SCHIZOPHRENIA SPECTRUM AND OTHER PSYCHOTIC DISORDERS

Mrs. Rachel James
RN, RM, MSN
Lecturer (RAKCON)

Watch video carefully

Learning outcomes:

At the end of this session, students will be able to:

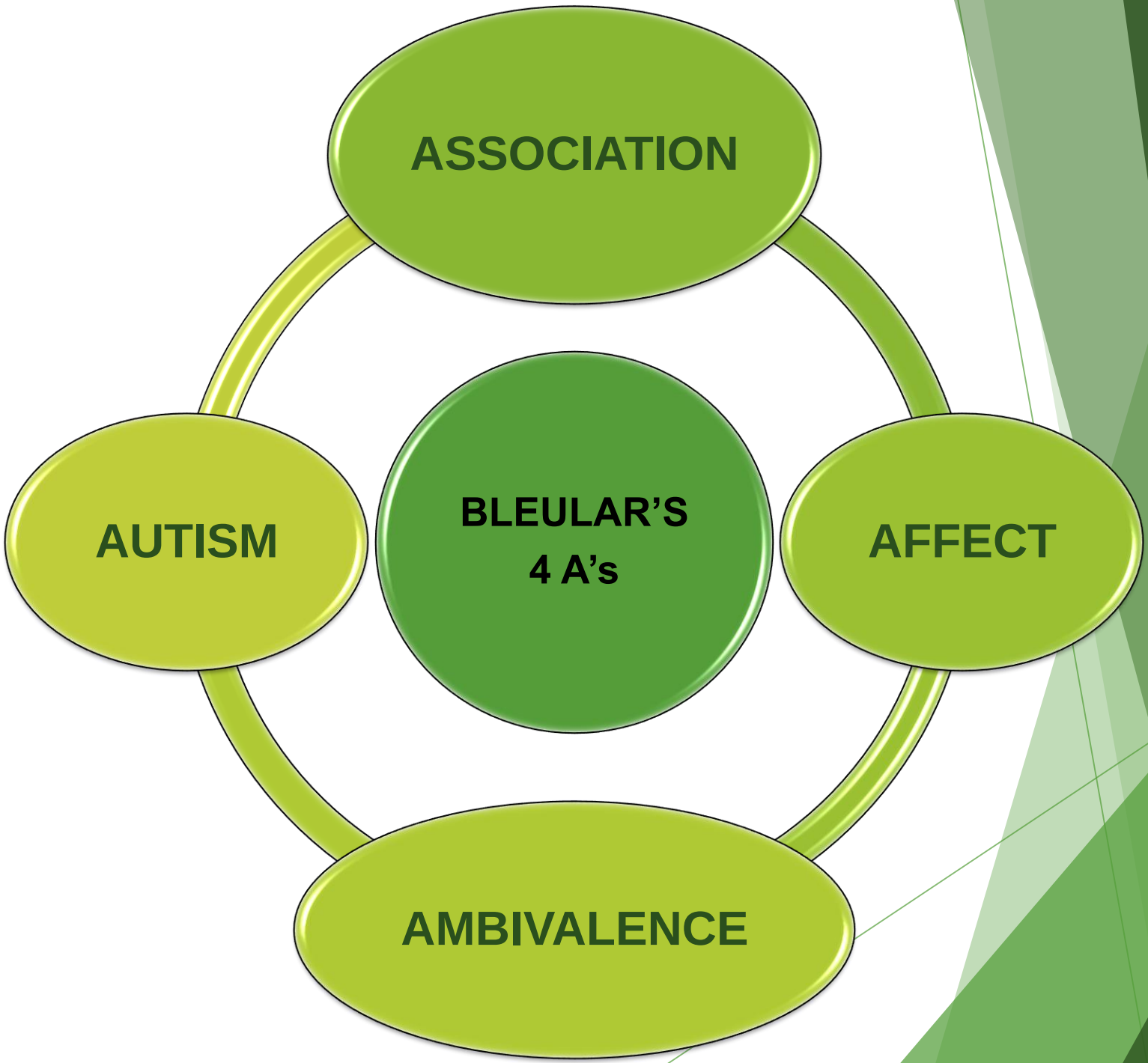
- Important definitions involved in schizophrenia.
- Identify the classification of schizophrenia
- List positive and negative symptoms of schizophrenia.
- Discuss nursing management of patient with schizophrenia.

