PCHIZOPHRENIA: THEORY AND CASE STUDY

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ABSTRAK

Skizofrenia adalah salah satu jenis gangguan mental yang berada pada kategori gangguan psikosis. Ada berbagai macam penyebab gangguan skizofrenia antara lain faktor genetik, gangguan pada areal tertentu di otak, gangguan pada sel saraf, pengaruh kesehatan ibu dan janin pra-natal serta pada waktu bersalin, dan faktor kognitif serta pengaruh lingkungan sosial. Para penderita gangguan ini, bila sudah kronis, pikiran dan perilakunya menyimpang seperti adanya delusi, halusinasi, dan bahkan tidak bisa mengurus atau merawat dirinya lagi. Penelitian ini menggunakan metode studi kasus pada tiga klien yang dirawat di Rumah Sakit Jiwa Nasional, Manila, Filipina. Data diperoleh melalui wawancara, psikotes, informasi dari orang penting yang mengenal mereka serta observasi langsung atas perilaku mereka, diinterpretasikan, dibuatlah diagnosa dan prognosa serta rekomendasi untuk penanganan psikoterapis sesuai dengan keadaan klien. Hasil menunjukkan bahwa para pasien/klien penderita schizophrenia perlu ditangani melalui terapi medis dari psikiater dan terapi psikologis dengan metode dan teknik terapi Kognitif Behavioral.

KEY WORDS:

Schizophrenia, Case Study, Diagnose, Psychotherapy

Introduction

Schizophrenia is a type of mental illness which is called psychosis, that is often suffered by patients who are treated at a mental hospital or homecare. According to the Diagnostic and Statistical Manual of Mental Disorder, Text Revision (DSM IV-TR), there are four subtypes of Schizophrenia; however, there are some changes of schizophrenia in DSM-5. Specific changes in its definition include elimination of the classic subtypes. Each type has certain criteria. If the sufferers of this mental illness were late to be treated, then as a the result the patients suffer from chronic psychiatric disorders. However, if the patients were treated quickly and appropriately, the patients may get better.

This study uses the case study method to describe characteristics of three persons that suffered from schizophrenia, including the analysis and diagnose of each person and recommendations for each person to undergo specific psychotherapy.

1. Theory of Schizophrenia

1.1. The meaning, Types and Criteria

The American Psychiatric Association (APA) describes Schizophrenia, in DSM-5 (Diagnostic and Statistical Manual of Psychiatric Disorder- 5th Edition), in terms of a severe, chronic and as potentially disabling thought disorder.[1] Meanwhile, Nolen- Hoeksema states that people with schizophrenia, at times, think and communicate clearly, have normal view of reality and function well in daily life. However, at other times, their way of thinking and speech are garbled. They don't have connection with reality and even are not able to take care of themselves.[2] In DSM IV-TR, APA states that the essential features of schizophrenia are a mixture of characteristic signs and symptoms, "both positive and negative, that have been present for a significant portion of time during a 1-month period with some signs of disorder persisting for at least 6 months".[3]

There are two categories of symptoms, positive and negative symptoms. Positive symptoms are characterized by distortions in their way of thinking (delusions), perception (hallucinations), language and thought process (disorganized speech), and self-monitoring of behavior. In contrast, negative symptoms include restriction in the range and intensity of emotional expression (affective flattening), in the fluency and productivity of thought and speech (alogia), and in the initiation of goal-directed behavior (avolition).[4]

DSM-IV-TR describes subtypes of schizophrenia. However, schizophrenia subtypes have been dumped in the DSM-5. The reason is their "limited diagnostic stability, low reliability, and poor validity," according to the APA.[5]

The following are the subtypes together with their criteria[6]. Firstly, the paranoid type. In this type, the following criteria are met: a) preoccupation with one or more deletions or frequent auditory hallucinations, and b) none of the following is prominent: disorganized speech, catatonic or disorganized behavior, or plat or inappropriate affect.

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[1]C. E. Zupanick, "DSM-5 Category: Schizophrenia Spectrum and Other Psychotic Disorders", Retrieved March 10, 2017 from *http://www.theravive.com/therapedia/Schizophrenia-Disorder-DSM--5-*.

