# Schizophrenia & Related Disorders

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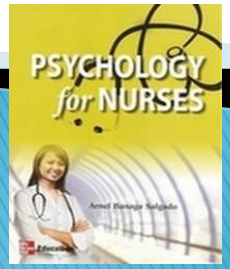


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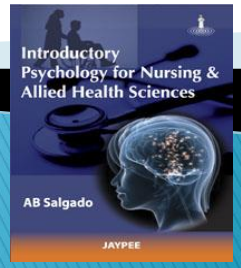


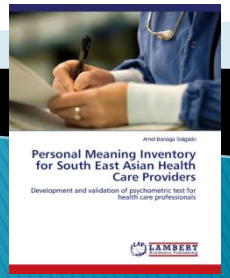

# Learning Objectives

- Describe the concept of schizophrenia
- Discuss various dimensions of schizophrenia
- Discuss the various aetiological theories of schizophrenia
- Chart out appropriate nursing diagnosis and outcomes for a patient with schizophrenia
- Describe various intervention strategies for the management of schizophrenia

# TERMS TO REMEMBER

Catatonic – a position of a body in a fix wax-like state

Clang Association – rhyming of words in a sentence that make no sense

Delusional Ideation – a false belief brought about without appropriate external stimulation and inconsistent with the individual's own knowledge and experience

Echolalia – an involuntary parrot – like repetition of words spoken by others

Echopraxia – a meaningless imitation of motions made by others

Hallucination – (Visual, Auditory, tactile, olfactory, gustatory)

Illusion – inaccurate perception or misinterpretation of sensory impressions

Neologism – New words that are invented by and have meaning to only one person

## TERMS TO REMEBER

Psychosis – a disorderly mental state in which a client has difficulty distinguishing reality from his own internal perception

Thought Broadcasting – the delusional belief that others can hear one's thoughts

Thought Control – The delusional belief that others can control a person's thoughts against one's will

Thought Insertion – the delusional belief that others have the ability to put thoughts in a person's mind against one's will

Word Salad – the combining of words in a sentence that have no connection and make no sense

# History

- Emil Kraeplin gave a detailed explanation of this disease and used the term dementia praecox.
- Bleuler named it schizophrenia (splitting of the mind). He listed this disease's symptoms under 4 A's:
  - Affective blunting
  - Association (loosening of association)

# History

- Ambivalence
- Autism

- Kurt Schneider described a group of symptoms believed to be pathognomic of schizophrenia in the absence of organic brain disease. These symptoms are known as first rank symptoms.

# History

- Schizophrenia represents the most severe form of psychotic disorders. The other psychotic disorders show all or some of the features seen in schizophrenia but differ in intensity, duration and functional impairment.

# Other Psychotic Disorders

- Brief Psychotic Disorder
  Presence of florid psychotic symptoms (delusions, hallucinations, formal thought disorder), disorganized behaviour or catatonic signs
- Schizophreniform Disorder
  Essential features of schizophrenia are present

# Other Psychotic Disorders (cont.)

- Schizoaffective Disorder
  Presence of both mood disorder (manic, depressive or mixed episode) and characteristic features of schizophrenia simultaneously for a considerable period of illness
- Delusional Disorder
  Presence of non-bizarre delusions

# I. Overview/Classification

A. Schizophrenia is one of a cluster of related psychotic brain disorders of unknown etiology
B. Schizophrenia is a combination of disordered thinking, perceptual disturbances, behavioral abnormalities, affective disruptions, and impaired social competency
C. Symptoms of Schizophrenia typically include
    1. Delusional Ideation: a false belief brought about without appropriate external stimulation and inconsistent with the individual's own knowledge and experience
    2. Hallucinations: a false sensory perceptions that may involve any of the five senses
    3. Disorganized Speech patterns
    4. Bizarre Behaviors

D. At least 2 of these symptoms must be present for a significant portion of the time during 1 month period.

E. Other Manifestations include social impairment and cognitive impairment: the subtypes of schizophrenia have similar features, but differ in their clinical presentations

F. Critical essential features of each sub types

1. Paranoid Type –

- Auditory Hallucination
- Preoccupation with one or more delusions usually of a persecutory type
- May appear hostile or angry
- None of the following are present: flat or inappropriate affect, disorganized speech or behavior, catatonia

2. Catatonic Type –

- Stupor (State of daze or unconsciousness) or extreme motor agitation
- Excessive Negativism
- Inappropriate or Bizarre Body posture
- Echolalia or Echopraxia

3. Residual Type –

- Absence of prominent psychotic Symptoms
- Social withdrawal and inappropriate Affect
- Eccentric Behavior
- Past history of one episode of Schizophrenia

4. Disorganized Type –
   - Disorganized Speech
   - Disorganized Behavior
   - Inappropriate or blank Affect

5. Undifferentiated Type –
   - Disorganized Behaviors
   - Psychotic Symptoms

# Other Psychotic Disorders (cont.)

- Shared Psychotic Disorder (Folie a deux)
  Psychotic disorder (delusions usually) in one person (primary) is shared by another one (secondary) in a close and dependent relationship
- Post-Partal Psychosis
  Presence of florid psychotic symptoms (delusions, hallucinations, formal thought disorder), disorganized behaviour or catatonic signs

# Epidemiology

- Lifetime prevalence : 1% throughout the world without any difference across various races, religions, cultures and economic groups
- Common age of onset : 14–25 years

# Other Psychotic Disorders (cont.)

- Gender : Affects both equally though the onset of illness
  : Is earlier in males and these patients have poor pre-morbid adjustment and tend to have poor prognosis

# Comorbidity

- Approximately 40–50% of patients with schizophrenia have substance abuse disorder.
- Depressive symptoms are quite common, especially when they are recovering from the disorder.
- About 20–40% of such patients attempt suicide and 10% die of suicide.