INTRODUCTION:

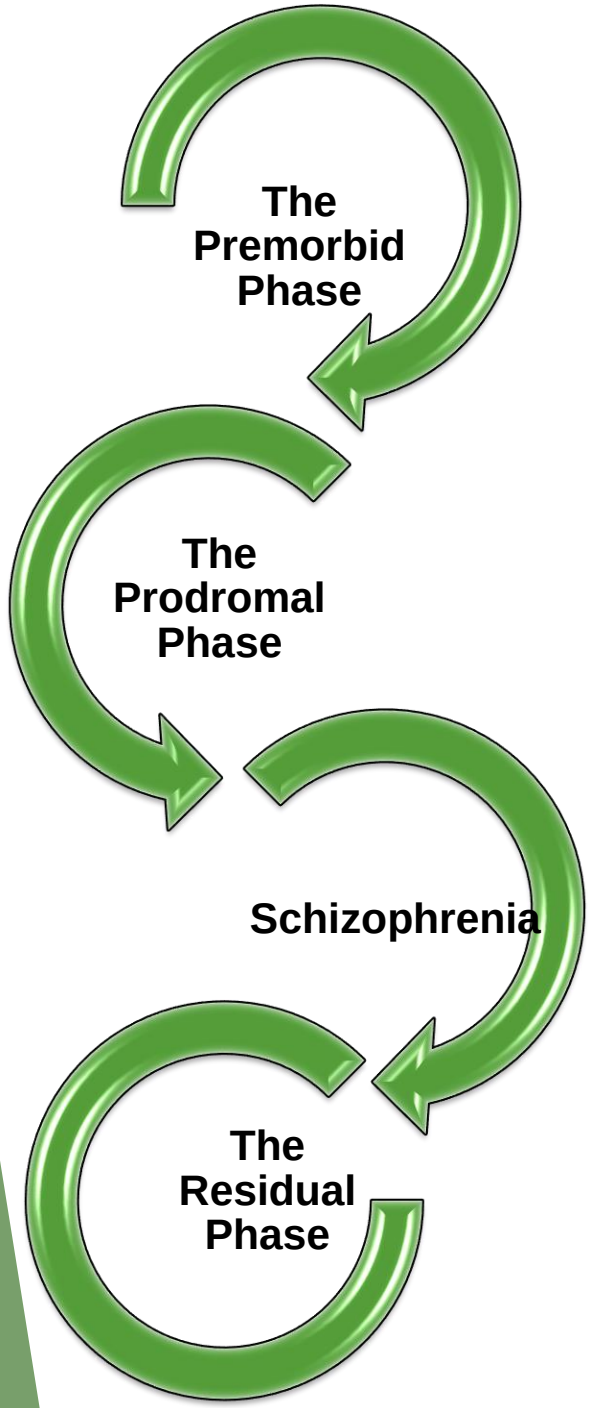
Schizophrenia spectrum and other psychotic disorders include schizophrenia, other psychotic disorders, and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following five domains: **delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms**.

SCHIZOPHRENIA:

Schizophrenia (from the Greek roots ***schizo* [split] and *phrene* [mind])** is <100 years old, it was **first described as a specific mental illness in 1887 by a psychiatrist, Emil Kraepelin. Eugen Bleuler, a Swiss psychiatrist, coined the term in 1911**. He was also the first individual to **describe the positive and negative** symptoms of schizophrenia.


ASSOCIATION
AUTISM
BLEULAR'S
4 A's
AFFECT
AMBIVALENCE

DEVELOPMENT OF SCHIZOPHRENIA



- ***Phase I: The Premorbid Phase:***

- The premorbid personality often indicates social maladjustment, social withdrawal, irritability, and antagonistic thoughts and behavior (Minzenberg, Yoon, & Carter, 2008).

