. As a result, there were several inconsistencies in the
title reported. BB seemed to have poor attention. He also appeared to have difficulty
comprehending some of the MMPI-2 questions and acknowledged that he often has trouble
comprehending what people say to him. He generally did not appear motivated, asking
several times whether or not he had to do the testing. During the clinical interview, BB’s
affect appeared blunted and his speech was monotone. When BB spoke of traumatic past
events no change in affect was observed.

Test results

MMPI-2

BB completed the Minnesota Multiphasic Personality Inventory-2 (MMPI-2). His
results indicated that this is a valid profile. However, his scores on the L and K Scales
suggested that BB was responding in a defensive manner, and was hesitant about revealing
too much information or becoming emotionally involved with people. Therefore, the
resulting profile may be an underestimation of BB’s difficulties. His score on the F Scale
suggested that BB has some deviant social, political or religious convictions. He responded
in a consistent manner throughout the testing.

Most of the Clinical Scales were within normal limits. His 4-8 codetype is suggestive
of chronic maladjustment. Individuals with this codetype generally have trouble maintaining
close relationships. They distrust others and are socially withdrawn. They usually have
feelings of insecurity, loneliness and a poor self-concept. Generally individuals with this
codetype have learned that relationships are dangerous, unreliable and rejecting due to
exposure to family conflicts during early childhood. They usually have difficulty modulating
or expressing their emotions. Their behaviour is typically unpredictable and impulsive. In
addition, their judgement is generally impaired. Consequently, they tend to get into social
and legal difficulties. Also, individuals with this codetype tend to have erratic academic and
employment histories. Suicide attempts are quite frequently reported and should be evaluated
carefully.

On closer inspection, his score on the Content Component Scale ASP1 (antisocial
attitudes) was extremely low, whereas his score on ASP2 (antisocial behaviour) was
elevated. This suggested that although BB may display aggressive, rebellious behaviour, the
intent to harm others is generally absent. His result on the O-H (overcontrolled hostility)
Supplementary Scale was also elevated, which indicated that BB is emotionally constricted,
bottles up his anger and may display outbursts of physical or verbal aggression without
apparent provocation. His low Do (dominance) score suggested that BB is generally
unassertive, easily influenced by others, has low self-esteem, and feels inadequate in
handling his problems.

Rorschach

When administered the Rorschach, BB provided a valid number of responses.
Consistent with the results of the MMPI-2, his Rorschach profile suggested that BB is in a
chronic state of feeling that he is unable to cope with his life. He generally has fewer
psychological resources available to plan and implement decisions than most people. In
addition to this chronic state, BB is also experiencing situational stress. This situational
stress exacerbates more chronic difficulties with his coping capacity, making him vulnerable
to impulsiveness and/or disorganisation.
In concordance with the MMPI-2 profile, BB's thinking is often marked by faulty judgement and he becomes disorganised rather easily. He is not very consistent with his problem-solving or decision-making processes. This inconsistency makes him more prone to making errors of judgement. BB also has a tendency to use fantasy excessively. He is prone to defensively substitute fantasy for reality in stressful situations more often than most people. This is a form of denial that provides temporary relief from stress.

BB is not very good at modulating his emotions. Furthermore, his emotions inconsistently influence his thinking, problem-solving and decision-making. Consequently, he is more vulnerable to becoming overly influenced by emotions when they become intense.

BB's self image is based more on past experience than imagination. Past social interactions seem to have greatly contributed to his sense of self. His interpersonal relationships seem to be superficial, as he is cautious about building or maintaining close relationships. He appears to be overly concerned with personal space and does not usually anticipate being close to others. BB also tends to be less concerned with issues of social acceptability than most people. The Rorschach also revealed that BB has an unusual body concern, which may reflect his concern about having hepatitis C.

Formulation and conclusions

BB is a 23 year old male who was referred for psychological testing to clarify his diagnosis. Clinical interviews revealed that factors that have predisposed BB to his overall current state of functioning include a family history of psychosis, an undetected hearing impairment, multiple losses, and witnessing domestic violence and sexual abuse in the home. He has experienced an acute psychotic episode, which appears to have been precipitated by extensive illicit drug use, a relationship breakdown, and the discovery that he has hepatitis C.
Maintaining factors include BB's continued drug use, his hearing impairment, his distrust in others, his negative self image, his inconsistent problem-solving strategies, his difficulty modulating his emotions, his tendency to use fantasy to escape from reality, and his poor coping strategies. As a result of these factors, it is my opinion that BB is extremely vulnerable to experiencing further psychotic episodes during and following drug use and/or periods of high levels of stress. Despite this, others have stated that BB generally has good intentions, is protective of his family, and has a "heart of gold". Furthermore, BB is a survivor who seems to have displayed resilience and strength through past traumatic experiences.

The results of the psychological testing regarding diagnosis are rather inconclusive. It is unclear as to whether or not BB has schizophrenia, or if he is vulnerable to distinct periods of (drug-related) psychosis, due to his chronic state of maladjustment. The factors that support the notion that BB has schizophrenia include past staff reports of delusions and hallucinations, age of onset, past familial history of psychoses, and past social, educational and employment history. However, there had been no significant deterioration in BB's general functioning, and no formal thought disorder was observed preceding and during his psychotic episode. Furthermore, it is uncertain as to whether or not BB experienced auditory hallucinations. Staff reports indicated that he had had auditory hallucinations, however, BB denied this, stating that he had only heard a laugh once while under the influence of illicit drugs. Psychological testing revealed that BB was not overtly psychotic at the time of testing. However, BB was taking prescribed anti-psychotic medication, which may have controlled his psychosis to some extent. BB's extensive illicit drug use has also been a confounding factor and a diagnosis of 'substance-induced psychosis' should not be excluded.
It should be noted that BB's personal style included elements of fantasy, denial and dissociation. He displayed anti-social personality traits, such as lack of empathy, failure to conform to social norms, impulsivity, and consistent irresponsibility. Additionally, schizotypal personality traits, such as ideas of reference, odd beliefs, magical thinking, constricted affect, and lack of close friends, were apparent. He seemed to have these personality traits as defence mechanisms to cope with his negative life events and to avoid close relationships. In the context of BB's history these defences were an adaptive way for him to avoid being hurt. However, during periods of drug use and/or increased stress, BB's usual defences may make him more vulnerable to episodes of psychoses. Monitoring of BB's mental state, general functioning, drug use, and compliance with anti-psychotic medication over the next one to two years will be important to establish BB's diagnosis.

