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Case Report / Olgu Sunumu

The Role of Individual Assessment on Increasing The Functionality of a Person with Schizophrenia

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ABSTRACT

The role of individual assessment on increasing the functionality of a person with schizophrenia

Schizophrenia is a chronic disease that often reduces quality of life and functionality by causing disabilities in many areas like interpersonal relationships and social communication. Solely medical treatment is inadequate to prevent symptoms and recurrences that impairs quality of life. Therefore psycho-social rehabilitation approach which is important for continuousness of recovery, reducing disability and increasing treatment compliance and quality of life should be integrated with pharmacological treatment. In this case report, we present a schizophrenia patient and her rehabilitation process who gains skills for living independently after rehabilitation program as a result of decreasing frequency of relapses and increasing functionality in social area.

Key words: Functionality, individual counseling, schizophrenia

ÖZET

Şizofreni tanısı ile izlenen bir olgunun işlevselliğinin artırılmasında bireysel danışmanlığın rolü

Şizofreni sıklıkla kişilerarası ilişkiler, sosyal iletişim gibi birçok alanda yeti yitimine yol açarak işlevselliğin bozulmasına ve yaşam kalitesinde düşüşe neden olan kronik bir hastalıktır. Tek başına medikal tedavinin semptomları ve yaşam kalitesini bozan tekrarlamaları önlemede yetersiz kaldığı bilinmektedir. Bu nedenle iyileşmede sürekliliğinin sağlanması, yeti yitiminin azaltılması, tedaviye uyum ve yaşam kalitesinin arttırılmasında önemli yer teşkil eden psiko-sosyal rehabilitasyon ve destek programları mutlaka farmakolojik tedavi ile bütünleştirilmelidir. Bu olgu sunumunda rehabilitasyon programı sonrası yineleme sıklığı azalan, sosyal ve mesleki işlevselliği artan bir şizofreni olgusunda bireysel danışmanlığın rolü ve iyileşme süreci ele alınmaktadır.

Anahtar kelimeler: İşlevsellik, bireysel danışmanlık, şizofreni

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INTRODUCTION

Schizophrenia is a chronic illness that starts in early ages and progresses with remissions and recurrences, which were manifested with impairment in cognition, perception and affect (1). Its life-long incidence and prevalence are 1% and 0.5%, respectively. Deterioration is observed in schizophrenia in many areas such as interpersonal relations, social and occupational functionality while some positive and negative symptoms stemming by the nature of the disease, cognitive impairments, affective symptoms, comorbidities such as alcohol and substance misuse and repetitive hospitalizations lead to functional impairment and decline in quality of life (2). Due to disease-induced losses as well as the stigmatizing attitude of the society, schizophrenia appears to be a public health problem, which deeply affects both the patient and their families.

Psychosocial rehabilitation programs play an important role in ensuring sustained recovery by preventing of aggravations, reducing the debilitation and increasing treatment compliance as well as the quality of life (3). These rehabilitation programs should essentially be integrated with pharmacotherapy. In conjunction with this matter, psycho education, peer support, career qualification, resourcing for patient-society communication and training activities about

problem solving skills, social skills and family relations are carried out (4).

In this paper, we present a schizophrenia case, which gains independent living skills as an outcome of reduced recurrence frequency, sustained occupational skills and increased social functionality at the end of a rehabilitation program.

CASE

A twenty-five-year-old single female, who lives with her parents and works as a supermarket cashier but left the university at first grade, applied to our psychiatric emergency unit upon sexual harassment by her boyfriend with the following manifestations seen within the last 10 days: insomnia, refusal to eat, nervousness, reduced self-esteem and social communication, self-talkativeness, thoughts of saving the world with her father, thoughts of being pursued and video-trailed, discontinuity to school. Her first admission to a psychiatry clinic is dated to 2007. Psychomotor retardation, restricted affect, reduced speech, megalomania, persecutory and reference delusions were observed during her psychiatric examination and she was hospitalized with the diagnosis of bipolar disorder (BPD).