- Premorbid personality and behavioral measurements that have been noted include being very shy and withdrawn, having poor peer relationships, doing poorly in school, and demonstrating antisocial behavior.

Phase II: The Prodromal Phase:

- During the prodromal phase the person experiences substantial functional impairment and nonspecific symptoms such as a sleep disturbance, anxiety, irritability, depressed mood, poor concentration, fatigue, and behavioral deficits such as deterioration in role functioning and social withdrawal.
- Positive symptoms such as perceptual abnormalities, ideas of reference, and suspiciousness develop late in the prodromal phase and herald the imminent onset of psychosis.

- Recognition of the behaviors associated with the prodromal phase provides an opportunity for early intervention with a possibility for improvement in long-term outcomes.
- Current treatment guidelines suggest therapeutic interventions that offer support with identified problems, cognitive therapies to minimize functional impairment, family interventions to improve coping, and involvement with the schools to reduce the possibility of failure.

- ***Phase III: Schizophrenia:***

In the active phase of the disorder, psychotic symptoms are prominent.

Diagnostic criteria according to DSM V classification:

- Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions
2. Hallucinations
3. Disorganized speech (e.g., frequent derailment or incoherence)
4. Grossly disorganized or catatonic behavior
5. Negative symptoms (i.e., diminished emotional expression or avolition)

- For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset.
- Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

- Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either (1) no major depressive or manic episodes have occurred concurrently with the active phase symptoms; or (2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.
- The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

- If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).
- **Specify if**: First episode, currently in acute, partial, or full remission; Multiple episodes, currently in acute, partial or full remission; Continuous; Unspecified.
- **Specify if:** With catatonia.
- **Specify current severity**.

Phase IV: Residual Phase:

- Schizophrenia is characterized by periods of remission and exacerbation. A residual phase usually follows an active phase of the illness (symptoms described in Phase III).
- During the residual phase, symptoms of the acute stage are either absent or no longer prominent.

- Negative symptoms may remain, and flat affect and impairment in role functioning are common.
- Residual impairment often increases between episodes of active psychosis.

PREDISPOSING FACTORS:

1. **BIOLOGICAL FACTORS:**

- **Genetics** → Twin studies
  → Adoption studies
- **Biochemical factors** → The Dopamine Hypothesis
  → Other Biochemical Hypotheses
- **Physiological Factors** → Viral infection
  → Anatomical abnormalities
  → Histological Changes
  → Physical conditions

2. PSYCHOLOGICAL FACTORS

3. ENVIRONMENTAL INFLUENCES → Socio- cultural factors
→ Stressful Life events

4. THE TRANSACTIONAL MODEL

Precipitating Event
(Any event sufficiently stressful to threaten an already weak ego)

Predisposing Factors
Genetic Influences: Family history of schizophrenia
Possible biochemical alterations
Possible birth defect

Past Experiences: Prenatal exposure to viral infection

Existing Conditions: Abnormal brain structure
Physical condition, such as epilepsy, Huntington's disease, brain tumor, Parkinsonism
Inadequate coping skills

Cognitive appraisal (subjective interpretation made by an individual to stimuli in the environment)

* Primary * (stressor poses a threat)

(Perceived threat to self-concept or physical integrity)

* Secondary * (evaluation of the resources or coping strategies)

Because of weak ego strength, patient is unable to use coping mechanisms effectively.
Defense mechanisms utilized: denial, regression, projection, identification, religiosity

Quality of response

Adaptive

Maladaptive

Initial psychotic episode or exacerbation of schizophrenic symptoms

Hallucinations
Delusions
Social isolation
Violence

Inappropriate affect
Bizarre behavior
Apathy
Autism

THE DYNAMICS OF SCHIZOPHRENIA USING THE TRANSACTIONAL MODEL OF STRESS/ADAPTATION

COMMON TERMS THAT YOU CAME ACROSS:

SCHIZOPHRENIA	INAPPROPIATE AFFECT	AMBIVALENCE	AUTISTIC THINKING
LOOSENING OF ASSOCIATIONS	DELUSIONS (GRANDEUR, PERSECUTION, REFERENCE, SOMATIC, CONTROL)	CIRCUMSTANTIALITY	CONCRETE THINKING
CLANG ASSOCIATION	TANGENTIALITY	NEOLOGISM	WORD SALAD
HALLUCINATIONS (AUDITORY/ VISUAL)	ALOGIA	ANHEDONIA	ASOCIALITY
AVOLITION	APATHY	DOUBLE- BIND SITUATION	HOSTILITY

CLASSIFICATION OF SCHIZOPHRENIA :

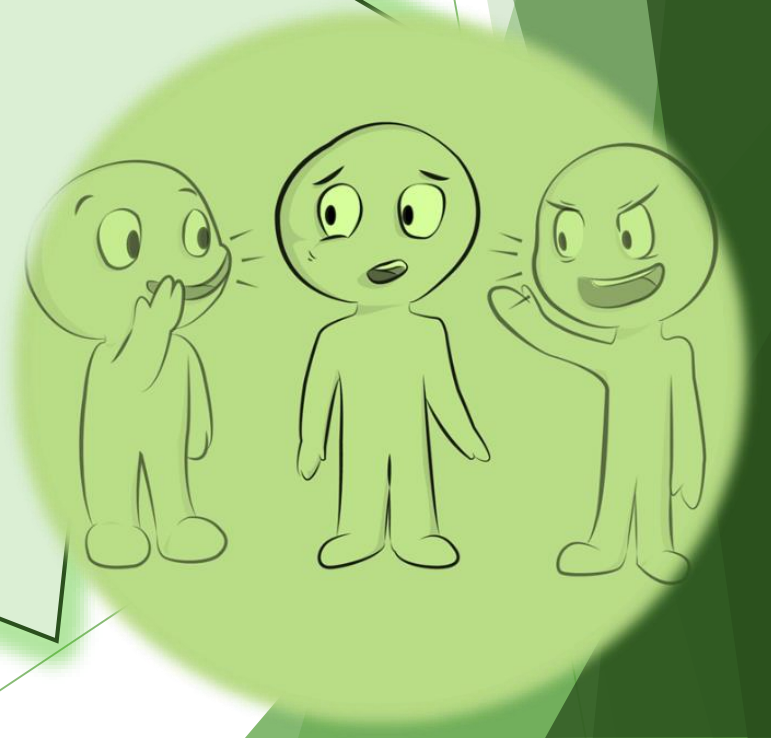
- Delusional Disorder
- Brief Psychotic Disorder
- Substance/ Medication – induced psychotic disorder
- Psychotic disorder due to another medical condition
- Catatonia

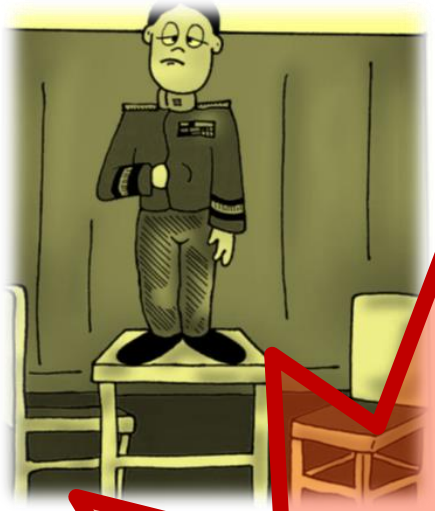
– catatonic dx with another mental dx

– catatonic dx due to another medical condition

–unspecified catatonia

- Schizophreniform disorder
- Schizoaffective disorder





DELUSIONAL DISORDER

- EROTOMANIC TYPE
- GRANDIOSE TYPE
- JEALOUS TYPE
- PERSECUTORY TYPE
- SOMATIC TYPE
- MIXED TYPE

BRIEF PSYCHOTIC DISORDER

- The disorder is identified by the sudden onset of psychotic symptoms that may or may not be preceded by a severe psychosocial stressor.
- These symptoms last at least 1 day but less than 1 month, and there is an eventual full return to the premorbid level of functioning (APA, 2013).
- The individual experiences emotional turmoil or overwhelming perplexity or confusion.