[2]Susan Nolen- Hoeksema, *Abnormal psychology, 4th Edition,* (New York: McGraw-Hill, 2007), p. 377.

[3]American Psychiatric Association, *Diagnostic and Statistical Manual of Mental disorder, 4th Edition, Text revision,* (Washington: APA, 2000), p. 298-299.

[4]Ibid., p. 299.

[5]Zupanick, Ibid.,

[6]American Psychiatric Association, Ibid., p. 314-317.

Secondly, the disorganized type. The following criteria are met: a) all of the following are prominent : (1) disorganized speech, (2) disorganized behavior, (3) flat or inappropriate affect, and b) the criteria are not met for the catatonic type.

Thirdly, the catatonic type. This type dominated by at least two of the following: motoric immobility, excessive motor activity, extreme negativism or mutism, peculiarities of voluntary movement as evidence by posturing, echolalia or echopraxia.

Fourthly, the undifferentiated type is a type of schizophrenia in which symptoms meet criterion A, such as delusions, hallucinations, disorganized speech and negative symptoms, but the criteria are not met for the paranoid, disorganized, or catatonic type.

Fifthly, the residual type. This type consists of this criteria: a) absence of prominent delusions, hallucinations, disorganized speech, and catatonic behavior, and b) there is continuing evidence of disturbance.

Aside from these subtypes, there is also another psychotic disorder, namely Schizophreniform Disorder. The following are the criteria of this disorder: a) criteria A, D, and E of schizophrenia are met, and b) an episode of the disorder lasts at least 1 month but less than 6 months.[7]

1.2. The cause

There are several factors that contribute to the risk of schizophrenia. Biological theories of schizophrenia have attributed the disorder to genetic factors, birth complications, structure brain abnormalities, prenatal exposure to viruses, and deficits in dopamine as well as other neurotransmitters.[8] Disordered genes cause schizophrenia, or at least vulnerability to schizophrenia. Enlarged ventricles may indicate deterioration of a number of brain areas, whereas reduced volume and neuron density in the frontal cortex, temporal lobe and limbic system cause cognitive and emotional deficits.

Birth complications, especially those causing loss of oxygen, and exposure to viruses during the prenatal period might damage the brain. Meanwhile, imbalances in levels of neurotransmitters such as dopamine, serotonin, GABA, and glutamate may also play a role. In addition, abnormal dopamine levels in the prefrontal cortex lead to deficits in working memory, reasoning, communication and problem-solving.[9]

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[7]Ibid., p. 319.

[8]Nolen Hoeskesma, *Ibid.,* p. 395. See also Ayano G. "Schizophrenia: A Concise Overview of Etiology, Epidemiology Diagnosis and Management: Review of literatures". J Schizophr Res. 2016; 3(2): 1-7.

[9]Ibid., p. 395.

Early psychodynamic theories viewed schizophrenia as the result of harsh and inconsistent parenting. Cognitive theorists see some schizophrenic symptoms as attempts to understand perceptual and intentional disturbances. Meanwhile, behavioral theorists view schizophrenia behaviors as the result of operant conditioning. Finally, different cultures have different native theories of schizophrenia.[10]

1.3. Current research on Schizophrenia

A current research conducted by Snowde c.s., focuses on showing how a nurse that prescribes a medicine, can achieve concordance with someone with schizophrenia. This case study research starts by briefly reviewing the origins of the concept of schizophrenia and then, based on the latest DSM-V criteria for diagnosis, introduces the current classification. The researchers also show the limits of this classification by introducing a research that challenges the salience of these criteria.[11] The results of their study also presents an evidence-based approach to helping someone diagnosed with schizophrenia. It uses the SBAR (situation, background, assessment, recommendations) format to conduct the case study. The result shows how important it is to understand what effects (good and bad) antipsychotic drugs can have, and goes on to demonstrate that as in any case of medicine management, the concept of concordance underpins optimal outcome.[12] The integrated importance of listening, building relationships, knowledge of medicines, critical understanding of current evidence and structured interventions should be considered.

