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Research Article

SCHIZOPHRENIA

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A R T I C L E I N F O

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A B S T R A C T

Schizophrenia is a major mental disorder. It is the most common of the psychotic disorders. It has been estimated that 50 percent of all mental hospital beds are occupied by patients diagnosed as schizophrenic. The word schizophrenic is derived from a Greek word schizo (split) and phrenic (mind). The term schizophrenia was first coined by a Swiss psychiatrist Eugen Bleuler. Schizoprenia indicates a group of disturbances which sometimes occur in different combinations and intensities. Hence, it is heterogeneous in nature. Schizophrenia has generally been considered to be of ancient origin.

INTRODUCTION

Definition

Schizophrenia is defined as a functional psychosis characterized by disturbances in thinking, emotion, volition and perception. Finally, it leads on to personality deterioration. The illness occurs in a state of clear consciousness. Unlike many psychological disorders, schizophrenia often incapacitates a person. People suffering from schizophrenia display sudden changes in mood, thought, perception and overall behaviour. These changes are often accompanied by distortions of reality.

Epidemiology

Schizophrenia is a common disease prevalent in all cultures and in all parts of the world. Three to four per 1000 in any community suffer from schizophrenia. About one percent of the general population stand the risk of this disease in their lifetime. About two-thirds of the cases are in the 15 to 30 years age group. The disease is more common in the lower social classes.

Etiology

How or why schizophrenia develops remains a puzzle despite extensive research. Current views indicates that it is most likely to be a breakdown in the balance between three interacting sets of factors, namely, biological, psychological and social.

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Genetic Factors

The case for a genetic basis of schizophrenic disorders has been supported by a variety of studies, including adoptional studies and twin studies. Such studies lend support to the hypothesis that genetic factors play an important role in the causation of schizophrenia, which probably varies from person to person.

Incidence of schizophrenia in specific populations

Population	Incidence (%)
General population	1.0
Sibling of schizophrenic patient	8.0
Child with one schizophrenic parent	12.0
Dizygotic twin of a schizophrenic patient	12.0
Child of two schizophrenic parents	40.0
Monozygotic twin of a schizophrenic patient	47.0

Biochemical Factors

The idea of the physical basis of schizophrenia is not new. A number of biochemical theories have been put forth as the probable cause for schizophrenia, but nothing has proved to be confirmative, although, there are some important theories.

Dopamine Hypothesis

It is based on the idea that the mechanism of action of antipsychotic drugs can shed light on the psychotic disorders they treat. Antipsychotic drugs block postsynaptic dopamine receptor sites in the brain. This led to the speculation that schizophrenia might involve excessive levels of dopamine as a neurotransmitter.

Transmethylation Hypothesis

Schizophrenia may result from abnormal transmethylation of catecholamines.

Indolamine Hypothesis

A defect in the metabolism of indolamine, most probably serotonin, is being investigated as a possible cause of schizophrenia. According to the biological view as the cause of schizophrenia, the environment triggers this behaviour in people who are predisposed to it. Thus, for those who opt for the combined view of nature and nurture, genetic abnormalities lead to situation in which environmental stressors trigger the behavioral pattern of schizophrenia.

Psychological Factors

Persons who are withdrawn and have very few social contacts (introverted personalities or schizoid personalities) are more prone to develop schizophrenic illness. Ego boundary disturbance is also considered to be a cause of schizophrenia. Behaviorists assert that negative reinforcement and extinction schedules cause schizophrenia. Most psychoanalysts and behavioural theories suggest that a person's relationship to the environment can bring about schizophrenia. Freud believed that schizophrenic patients regress to a phase of primary narcissism and ego disintegration.

Social or Environmental Factors

Children and adults develop schizophrenia because their home environment is not conducive to normal emotional growth. People who have developed schizophrenia tend to come from families where there is considerable conflict. Generally, communication between parents and children in such families is inadequate. There is communication deviance. Some studies have shown that schizophrenia is more prevalent in areas of high social mobility and disorganization, especially, in members of very low social class.

Clinical Features of Schizophrenia

Schizophrenia can be grouped as

- Schizophrenia with positive symptoms
- Schizophrenia with negative symptoms

Positive symptoms of schizophrenia are

- Delusions
- Hallucinations
- Bizarre behaviour
- Aggression
- Agitation
- Suspiciousness
- Hostility
- Excitement
- Grandiosity
- Conceptual disorganization

Negative symptoms of schizophrenia are

- Apathy
- Avolition
- Social Withdrawal
- Diminished emotional responsiveness.
- Blunted affect
- Stereotyped thinking
- Artificial gestures/ detachment
- Lack of spontaneity.