**Provisional diagnoses**

**AXIS I:** 295.20 Schizophrenia Paranoid Type – Single episode in partial remission.

- Polysubstance Abuse
- Substance-induced psychotic disorder (differential diagnosis)

**AXIS II:** Schizotypal and antisocial personality traits

**AXIS III:** Hepatitis C, Mastoiditis

**AXIS IV:** Familial discord, witnessing domestic violence, disruption of family by separation, divorce and remarriage, removal from the home, death of friends.

**AXIS V:** GAF = 55 (on assessment).

**Recommendations and implications for treatment**

On the basis of the psychological assessment, the following recommendations are suggested.
1. It is important to consistently monitor BB's mental state, suicide risk, general functioning, drug use, and compliance with anti-psychotic medication.

2. Referral for a Neuro-psychological Assessment to determine what effect BB's accident and period of unconsciousness had on his functioning. Also an assessment of BB's cognition, memory and learning difficulties is warranted. The assessment must take into account BB's hearing impairment.

3. Referral to an audiologist for a review of BB's hearing impairment.

4. Drug and alcohol counselling would be useful in order to reduce the likelihood of precipitating a psychotic episode. However, it is probable that BB will continue to use illicit drugs as a means to escape from reality.

5. As a result of BB's chronic state of maladjustment, any form of psychological intervention will be of limited benefit. Long-term psychotherapy may be useful. However, BB is unlikely to engage in treatment due to his distrust in others and his tendency to avoid close relationships. Initially, much time will need to be invested to develop a therapeutic relationship with BB. Also, therapy sessions are likely to seem chaotic and unproductive. There will often be many different problems to work on, and it may be difficult to know where to begin. Due to BB's distrust in others, it is also likely that he will terminate therapy prematurely.

6. It is unlikely that BB will be compliant with prescribed medications due to his limited insight, impulsivity, and impaired judgement.

Reflection

Prior to deinstitutionalisation, when an individual was diagnosed with schizophrenia they went to an institution, primarily for containment. Due to the lack of effective treatments
available at that time, the majority of these clients lived their entire lives within the institutions, with minimal relief from their symptoms. However, since effective anti-psychotic medications and deinstitutionalisation occurred, individuals with schizophrenia have more freedom and more options available to them. With treatment, these individuals may return to their pre-morbid level of functioning. An unfortunate and perhaps unforeseen outcome, however, is that many of these patients, once recovered, choose to stop taking their medications and refuse treatment. This usually precipitates a further psychotic episode. Community management of individuals with chronic schizophrenia, comorbid substance abuse and low level of insight, such as BB, becomes cyclic and often clinicians have to wait until the next psychiatric crisis before they are able to intervene.

One of the functions of the Mental Health Act (1986) is to ensure that individuals with a serious mental illness receive appropriate treatment even if they are unwilling or unable to provide consent for that treatment. This treatment should always be carried out in the least restrictive manner. One of the difficult tasks facing the mental health practitioner involves balancing a client's civil liberties and the practitioner's duty of care. According to the Mental Health Act (1986), Section 8, involuntary treatment should be considered when an individual appears to be mentally ill; their mental illness requires immediate treatment; their illness poses a risk to the client's health or safety or for the protection of members of the public; and when the individual refuses or is unable to consent to treatment. Involuntary treatment usually occurs via a hospital admission. However, with the introduction of the Crisis Assessment and Treatment Teams (CATT), Community Treatment Orders may be used to treat an individual on an involuntary basis whilst he/she continues to live in the community. As a result of BB's lack of insight and poor history of compliance with
medication, a combination of a Community Treatment Order and a long-acting anti-psychotic injection will be essential to ensure that BB maintains contact with his case-manager and receives suitable treatment.

The psychological assessment revealed that BB is unlikely to engage in treatment. As a consequence of his personality style, the likely outcome is that once BB begins to feel better, he will discontinue contact with his case-manager, stop taking his medication, and recommence illicit drug use. All these factors increase the likelihood of BB having another psychotic episode. The more psychotic episodes BB has, the more likely he is to have another. The way the mental health system is structured at present, involuntary treatment is likely to be necessary in order to prevent BB experiencing another episode of psychosis and to improve his prognosis.

Another important issue that arises from an examination of this second case study involves the treatment of comorbid substance abuse and schizophrenia. Many individuals with schizophrenia also have drug and alcohol issues. The present health system is structured in a way that BB has to attend separate treatment centres for his substance abuse and his mental health problems. Case conferences are sometimes useful in order to integrate the treatment approaches of the two services. Case conferences involve all the professionals involved in the treatment of the client, and may also include the client's family and/or friends. Although these conferences are generally useful, unfortunately, due to work constraints and decreased funding, they tend to be rare and are generally used only for the most troublesome clients.