The aim of a qualitative study conducted by Gater c.s., was to explore caregiver burden in schizophrenia. This study was conducted in the USA by using face-to-face, open-ended, semi-structured, qualitative interviews. The participants were 19 English speaking informal caregivers of people with clinician confirmed diagnosis of schizophrenia. Interview transcripts were analyzed by using grounded theory. Findings from interviews reveal that the most frequently reported impact of caring for a person with schizophrenia was feeling “emotional” which was reported by 14 (74%) of the caregivers such as feel overwhelmed, feel sad, frustrated, embarrassed, angry and stressed. In addition, caregivers also reported that the unpredictable nature of the person with schizophrenic behavior was often the reason for them feeling stressed, anxious, and worried. They worried about their future and the cost of caring for the person with

[10]Ibid., p. 407.

[11]Austyn Snowden, Mick Flemming, Glenn Marland and Lisa McNay (2011). “Towards concordance in schizophrenia: a case study”. *Nurse Prescribing* (l 9) 5.

[12]Ibid.,

schizophrenia. They appeared to have also lack of time to do their others daily activities and take care of themselves.[13]

2. Research Method

Describing behavior is an important goal of psychology.[14] This study uses a case study method. A case study is an intensive description and analysis of a single individual.[15] In this study, the researcher obtained data from several sources such as information from significant persons, naturalistic observations, interviews and psychological tests during the practicum period of the researcher. This article presents three cases of the results of data analysis, diagnosis and prognosis of persons diagnosed with schizophrenia. All the data are described as follows:

3. Results of the Case Study:

3.1. Case A: B.J's Case[16]

a. Pre-Intake Interview

1. Identifying Data

Name	:	B.J.
Address	:	Manila
Age/Sex	:	41 years old/ Male
Civil Status	:	Single
Birth date/Birthplace	:	May 5, 1970 / Manila
Nationality	:	Filipino
Religion	:	Roman Catholic
Educational Attainment	:	Elementary level
Occupation	:	Unemployed (used to be a Construction Worker)
Mental Health Center	:	NCMH Adult Male Section
Date of Confinement	:	May 15, 2011

[13]Adam Gater, Diana Rofail, Chloe Tolley, ChrisMarshall, Linda Abetz-Webb, Steven H. Zarit, and Carmen Galani Berardo. ''Sometimes It's Difficult to Have a Normal Life'': Results from a Qualitative Study Exploring Caregiver Burden in Schizophrenia". *Schizophrenia Research and Treatment* (2014): 1-13**.** Doi.org/10.1155/2014/368215.

[14]Geraldine Tria and loreto Jao, *Research for Behavioral Sciences*: *Made Easy* (Quezon City, Manila: Ken Inc., 2009) p. 19.

[15]John J. Shaughnessy, Eugene B Zechmeister, Jeanne S. Zechmeister, *Research Methods in Psychology, 8th Edition*, (New York: McGrawHill: 2009), p. 308. .

[16]This Psychological Report written based on the results of interviews and psychological tests during my internship in the National Center for the Mental Health (NCMH), Mandaluyong, Manila from April-June 2011. Data collected was approved, and the psychological report was edited, by Baden de Leon, my practicum mentor from NCMH.

2. Brief Statement of the Problem

He was brought by his sister for the first time to the Center last March 21, 2011 due to complaints of restlessness, poor appetite, impaired sleep and behavioral oddities such as walking aimlessly, blank stares, silly smiles and talking to self. He was also noted to be unmindful to his physical hygiene. Hence, he was admitted for confinement for treatment purposes.

b. Intake Interview

Case History

1. Family History

a. Parents

His father is already deceased due to diabetic complications. He also manifested signs and symptoms of mental illness and was previously confined at the National Center for Mental Health (NCMH). After which, he has been taking maintenance medications to prevent relapse as his condition was diagnosed as Schizophrenia – Paranoid Type.

On the other hand, his mother reached elementary school level and used to support their family's needs by managing a sari-sari store. At present, she is already sickly and is being taken care of by one of her daughters.

b. Siblings

He is the youngest and only male in a brood of three siblings. His eldest sister is still single while the younger one is married and lives in their province.

c. Physical Surrounding

He lives in his parents' house together with his mother and eldest sister. Their house is situated in one of the slum areas in Tondo, Manila.

