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Case Report

Psycho-education and home visit nursing for the families of atypical psychotics

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Abstract

Home visit nursing and psycho-educations are important after the discharge of psychotic patients. The purposes of home visit nursing are to adjust family relationships, offer guidance with the use of medicines and support daily life activities. Here we present a case in which siblings and their father were affected by atypical psychoses (oneirophrenia). The problematic personality of their parents were led the family to be classified as high EE (Emotional Expression) because the strain in the family was always high. Thus, the illness of the siblings relapsed and they had to be re-hospitalized. To prevent further relapse, psycho-education and home visit nursing were conducted. As a result, the father's attitude toward the siblings changed and the strain in the family decreased with the changes in their life style. Psycho-education and home visit nursing can have a good influence on atypical psychoses which are prone to relapse due to psychogenic factors.

Key word : home visit nursing, psycho-education, atypical psychoses

I Introduction

In psychiatry, three classification systems (Schizophrenia, Manic-depressive psychoses and Epilepsy) have been mainly accepted as classifications of endogenous psychoses. However, many clinical psychiatrists encounter cases that are difficult to classify. Mitsuda (1942, 1953, 1964, 1967, 1974) established the concept of "atypical psychoses" for borderline cases of these three psychoses on the basis of clinico-genetic studies. (Fig. 1)

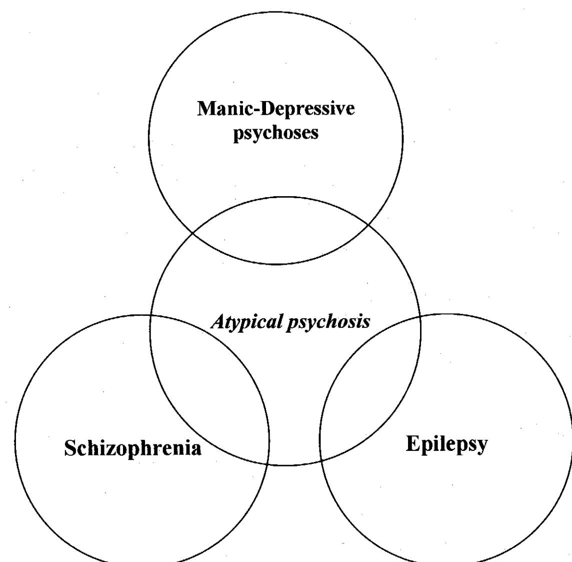

Fig. 1 Schematic representation of relationship between atypical psychoses and endogenous psychoses

Mitsuda's and Toyoda (1988)'s diagnostic criteria of atypical psychoses were (1) acute onset and triggered by motivation (2) the simultaneous or successive appearance of various kinds of symptoms such as hallucination, delusion, psychomotor unrest, affective symptoms, consciousness changes (3) phasic or periodic course with recovery within six months (4) no residual symptoms in general,

but sometimes slight residual symptoms (bradyphrenia) (5) exclusion of organic brain disease and symptomatic psychoses. Mitsuda proposed classifying atypical psychoses into three subtypes: Oneirophenia, Schizo-affective disorder, and Ictal depression. (Fig. 2)

Clinical pictures of atypical psychoses were frequent relapses due to psychogenic motivations. These patients repeat relapse and re-hospitalizations many times, making it important for patients and their family members to be given psycho-education.

Here we present the case report of two siblings, who were suffering from atypical psychoses (oneirophrenia) with frequent relapse and re-hospitalizations. But, when given psycho-education and home visit nursing to the family members, no relapses occurred for about two years.

Ⅱ Family history

Father (Ⅱ-1)

The father suffered from atypical psychoses (oneirophrenia). His premorbid character was short-tempered and explosive. He threatened to kill his daughters and their pet dog with a wood sword when they refused to obey him. In October 1998, his elder daughter broke into the Buddhist altar and stole the money that he had saved. In the first few days, he showed disturbed consciousness and felt that his body had shrunk (Body image disorder), and he couldn't recognize his wife when she came to the hospital to inquire after his condition. After several days, he underwent remission.

Mother (Ⅱ-6)

The mother was vain and often gave others various things althought she was not wealthy.