In addition to drug and alcohol services, many other services are also involved in providing care for BB. For example, he receives private psychological services from his
clinical psychologist, financial and housing assistance from the welfare services, medical assistance from his GP, and he has contact with the forensic system for past crimes he committed. A further problem with coordinating these different services is related to funding sources. For example, housing is funded separately from the mental health services. Therefore, each service has its own geographical boundaries around care, rather than providing collaborative care for the client. Essentially, the role of BB’s case-manager at the CMHC is to integrate these services to meet BB’s needs and ensure consistent treatment.

In conclusion, clients such as BB challenge even the most experienced mental health clinicians. Their personality style, level of non-compliance, lack of insight, drug and alcohol issues, and involvement with many services need to be considered when planning their treatment. Often these clients experience several relapses of their illness before involuntary community treatment is considered. Perhaps management and containment of BB’s illness would have been better facilitated within an institutionalised setting. Within institutions, treatment compliance was enforced, drugs and alcohol were prohibited, and a variety of services were coordinated. Furthermore, prior to deinstitutionalisation, BB’s family would have been relieved of their burden of care. Although the majority of clinical research supports the notion of deinstitutionalisation, the present case study highlights some of the difficulties inherent in community treatment and raises the issue that some clients may benefit more from institutionalised care.
CHAPTER FIVE
CASE STUDY THREE

Background

CC is a 54 year old married woman who was referred by her psychiatrist in November 1999. She was being case managed by the Mobile Support and Treatment Team (MSTT). The MSTT provide more intensive support than the Community Mental Health Clinics, and services clients with chronic mental illnesses who require longer-term rehabilitation. CC’s psychiatrist requested psychological therapy in order to reduce the severity of CC’s somatic delusions.

Presenting problems

CC is preoccupied with and distressed by somatic delusions. These multiple somatic complaints include “having no head”, “bleeding from her stomach and head”, and that her “head, stomach (and other organs) are bursting”. She also reported that her body has “gone to ash”, that she is “dead”, and that she is “not here”.

Relevant personal history

Past reports suggest that CC had a normal birth and developmental milestones, and grew up with a close, supportive family. However, CC reported that her father was an alcoholic who did not spend much time at home. She also noted that her father physically abused her mother and other siblings. CC has an older sister and brother, and a younger brother. CC reported that her mother had been treated for at least one episode of depression with ECT. CC’s father died in 1977 and her mother died in 1987. The details of their deaths
are not known. CC’s younger brother also passed away due to renal failure/cancer several years ago.

CC attended school until age 14. She reported that she was an average student but was never really interested in school. CC was employed in various secretarial and administration occupations until she was 21. The reasons for leaving these workplaces are unclear. CC had a tonsillectomy at age 21 and did not return to work following this due to her somatic complaints.

Socially, CC stated that she had several friends at school. She reported that she was engaged in her early twenties for three years. However, this relationship ended because she was unwell as her somatic symptoms began around this time. At 28 years of age, CC married a man 15 years her senior. This man used to go fishing and drinking with CC’s father. CC became pregnant soon after the wedding, however, this pregnancy was terminated because doctors believed she had multiple sclerosis. CC has no children.

There are no reports of drug or alcohol abuse.

**Psychiatric history**

CC has had multiple admissions to psychiatric institutions since 1969. Each admission was relatively short. During her first admission, she was treated with antidepressants and was reported to have settled quickly. One month later she was admitted and diagnosed with Major Depression with mood congruent delusions in the context of Somatisation Disorder. She was treated with Imipramine and Trifluperazine 40mg/day. Approximately one year later CC was again admitted and diagnosed with Depression Disorder with Somatic symptoms. She received the same pharmacological treatment. Six months later she was managed in the community by the Crisis Assessment and Treatment
Team and admitted for two weeks when community treatment failed due to the level of stress placed on her husband. At this point, in 1972, she received a diagnosis of Somatisation Disorder with underlying depression.

In June 1980, CC's diagnosis changed from severe Somatisation Disorder to Schizophrenia. She was treated with Stelazine and then Flupenthixol. Over the next 20 years, CC has been hospitalised on 22 separate occasions. Each admission has lasted between two and four weeks. There has been no identified precipitant for these episodes.

In August 1996, a psychological assessment reported that CC was very responsive to sympathy, more engaging when her symptoms were taken seriously, and was always preoccupied with somatic complaints. Despite psychological, pharmacological and physical treatments CC has remained fixated in her somatic beliefs. Test results from the WAIS-R showed that CC was in the Borderline range (70 - 79) on Verbal subtests. Her cognitive and visuo-spatial abilities were impaired, however, her concentration, attention and memory were within the normal range. The findings from the Rorschach were that CC did not produce responses typical of psychosis. She provided deviant responses to achromatic colour, which supported the notion that depressive features were involved. Recommendations included that CC's external focus and lack of ideational resources would make her a poor candidate for traditional verbally oriented counselling. It was also stated that CC was in great need of company and contact.

In December 1997, CC was placed on a Community Treatment Order (CTO) due to her inability to provide consent to treatment. The CTO is a legal order that indicates that CC is an involuntary patient living in the community. The MSTT have been managing her since that time. Her pharmacological treatments have included Flupenthixol and Respiridone. Her
husband noted no change in CC’s behaviour with these medications. Six months ago, CC was commenced on the new atypical anti-psychotic, Clozapine. This medication significantly reduced the degree of CC’s preoccupation with and the intensity of her delusional beliefs. Although improvement was noted, the delusions persist and still significantly affect her quality of life and her level of general functioning.

**Provisional diagnoses**

**AXIS I:** 295.20 Schizophrenia, paranoid type, continuous course

**Differential diagnoses:**

- 296.34 Psychotic Depression
- 300.81 Somatisation Disorder

**AXIS II:** Dependent and histrionic personality traits

**AXIS III:** None

**AXIS IV:** Marital discord, domestic violence.

**AXIS V:** GAF = 30 (at the commencement of therapy).

**Treatment plan**

On the basis of the information gained from her file notes and the psychiatrist, the following treatment plan was developed.