Interview with the patient and her medical records revealed that she had been hospitalized 6 times within the last 3 years for refusal to eat, reduced self-esteem, introversion, self-talkativeness and religiousness. No full remission was obtained in the midst of those hospitalizations. She had been displaying negative symptoms and a catatoniform clinical picture with occasional positive symptoms such as auditory delusions, megalomania and persecutory delusions as well as mood symptoms like irritability. Though her admission diagnosis was BPD, it was concluded during the follow up that, mood symptoms were accompanying the progressive psychotic symptoms, which were recognized to be predominant during longitudinal evaluation. No remission was observed between psychotic aggravations. Therefore, the diagnosis was changed to schizophrenia and she went under follow up in the psychotic disorders outpatient unit.

The patient was assigned a counselor after her admission to our daytime hospital and rehabilitation center in February 2010. Her pre-rehabilitation and follow-ups ratings were carried out with Positive and Negative Syndrome Scale (PANNS) (5) and Psychiatric Rehabilitation Form of Chronic Mental Patients (PRFCMP) (6).

PRFCMP, which was validated by Yazici et al., is used for all patients admitted to our clinics, to collect the sociodemographic data, illness symptoms and progression, treatment compliance, features of the patient irrelevant to the illness, preserved features and strengths of the patient and needs for rehabilitation. PRFCMP was utilized to our patient to explore the needs and design the rehabilitation. By using PRFCMP, we learned the followings about the patient: her insight is insufficient; she knows very little about the disease and her compliance to the treatment is low; she has difficulties associated with daily functioning such as housekeeping, cooking and keeping dresses clean; she avoids communicating people and using community places; she often experiences problems in the workplace; her family does not allow her go out as they are concerned about her failure to cope with problems because of illness; aggravation periods push forward commotion and often result in hospitalization. The patient's and her parents' expectations regarding the rehabilitation were investigated and the work flow was designed to proceed from the simplest to the most complicated. As per the plan, priority tasks were determined as improving the insight, the treatment compliance, self-esteem and independent living skills, socialization and occupational functioning.

In the course of data collection, patient was informed in every interview that knowing about her well rounded was the primary goal while helping her understand her illness, the manifestations of her illness and coping with the illness. Utmost effort was spent to make her perceive the center as a safe place. Our communication revealed that she has been looking forward to complete her education and get started working so as to support her family economically and she has been extremely afraid of being hospitalized.

Her family was expecting her to live on her own, have a job and never get ill any more.

Once-weekly private interviews were planned with the counselor and the frequency was reduced to once monthly except the periods of aggravation. In a 30-minute structured interview, the counselor gave her information about the disease, the treatment, the side effects and the ways to handle them in the first part. The remaining time was allocated to the improvement of the above-mentioned skills with homeworks and performance appraisals. Self-esteem and treatment compliance improved significantly within the first month of the rehabilitation program. Improvements were communicated with the family and these achievements were used to motivate the patient and the family. Interviews with the family have been carried out also and she was allowed by her family to go to the rehabilitation center alone by using community transportation, in the third month. In the subsequent period of the rehabilitation program, her family came to the center only if invited and they have encouraged her coming to the center alone.

In the next step of the rehabilitation program, social functioning has been aimed to improve. She received homeworks about initiating and maintaining interpersonal relations as well as behavior control. To create an appropriate environment for her, she was proposed to attend an artistic and occupational training course held by the municipality and she willingly took the English Language program.

She was retained by her company, where she had been working as a cashier, by the courtesy of her manager's motivation about sharing her problems, our communication with the company physician, reconfiguration of her working conditions for the favor of treatment as a joint effort of the counselor, her manager and the company physician. By the sixth month of her rehabilitation, she started participating the social activities held by the company and taking up with people.

She started dating with another patient, who has been attending a rehabilitation program in our center and problems associated with or borne by her relationship as well as the coping strategies became a field of evaluation in the interviews. Suicidal thoughts required hospitalization in September 2011, for the first time. After she had been discharged, she has kept attending interviews and a special allowance for participating psychoeducation groups was acquired by the help of the company physician. She had completed a 14-week psychoeducation program.