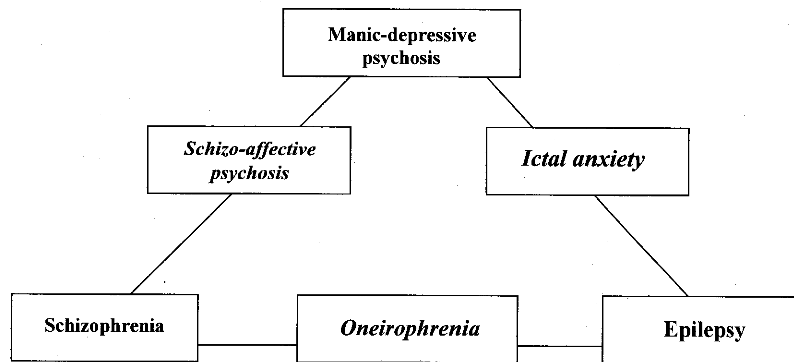

Fig. 2 Schematic representation of relationship between various clinical types of atypical psychoses and the type major psychoses

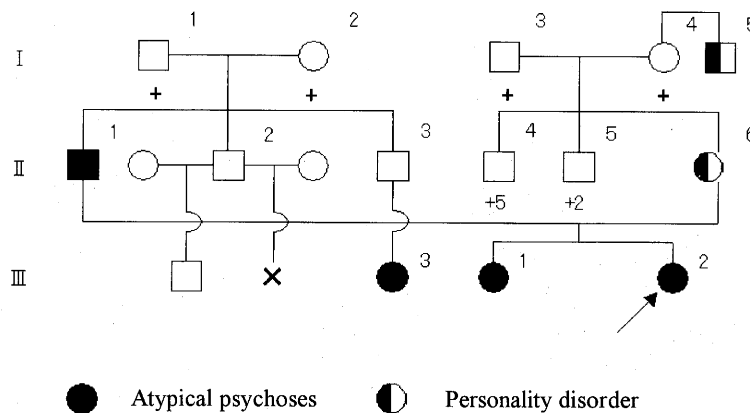

Fig. 3 Pedigree

When her family admonished her, she would run out and squander money. She had an egocentric character and did not listen to what another people said. Her way of thinking deviated from that of the norm. For example, she said, "a human being should commit suicide if he or she came to a deadlock in life". When telephoned to ask her to come to hospital to see her daughter who was hospitalized, she replied, "Why should I go? I'm very busy." and hung up. When her daughter was put in a protective surveillance room in the hospital, she complained aggressively. However, at the next meeting with the hospital staff, she didn't speak about that and behaved as though nothing had happened. She was always aggressive when she called the hospital.

Ⅲ Presentation of the cases

CASE No. 1

Younger sister (Ⅲ-2), 29 years old, female

Diagnosis

Atypical psychosis (oneirophrenia)

Developmental history

She was too shy to come out to the barber shop run by her mother from when she was young. The mother was always busy, did not talk with her enough. The mother would start a fight if daughter did not obey.

Educational background

She graduated from a hairdressing technical school but could not pass the examination for the certification.

Hospitalization history

She had been hospitalized in Hospital A three times for short periods (one month, three months, one month) until she came to our hospital. She has since been re-hospitalized five times due to psychogenic factors.

Each time, she recovered in a short time and was discharged from the hospital. She worked as a part-time waitress with her older sister, while helping the family business.

Clinical findings

Her consciousness was disturbed and she could not recall things every time she was admitted. For the first few days, she could not understand how many days had past. She would state that she had slept for several days in the protection room. She said that she had been in a dreamy state, and could not recall all of her behavior. She could not understand why she was in such a place. She partially recalled having had a hot drink and sandwich in the protection room and having been keening on the ground. There were no pathological experiences such as hallucination, and she was not in manic or depressive state. After treatment, she was courteous and spoken clearly. Her expression was not rigid and cold, differed from that of typical schizophrenia. Except for an inferiority complex, she talked well with a roommate. She displayed complete remission and was discharged.

Psychological test findings

1 Personality Test

〈Rorschach test and HTTP〉

Her potential ability is low and she tends to have a negative view of the world. However, there is no strong distortion of thought such as schizophrenia. With some stimulation from the outside world, she loses self control and logical thought and may act on impulse. She has a fanciful character and shows strong persistence. Friction arises with other person.

2 Intelligence test

〈WAIS－R〉

Total IQ=47, Verbal IQ=51, Performance IQ=52

EEG findings

The basics wave was consist of 50μV, 13–14 Hz, with little appearance of α waves. α-Blocking with the opening-eye posture is observed, but not activation by light stimulation. A borderline EEG was suggested.

MRI findings

No pathological findings were observed on the images.