- Engage with CC and develop a therapeutic relationship. This may take several sessions. Therapist to use reflective listening and empathy.
- Establish goals for treatment with CC. What can I do that hasn't been done before?
- Support the notion that CC’s symptoms are real.
- Do not focus on symptom reduction, rather on other aspects of CC's quality of life. For example, self-esteem, loneliness, increasing recreational activities and social supports.
Clinical presentation

CC is a moderately overweight woman who usually wears night attire during the day. She is able to maintain appropriate eye contact and is generally cooperative throughout interviews. During interviews CC smokes cigarettes almost constantly. Her affect is restricted, dysphoric and congruent with conversations. She is not able, or is unwilling to rate her mood. CC’s speech is slightly pressured. At times she is easy to engage in conversation and initiates spontaneous speech. However, in other sessions, CC only provides monosyllabic answers to questions. CC’s thoughts displays elements of tangentiality, circumstantiality, and loosening of associations. Her thought content revolves around her somatic delusions, such as “my head and stomach are bursting”, “my body is ash”, and “I have no head”. CC denied suicidal, self-harm and homicidal ideation. No perceptual disturbances were noted. CC appeared orientated to time, person and place. Her intelligence was estimated to be within the low-average to borderline range. CC’s memory was not formally tested, however, no obvious memory difficulties were evident. CC has poor insight – she believes that she does not need psychological treatment and that she requires surgery to fix her physical complaints.

Synopsis of treatment

The following section briefly describes the content and process involved in the 17 weekly treatment sessions.

Session 1: CC was superficially welcoming. I took a one-down therapeutic approach, stating “I don’t know if I will be able to help you or not. I do not want to disappoint you. I realise that many so-called experts have tried to help you and failed, and I am sure that these people would have had more experience than I. Why don’t we just talk and you can tell me
more about yourself and the ways you think I may be able to help you — but I can't guarantee anything.” Most of the session was spent listening to CC complain of numerous somatic symptoms. I attempted to clarify some of CC’s history, including her childhood, and her familial, medical and social history.

Session 2: CC presented as more settled and warmer compared with the last session. We continued to develop rapport. We discussed CC’s family background, in which themes of alcohol abuse and sickness were apparent. CC also talked about her abortion. She stated that she would have liked to have a few children for her husband. She stated that the abortion may be related to her current symptoms. CC also reported that she did not like anything about herself. On challenging, she stated that she liked the fact that she enjoyed spending time with people. During this session, CC mainly discussed topics other than her somatic complaints. However, when I said it was time for me to leave she began describing her symptoms again.

Session 3: This week I entered CC’s home and complimented her, saying “CC, you look well.” For the remainder of the session CC was preoccupied and very distressed about her somatic complaints. In addition to the usual complaints noted, CC was also concerned about her teeth, thyroid gland and being ugly. I attempted to establish some therapeutic goals with CC. This was unsuccessful because CC kept repeating that she “is not here.” We briefly discussed her marital relationship. CC stated that she feels bad for her husband because “men have needs and she can't provide these needs.” She also stated that she has not had sex with her husband for many years.

Session 4: This session I did not ask CC any questions. CC settled very quickly and occasionally made reference to her somatic complaints. CC spoke about her beliefs that her
stomach is making her bad; that I will not be able to help her because all I do is talk and she needs surgery; that medication is not useful and is making her “out of this world”; and that other people think she is dirty.

Session 3: Rapport with CC is gradually improving. The majority of this session was spent discussing her abortion. CC stated that her abortion had affected her greatly. She said that no one had discussed the abortion with her, either before or after the operation. She stated that she had received no grief/loss counselling about this and that she had not talked with her husband about it. The remainder of the session was spent discussing what CC’s life would have been like if she was well. She stated that she would like to take cooking classes, for example, cake decorating. She would also like to go to Queensland for a holiday. I asked CC whether she thought her body may be trying to tell her something. I requested that she think about this over the next week.

Session 6: CC was asleep on arrival. I approached CC in a neutral manner, which she responded to well. We discussed the reduction of Clozapine. CC stated that she was pleased about this decision, but that she would prefer no medication. We also spoke about CC’s relationship with her husband. We talked about how they met each other. CC disclosed that her husband “gets wild with her.” Without prompting, CC described a situation that occurred last week, in which her husband shook her and knocked her about, causing bruises. She stated that this occurred because she had only rinsed the dishes and had not washed them properly. When I asked how often this occurs, she replied “a lot.” We explored her feelings surrounding her marital relationship. CC’s husband then returned home and sat with us. I observed an immediate increase in CC’s somatic complaints and her level of distress.
Session 7: Spoke with CC alone. Discussed CC’s views regarding the function of psychiatric services. She stated that it is nice to have company, however, psychiatric services are not really helping her. CC also stated that if psychiatric services ceased their involvement with her, she would stay in bed and wither away.

Session 8: CC was not home. I left a note explaining that I will contact her next week.

Session 9: Phone call to CC. CC’s level of distress and preoccupation with her somatic complaints was higher than usual. She stated that her husband had gone fishing and that she was scared to be in the house alone. She described her husband as “her back-up.” CC acknowledged that she is in a difficult position because she relies on her husband for company and at the same time, would like to leave her husband because of the physical and psychological abuse.

Session 10: Spoke with CC alone. She talked more about her relationship with her husband. She stated that he calls her “dirty” and “ugly”. We spoke about how CC feels about her husband. She reported that they have not been sexually intimate for years and that this does not bother her. CC stated that even if she were well she would not want to have sex with her husband. She acknowledged that her somatic complaints keep her husband away from her.