2. Personal History

His eldest sister provided information about his prenatal and natal; and childhood development.

a. Early Development

He is a product of unplanned but wanted pregnancy, borne via normal delivery in a hospital with no feto-maternal complications. His mother did not have regular prenatal check-up with her OB Gynecologist due to financial constraints. However, during the first trimester of pregnancy, she was stressed due to her family's financial situation especially so since her spouse was also unemployed and afflicted with mental illness.

He is primarily taken care of by his mother as he is breastfed all throughout his infancy years. He was mostly placed under the care of his eldest sister and was said to be neglected most

of the time since the former also had a lot of obligations in their house such as performing household chores and errands for their parents.

Discipline was instilled primarily by his mother at 5 years old through verbal reprimands and spanking. He used to spend his time alone by playing with his older siblings and other kids in their neighborhood. However, he and his siblings were bereft of toys and other material things due to their family's poor living condition and lack of financial resources. He has no history of any serious illnesses during his childhood years.

b. School History

At age 6, he started his schooling in a public school although, he had difficulty in coping with school requirements since he often go to school hungry and without an allowance from his parents. Hence, he eventually became truant with his studies until he stopped going to school completely.

c. Sex History

He was circumcised at the age of 12 with a "quack" doctor without assistance from his parents. He was just with other boys in their neighborhood who also underwent the procedure.

He had his first crush when he became a teenager. Unfortunately, he was timid around girls so that he never experienced having a girlfriend. However, he had his first sexual experience with a prostitute as instigated by his friends in their neighborhood.

d. Major Experiences

He has been doing well until sometime in the late part of 2010 he had a sudden onset of behavioral oddities such as restlessness, poor appetite, impaired sleep and behavioral oddities such as walking aimlessly, blank stares, silly smiles and talking to self. He was also noted to be unmindful to his physical hygiene. These came about after he was laid off from his job as a Construction Worker for which he explained that he was framed-up by other co-workers so that his employer got mad and had lost trust in him.

Initially, his family members tolerated his behavior and attitudes until sometime in March 2011, he started being irritable and was always threatening his family members with physical harm. Hence, they finally decided to bring him to NCMH for possible treatment and management.

e. Estimate of Self and the World

He perceives the world as hostile that he reports "feeling ko, pinagkakaisahan ako ng mga kasamahan ko, kaya dapat unahan ko na". He related that "mabuti naman ang gawa ko pero lagi

sila may ginagawa laban sa akin." More so, he affirmed the presence of perceptual disturbances as he heard mixed voices telling him that other people are attempting to betray and harm him.

He also admitted feeling depressed ever since he lost his job due to his co-workers "evil designs" towards him.

c. Psychological Testing Atmosphere

Test Administered

Wechsler Adult Intelligence Scale – R	May 27, 2011
Bender Gestalt Visual Motor Test	May 27, 2011
Draw a Person Test	May 27, 2011
Sach Sentence Completion Test	May 28, 2011

Observational Data

1. General Appearance, attitude and behavior

B.J. is an adult male with tall stature, lean physique and dark complexion. He was attired in a blue ward uniform for NCMH's in-patients. Eye contact was poorly established. He was noted to be easily distracted by other examinees and practicum psychology students.

2. Stream of talk and mental activity

During the initial interview, he was evidently restless and minimally responsive to queries. As the session progressed though, he became more relaxed and elaborative with his responses. However, he was still noted to be suspicious and irritable when exposed to tasks which he found to be difficult.

3. Affect

He appropriately expressed his feelings or emotions whenever he was asked about his experiences in work and social relationship. His facial expression and tone of voice signify his real feelings or emotions. He admitted feeling depressed over the loss of his job as well as hostile and fearful of perceived threat from other people and his environment.

4. Special preoccupation, trends and thought content

Since the first meeting, he was preoccupied with people who are out to betray or harm him. As such, he is always guarded and vigilant in dealing with other people and his environment. He admitted auditory hallucination and persecutory delusion.

5. Sensorium and Intellectual Resources

He was aware of the place, date and time of the session that he came here with his family to this date and other scheduled dates for consultation of his mental condition and amenable to

undergo medication and the needed testing such as these psychological tests. He tried to be attentive or kept his focus to the queries. He has good memory recall of the significant events of his life as he was able to narrate them in details and according to the sequence when it had happened.