- Evidence of impaired reality testing may include incoherent speech, delusions, hallucinations, bizarre behavior, and disorientation.
- Individuals with preexisting personality disorders (most commonly histrionic, narcissistic, paranoid, schizotypal, and borderline personality disorders) appear to be susceptible to this disorder (Sadock & Sadock, 2007).

SUBSTANCE/MEDICATION-INDUCED PSYCHOTIC DISORDER

- The prominent hallucinations and delusions associated with this disorder are found to be directly attributable to substance intoxication or withdrawal or to exposure to a medication or toxin.
- This diagnosis is made when the symptoms are more excessive and more severe than those usually associated with the intoxication or withdrawal syndrome (APA, 2013).
- The medical history, physical examination, or laboratory findings provide evidence that the appearance of the symptoms occurred in association with a substance intoxication or withdrawal or exposure to a medication or toxin.

SUBSTANCES THAT MAY CAUSE PSYCHOTIC DISORDERS:

Drugs of abuse	Alcohol, Amphetamines and related substances Cannabis, Cocaine, Hallucinogens, Inhalants, Opioids, Sedatives, hypnotics, and anxiolytics
Medications	Anesthetics and analgesics, Anticholinergic agents, Anticonvulsants, Antidepressant medication, Antihistamines, Antihypertensive agents, Cardiovascular medications, Antimicrobial medications, Antineoplastic medications, Antiparkinsonian agents, Corticosteroids, Disulfiram, Gastrointestinal medications, Muscle relaxants, Nonsteroidal anti-inflammatory agents
Toxins	Anticholinesterase, organophosphate insecticides, Nerve gases, Carbon dioxide, Carbon monoxide, Volatile substances (e.g., fuel, paint, gasoline, toluene)

PSYCHOTIC DISORDER DUE TO ANOTHER MEDICAL CONDITION:

- The essential features of this disorder are prominent hallucinations and delusions that can be directly attributed to another medical condition (APA, 2013).
- Following are few medical conditions that can cause Psychotic symptoms: Acute intermittent porphyria, Cerebrovascular disease, CNS infections, CNS trauma, Deafness, Fluid or electrolyte imbalances, Hepatic disease, Herpes encephalitis, Huntington's disease, Hypoadrenocorticism, Hypo- or Hyperparathyroidism, Hypo- or Hyperthyroidism, Metabolic conditions (e.g., hypoxia, hypercarbia, hypoglycemia), Migraine headache, Neoplasms, Neurosyphilis, Normal pressure hydrocephalus, Renal disease, Systemic lupus erythematosus, Temporal lobe epilepsy, Vitamin deficiency (e.g., B12), Wilson's disease

CATATONIC DISORDER DUE TO ANOTHER MEDICAL CONDITION:

The clinical picture is dominated by three (or more) of the following symptoms:

1. Stupor (i.e., no psychomotor activity; not actively related to environment)
2. Catalepsy (i.e., passive induction of a posture held against gravity)
3. Waxy flexibility (i.e., slight, even resistance to positioning by examiner)
4. Mutism (i.e., no, or very little, verbal response [exclude if known aphasia])
5. Negativism (i.e., opposition or no response to instructions or external stimuli)
6. Posturing (i.e., spontaneous and active maintenance of a posture against gravity)
7. Mannerism (i.e., odd, circumstantial caricature of normal actions)
8. Stereotypy (i.e., repetitive, abnormally frequent, non-goal-directed movements)
9. Agitation, not influenced by external stimuli
10. Grimacing
11. Echolalia (i.e., mimicking another’s speech)
12. Echopraxia (i.e., mimicking another’s movements)