CASE No. 2

Older sister (Ⅲ-1), 32 years old, female

Diagnosis

Atypical psychosis (oneirophrenia)

Developmental history

This sibling suffered from a complex fracture in a traffic accident when in elementary school. From that time, she came to have a gloomy character, and study began to lag behind in her studies. When chatting with her mother, they seemed to be having a comic dialogue. She had a sensitive character and became very easily depressed. For example, when told that she was fat, she became depressed and anorexic. Small stress factors caused a large amount of damage to her. She also had an explosive character, begin short-tempered and complaining a lot.

History of hospitalization

She was hospitalized for short terms (for

from 2 months to 1 year) with re-hospitalization five times at our hospital. She showed a dreamy and phantasm-like state for the peak period of every hospitalization. After the appearance of clear visual hallucinations, division of self and auditory hallucination, these pathological experiences disappeared after a short term and she was discharged from the hospital.

Clinical history

On admission, she was a state of so-called oneirophrenia, in which she could not understand whether she was in a dream or facing reality. She saw scenes such as "black and white or colorful scenes of men and women, and unknown materials on a track" (visual hallucination). She experienced autoscopy such as a "figure of herself floating to the ceiling." She also had auditory hallucinations of somebody complaining about her.

In addition, she experienced an imaginary pregnancy with a member of the idol group on which she had spent much money. She also said she had two "her-selves" senses (the second self, splitting of the ego). One of her cried and the other watched it. One of her told the other "please kill me", one said "someone will come to save you, so you cannot die now". These symptoms improved with treatment. After being discharged from hospital, she helped her parents with their hairdressing business.

Psychological test findings

1 Personality Test

〈Rorschach test and HTTP〉

A marked distortion of thought such as schizophrenia is not observed. There is escape from reality to a dream world. She shows a tendency to regress. In addition, she is immature and anaclitic and act impulsively with strong emotional stimulation. However, superficial rapport could be kept, and she seems to be capable of reaction to fit the situation.

EEG findings

The basics wave was 50μV, 13–14Hz, with little few appearance of α waves. α-Blocking with opening-eyes was accepted, but activation by light stimulation or hyperventilation was not. No ictal abnormal wave was seen. EEG findings seem to be within the normal range.

MRI findings

No organic change was found in the normal range.

Ⅳ Psycho-education and home visit nursing for family members

Psycho-education for parents

The problem in this case was that their parents did not understand the cause of the disease of the siblings. In addition, their parents, especially their mother, displayed a non-cooperative attitude toward their treatment. The physician had to repeatedly give psychiatric explanations about the cause of the illness and the treatment policy to the parents.

In addition, the strain state got high easily because they ran a hair dressing shop as a family business, spending all their time. This contributed to the relapse process of the sisters. Thus there was a need for home visit nursing care and adjustment of family relationships.

Home visit nursing

Home visit nursing was started after the discharge of the older sister. We visited them three times in the first month. The number of visits was reduced, and is now done once a month. Two nurses visited their home for two hours in the afternoon on a regular holiday of the hairdressing shop. on the first home visit, they were not receptive. For example, the father lay down with fanning himself and watching television. In addition, the strain level in the family was high and the quarreling did not stop.

We gave guidance on the taking medicine and offered consultation. We also tried to adjust the family relationships. As working together all day long seemed to be a cause of stress, we advised and arranged for the family member to spent time separately. The sisters began to go to different job training institutes and became independent in terms of time and money.

Changes

As a result of such guidance, the sisters began to organize their lives, comply with medicine schedules and continue consultation with hospital after the discharge of the older sister. In addition, the father's attitude toward daughters became more patient and gentle. He stopped his fits of emotional anger. Freedom from a stressful situation allowed the sisters to go to work happily and achieve a more stable state of mind and body. Quarrels among

family members decreased.

After the change

As the condition of the sisters began to stabilize with our intervention, their attitude toward us became courteous. The father's attitude also changed. He began to display affection for his daughters and their pet dog of the sisters, which he had previously threatened to kill. His emotional quarrels disappeared. The sisters talked about an event of the day and at work at dinner time. The older sister stated "So far, it was stressful for the family to work in the same place together every day. Now by working separately in the daytime, we have a sense of self-composure. As for the trouble with my parents, I was a bad daughter. Now I feel sorry for that.". The sisters haven't suffered from relapse for about 2 years.