Session 11: Spoke with CC alone. I informed CC that the therapy sessions will be terminating in 6 weeks. We discussed the possibility of CC doing volunteer cooking. Encouraged this as a way for CC to increase her social support and use her skills (i.e. cooking) to increase her self-esteem. She requested more information about it but she stated that she is “too dead to do it.”
Session 12: I again mentioned the termination of therapy in 5 weeks. We spoke about follow-up options. CC stated that she enjoyed the company but that psychiatric services weren’t really helping her. Spoke about whether the MSTT is providing the care she needs. Also discussed alternative options of follow-up.

Session 13: This session revolved around how lonely CC feels. She stated that she really doesn’t have anyone she is able to talk with. CC stated that she used to have several friends, however, her friends “got sick of the complaining.”

Session 14: This session was spent discussing CC’s relationship with her husband and how he reminds her of her father. CC disclosed that her husband used to force her to have sex after he had been drinking. She acknowledged that she does not have to worry about that now because he does not find her attractive as a result of her illness.

Session 15: Spoke about CC’s perception of her illness. She described how scared she is because of her illness and her fear of death. We spoke about how it feels to be made up of ash and what she feels when her head or stomach bursts.

Session 16: Spent the session exploring what CC’s life would have been like if she had been well. Spoke about her childhood dreams and aspirations and how her illness has interfered with her life. Also discussed what may happen if CC’s husband decided to leave her and what her life may have been like without him.

Session 17: Final session with CC. CC was very appreciative and grateful for my company over the past few months. She acknowledged that she liked talking with me and felt that she could open up to me. I thanked CC for the opportunity to have worked with her and acknowledged that I will miss our weekly sessions.
Formulation

CC is a 54 year old married woman with a 30 year history of somatic delusions. Predisposing factors may include her mother's mental illness and father’s substance abuse. Also, CC was a victim of child abuse as she witnessed domestic violence. The events that precipitated CC’s first episode are unclear. However, during her early twenties CC had a tonsillectomy, gall bladder operation and a forced abortion. CC may have learnt not to trust medical professionals as they made a mistake when they misdiagnosed her with multiple sclerosis. Additionally, CC received no grief/loss counselling following the abortion and did not speak to anyone about this. CC’s current mental state appears to be maintained by several factors. By playing the sick role CC is able to avoid marital conflict, domestic violence, marital rape, and facing issues relating to the trauma she experienced during her childhood and adolescence. Despite this, CC is able to engage in some form of therapy.

Reflection

It is difficult to accurately measure the effectiveness of the therapy used. CC reported that she did not find the therapy useful, however, she stated that she enjoyed the company. CC’s husband and her MSTT case manager noted no change in the nature, intensity and frequency of CC’s delusions. Overall, the therapist noted significant improvements in CC’s mental state and a lessening of the frequency and intensity of her delusions. However, it is unclear that these improvements were due to the therapy and whether these improvements were maintained and generalised to periods other than the therapy sessions.

The therapist also made numerous observations regarding CC’s behaviours and symptoms. These observations may be useful in terms of CC’s future management. The following recommendations were developed based on the observations. Therapy with CC
will need to be planned on a long-term basis as it may take several months to develop a therapeutic relationship with CC. It seems futile to attempt developing therapeutic goals in conjunction with CC. It seemed to be useful for the therapist to use a slightly paradoxical approach, for example, stating “I don’t really know if I will be able to help you CC. I don’t want to get your hopes up and disappoint you.” It is important to spend the first few months listening to CC. It is also important that CC is convinced the therapist believes her. It is not useful to tell CC that she has a mental illness like schizophrenia. This seems to increase her distress and will lead her to believe that the therapist does not believe her. CC should determine the pace of the therapy. The therapist should not ask her to disclose personal information until she is ready to do so. CC will disclose when she feels comfortable doing so.

The therapist should endeavour to gain a thorough understanding of the impact of CC’s marital relationship. The therapist should be aware that CC’s symptoms are usually worse when her husband is present. Her relationship with her husband is a constant source of conflict for CC. On the one hand, CC feels grateful and thankful for her husband. However, she stated that at times she hates him. It is important to realise that CC feels “helpless” and “stuck” in her current situation. She is an incredibly lonely person who desperately desires people contact. It is also important that CC feels that the therapist is on her side. It is preferable for the therapist to minimise his/her contact with CC’s husband.

Therapy may involve CC talking about the traumas she has experienced, including witnessing domestic violence; growing up with an alcoholic father and a depressed mother; marrying a man who becomes verbally and physically aggressive when he drinks alcohol; and having an abortion, with no grief/loss counselling. Also, CC has a very negative self-
image. Her somatic complaints seem to reflect this, e.g., her body is bad and rotten. The therapist should work on issues of self-esteem and reinforce CC’s strengths (e.g., resilience, consideration and concern for others, good intentions) as much as possible.

This case illustrates the importance of the psychiatric home visit. By seeing people in their own environment, mental health workers are able to appreciate the social and relational difficulties their clients are facing. It is important that clinicians endeavour to understand these dynamics and how they may impact on the client’s mental illness. However, due to lack of funding and resources, case-managers have heavy workloads and as a result of this, are unable to spend much time getting to know their clients as people rather than diagnoses and symptoms. Whether this is done in an institution or in the community is not the issue.

If CC had lived her life in a long-stay hospital, it is likely that she would have been given high doses of tranquillisers and sedated most of the time. She may have also lost contact with her husband and the few friends/family members she has. In addition, CC may have lost some of her skills, such as cooking. In a long-stay hospital, psychological therapy as described above, would have been an unlikely occurrence. Overall, although CC’s current quality of life is poor and she is chronically impaired by her illness, institutionalised care is unlikely to have improved her general state of functioning.
CHAPTER SIX
CASE STUDY FOUR

Background

DD is a 22 year old male who was referred to the Community Assessment and Treatment Team (CATT) by his mother in March, 1999. The CATT conducted an initial assessment, treated DD in the community during his acute phase of the illness, and referred him to the local Community Mental Health Clinic (CMHC) for case management. Six months after the initial referral DD was referred by his case manager for cognitive-behaviour therapy surrounding issues of self-esteem.