Test Behavior

He initially showed resistance towards testing but had become cooperative as the session progressed. He was able to follow the instructions and worked on the presented tasks silently but he always exceeded the allotted time frame.

Test Results, Protocols and Interpretation

Level of intellectual functioning remains at the Average classification. Nonetheless, judgment and decision-making ability, object relations and social intelligence are already affected.

Projective materials describe Arthur as an emotionally disturbed man whose confused thought processes pose a negative effect on his social dealings as he has poor grasp of reality situations. Subsequently, he becomes maladjusted with his actions and decisions for he is prone to be self-absorbed with his fantasy ruminations as his way to dull the impact of his frustrations in life.

Also hypersensitive and wanting for affection and support, he tends to expect others to be tolerant and agreeable to him although hostility and aggression readily sets in when such expectations don't materialize. Hence, insecurities also crop up so much so that he is strongly inclined to seek refuge by way of withdrawal and high level of evasiveness as well as stubborn behavior. Strong feelings of confusion and suspiciousness are also likely to set in as brought about by his high level of suspiciousness and negativism.

Goal-setting ability on the other hand is affected by his tendency to become fantasy-bound. His insecurities are likewise indemnified through his lofty goals which do not jive with his current resources and poor motivational level. As such, he becomes extremely unreliable as well as ineffective in the assumption of his gender roles. More so, painful experiences of rejection are pushed beyond awareness by way of repressive defenses.

Other means of dealing with psychical stress and difficulties include denial, acting-out, compensation, projection, intellectualization and regression.

d. Findings And Conclusions

a. Summary Formulation

B.J. is an adult male with tall stature, lean physique and dark complexion. He was attired in a blue ward uniform for NCMH's in-patients. Eye contact was poorly established. Initially, he offered resistance to undergo interview and psychological assessment procedures but later on became more compliant and cooperative in responding to queries as well as performing assigned tasks. His cooperation, responsiveness and good memory recall contributed a lot in gathering data and information to come up with comprehensive case study.

His IQ is within the Average level which indicates that his cognitive abilities did not deteriorate. However, lapses in judgment and reasoning ability are already evident based from the presence of delusion and hallucination.

He belongs to a family who basically neglected his needs. Compounded by economic constraints and his interpersonal conflicts with his work colleagues as well as history of mental illness in their immediate family (late father who was also mentally ill), he became strongly predisposed to develop mental illness.

Hence, when he was exposed to a severe stressor which was the loss of his job, he started to manifest behavioral oddities. And since his condition was neglected or initially tolerated by family members, it escalated into a psychiatric condition.

b. Diagnostic Formulation (Diagnostic Assessment)

1. Diagnosis According to Classification

Based on the data gathered from the interview and psychological tests administered on him, he exhibits symptoms of Schizophreniform Disorder. His condition manifests positive symptoms of Schizophrenia such as delusion and hallucinations but it did not meet the duration requirement which is more than 6 months.

2. Diagnosis According to Dynamics

He has the capacity to manage his present condition if his treatment would be continuous and if his family will accord him with support and proper care. As revealed from the interview and the tests, his cognitive processes are intact which could provide good prognosis for psychotherapy.

He is so concerned with his fear that other people might betray of harm him so that he becomes unduly suspicious and negativistic. This also triggers persecutory delusion and auditory hallucinations as he wants to protect himself at all times.

His way of coping is ineffective/unhealthy as he resorts to withdrawal, projection, intellectualization and repressive defenses.

3.2. Case B: Case of E.B[17]

1. Identifying Information

NAME	: E . B
SEX	: Male
AGE	: 33 years old
BIRTHDATE	: February 19, 1977
BIRTHPLACE	: San Jose, Tarlac City
CIVIL STATUS	: Married but Separated
EDUCATION	: High School graduate
CLINIC/HOSPITAL	: National Center for Mental Health
DATE OF ADMISSION	: May 2011

2. Referral Question

He was referred for psychological assessment for diagnostic purposes.