# Aetiology

- The exact cause of schizophrenia is not known. It is highly likely that multiple causative mechanisms interact to cause the illness.

**Biological Factors**

i. Genetic factors

- Rate of schizophrenia is much higher in the first-degree relatives of persons with schizophrenia.

# Aetiology (cont.)

- Risk is about 50% in children of both parents with schizophrenia, 12% when one parent has schizophrenia risk of 10% in the siblings.
- In monozygotic twins, the chances of second twin having schizophrenia is 50% if one twin does, dizygotic twins is 8–12%.

# Aetiology (cont.)

- Studies suggest that multiple genes on different chromosomes interact within themselves and with the environment to cause schizophrenia.

# Aetiology (cont.)

ii. Neuroanatomical Theories

- Enlarged cerebral ventricles
- Cerebral atrophy especially of frontal lobes
- Cerebellar atrophy
- Reduced cerebral blood flow,
- EEG and evoked potential abnormalities in prefrontal cortex, limbic and temporal lobes.

# Aetiology (cont.)

iii. Neurochemical Theories

- Hyperactivity of dopamine
- Increased activity of serotonin
- Decreased activity of gamma aminobutyric acid (GABA)
- Increased activity of noradrenalin and peptides

# Aetiology (cont.)

iv. Miscellaneous

Other factors include:

- *in utero* viral infections,
- increased pregnancy and birth-related complications, and
- late age of fathers at the time of birth (55 or more).

# Aetiology (cont.)

## Psychosocial Theories

- Two theories about the role of family in the aetiology of schizophrenia have been proposed:
  - Deviant roles of parents where either one parent yielded to the eccentricities of another parent who dominated the family (marital skew) or both the parents had conflicted views so the child develops divided loyalties (marital schism).

# Aetiology (cont.)

- Disordered communication (double bind)—overt instruction is contraindicated by a second subtle or covert instruction.

# III. Assessment for Symptomatology (S/Objective)

**A. POSITVE Symptoms indicate a distortion or excess of normal functioning; they occur as initial Sxs of schizophrenia and precipitate the need of hospitalization**

1. Delusions
    1. Paranoid type – client is hostile, suspicious and aggressive
    2. Grandiose Type – Excessive feelings of importance and power over others
    3. Religious Type – Religious Context
    4. Somatic Type – irrational belief about his body
    5. Nihilistic Type – delusions of non-existence
    6. Persecutory – others are out to get him
    7. Thought Broadcasting – others can hear his thoughts
    8. Thought Insertion – put his thoughts to others
    9. Thought Control - he can control one's thought against will

## III. Assessment for Symptomatology (S/Objective)

2. Hallucinations (usually auditory)
3. Psychosis
4. Illusions
5. Agitation
6. Hostility
7. Bizarre Behavior (catatonic, etc.)
8. Association Disturbances
    1. Echolalia
    2. Echopraxia
    3. Clang associations (rhyming)
    4. Illogical Thinking
    5. Neologism
    6. Word Salad

**B. NEGATIVE Symptoms indicate loss or lack of normal functioning; these develop over time and hinder one's ability of enduring tasks.**

1. Anhedonian (inability to experience pleasure)
2. Alogia (poverty of speech)
3. Anergia (lack of energy)
4. Avolition (lack of motivational goals)
5. Ambivalence (conflicting emotions)
6. Affective disturbance
   - Blunted
   - Flat
   - Inappropriate
7. Restricted emotion

## III. Assessment for Symptomatology (S/Objective)

8. Social withdrawal
9. Dependency
10. Lack of ego boundaries
11. Concrete Though processes
12. Lack of self-care
13. Sleep Disturbance

# Nursing Assessment

## Dimensions of Schizophrenia

| Positive dimensions | Negative/deficit dimensions | Cognitive dimensions | Affective dimensions |
|---|---|---|---|
| - Delusions<br>- Hallucinations<br>- Formal thought disorder<br>- Bizarre behaviour | - Alogia (decreased speech)<br>- Asociality<br>- Avolition (lack of initiative)<br>- Apathy<br>- Anhedonia (inability to experience pleasure)<br>- Affective flattening<br>- Attention deficits | - Poor attention and concentration<br>- Poor memory<br>- Inability to make decisions<br>- Poor problem solving skills<br>- Illogical thinking<br>- Poor judgement | - Depression<br>- Dysphoria<br>- Irritability |

# Nursing Assessment
## Course of Illness

- Various phases in the course of the illness can be described as the following:
  - i. The acute phase presence of florid psychotic symptoms such as delusions and hallucinations. Negative symptoms also may be present but may not be quite evident.
  - ii. The stabilization phase is the period when the acute symptoms decrease in severity but may be present. Rehabilitation process is started in this phase
  - iii. Maintenance phase is the period of remission, although mild symptoms may persist.

