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CASE REPORT

Beyond the Clinic Walls: Fostering Well-Being in a Client with Schizoaffective Disorder (SAD) Through Home Care and Clozapine Therapy - A Case Report

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Abstract

Schizoaffective disorder (SAD) is a chronic, severe and disabling illness associated with concurrent presentation of symptoms of schizophrenia and affective disorders. The mainstay of treatment is a combination of antipsychotic medications, and depending on the subtype of schizoaffective disorder, either mood stabilizers or antidepressants are given. Clozapine is a second-generation antipsychotic used in the treatment of SAD. Clozapine-induced agranulocytosis has the highest risk of occurrence during the first few months of treatment. Other common side effects are sialorrhea, constipation, dehydration, and hyperglycaemia. Adequately managing side effects can improve adherence and quality of life. Physical health should be monitored at each clinical review, particularly in the first few months of treatment, to reduce the occurrence of serious, sometimes fatal adverse reactions. Many clients find clozapine to help with their psychosis, but they often need to balance the positive effect of psychosis with some of the side effects that clozapine can cause.

Keywords: Schizoaffective disorder, Clozapine therapy, Home care

Introduction

A mental disorder can affect every aspect of a person's life, including thinking, feeling, mood, outlook, and areas of external activity, family, and marital life. Schizoaffective disorder (SAD) is a complex and persistent mental disorder recognized in 1933 by Kasanin.[1] Schizoaffective disorders are characterised by periods of intense symptom exacerbation alternating with quiescent periods during which psychosocial functioning is adequate. In other cases, both pervasive mood changes occur concurrently. This condition is complicated to treat because it combines two distinct types of mental health disorders that require different types of treatment.

Schizoaffective disorder is relatively rare with a lifetime prevalence of less than 1%. Schizoaffective disorder can affect all age groups. In older adults, this disorder becomes complicated because of frequent comorbid medical conditions. The typical onset of this disorder is during early adulthood, and the most common type present is bipolar. Men and women experience

schizoaffective disorder at a similar rate. However, men can often develop the disorder at an early age.[2]

The two key symptoms of SAD are, the symptoms related to schizophrenia such as delusions, hallucinations, disorganized speech, disorganized or catatonic behaviour and the negative symptoms such as affective flattening, avolition, and alogia. In addition, the client has symptoms associated with major depressive disorder, mania or mixed episodes of bipolar disorder. The major feature that differentiates the SAD from schizophrenia is that the mood symptoms co-occur for a prolonged time period with the psychotic symptoms.[3]

The mainstay of treatment of patients with schizoaffective disorder includes mood stabilizers, antidepressants, and anti-psychotics.[4] The use of Electro Convulsive Therapy (ECT) should be considered in clients with more mood responses and tendency towards suicide.[5] The patient diagnosed with SAD (Schizo-Affective Disorders) benefits from a combination of family therapy, social skill training and cognitive rehabilitation. The range of symptoms can be quite large as patients contend with both ongoing psychosis and varying mood states.[6] It can be very difficult for family members to keep up with changing needs of their relative with this mental disorder.

Case presentation

Mr. K, an unmarried, 38-year old male living with parents in an urban community was diagnosed as a case of Bipolar affective disorder (BPAD). The first episode occurred when he was 21 years old. He was treated as an inpatient and underwent one course of ECT (12 ECT) at the age of 23 years. Though he demonstrated signs of improvement and was on regular follow-up with the psychiatrist, he frequently exhibited noncompliance to treatment which was a major hurdle in his recovery.

Mr. K was previously hospitalized on multiple occasions for aggressive behaviour and non-compliance with medications. From past 10 years, client was on regular treatment. Six months ago he developed irritability, suspiciousness, muttering to self, had death wishes and lack of sleep. Partial response was noted with Tab. Valproate 1250 mg, Tab. Quetiapine 300 mg, Tab. Aripiprazole 45 mg and Tab. Risperidone 8 mg. Mr. K was admitted for four weeks to a mental health facility. After a series of MSE (Mental Status Examination), the client was diagnosed with SAD. After conducting relevant investigations (Hb, total and differential count, ESR, serum electrolytes, urine routine lipid profile, and ECG), Tab. Clozapine was added to the treatment. The dose was optimised to 150 mg at night along with Tab. Depakote 1000 mg in two divided doses, in morning and night. Mr. K responded well to the treatment and psychotic symptoms reduced drastically.

Parent's socio-demographic history

Mr. K belonged to a middle class family. His father was a retired bank manager and mother was a homemaker. Mr. K was the only son. There was no family history of mental disorders or substance abuse in the family.

