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# APPLICATION OF ACCEPTANCE COMMITMENT THERAPY IN SCHIZOAFFECTIVE PATIENTS WITH HALLUCINATIONS AND SELF-CARE DEFICITS

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***ABSTRACT***

Schizophrenia is the most widely treated psychotic disorders in mental hospitals. The prevalence of the schizoaffective disorder is difficult to determine precisely because of the limited data available. Schizoaffective disorder has positive symptoms include hallucinations and negative symptoms include self-care deficits. Interventions that can be used to resolve hallucination problems and self-care deficits, among other acceptance commitment therapy that are part of behavioral therapy. This study aims to describe cases of treatment hallucinations and self-care deficits in schizoaffective patients using acceptance commitment therapy. This study is a case report using a descriptive observational design on one patient. In this study, patients were medically diagnosed schizoaffective with nursing problems, sensory perception disorders, and self-care deficits. Patients receive treatment in the form of acceptance commitment therapy for four sessions. There was a decrease in hallucinations and self-care deficit symptoms after acceptance commitment therapy was given. Acceptance commitment therapy can reduce symptoms of sensory perception disorder hallucinations and self-care deficits in schizoaffective patient.

Keywords: acceptance commitment therapy; hallucination; self-care deficit; schizoaffective

## INTRODUCTION

The most common diagnoses in mental hospitals are schizophrenia and other psychotic problems (27,6%) (Addisu et al., 2015). Schizophrenia is a complex clinical syndrome of psychiatric disease, with psychopathological manifestations, which include changes in thinking, perception and emotions, as well as disorders of motricity and behavior (Mendes Braga et al., 2015). Many other mental disorders have schizophrenic signs such as schizophreniform, acute psychotic disorders, and schizoaffective. Schizoaffective disorder is a period of continuous mental illness, during which major depressive episodes, manic episodes or mixed episodes occur along with schizophrenic symptoms. (Mohr, 2013).

The prevalence of schizophrenia disorders in general nationwide in Indonesia based on basic health research in 2018 is 6.7 ‰ (Badan Penelitian dan Pengembangan Kesehatan Kementerian Kesehatan RI, 2018). It is difficult to determine the prevalence of schizoaffective disorder precisely because of the limited data available (Padhy & Hedge, 2015). In Indonesia, research on schizoaffective is still very rare (Supriyanto, n.d.).

Schizoaffective is a psychotic symptom that persists and simultaneously experiences mood disorders (Videbeck, 2011). Psychotic symptoms that appear are categorized into positive symptoms and negative symptoms (Stuart, 2013). Positive symptoms are symptoms of enlargement/distortion of normal brain function, including hallucinations, delusions, thought disturbances, slurred speech, and strange behavior. Hallucinations are sensory-perceptual

errors that involve the five senses, and the most common are auditory and visual hallucinations (M. C. Townsend & Morgan, 2018). Meanwhile, negative symptoms are a decrease/loss of normal brain function such as flat affect, alogia, apathy, anhedonia, asocial and attention deficit. Negative symptoms can lead to nursing problems such as self-care deficits. Self-care deficits include bathing, dressing, eating, and toileting (NANDA International, 2018).

Interventions that can be done in patients with hallucinations include observation for signs of hallucinations; avoid touching the patient if not notified as this could be a threat to the patient; acceptance will encourage the patient to share the contents of the hallucination; do not amplify hallucinations; distract the patient from hallucinations; counter hallucinations/voice rejection to exert conscious control over patient behavior (Mary C. Townsend, 2011). Self-care deficit problems, especially bathing, can be overcome with management interventions and behavior modification (Moorhead et al., 2013). Acceptance commitment therapy is one of behavioral therapies (Twohig, 2012).

Based on this description, the authors are interested in conducting a case study of the treatment of schizoaffective patients who experience hallucinations, self-care deficits, and have received acceptance commitment therapy. This study aims to describe case management of hallucinations and self-care deficits in schizoaffective patients using acceptance commitment therapy intervention.

## METHOD

The method used in this study is a case report with a descriptive observational design. The case report sample consisted of one patient with inclusion criteria who experienced schizoaffective with sensory perception disorders hallucinations, and deficits in self-care and received acceptance commitment therapy. The place to do the case report at the Mental Hospital Marzoeki Mahdi Bogor. The patient has been willing to participate in this study. This study has also received permission from the Marzoeki Mahdi Mental Hospital.