History of presenting problem

DD’s mother reported that DD had a first episode of psychosis approximately five years ago, when he was 17 years of age. At that time, DD presented primarily with the negative symptoms of psychosis, which included avolition, alogia, and affective flattening. Additionally, DD had withdrawn from his family and friends. His brother reported that during this episode he had seen DD sit in the “same position for hours staring blankly into space.” This episode had been precipitated by a relationship breakdown, in which his first girlfriend had ended the relationship. DD had been dating this girl for one year and he stated that he “still loves her.” The positive symptoms of this episode remain unclear, due to DD’s guardedness. Furthermore, it was not possible to obtain DD’s case notes. DD did say that he could hear a female voice talking to him even when no one was around. He believed it may have been his ex-girlfriend.
This episode occurred while DD was living in Iran with his mother and brother. During this episode DD spoke about his wish to return to Australia so that his family could be reunited. While living in Iran, DD was treated using a homeopathic type of medication (marijuana base), which exacerbated his symptomatology. DD was admitted to a psychiatric hospital for ECT. He has been taking prescribed anti-psychotic medication since that time and has had no relapse episodes thereafter. DD became non-compliant with his medication approximately six months ago. This occurred in collaboration with DD’s general practitioner who stated that he did not believe DD needed the medication.

On referral, DD’s mother expressed concern that DD had been socially withdrawing gradually over the last few years and has not left the family home for the past five months. He was also becoming increasingly amotivated and lethargic; was not eating; was sleeping during the day and night; and presented with odd movements and posturing.

**Family history**

There is a strong maternal and paternal family history of psychiatric illnesses in DD’s first-degree relatives, including schizophrenia, manic-depression and major depression.

DD currently lives with his mother, his father, and his younger brother (aged 17). DD was born in Iran. His father was employed as an architect in Iran and the family was financially secure. The family migrated to Australia when DD was 15 years old. DD’s father was unable to obtain work as an architect in Australia and as a result he worked as a taxi driver. DD’s mother works from home on a part-time basis as a dress-maker. DD indicated that he wishes to return “home” to Iran where he believes the family was “happier.” DD and his mother moved back to Iran for two and a half years during the onset of DD’s illness. Since his return to Australia, DD has been functioning well.
DD’s parents acknowledge some degree of marital conflict. His father believes his role in the family is to earn money to support his family, while his mother would prefer that her husband spent more time with the family. She states that she needs more support from her husband to help care for DD. There also appears to be some conflict between DD and his father. DD’s father seems to be having difficulty coming to terms with DD’s illness and believes he is just being “lazy.” DD and his mother appear to have an enmeshed relationship.

**Developmental history**

DD’s speech development was significantly delayed. His mother reported that DD was mute until he was four years of age. Prior to this, DD communicated through art and drawings. All other developmental milestones were reported to be within the normal range. DD spent his childhood living in Iran, and he reported witnessing war traumas, bombs, explosions and many deaths.

**Interests and hobbies**

DD is a talented artist, however, this ability has deteriorated over the past five years.

**Educational and employment history**

DD completed Year 12 and his results were within the high average range. He commenced an art course at university. However, DD deferred the course approximately one year ago due to decreased energy and motivation levels (possibly prodromal period). DD has never been employed. Currently, he receives social security benefits (Austudy).

**Social history**

His mother reported that DD was always a quiet child. She noted that he had a group of close friends throughout his primary and high school years before moving to Australia. DD stated that he only had a couple of friends in Australia that he met through religious
groups. When he was sixteen, DD had a girlfriend for one year. She ended the relationship and according to his mother, “broke DD’s heart”. DD has not been in a serious relationship since that time. Currently, he expresses a desire to have a girlfriend.

**Substance abuse history**

There is no substance abuse or alcohol abuse reported.

**Current clinical presentation**

On mental state examination, DD presented as a slim man of average height for his age. He appeared unkept, unshaven, his hair was greasy and uncombed and he was dressed in casual clothes. DD tended to avoid eye contact, often looking down at the floor or around the room. DD’s posture was erect and his motor activity was retarded. Posturing was observed. DD appeared guarded and suspicious throughout the interview. DD’s affect was dysphoric and restricted in range. He did not initiate spontaneous speech, and poverty of content and latency was observed. DD’s thought stream, form and content were difficult to assess due to his guardedness. He denied suicidal or homicidal ideation, and any perceptual disturbances although he had previously told his mother that he experienced auditory hallucinations, e.g., he hears a female voice that reminds him of his ex-girlfriend. Concentration appeared to be intact. Memory was not formally assessed. DD displayed partial insight. He was aware that he was unwell but he labelled this as a “depression” and didn’t believe that treatment and medication would be able to assist him.

**Summary and formulation**

DD is a 22 year old male with schizophrenia. The onset of his illness occurred five years ago while he was living with his mother in Iran. A combination of a strong family history of mental illness and having witnessed warfare are likely to have predisposed DD to
developing schizophrenia. DD’s non-compliance with his prescribed anti-psychotic medication seems to have precipitated his current episode. It appears that a combination of DD’s illness, his lack of insight, and the marital conflict within the family may be perpetuating DD’s symptoms. Furthermore, it seems that DD’s illness may be a way to unite his family as they can focus on DD’s symptoms rather than familial conflict. DD has a strong and supportive family who believes that the family must stick together.