SCHIZOPHRENIFORM DISORDER:

- The essential features of schizophreniform disorder are identical to those of schizophrenia, with the exception that the duration, including prodromal, active, and residual phases, is at least 1 month but less than 6 months (APA, 2013).
- If the diagnosis is made while the individual is still symptomatic but has been so for less than 6 months, it is qualified as “provisional.” The diagnosis is changed to schizophrenia if the clinical picture persists beyond 6 months.
- Schizophreniform disorder is thought to have a good prognosis if the individual’s affect is not blunted or flat, if there is a rapid onset of psychotic symptoms from the time the unusual behavior is noticed, or if the premorbid social and occupational functioning was satisfactory (APA, 2013). Catatonic features may also be associated with this disorder

SCHIZOAFFECTIVE DISORDER:

- This disorder is manifested by schizophrenic behaviors, with a strong element of symptomatology associated with the mood disorders (depression or mania).
- The client may appear depressed, with psychomotor retardation and suicidal ideation, or symptoms may include euphoria, grandiosity, and hyperactivity.
- The decisive factor in the diagnosis of schizoaffective disorder is the presence of hallucinations and/or delusions that occur for at least 2 weeks in the absence of a major mood episode (APA, 2013).
- However, prominent mood disorder symptoms must be evident for a majority of the time. The prognosis for schizoaffective disorder is generally better than that for other schizophrenic disorders but worse than that for mood disorders alone (Andreasen & Black, 2011).

POSITIVE AND NEGATIVE SYMPTOMS OF SCHIZOPHRENIA:

POSITIVE SYMPTOMS	Content of thought	Delusions, Religiosity, Paranoia, Magical thinking
	Form of Thought	Associative looseness, Neologisms, Concrete thinking, Clang associations, Word salad, Circumstantiality, Tangentiality, Mutism, Perseveration
	Perception	Hallucinations, Illusions
	Sense of Self	Echolalia, Echopraxia, Identification and imitation, Depersonalization
NEGATIVE SYMPTOMS	Affect	Inappropriate affect, Bland or flat affect , Apathy
	Volition	Inability to initiate goal-directed activity, Emotional ambivalence, Deteriorated appearance
	Interpersonal Functioning and Relationship to the External World	Impaired social interaction, Social isolation
	Psychomotor Behavior	Anergia, Waxy flexibility, Posturing, Pacing and rocking
	Associated Features	Anhedonia, Regression

NURSING DIAGNOSIS TO BEHAVIORS COMMONLY ASSOCIATED WITH PSYCHOTIC DISORDERS:

- Disturbed sensory perception*
- Disturbed thought processes*
- Social isolation
- Risk for violence: Self-directed or other-directed
- Impaired verbal communication
- Self-care deficit
- Disabled family coping
- Ineffective health maintenance
- Impaired home maintenance

TREATMENT MODALITIES :

- PSYCHOLOGICAL TREATMENTS:
  - Individual psychotherapy
  - Group therapy
  - Behavior Therapy
  - Social skills training
- SOCIAL TREATMENTS:
  - Milieu Therapy
  - Family Therapy
- PSYCHOPHARMACOLOGY

CLIENT / FAMILY EDUCATION:

- How to manage illness and symptoms
- Recognizing early signs of relapse
- Developing a plan to address relapse signs
- Importance of maintaining prescribed medication regimen and regular follow-up
- Avoiding alcohol and other drugs
- Self-care and proper nutrition
- Teaching social skills through education, role modeling, and practice
- Seeking assistance to avoid or manage stressful situations
- Counseling and educating family/significant others about the biologic causes and clinical course of schizophrenia and the need for ongoing support
- Importance of maintaining contact with community and participating in supportive organizations and care

REFRENCES:

- Mary C. Townsend, Concepts of Care in Evidence-Based Practice-Psychiatric Mental Health Nursing. 8th Edition

- Louise Rebraca Shives, Basic Concepts of Psychiatric–MentalHealth Nursing. 8th Edition


THANK
YOU