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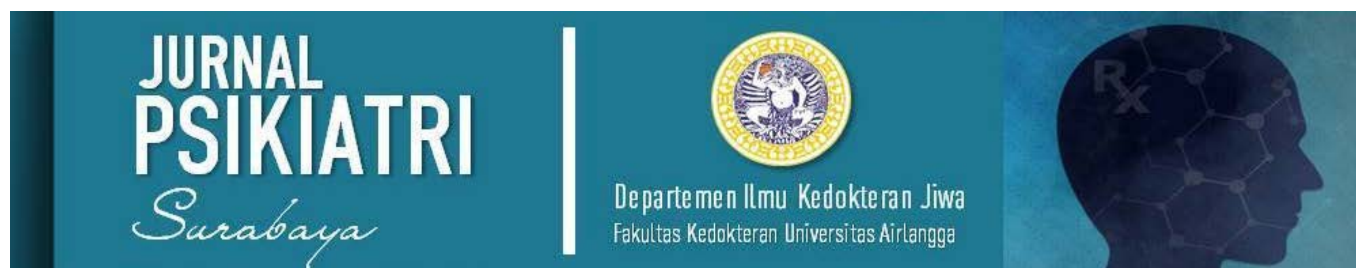

CASE REPORT

Family Role on Schizoaffective Mixed Type Patient Treatment

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Abstract

Schizoaffective disorder is a mental disorder accompanied by affective and schizophrenic symptoms that are equally prominent at one time. Affective symptoms that appear are symptom manic, depressive, or both. The prevalence of patients with schizoaffective disorder is about 0.3% of the general population. The case that will be discussed here is Ms. MM age 19 years old with first suffered from a schizoaffective mixed type disorder, low motivation, and unstable mood. The difficulty faced in handling this case is to provide an understanding of the patient and family about schizoaffective disorders and how patients take medication regularly for a long time. Therefore, a biopsychosocial approach is considered the most suitable to overcome the difficulties in handle this case. Family role for patients is to increase medication adherence and reduce recurrence rates, while for the patient's family are to increase knowledge about mental disorders suffered by patients and reduce the psychological burden suffered by the patient's family.

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INTRODUCTION

Schizoaffective disorder is a mental disorder with schizophrenia symptoms and affective symptoms that appear simultaneously in a continuous period, there is delusions or hallucinations congruent criteria schizophrenia, affective symptoms appear in most of the active and residual phase, and the disturbance is not caused by a substance [1]. The cause of schizoaffective disorders has not yet been obtained clear data [2] but it is suspected that multiple factors contribute to each other, namely genetic factors, environmental factors, neuronal development factors, neurochemistry, neurofunctional, neuroanatomy, and neuroimmunology [3].

The prevalence of patients with schizoaffective disorder is about 0.3% of the general population [2]. Schizoaffective disorder results in significant morbidity and mortality [4]. Also often appears in young adulthood, although sometimes it can appear in adulthood and the elderly. Women suffer more from schizoaffective disorders than men. But a study conducted in Finland found that there was no difference between women and men who suffered from schizoaffective disorder. But it found that women had more depression-type schizoaffective disorder and men had more manic-type schizoaffective disorder [2].

The management of schizoaffective disorder is a long-term treatment and sometimes is a lifelong treatment, requiring a chronic treatment approach [3]. This disease, if suffered in adolescence, can interfere with development. Appropriate early intervention and specific psychological and pharmacological modalities can provide optimal results, especially in adolescent patients [4]. Treatment expectation for adherence treatment and avoiding relaps without considering the patient's needs and drug side effects experienced by the patient will result in non-compliance of treatment. Hence the biological approach alone is not sufficient to facilitate the recovery process according to the patient's psychosocial needs [3].

The psychosocial needs of the patient depend on the etiology, course of the disease, and the prognosis of the disorder. Patients with persistent severity of symptoms and course of the disease need psychosocial support beyond what primary health care systems can afford. Psychosocial approaches include promotional, preventive, early detection and intervention activities, psychotherapy, and rehabilitation [3].

CASE REPORT

Ms. MM, 19 years old, 3rd-semester student majoring in chemistry at the State University of Surabaya, Javanese, Muslim, not married, and not yet working. The patient was suffering from mixed-type schizoaffective disorder for the first time. The patient's parents took her to the Psychiatry Clinic of Doctor Soetomo General Hospital with chief complaints of rambling speech, difficulty sleeping, and anger for no apparent reason since one week before admitted to the hospital. Doctors prescribe risperidone 2x1 mg daily and lorazepam 2 mg at night and advise patients to be hospitalized if after taking the medication there is no change. After taking the medicine for one week, the patient's condition did not change so that the parents decided to take the patient to Doctor Soetomo General Hospital for hospitalization.

The patient underwent treatment for 8 days at the hospital by getting risperidone 2x1 mg daily, Depakote 1x250 mg daily in the morning, and lorazepam 0.5 mg at night if she can't sleep with a maximum dose of 1 mg/day. While being treated, the patient was a few times anxious with the excuse of wanting to go home but could be persuaded by the doctor and family. After hospitalization, the patient had no complaints of rambling speech, difficulty sleeping, and angry without being clear. Patients receive home remedy risperidone 2x1 mg daily and Depakote 1x250 mg daily in the morning.