# Nursing Diagnosis

- The nursing diagnosis for a patient with schizophrenia is formulated based on the mental and physical status assessment.

| Symptoms | Nursing Diagnosis |
|---|---|
| Delusions | Disturbed thought process<br>Defensive coping |
| Formal thought disorder | Disturbed thought process<br>Impaired verbal communication |
| Auditory hallucinations | Disturbed sensory perception<br>Risk of violence to self or others |

# Nursing Diagnosis (cont.)

| Symptoms | Nursing Diagnosis |
|---|---|
| Alogia<br>Asociality<br>Apathy<br>Anergy<br>Avolition | Impaired social interaction<br>Social isolation<br>Risk for loneliness<br>Ineffective coping<br>Self-care deficit |
| Depression/dysphoria<br>Ideas of worthlessness<br>Poor drug compliance | Low self-esteem<br>Risk for self-directed violence<br>Non-adherence |
| Family members—ignorant of illness, feel stressed or burdened | Deficient knowledge<br>Caregiver role strain<br>Compromised family coping |

# Nursing Outcome Criteria

- The desired outcome criteria may vary with the phase of the illness.
- Outcome criteria should focus on minimizing the deficits and improving the quality of life.
- Acute phase: The main goal during this phase is the safety of the patient and control of symptoms with medication.

# Nursing Outcome Criteria (cont.)

- Stabilization phase: Outcome criteria focuses on treatment compliance and educating the patients and families regarding the nature of illness, course, prognosis, need for treatment and regular follow-up.
- Maintenance phase: In addition to the outcome criteria during stabilization phase, the focus is on the negative symptoms as well as on psychosocial rehabilitation of the patient. Involvement of the family and other social support systems is encouraged.

# Planning and Implementation

- The planning of the appropriate intervention is guided by the phase of the illness.

1. Acute Phase

   a. Hospitalization.

   – Various indications for hospitalization include aggression, suicidal ideas, refusal to eat or drink and neglect of self-care as well as a need for detailed medical workup and treatment.

# Planning and Implementation (cont.)

b. Medications.

- Acute symptoms are controlled by both typical and atypical antipsychotic drugs.

c. Electroconvulsive therapy

- This is another option to control continued violence and catatonic symptoms, both in the withdrawn and excitatory phases.

# Other Strategies Used in the Management of Acute Phase

- Milieu Therapy
  The hospital provides a structured environment, which should have the necessary safety features.
- Communication Strategies
  Appropriate communication strategies will reduce the patient's distress.
- Psycho-education
  Education is an essential and powerful strategy in preventing relapse.

# Communication Strategies

- Be open, honest and non-judgemental
- Maintain your calm and be relaxed
- Do not negate or accept the experience (voices or delusions)
- Do not react as if the experiences are real
- Offer your own perceptions of the reality
- Focus on the feelings associated with the voices or delusions

# Communication Strategies (cont.)

- Try to find out the events that trigger or exacerbate these experiences
- Help the patient to divert his attention by using simple techniques such as reading aloud, listening to music, watching TV, singing, etc.
- Plugging the ears with cotton or listening the music through earphones may cut off the voices

# Psychoeducation

Both the patient and the family are provided with the information about the following:

- Cause and nature of illness, course and prognosis
- Available medications and their side effects
- Need for regular treatment, duration of treatment and follow-ups
- Recognition of early signs of relapse

# Psychoeducation (cont.)

- Role of stress in precipitating and maintaining the illness
- Importance of healthy lifestyle
- Regular participation in psycho-educational activities and rehabilitation process
- Maintaining liaison with various support groups

# Stabilization Phase

- The patient is helped to understand and accept the illness.
- The patient and the family are educated about the early signs of relapse, need for continued treatment and follow-up and the side effects of drugs.
- The patient is assisted to deal with any precipitating factors or situational problems.
- Assessment for psychosocial rehabilitation is initiated at this stage.

# Maintenance Phase

- Medication is continued and strategies to prevent the relapse are intensified.
- The risk of relapse and exacerbation is high if not maintained with adequate dose of antipsychotics.
- The dose of maintenance therapy is usually kept the same at which the symptoms were controlled.

# Maintenance Phase (cont.)

- The duration of maintenance therapy depends upon the length of illness and number of episodes.
- If the patient is non-compliant, long acting depot antipsychotics are an option.

# Evaluation

- The progress made by the patient may be slow and need a longer period.
- Interventions should be evaluated realistically to see whether the particular outcome is what is hoped for.
- It is important to realize that relapse is a part of the illness, not a sign of failure.
- Regular evaluation and assessment of patient's problems and needs should be done.