V Discussion

The sisters of this case study were diagnosed as suffering from schizophrenia at first. However, from the symptoms, course of illness and outcome, it was not typical schizophrenia but atypical psychoses proposed by Mitsuda (1942, 1953, 1964, 1967, 1974). This classification system of endogenous psychoses was based on clinical genetics studies. Atypical psychoses were identified in the borderline area of three endogenous psychoses (Schizophrenia, Manic-depressive psychoses, Epilepsy). In addition, Mitsuda (1942, 1953, 1964, 1967, 1974) showed that atypical psychoses tend to be dominant inheritance, which according to the family tree, was also the case for these siblings.

Mitsuda (1942, 1953, 1964, 1967, 1974) proposed that atypical psychoses could be divided into three subtypes : oneirophrenia, ictal depression and schizo-affective disorder. These cases were classified as oneirophrenia according to Mitsuda (1942, 1953, 1964, 1967, 1974)'s diagnostic criteria.

Hosaki (2003) described atypical psychoses as consciousness disorder at the peak period without being able to recall this later. Deficit of partial memory was also seen.

Various symptoms other than consciousness disorder were pointed out by Mitsuda (1942, 1953, 1964, 1967, 1974), such as splitting of the ego, colorful visual hallucinations and autoscopy.

Visual hallucinations tended to be seen in epilepsy (temporal lobe epilepsy), various toxic psychoses and organic brain-related disease according to Wada (1972), Otsuki (2003), Miyasaka et al. (1984) and Kawaguchi et al. (2002).

According to Furuta (2002), colored visual hallucinations were regarded as mesencephalic hallucinosis. Kawaguchi (2002) considered them from the fusiform gyrus and inferior temporal gyrus. However, generally there are few visual hallucinations in endogenous psychoses. In addition, disturbance of consciousness, colored visual hallucination and autoscopy were seen in this case. It was thought that atypical psychoses were close to epilepsy as Mitsuda (1942, 1953, 1964, 1967, 1974) pointed out.

In psychological tests, Otsuka (1960) compared the characteristic of schizophrenia and atypical psychoses. In addition, Terashima (1989) said atypical psychotic patients did not show marked distortion of thought and recognized the outside world objectively. However, they were poor in ability to deal with emotional stimulation adequately and become emotional easily. The same tendency was recognized by the psychological test that we carried out for this case.

However, atypical psychoses (oneirophrenia) as this case correspond to F23.9 acute and transient psychotic disorders, unspecified in ICD-10 (World Health Organization, 1992) classification as an international diagnosis standard. In DSM-IV (American Psychiatric Association, 1994), it corresponds to 298.9 : psychotic disorder, unspecified. However, these diagnostic criteria were like waste basket diagnosis, not classifying atypical psychoses as an independent diagnosis. The concept of atypical psychoses needs to be emphasized on the basis of clinical biological study. Mitsuda (1942, 1953, 1964, 1967, 1974) stated that atypical psychosis was "illness of consciousness" related mainly to disturbance of consciousness whereas typical schizophrenia was "illness of personality". Further examination of classification system is necessary.

The cause of this case, as described by Plomin (1994), could be thought from both sides of nature and nurture. As three people (two siblings and their father) were affected with atypical psychoses (oneirophrenia), a tendency of dominant inheritance was sus-

pected. Mitsuda (1942, 1953, 1964, 1967, 1974), Sakai (1981) and other researchers proposed that atypical psychoses occur easily and recur with stimulation from psychogenic factors. Thus, the family members need counseling to prevent relapse. Therefore, we started psycho-education and regular home visit nursing and tried to moderate the strain for the siblings who had repeated relapses.

Generally, the purposes of home visit nursing for psychotic patients are guidance (confirmation) for taking medicine, daily support, and adjustment of family-relationships. For atypical psychoses, the purposes of home visit nursing were approximately the same. In this case, adjustment of the family-relationships was most important.

Of the four family members, the father and sisters had a history of atypical psychoses. The characters of parents were deviant. In addition, family strain was particularly high because they spent all the day working together in the hairdressing shop in addition to living together.

From such a point of view, this home was of high EE (High Emotional Expression), as described by Oshima (1994), Ito (1994). As a result, quarrels occurred frequently in the home. Such stress and strain in the family led to the siblings relapse.

Since the start of home visit nursing, the father's attitude toward the family became gentle. Stress and strain in the home was decreased, and the state of the siblings has been stable for about two years. To prevent relapse, we will continue temporary nursing at home, promote family-related adjustment as necessary.

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