The patient has no history of mental illness and other physical illnesses. None of the family members suffer from mental disorders. Normal birth, full-term, assisted by a midwife, no complications during pregnancy, and childbirth. Growth and development according to age, not too late. There was no history of seizures, jaundice, and head trauma. The patient is the first of three children and was raised by her parents. She lives in the same house with her parents, two younger brothers, and grandmother. There is no history of drug and legal use. On physical, neurological, and laboratory examinations within normal limits.

Three days after being hospitalized, the patient went control to the Psychiatry Clinic. The patient appears to be mostly silent and looks sad. The patient's mother said the patient was not like before she was sick. Previously, the patient was a child who was agile and nimble, but now the patient is mostly silent, looks sad, low concentration, lacks initiative, and lacks enthusiasm. Then doctor given an additional prescription, fluoxetine 1x10mg daily in the morning to improve symptoms of depression.

Two weeks after receiving fluoxetine therapy, the patient began to talk a lot and felt less sad. The patient's mother said the patient was able to do household chores such as cleaning the house and washing clothes. But the work was done by the patient after being told by her mother not because of her own will. The patient still lacks initiative and lacks enthusiasm. Patients also complain that it is difficult to concentrate on completing assignments from the lecturers and experience difficulties in following lectures because of drowsy, which makes her feel sad. Then the patient received the addition of Depakote to stabilize mood so that the treatment became fluoxetine 10 mg daily in the morning, risperidone 2x1 mg daily, and Depakote 2x250 mg daily for 2 month.

The problem that is still faced by this patient is the affective symptom of the patient who is still unstable, where the patient cries easily and gets angry. During taking medication, the patient is often drowsy, so often sleepy in class. The patient's ability to learn is not as optimal as before the illness and low motivation. Several conditions experienced by patients, provide obstacles in carrying out daily activities. This made the patient decide to take one semester off from college but the lecturer refused and asked the patient to continue studying. As a result, this becomes a burden on the patient's mind because the patient feels less able to attend lectures.

DISCUSSION

This patient had cognitive dysfunction because of her illness. Cognitive disfunction is also influenced by changes in neurodevelopment that change the mediation of BDNF hippocampal neuroplasticity, genetic factors involving Disrupted gene In Schizophrenia-1 (DISC-1), Akt 1 (Serine/Threonine specific protein kinase), and M6a Neuron glycoprotein (N6 Methyladenosin). Where the dysfunction of these factors will result in hallucinations, apathy symptoms, social dysfunction, and reduced self-control [5]. We explained to the patient and family that cognitive dysfunction is one of the symptoms of schizoaffective disorder and adherence treatment can improve the symptoms.

It is important to understand that medication adherence occurs within the broad context of adherence. Adherence is not a treatment goal because if the treatment target adherence without knowing what patient needs and hope from the treatment. It will fall to nonadherence. In recovery-oriented practice, adherence is invaluable if it helps patients achieve their goals. The first challenge faced is the problem of involvement. We must identify the people who benefit from treatment and involve them in the choice of treatment. WHO states that five factors influence medication adherence. The five factors are social and economic, factors of the health care team and health care system, factors related to the patient's clinical condition, factors related to patient medication therapy, and factors related to the patient [6].

To ensure better engagement with the treatment program, as a major unit of action, the involvement of family members is required. Psychoeducation is applied as a family intervention. After the first contact with the patient, a family psychoeducation intervention is provided, and staff always try to contact at least one family member or other emotionally close person and motivate them to participate in the psychoeducation session. This approach is mainly built on the foundation of friendly, assertive, optimistic, open communication, and collaboration [7].

The treatment strategies used for patients with first-episode psychotic episodes in young adults are adapting treatment to the patient's life development process, early involvement, increased treatment motivation, and improved disease management skills [8]. Psychosocial interventions are considered to be the most effective, low risk, and high benefit for patients who have had the first episode of psychosis and are aged between 15-25 years [9]. There are four strategies for optimizing psychosocial interventions in patients with the first episode of psychosis, namely reducing delays in receiving evidence-based psychosocial therapy, a synergy of partner psychosocial interventions, delivery of personalized psychosocial interventions according to patients, and use of technology to enhance psychosocial interventions [10].

We used family intervention and psychoeducation for psychosocial interventions in this patient. Family intervention and psychoeducation of patients and families went well. Although the patient's family comes from the middle to lower socioeconomic level and secondary education level, they can understand the psychoeducation provided by the doctor about the disease and patient treatment and are willing to be involved in the patient's treatment. The patient's mother is willing to be involved in supervising the patient's daily medication at home so that medication adherence runs well. The cost of medical treatment and medicines is borne by government insurance so that patients can seek regular treatment every month at Psychiatry Clinic General Hospital Doctor Soetomo.

Psychopharmaceutical therapy has been adjusted several times to suit the patient's symptoms. The psychosocial interventions provided were family intervention and psychoeducation that had been carried out for 6 months after being hospitalized. Family intervention and psychoeducation in patients are useful for medication adherence and reducing the recurrence rate [11] whereas in the increasing family and reduce the psychological burden felt by the family while caring for patients [12].

CONCLUSION

Patients with first-episode schizoaffective disorder and young adults have different therapies because they have to adapt to their developmental phase of life. The involvement of family in treatment is needed to increase medication adherence. A combination of psychopharmaceutical and psychosocial is needed to accelerate the healing process. The benefits of family intervention for patients are to increase medication adherence and reduce recurrence rates, while the benefits of family intervention for the patient's family are to increase knowledge about mental disorders suffered by patients and reduce the psychological burden suffered by the patient's family.

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