Assessment

A mental status examination of the client during the follow-up OPD visit revealed normal mental functioning with an insight score 4. Client was adherent to medication (Medication Adherence Rating Scale (MARS) score was 7). The MARS is a 10 item self-reporting multidimensional instrument describing three dimensions: medication adherence behaviour (items 1 to 4), attitude towards taking medication (items 5-8), and negative side effects and attitude towards psychotropic medication (items 9-10). Higher the score, better the adherence. The blood investigations, especially WBC counts, vital signs and BMI were within normal parameters. The client was groomed appropriately and communicated well. Glasgow Antipsychotic Side Effect Scale (GASS) score for clozapine was 16 which indicated mild side effects of clozapine. GASS is a 16-item self-assessed scale to monitor clozapine side effects with the score ranging from 0-48. A score of 0-16 indicates mild/no side effects, 17-32 mild or moderate side effects, and a score of 33-48 indicates severe side effects.

The parents were assessed for stress related to caregiving with KCSS (Kingston's Caregivers Stress Scale). This five point scale allows the family caregivers to express the level of stress they are experiencing. The scale is designed for community living lay caregivers. The scale can be used to monitor change in individual caregiver's stress over time. KCSS is a 10-item scale that measures stress related to caregiving issues (items 1-7), family issues (8, 9), and financial issues (10). KCSS Subjective Level of Stress is graded as mild (10-14), moderate (15-23) and severe (24 - 50). Stress assessment score of mother was 26 (severe) and of the father was 21 (moderate). The home care problems identified are tabulated below (Table 1).

Table 1: Various home care problems identified

Lifestyle modification	Instructional activities
Caregiver's stress	• Actively listened to the caregivers and patient • Allowed them to reflect on their coping mechanisms • Encouraged to identify the impact of stress on caregiver's mental health • Explained the importance of Pranayama on stress management and demonstrated the same
Management of side effects of clozapine after discharge	**Hyper salivation** • Educated the patient and family regarding the therapeutic effects of clozapine and the side effects of excessive salivation • Instructed the patient to swallow more often during the day, which can be encouraged by chewing sugarless gum • Recommended to lie down in lateral decubitus position and aspiration can be prevented • Use towels over the pillow during the night time to avoid wetness • Use extra pillows to prop up head during the night **Constipation** • Encouraged high fibre diet (green leafy vegetables, seasonal fruits) • Advised fluid intake of 1.5 to 2 litres /day (6-8 glasses) • Encouraged physical activity within the current ability to mobilize (30 mts walk/day) • Encouraged to follow relaxation techniques to control stress
Prevention of complications related to clozapine therapy	• Do not engage in any hazardous activity until response to the drug is known. Drowsiness and sedation are common adverse effects • Due to the risk of agranulocytosis, it is important to comply with blood test regimen • Report flu like symptoms, fever, sore throat, lethargy, malaise, or other signs of infection
Prevention of complications related to clozapine therapy	• Rise slowly to avoid orthostatic hypotension • Report immediately any of the following: unexplained fatigue, especially with activity, shortness of breath, sudden weight gain or oedema of the lower extremities • Take drug exactly as ordered • Do not use over the counter drugs or alcohol without permission of physician • Monitor for seizure activity. Seizure potential increases at higher dose levels • Check for recurrence of psychotic symptoms if the drug is being discontinued • Monitor for seizure, weight-gain, and hyperglycaemic index

Discussion

This case report describes the common problems and home care management of a client with SAD on clozapine therapy. The patient's level of insight into his or her own illness plays a significant role in the treatment of SAD. Patients with SAD tends to have better insight than schizophrenia.[7] The psychiatric nurse needs to assess the medication adherence level of the patient and GASS to ensure drug compliance. Assessment of the patient after 30 days, during the OPD review found the medication adherence of the client to be good. GASS score reduced to 8 and the KCSC of both the parents was 15.

Though there was increased salivation, patient was comfortable and was confident to manage it. Both the patient and family were able to manage the presenting side effects of clozapine and were aware about monitoring the life-threatening complications.[2] This case report throws light on the vital role the nurses could play in tertiary level of prevention and the need to involve family in caring the chronic mentally ill clients.

Home management of a client with schizoaffective disorder and on clozapine therapy is challenging for the family. The SAD is characterized by psychotic symptom exacerbation, mood disturbances and medication related adverse effects. Helping families to support the patient at home is an integral part of nursing care. By collaborating with family members, the patient's willingness to follow treatment and monitor symptoms, the recovery can be strengthened.

Conflict of interest

Nil

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