There are fundamental groups of signs and symptoms which may occur singly or together in various clinical patterns. The groups of symptoms are: hought disturbance

- Autistic behaviour
- Volitional disturbance
- Emotional disturbance (affective)
- Perceptual disturbance
- Behavioural disturbance.

Thought Disturbance

A prominent disturbing symptom of schizophrenia. In thought disorder, the derangements is basically due to three mechanisms, namely: Condensation Ideas are mixed, having something in common, though not necessarily logical. Displacement An associated idea instead of the correct one is used. Symbolisation Abstract thoughts are replaced by concrete ones. Sometimes, there will be over-inclusive thinking in schizophrenia, where irrelevant thoughts are incorporated into the speech. Some schizophrenics may coin new words which others cannot understand. This is known as neologism. The end result of this combination is a meaningless jumble of words and ideas leading to incoherence and mutism. In some cases, there will be a sudden block in the train of thought for a fraction of a second, followed by a change in discussion of an unrelated topic (thought block), or diversion of thought where the individual does not seem to be thinking much at all.

People with schizophrenia often have delusions-disturbances in the content of thought. A delusion is a false belief, inconsistent with the relationship that is held, inspite of evidence to the contrary. Many schizophrenics have delusions of persecutions believing that they are victims of plots and conspiracies. Some patients may have delusions of persecutions believing that he or she is an important popular or highly pi aced person. Passivity feelings or delusion of control include the belief that thoughts are being inserted into his /her mind or that his/her behaviour is controlled by outside forces.

Autism

Autism is a slow progressive withdrawal from reality. The patient loses interest in his environment, is remote and preoccupied with fantasy.

Volitional Disturbance

Volitional disorder is deterioration in will power, drive and ambition. Apathy may become so profound that self-neglect occurs.

Emotional (or Affective) Disturbance

This develops insidiously, or suddenly, as episodes of unexplainable depression, elation, ectasy, giggling or perplexity. The most common change is the flattening or blunting of emotion. In other cases, the mood is incongruous, that is, inappropriate to thoughts and current situation. Without reason the person may laugh or cry.

Perceptual Disturbance

Hallucinations are important perceptual disturbances occuring in schizophrenia. A hallucination is a perception in the absence of an external stimulus. Hallucinations may be auditory,

visual, tactile, olfactory or gustatory. Auditory hallucinations are the commonest form of hallucination in schizophrenia.

Behavioural Change

The withdrawal from reality into fantasy may increase apathy and indifference to the point of complete inability and stupor or catatonic stupor. The reverse may also occur, that is catatonic excitement. There is purposeless repetition of words and movements and imitation of words (echolalia) and actions (echopraxia). Sometimes, the patient exhibits negativism that is disobeying or doing the reverse of what has to be done. Some chronic patients may reveal various minor, bizarre mannerisms, like pouting, blinking, grunting etc. Usually, in schizophrenia, there will be poor personal hygiene. They do not take care of themselves. Various degrees of sleep disturbances will always be present. Orientation and memory remains intact, although they may be difficult to test. The patient is invariably in dear consciousness, although his insight and judgement are defective. Lack of insight means the person is not aware that he/she is suffering from the illness.

Types of Schizophrenia

Paranoid Schizophrenia

The essential features are prominent persecutory or grandiose delusions together with associated jealousy. Hallucinations are common. Associated features include unfocussed anxiety, anger, argumentativeness and violence. In addition, there may be doubts about gender identity.

Hebephrenic Schizophrenia

The essential features are marked incoherence and flat, incongrous or silly effect. Age of onset is 15-25 years. The clinical picture is usually associated with extreme social impairment, poor premorbid personality, an early and insiduous onset and a chronic course without significant remissions. In other classification this type is termed as disorganised type.

Catatonic Schizophrenia

The clinical picture is dominated by psychomotor disturbance. This may take the form of catatonic stupor or rigidity, catatonic excitement, catatonic posturing or negativism.

Residual Schizophrenia

This category should be used when there has been at least one episode of schizophrenia in the past but without prominent psych tic symptoms at present. Emotional blunting, social withdrawal, eccentric behaviour, illogical thinking and loosening of associations are common.

Undifferentiated Schizophrenia

Prominent psychotic symptoms that cannot be classified in any category previously listed or have features of more than one.

Simple Schizophrenia

An uncommon disorder, insidious in onset but with progressive development of odd behaviour. Wandering tendency, self-absorbed idle and aimless activity are present.