3. Case Background

E.B. was brought by his mother to the Center for the first time last May 2011 due to noncompliance in taking his medications, assaultive behavior as he was said to be "nambabato" and behavioral oddities such as disrobing in public, shouting spells, walking aimlessly and impaired sleep.

It was also gathered that the patient has been mentally ill since 1997and had previous admissions at NCMH, the last one of which was in 2010. However, after 9 months of discharge from his last confinement, he suddenly refused to take his medications thus, leading to a relapse which lasted for about 2 weeks already hence, his current confinement. Nevertheless, during the interview, he negated the presence of perceptual disturbances, which was previously confirmed by his mother during admission.

[17]This Psychological Report written based on the results of interviews and psychological tests during my internship in the National Center for the Mental Health (NCMH), Mandaluyong, Manila from April-June 2011. Data collected was approved, and the psychological report was edited, by Baden de Leon, my practicum mentor from NCMH.

History of substance use includes liquor drinking since 4th year high school level as well as smoking about 30 sticks of cigarettes on a daily basis. However, he negated indulgence of prohibited drugs.

Meanwhile, about his family background, he claimed to be youngest child in their family and sibling relationship is depicted as harmonious and closely-knit. His father is said to be a farmer while his mother is a plain housewife. He is also married yet now separated from his wife since the latter abandoned him after learning about his current illness/condition. Their 4 children are currently under the custody of his wife.

4. Physical And Behavioral Observation

Client reported for testing attired in a blue ward uniform. He is of average height with dark complexion and medium physique.

Meanwhile, he was observed with pleasant mood and had answered queries in a spontaneous manner with fairly sustained eye contact.

5. Testing Behavior

He had complied with test procedures without complaints. However, he had slow performance rate due to lack of interest in taking the tests.

6. Test Results And Interpretation

Wechsler Adult Intelligence Scale-Revised, Bender Visual Motor Gestalt Test, Draw-A-Person Test, House-Tree-Person, Sach's Sentence Completion Test.

Date Administered : May 11 and 12, 2011

WAIS-R:

Verbal Scale IQ	- 74
Performance Scale IQ	- 74
Full Scale IQ	- 73
Classification	- Borderline

Intelligence function is gauged under the Borderline range of efficiency. However, pre-morbid capacity is on the Average level.

Capacity for sustained effort and visual-motor dexterity remain at par with his potentials and age group. However, poorly maintained are the spheres of analytical skills, verbal-concept formation, alertness to details, anticipatory planning and reasoning skills while fund of practical information, social judgment and immediate recall are impaired.

Projective data bespeak of an individual who shows limited resources at present to adequately cope with environmental demands along with the varied expectations of his environment and social milieu. As such, he chooses to engage in compensatory mechanisms and

activities such as his vices without sufficient insight as to how it brings negative effects on his health and relationship with the significant others in his life. Compounded by painful events such as the abandonment of his wife and separation from his children, he has chosen to dwell in fantasy ruminations as he didn't want to wallow in self-pity and bitterness. Other defenses utilized are denial, reaction-formation and withdrawal. However, when tension becomes overwhelming, he is also driven to externalize his negative impulses by way of aggressive temperamental outbursts thus, causing a detriment on his capacity to sustain harmonious relations with other people.

7. Summary Formulation

Significant indications in the protocol include maladjusted behavior with accompanying depressive trends which are brought about by his frustrations in life and compounded by his separation from his wife and children.

8. Diagnostic Impression

SCHIZOPHRENIA – Undifferentiated Type.

3.3. Case C: R. U[18]

1. **Identifying Information**

NAME	:R. U.
SEX	: Male
AGE	: 21 years old
BIRTHDATE	: April 14, 1989
BIRTHPLACE	: Sta. Teresita, Cagayan
CIVIL STATUS	: Single
EDUCATION	: BS MT
CLINIC/HOSPITAL	: National Center for Mental Health
DATE OF ADMISSION	: May 1, 2011

2. Referral Question

He was referred for psychological assessment for diagnostic purposes.

3. Case Background

R.U. was brought to the Canter for confinement last May 1, 2011 as he mentioned, "sa sobrang talino ko, nabaliw ako." Subsequently, he admitted the presence of auditory hallucinations which started during his birthday celebration last April 14 of the same year. He described it as woman's voice telling him, "magpagawa ka ng barko mo." More so, he was

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observed with shouting spells and behavioral oddities such as getting other people's laptop and being suspicious.

