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THE EFFECT OF TREATMENT OF A COMORBID ANXIETY DISORDER ON PSYCHOTIC SYMPTOMS IN A PATIENT WITH A DIAGNOSIS OF SCHIZOPHRENIA: A CASE STUDY

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Abstract. This case study deals with the effect of treatment of social phobia on psychotic symptoms in a patient with a diagnosis of schizophrenia. Stress vulnerability models were used to provide a rationale for treatment. The phobia was treated using standard CBT techniques while the therapist avoided any direct treatment of the psychotic symptoms. Scores for social phobia reduced to a sub clinical level over the course of treatment and the psychotic symptoms rapidly abated. Although only a single case study and therefore impossible to generalize to a wider patient group the study would seem to suggest that treatment of comorbid anxiety disorders can effect psychotic symptoms. Some thoughts are presented as to why this might be the case.

Keywords: Psychosis, neurosis, social phobia, CBT.

Introduction

It is known that anxiety disorders frequently exist comorbidly with psychotic disorders. In a cohort of 96 patients hospitalized in the USA with psychosis it was found that the overall prevalence of psychiatric comorbidity was 57.3% (Cassano, Pini, Saettoni, Rucci, & Dell'Osso, 1998). Of these, approximately 62% had some form of anxiety disorder.

Zubin and Spring (1997) propose a stress vulnerability model that could link neurotic and psychotic disorders. This model suggests that each person has a threshold for psychosis and stressful events can push a person over that threshold and into the disorder. Theoretically, therefore, the stress created by a comorbid anxiety disorder could push a person over their threshold.

Morrison (2001) suggests a cognitive model that explains both anxiety states and psychotic experiences. This theory argues that both disorders are caused by intrusions into consciousness, which are then misinterpreted and it is this misinterpretation that leads to the disorder. Morrison (2001) also argues that if the same underlying processes occur in psychosis as do in anxiety disorders, then the same CBT treatments should be effective in both. He further highlights the importance of this in the implications for clinical practice.

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History

Roger had a five-year history of psychotic illness and had suffered with residual symptoms all of this time in spite of adequate doses of medication. He was referred to the author as there were concerns about his lack of progress and occasional odd behaviour at the employment rehabilitation centre he was attending. The staff at the project had noticed that he was sometimes very agitated and talkative and had trouble concentrating on his work.

Assessment

Assessment consisted of an in depth investigation of Roger's current problems and their history. Roger described hearing people refer to his illness at the employment project. This resulted in him believing that everyone knew his business and he became very anxious and agitated as a result. His method of dealing with this was to talk non-stop to distract himself and this explained the odd behaviour mentioned by the staff at the project. He also had the experience that other people could read his thoughts and that he could read theirs. In addition, he stated that he was having problems going into town, only being able to go there for very short periods as he heard people referring to his illness and feared that someone might approach him and ask him about it. He dealt with this by only going to town for very short periods and then rushing back to his car, classic avoidance behaviour. These trips into town were invariably accompanied by tremors, palpitations, increased breathing rate and occasionally headaches. While rushing through town he kept his eyes fixed on the ground as he believed that if he made eye contact with anyone, they might approach him and ask him about himself and his illness. He also worried that his anxiety symptoms were obvious to others and that they were staring at him, seeing him as odd or even crazy.

This clinical picture fitted a diagnosis of social phobia and further backing was given to this by the administration of the Modified Fear Questionnaire (Marks & Mathews, 1979). Scores for social and agoraphobia were both significant. The Hospital Anxiety and Depression scale (Zigmond & Snaith, 1983) was also administered and showed clinically significant scores for both subscales. Roger was then screened for any possible psychotic symptoms using the KGV symptom scale (Krawieka, Goldberg, & Vaughan, 1972), revealing mild auditory hallucinations among other symptoms.

Treatment

Treatment consisted of graded exposure as usually used in agoraphobia with adjunctive CBT for both social and agoraphobia. Roger's psychotic symptoms were not mentioned during therapy apart from during assessment to try to make sure that any observed effect of treatment was due to treatment of the phobia alone. More complete details of the treatment programme are given in the full-length report available from the author.

Outcome

Table 1 shows the change in Roger's scores for social phobia, agoraphobia, anxiety, depression and psychotic symptoms. All the scores show a significant reduction and all of them were at a sub-clinical level by week 16 and remained sub-clinical at follow-up 8 weeks

later. These scores concur with Roger's self-report, as he said he found it much easier to go into town and was able to stay in town and browse at his leisure. This contrasted dramatically with the situation prior to treatment. Roger also reported that his anxiety at the employment project was much reduced and he was no longer agitated and was more focused on his work; this was confirmed by a worker at the project. In addition, Roger reported that he no longer had psychotic symptoms in any situation and his KGV scores confirm this.

Discussion and conclusions

It is striking that Roger had suffered with residual psychotic symptoms for five years and that these symptoms abated when an identified neurotic disorder was treated. One explanation for this is that the stress vulnerability models are valid and that the treatment of the phobic disorder brought Roger's stress levels below his personal threshold for psychotic experiences. Another explanation of this treatment effect comes from the work of Morrison (2001). It would seem possible that intrusions into consciousness were being misinterpreted in such a way as to produce symptoms of both anxiety and psychosis. If this were the case, then it could be argued that by tackling the anxiety producing misinterpretation, the psychotic misinterpretation was also negated leading to abatement of the psychotic symptoms.

The only other explanation offered by the author is that the therapy for the neurotic disorders had a beneficial effect on core beliefs or schema. Although direct schema work was not carried out it is possible that Roger's growing confidence served to change or mask the underlying beliefs, thereby effecting the psychosis.

As an isolated case study this paper in itself proves nothing and it is impossible to say for certain what process produced the change. It is, however, the author's experience that control of anxiety plays an important part in the management of psychotic symptoms. It is important therefore that comorbid neurotic disorders are identified and treated. If these disorders are ignored, the psychosis may be well controlled but the patient may be left with considerable handicap from the neurotic disorder.

Table 1. Scores for social phobia, agoraphobia, anxiety, depression and psychotic symptoms

	Week 1	Week 8	Week 16	Week 24
Fear quest: Agoraphobia				
Fear	28	17	12	9
Avoidance	28	17	9	9
Fear quest: Social phobia				
Fear	20	15	13	8
Avoidance	22	12	12	9
HAD				
Depression	11	6	4	5
Anxiety	14	7	6	6
KGV				
Anxiety	2	1	1	1
Depression	3	0	0	0
Hallucinations	3	0	0	0
Delusions	3	0	0	0

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A greater understanding of the links between not only anxiety but also other neurotic disorders and psychosis would be of great benefit to clinicians/therapists working in the field of psychosis and more research is therefore required.

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