Management of Schizophrenia

The treatment of schizophrenia can be arduous process for patients, families, and clinicians alike. No cure exists for this tenacious disease. So, therapeutic efforts are aimed at management of symptoms and at social and psychological rehabilitations. Nevertheless, carefully designed treatment programmes can help many schizophrenics to regain lost functioning and a greater sense of psychological well-being. Long-term support is necessary for most schizophrenics to maximize both, their ability to function and their quality of life.

Treatment Methods in Schizophrenia

- Somatic (Physical) Therapies
- Antipsychotic medications

Psychological Treatment

- Psychotherapy
- Rehabilitation-social, vocational
- Aftercare-day treatment, halfway homes
- Education about the illness for patients and families.

The Principles of Treatment

The patient is initially admitted to a hospital or day hospital for assessment over a period of time. Out-patient treatment is unsatisfactory, especially in more acute cases because of the patient's uncooperativeness and unpredictability, usually during his medication.
as he is.

Nursing management of patient with schizophrenia

Introduction

Within the care-planning process, nurses should support people with schizophrenia to prepare advance statements (of preferred treatments) and advance decisions (to refuse treatment); this is especially important for those whose illness is severe and those who have been treated under the Mental Health Act.

Assessment

The nurse may assess a client with a known history of schizophrenia or a client with a unknown to the mental health care system. Assessment begins with an interview and focuses on establishing the client's signs and symptoms, degree of impairment in the thought process, risk for self injury or violence towards others, and available support systems. The nurse may wish to interview the client with a family member or a friend to obtain all information regarding family history, previous episodes of psychotic symptoms, onset of symptoms, and thoughts of suicide or violent behaviour.

Assessing mood and cognitive state

- The nurse is alert for the signs and symptoms such as:
- Absence of expression of feelings
- Language content that is difficult to follow
- Pronounced paucity of speech and thoughts
- Preoccupation with odd ideas
- Ideas of reference
- Expression of feelings of unreality
- Evidence of hallucinations such as comments that the way they things appear, sound, or smell is different.
- The nurse can also inquire about recent stressors, which can precipitate a psychotic episode in the client with a thought disorder, and signs and symptoms of impending relapse. These signs include disturbed sleep cycle, significant mood changes (mostly depression),

decreased appetite, and somatic complaints such as headache, malaise, and constipation. Resistance, and preoccupation with psychotic symptoms.

Assessing potential for violence

- The nurse assess the potential for violence by inquiring about the following:
- History of violent or suicidal behavior
- Extreme social isolation
- Feeling of persecution or being controlled by others.
- Auditory hallucinations that tells the client to commit violent acts.
- Concomitant substance use.
- Medication noncompliance
- Feelings of anger, suspiciousness, or hostility.

Assessing social support

Availability and responsiveness of a social support network and the client's role in the family and community are important factors in nursing assessment

Assessing knowledge

The nurses assess the client's and families knowledge of schizophrenia, its treatment, and the potential for relapse. Adherence to medication regimens and other therapeutic schedules is bolstered when clients and families understand the biologic basis of the illness, signs of recovery and relapse, and their role in treatment.

Assessing the hallucination and delusional thought of the patient

Assess for symptoms of hallucination including, duration, intensity and frequency. Focus on to the symptoms and the patient to describe what is happening

Assessing the sleeping disturbance of the patient:

Assess the patient sleeping hours and disturbing factors of sleeping.

Nursing Diagnosis

1. Disturbed thought process related to biochemical imbalances, as evidenced by distractibility, poor concentration, disordered thought sequencing, inappropriate responses, and thinking not based in reality.
2. Disturbed sensory perception (auditory/visual) related to biochemical imbalances, disordered thought sequencing, rapid mood swings as evidenced by auditory or visual hallucinations.
3. Risk for other- directed or self directed violence related to delusional thoughts and hallucinatory commands, history of childhood abuse, or panic, as evidenced by overt aggressive acts, threatening stances, pacing, or suicidal ideation or plan.
4. Social isolation related to alterations in mental status and an ability to engage in satisfying personal relationships, as evidenced by sad, flat affect, absence of supportive significant others, withdrawal, uncommunicativeness and inability to meet the expectations of others.
5. Impaired verbal communication related loose association of ideas, neologisms, word salad, clang associations, inappropriate verbalization.
6. Self care deficit related to difficulty carrying out tasks associated hygiene, dressing, grooming, eating and toileting.
7. Ineffective coping related to disturbed thought process as evidenced by inability to meet basic needs.
8. Interrupted family process related to shift in health status of a family member and situational crisis, as evidenced by changes in the family's goals, plans, and activities and changes in family pattern and rituals.

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