Meanwhile, he had previous admission at the Center sometime in 2009 due to the same presenting complaints. However, he just stayed at the ACIS for 2 weeks and was discharged. After which, he had taken unrecalled medications.

History of substance abuse includes consuming either 12 bottles of San Miguel beer or 5 bottles of Red Horse beer per session with a twice a week frequency. However, he negated cigarette smoking and prohibited drug use.

Meanwhile, he said that he is the youngest in a brood of 5 siblings. His father is a Pharmacist by profession while his mother is also gainfully employed as a Security Guard. More so, he has a paternal uncle who is now deceased but is remembered to be a previous in-patient of NCMH.

He is a graduate of BS MT course at the Philippine Maritime Institute in Quezon City last April 2009. Looking back, while he was still a student, he stayed in a boarding house in 5th Avenue, Caloocan City. Immediately after graduation, he applied for work as a local Seaman but was unfortunately rejected. Since then, he was noted with blank stares and was always in deep thought.

Psychosexual history states that he had 3 girlfriends while he was staying in Caloocan City while he had 4 girlfriends while he was in Cagayan Valley. He even mentioned that a certain Jane was his last girlfriend whom he loved so much.

4. Physical And Behavioral Observation

Client reported for testing attired in a blue ward uniform. He is a tall man with dark brown complexion and muscular physique.

Meanwhile, he was observed with pleasant mood and had answered queries in a spontaneous manner with fairly sustained eye contact.

5. Testing Behavior

He had complied with test procedures without complaints. Performance rate was adequate and he had good comprehension.

6. Test Results and Interpretation

Wechsler Adult Intelligence Scale-Revised, Bender Visual Motor Gestalt Test, Draw-A-Person Test, House-Tree-Person, Sach's Sentence Completion Test.

Date Administered : May 19, 2011

WAIS-R:

Verbal Scale IQ- 83
Performance Scale IQ - 81
Full Scale IQ - 82
Classification - Dull Normal

R.U. is currently equipped with a Dull Normal range of IQ. However, when efforts are maximized and under better condition in which he could perform, he is still capable of attaining his pre-morbid IQ level which in under the Average classification.

Visual-motor dexterity and attention-concentration span are preserved. On the other hand, most of his mental faculties such as reasoning skills, anticipatory planning, reflective thinking and social judgment are poor.

Test data highlight a weak-willed individual who has a great difficulty in handling the frustrating events in his life. As such, he tends to brood excessively to the extent of conceptualizing expansive if not grandiose wishes and goals, which in his mind would help ease the pain of his failures in life. More so, his thinking pattern is evidently affected as he now dwells in fantasy ruminations and unrealistic ideas thus, making him increasingly maladjusted in his manner of relating with his immediate environment.

Meanwhile, he identifies with his own gender group but he feels weak and insignificant. In order to cope, he strives to assert his virility by way of sexual preoccupations.

7. Summary Formulation

Significant indications in the protocol include maladjusted behavior with accompanying hallucinations and grandiose goals as he aims to dull the impact of his frustrations in order to protect his fragile self-concept.

8. Diagnostic Impression

SCHIZOPHRENIFORM Disorder

CONCLUSION

Client A who diagnosed with Schizophreniform Disorder is recommended that he will undergo a combination of psychopharmacology under his Psychiatrist. After managing his psychiatric symptoms, he could undergo psychotherapy such as Cognitive-Behavior Therapy to gain insight about his maladaptive pattern of thinking.

Client B who diagnosed with Undifferentiated Type of Schizophrenia should undergo pharmacologic treatment and regular consultations with a Psychiatrist to prevent relapse of his condition/illness. His family should also undergo psycho-education in order to manage him well after discharge from the hospital.

Client C who suffered from Schizophreniform Disorder, continuous pharmacologic treatment and regular consultations with a Psychiatrist is suggested to prevent relapse of his condition/illness. More so, he needs to undergo psychotherapy in order to develop insight with regards to proper ways of handling stress and failures in order to boost his fragile self-concept.

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