## RESULTS

Case report

Patient Mr. W has been admitted to the 10th day in the mental inpatient ward. The main complaints while being hospitalized include being angry for no reason, talking to himself, laughing to himself and not being able to sleep in the last few days. The 47-year-old patient was diagnosed with schizoaffective. The patient has been hospitalized many times since 20 years ago. The patient has a history of head injury. One month before being admitted to the hospital, the patient stopped taking medication. The patient has the unpleasant experience such as divorce from his wife. Most recent high school patient education and work self-employed. The patient conflicts with his wife. Mr. W has no close friends and has never participated in any social activities in his neighborhood.

The mental status assessment results showed that the patient did not look neat, did not change clothes, bathed only once a day. The patient's speech is domineering, talkative, and often incoherent. The motor activity of the patient is restless during the cooperative patient interview. The patient's feelings are happy with unstable effects. Perception experiences visual hallucinations. The content of thought is about obsession—the process of thinking of the patient's flight of idea. The level of awareness patient shows the orientation of reality, time, and good people. The patient has short-term memory impairments. The patient can

count, and the concentration is easily distracted. The assessment has impaired the ability to assess meaningful and negative self-view, blaming others.
Patients receive medical therapy in the form of haloperidol 2mg x 1, trihexyphenidyl 2mg x 2, clozapine 25mg x 1 and Depakote ER 500mg x 1. The nursing actions given are generalist nursing actions in fighting hallucinations; controlling hallucinations by taking medication; talking and doing activities to divert attention to hallucinations. The patient also received acceptance commitment therapy for four sessions. Changes in signs and symptoms of hallucination and self-care deficits after receiving Acceptance Commitment Therapy can be seen in Table 1.

Table 1.
Changes in Signs and symptoms of hallucination and deficit self-care

| Nursing Diagnosis | Signs and Symptoms before intervention of ACT | Signs and Symptoms after intervention of ACT |
|---|---|---|
| Hallucination | Poor self-perception, unable to focus your mind, circumstances, flight of ideas, feeling shackled / tied up, sad, having trouble sleeping, indifferent to the environment, unable to maintain the conversation | unable to focus your mind, circumstances, flight of ideas, indifferent to the environment |
| Deficit self-care | Feeling lazy, dirty body, smelly skin, dirty teeth, smelly teeth, dirty clothes, untidy clothes, difficulty asking for help from others for self-care, not conveying any problems in self-care | dirty teeth, smelly teeth, difficulty asking for help from others for self-care, not conveying any problems in self-care |

## DISCUSSION

In this case, it appears that the patient has stopped taking medication one month before being admitted to the hospital. The age of schizoaffective onset and genetic risk is similar to that of schizophrenia, but the long-term prognosis of schizoaffective is likely to be better.. The prevalence in women is slightly higher than in men (Rose, 2014). 37.1% of patients who stopped taking their own medication experienced a relapse of 76.9% (Üçok & Kara, 2020). The relapse rate of psychotic patients is 61% after 7-12 months of stopping antipsychotic drugs in the first episode and will be getting bigger in the future (Gaebel et al., 2020)

People with schizoaffective disorder are often treated with a combination of psychotherapy and drugs (National Alliance on Mental Illness, 2015). In this study patients received 2 mg x 1 haloperidol, 2 mg x 2 trihexyphenidyl, 25 mg x 1 clozapine and 500 mg x 1 ER Depakote. Some of the drugs approved to treat schizoaffective disorders include: antipsychotic drugs, health care providers will prescribe antipsychotics to reduce symptoms of psychosis, such as delusions and hallucinations; antidepressant drugs, when symptoms of major depressive disorder appear, depressive type antidepressants are given to relieve feelings of sadness, hopelessness and difficulty concentrating; mood stabilizers, when bipolar disorder appears, mood stabilizers can help stabilize fluctuations (National Alliance on Mental Illness, 2015).

A mood stabilizer was given for the bipolar subtype. Depakote is a drug derived from valporic acid, which has a better therapeutic index and better toxicity. It is more effective on the bipolar subtype compared to lithium (Stuart, 2013). Antidepressants for depressive subtypes and antipsychotics for persistent psychosis. If these treatment strategies fail, clozapine is given (Padhy & Hedge, 2015). The patient also received an atypical antipsychotic drug, namely clozapine. Administration of atypical antipsychotics resulted in less tremor, nervousness and saliva production. Olanzapine is also beneficial in the treatment of both positive and negative symptoms at the same time (brar et al., 2016). This is different from haloperidol, which is a typical antipsychotic drug that deals more with positive psychotic symptoms. Positive psychotic symptoms include aggressive behavior (Khushu et al., 2016). In this case the patient committed violent behavior so that he received haloperidol treatment.