After a two-year follow-up, PANNS positive syndrome score of 17 at admission went down to 12, negative syndrome score from 22 to 10 and general psychopathology subscale score from 30 to 21. At the end of the rehabilitation program, rating with PRFCMP form revealed that her "Qualification for Daily Activities (QDA)" subscale score of 50 went up to 63, "Qualification for Coping with Illness (QCI)" subscale score from 32 to 37 and "Qualification for Social Activities (QSA)" from 28 to 36.

The case is still attending the rehabilitation in our center. Delusional perception sometimes creates problems in her life. However, she is able to recognize her delusional ideation early enough, implement the strategies she learned about coping with them, and take the responsibility about her treatment and prevent a conversion of these into a "crisis".

DISCUSSION

Long-term observational studies on schizophrenia patients demonstrated that, only a few patients could have a full remission whereas the majority keeps on facing life-long problems associated with symptoms, cognitive impairments and psychosocial problems (7). The constraints of pharmacotherapy in schizophrenia bring a multi-dimensional approach that covers psychosocial rehabilitation as an adjuvant to pharmacotherapy (8).

The success of regular use of antipsychotics to reduce the recurrence ratio to 40% was reported to be improved to 20% by adding psychosocial treatment (9). In consistency with the matter, our case, which had been hospitalized 7 times in 3 years time, had only two aggravations (only one needed hospitalization) in approximately two years time after rehabilitation. In fact, PANNS scores were decreased significantly after

the rehabilitation program. Patient's proficiency in recognition of the aggravation symptoms that is leading to early medical intervention as well as the regular use of medications and outpatient follow-up are the factors reducing the recurrence. Literature demonstrates the efficacy of psychoeducation in the improvement of treatment compliance, insight and recurrence ratios (10). Our case had interpreted her situation as depression at the beginning and quit treatment under the pretext of getting well or side effects. In compliance to the findings of Eryilmaz et al. (11) showing the improvement effect of rehabilitation on insight, the increase in the PRFCMP subscale scores prove the solid outcome that the patient embraced the illness after the rehabilitation program covering the symptoms, the treatment and its side effects and her treatment compliance was improved. The overall consequence of the program is reduced in aggravation and hospitalization frequency.

Another axis of the treatment of chronic diseases such as schizophrenia is family participation. Rehabilitation activities grounded on the education of family members about the illness and coping strategies aims to improve the social functioning of patients and to enable them to live independently (12,13). Our case, which had not been allowed by her extremely protective family to come to the hospital alone, then became skilled at reaching the hospital alone and going out for personal needs in time, after rehabilitation. This supports the importance of family participation in the treatment of schizophrenia for helping the live independently in the society.

Reducing the symptoms of an illness is not sufficient for a complete psychosocial therapy. Clinicians should be knowledgeable about social stress factors influencing the patient, the level of overcoming skills of the patient in daily life, interpersonal factors that help establishing and sustaining supportive measures. Clinicians should design treatments by taking the weaknesses and strengths of the patients into account (14). Our case is a sample for personal development plan in reference to her difficulties associated with her professional performance and education about communication of her problems (to whom and how). Communication with the company physician as well as being not limited to psychiatry specialist for implementing a good rehabilitation as a part of her personal development plan and collaboration with all other individuals and institutions were shown to be essential.

The patient started to take care of herself and her house, attended an English course and group activities where she can meet people; in the course of a two-year follow-up, QDA,QCI and QSA subscale scores displayed a significant rise. Above listed changes, in consistency with the literature, demonstrate the role of the psychosocial rehabilitation programs in the improvement of social and occupational functioning as well as increasing the quality of life in schizophrenia.

In conclusion, symptomatic treatment alone is not sufficient to treat debilitating chronic psychiatric diseases such as schizophrenia; a multi-dimensional and integrated approach is needed alongside the pharmacotherapy.

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