**Provisional diagnoses**

**AXIS I:** 295.20 Schizophrenia Undifferentiated Type with predominant negative symptoms

296.34 Psychotic Depression (differential diagnosis)

**AXIS II:** 71.09 No Diagnosis

**AXIS III:** None

**AXIS IV:** Parental discord, difficulty with acculturation, exposure to war.

**AXIS V:** GAF = 30 (on assessment).

**Synopsis of treatment**

The Crisis Assessment and Treatment Team treated DD for two months in 1999. Treatment involved crisis intervention, consisting of pharmacological treatment (anti-psychotic medication), monitoring of mental state and risk, psycho-education to family, and support to family.

DD was commenced on Risperidone 3mg nocte - increased to 6mg nocte, and Clonazepam PRN. He was initially seen twice daily to monitor his mental state and provide support and psycho-education to his family.
Improvements in DD’s mental state were observed after approximately three weeks. DD became more engaging and began interacting more with his family and friends. His appetite and range of affect increased, and he was sleeping less hours. However, after six weeks of medication, DD appeared more lethargic and sedated. Hence, the Risperidone dose was reduced to 4mg nocte. Again, improvements in mental state were observed.

Psychoeducation and support was provided to DD’s family. They were linked into the Schizophrenia Fellowship and encouraged to contact carer support groups. A family meeting was conducted to explore cultural and family issues that may be impacting on DD’s illness and the way in which DD’s illness may be affecting the family. The family meeting gave each member an opportunity to ventilate his or her feelings about DD’s illness. For example, DD’s father expressed guilt regarding his attitude towards DD. He stated that he had not realised DD had an illness and thought he was being lazy. DD’s mother expressed some degree of anger towards her husband and blamed him for DD’s illness. DD’s brother was able to express his concerns regarding the causes of schizophrenia and the probability that he may also develop the disorder. He also stated that he had been trying to distance himself from DD and the rest of his family so that he could concentrate on his studies.

Following the acute phase of his illness, DD was referred for case-management at his local community mental health clinic. This case-management was necessary to ensure compliance with maintenance medication, continuing care and support, re-integration into social and vocational activities, and family support. During the next four months, DD’s case manager met regularly with DD and occasionally with DD’s family. Rapport was established and a list of treatment goals was developed. DD expressed a desire to return to Art School and start doing “normal” things, such as “getting a girlfriend” and “getting laid”. DD
returned to school and began painting again. He started spending more time with his family and with close friends. DD acknowledged that he has an illness and stated that he preferred not to think about it and get on with his life.

Despite these improvements, DD had considerable difficulty meeting new people and interacting with strangers. He stated that he thought people could tell he was “mental” and that he was taking medication. DD acknowledged that he avoided talking to people he didn’t know because he thought they would not want to talk with him. DD’s case manager was concerned about DD’s poor self-esteem and thought his self-perception may precipitate a post-psychotic depression. This is common when individuals with schizophrenia gain greater insight into their disorder.

DD’s case manager was preparing for him to be discharged from the clinic to be managed by a general practitioner. However, as a result of her concerns, a referral was made for cognitive behavioural therapy for self-esteem. Upon meeting with DD and his case manager, a contract was made for 8 sessions of cognitive behavioural therapy to be conducted on a weekly, outpatient basis. This treatment was based primarily on the techniques described in McKay and Fanning (1987). The following is a brief account of the treatment sessions.

Session one: Outlined the basic premises of cognitive behaviour therapy and provided information about how the sessions will be structured. Obtained information regarding DD’s level of motivation and clarified DD’s personal goals of therapy.

Session two: Introduced the concept of the pathological critic. Spoke about when the critic is most prominent and why. Homework task: count the amount of times DD hears the critic over one day, monitor the critic for one day and write down what the critic says.
Session three: Reviewed homework. Discussed what purpose DD’s critic may be serving. Homework task: write down what the critic says over one day and note how this helps DD feel or do something, or avoid feeling or doing something.

Session four: Reviewed homework. Discussed thought blocking and distraction techniques. Spoke about developing DD’s rational voice. Homework task: write down five incidents where DD hears the critic and write down something the rational voice may say.

Session five: Reviewed homework. Homework task: Write down five events, then what the critic says and the possible outcome of listening to the critic, then the rational response and the possible outcome of listening to the rational voice.

Session six: Reviewed homework. Homework task: Practice blocking out the critic and replacing the critic with rational voice. Write down another five events, then what the critic says and the possible outcome of listening to the critic, then the rational response and the possible outcome of listening to the rational voice.

Session seven: Reviewed homework. Discussed cognitive distortions that DD uses and why. Homework task: Write a list of DD’s strengths and accomplishments.

Session eight: Final therapy session. Reviewed homework. Reviewed the eight treatment sessions and how these sessions were related to his personal goals.

Reflection

With deinstitutionalisation, mental health services have been able to offer consumers a more responsive and flexible service. DD was initially assessed and treated in the privacy and comfort of his own home. The psychiatric home visit is a positive outcome of deinstitutionalisation. This type of intervention is cost-effective in preventing hospitalisation and more successful in rehabilitation following an acute phase of illness (Sullivan & Cohen,
1990). The home visit is useful to engage the resistant, or more disabled/disorganised patient; to gather data and form diagnoses; to investigate the client's level of day-to-day functioning, and their family and social support systems and enhance these in-situ; and as a therapeutic tool/intervention.

The treatment of DD's psychotic episode within the community was successful for several reasons. Firstly, DD was cooperative with the treatment provided. Fortunately, his illness did not hinder his treatment. Secondly, DD was not at risk to himself or to other people. He had no suicidal, self-harm or homicidal thoughts, intent or plan. Furthermore, DD was able to follow instructions to attend to his activities of daily living, such as drinking water, showering, eating etc.