The majority of antipsychotic drugs are domanin D2 receptor antagonists and can cause side effects such as extrapyramidal syndrome (EPS). Dopamine is an inhibitory neurotransmitter in the caudate nucleus of the basal ganglia that is known to balance cholinergic oxytatory neurons in the same pathway. The use of antipsychotics can decrease dopaminergic activity by blocking dopamine D2 receptors and altering this balance. (Ogino et al., 2014). To overcome the extrapyramidal effect of antipsychotic drugs, an anticholinergic drug, trihexyphenidyl, is used, although most of these are not preceded by EPS testing. (Azmi & Desrini, 2016; Sheikh, 2019). The use of trihexyphenidyl requires caution because it can be abused by patients by taking it in increasing doses and tends to report pleasant sensations. (Mahal et al., 2018). The best evidence for schizoaffective treatment is the administration of atypical antipsychotics as well as added psychotherapy (Bianca & Hans-joerg, 2020). The psychotherapeutic approach recommends avoiding direct confrontation with delusion/hallucination and focusing instead on the consequences of negative behavior (Rose, 2014). Psychosocial interventions in patients who did not receive antipsychotics also showed similar results compared to patients taking antipsychotic drugs. (Cooper et al., 2020)

Acceptance and commitment therapy focuses on active acceptance and at the same time orienting the person to achieve the worthy goal of being able to escape hallucinatory symptoms (Harris, 2007; Veiga-Martínez et al., 2008). Hallucinations are one of the positive symptoms of psychosis patients (Pankey & Hayes, 2003). Hallucination is a perceptual experience without any real external stimulus (Halter & Varcarolis, 2018). Hallucinations are different from delusions. Delusions are mistakes/misperceptions of real experience. Hallucinations could happen due to mental disorders, drug abuse, medication, organic disorders, hyperthermia, poisoning, and other conditions. There are five hallucinations: auditory hallucinations, visual hallucinations, hallucinations, taste hallucinations, tactile hallucinations, and olfactory hallucinations. In reducing hallucinations, self-management is necessary as an effective strategy (Suryani, 2015). The therapeutic process in ACT includes facing the system; recognizing control as the problem; identify cognitive and conscious defusions; develop a transcendent sense of self, promoting acceptance and willingness; explain values; building commitment (Hayes, 2004). ACT in the process of treating mental illnesses by encouraging therapeutic participation using techniques that reduce self and social stigma associated with psychological disorders and disabilities (Larmar et al., 2014).

In patients experiencing hallucinations, ACT instead looks for the development of new responses in the face of previously avoided events that reduce the power of its behavioral regulation, such as being more willing to experience hallucinations as an experience, not as it is said to be, to accept the feelings that occur and to focus on behaviors that promote value and goals even in the presence of difficult experiences.

In this study, the symptoms of self-care deficit decreased. Self-care deficit is a negative symptom of a psychotic condition. Negative symptoms are conditions in which reduced behavior in normal/healthy people should be present (Stuart, 2013). The severity of negative psychotic symptoms is associated with poorer cognitive performance (Gotra et al., 2020). Schizoaffective patients showed significantly greater disease duration on the Anxiety Score and Depression Anxiety and Stress Scale (Lee et al., 2019).The use of ACT in psychosis patients using the randomized control trial method shows that ACT is proven to be more suitable in patients who fail with CBT and can reduce the behavior of negative symptoms better than CBT and also be more cost-effective because of the use of fewer sessions and can be applied by many health practitioners (Thomas et al., 2014; Tonarelli et al., 2016).

The psychotic disorder is a chronic disease condition (Tonarelli et al., 2016). ACT can improve patients' quality of life with chronic diseases (Suhardin et al., 2015). An increase in life quality occurs because it increases acceptance of the disease, self-awareness, and values-based life (Dewantoro & Kurniawan, 2019). After four months, the application of ACT and general measures showed a decrease in the incidence of re-hospitalization, namely 9% compared to only having general measures of 40%. (Tyrberg et al., 2017). It is hoped that by doing ACT in schizoaffective patients, patients can reduce re-hospitalization. This is because in this case study, the patient had often undergone re-hospitalization.

## CONCLUSION

The acceptance commitment therapy application reduces signs and symptoms of nursing problems, hallucination/ sensory perception disorders, and self-care deficits. This study implies that psychotherapy in people with a mental health disorders can be further enhanced and increase the number and role of mental nursing specialist nurses in the clinical setting.

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