Thirdly, DD had a very supportive family who was able to provide 24 hour care. Family members played a critical role in helping DD engage in the therapeutic process. In this particular case study, the family's cultural beliefs reinforced the idea that families must stay together and provide support to each other through good and bad times. In particular, DD's mother made the initial referral to psychiatric services. She also aided the intervention by staying at home to care for DD and by providing the treating team with information about DD's progress.

The family meeting played an important role in the treatment of DD's psychotic episode. As the family meeting progressed, DD's mother disclosed that her doctor had prescribed anti-depressant medication and that she had commenced seeing a church counsellor due to her increased stress that resulted from caring for DD, her marital conflict, and managing the family. It is important to remember that family members may also be in crisis and may require intervention. Community treatment should always involve the
individuals living with the identified patient and should endeavour to provide the carers with the support and information they require.

This case study also illustrated that although a person may present with symptoms of schizophrenia, the treatment and management of their disorder may involve dealing with other areas of their life, which may have been affected by their illness. These may include problems with self-esteem, social phobia, anxiety, depression, sexual problems, vocational issues and relationship difficulties. A holistic approach is required to treat not only the symptoms of schizophrenia but the individual’s difficulties incurred as a result of these symptoms.

In conclusion, this case study illustrates that community treatment can be an effective way to manage clients through the acute phases of schizophrenia. Currently, very few individuals require hospital treatment. The decision to hospitalise someone is not solely based on the severity of the psychotic episode. Rather, a variety of factors, such as level of family/social support and level of risk to self or others, are considered when determining the best location of treatment. Even the most severely disturbed individual can be managed within a community setting if provided with sufficient resources and the risk factors are low.
CHAPTER SEVEN
CONCLUSIONS

Deinstitutionalisation has had an enormous impact on the philosophy, structure and
day-to-day running of the public mental health system. Individuals with severe mental
illnesses, predominantly schizophrenia, have been affected by this change. This portfolio
demonstrates how deinstitutionalisation affected four individuals with schizophrenia.

The four case studies presented in chapters three to six of this portfolio illustrate the
heterogeneity of the presentation, course, causes, and treatments of schizophrenia. To
summarise, AA has chronic schizophrenia and is maintained in the residual phase of the
illness. Currently, she has no florid psychotic symptoms and her medication enables her to
live and function within the community with long-term intensive support. CC also has
chronic schizophrenia. However, CC differs from AA because her psychotic symptoms have
failed to respond to treatment. Her delusions remain fixed in terms of severity, frequency and
the way in which they interfere with her daily functioning. Without her husband, it would not
have been possible to manage CC in the community. In contrast, BB appears to have distinct
short-lived periods of drug- and stress-induced severe psychosis, which requires brief
hospitalisations. BB’s illness is complicated by his comorbid substance abuse. During the
residual phases of his illness he does not seem to be impaired by his illness and is able to
work and function with minimal input from psychiatric services. Like BB, DD’s illness also
appears to involve acute episodes related to non-compliance with medication. However,
DD’s level of insight, personality traits and lack of comorbid illnesses improve his prognosis and he is likely to have a higher quality of life compared with BB.

While these four case reports show the heterogeneity of schizophrenia, they obviously do not provide a full appreciation of the complexity and heterogeneity of individuals with schizophrenia. However, they do suggest that as a result of this heterogeneity, the mental health system must incorporate a broad range of services to meet clients’ diverse needs. The closure of large-scale institutions and the subsequent development of smaller in-patient settings, Community Mental Health Clinics, Crisis Assessment and Treatment Teams, Mobile Support and Treatment Teams, and Continuing Care facilities have expanded the range of services now available.

Due to the variation observed in the course of schizophrenia, mental health services should be flexible to meet clients’ needs. Mentally ill individuals should be able to move from one area of the service to another, as required, in a smooth transition. Clinicians should always strive to achieve continuity of care. For example, during acute phases of illnesses, clients who are normally managed by the CMCH may be transferred to CATT or the in-patient unit for more intensive treatment. To ensure continuity of care, it is preferable that case managers maintain contact with their clients whilst they are managed by other parts of the service. Furthermore, if a client is assessed by CATT and admitted to the in-patient unit, CATT staff should endeavour to facilitate discharge of that client as soon as possible for community management. Individuals with schizophrenia should always be discharged when the specific indications for hospitalisation are no longer present (e.g., aggressiveness, suicidal or homicidal ideation, florid and disabling psychotic symptoms). Furthermore, clinicians should attempt to ensure that appropriate continuity of care, social and family
supports and housing are available before the patient is discharged. This will lower the rate of homeless mentally ill individuals and will avoid the “revolving door” phenomenon of hospitalisation-discharge-hospitalisation.

The case studies presented in this portfolio have been used to explore the ways in which deinstitutionalisation has affected individuals with schizophrenia. It is important to examine the characteristics of this sample. All four individuals were connected to family, they all had homes to live in, they generally came from middle-class socioeconomic backgrounds, and they had some level of social and behavioural skills. This portfolio suggests that community care is a feasible and preferable option for individuals who share these common factors. Without these, individuals may require some form of institutionalised care, or they risk becoming impoverished and/or homeless. This portfolio highlights the need for more research to identify which individuals may benefit more from community-based care and which from institutionalised care.

In conclusion, following deinstitutionalisation, very few individuals with serious mental illnesses like schizophrenia require long-term institutionalised care. Modern treatment approaches and the structure of the current mental health system ensure that the majority of individuals with schizophrenia are able to live within the community if the appropriate supports are in place. When carefully planned and adequately resourced, community care for individuals with schizophrenia is generally beneficial for most individuals and has minimal detrimental effects on society.
REFERENCES


*Mental Health Act (1986)*. Australia: Anstat Pty Ltd.


