

Schizophrenia

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Introduction:-

Schizophrenia is discussed as if it is a single disease; it probably comprises a group of disorders with heterogeneous etiologies. The disorder usually begins before age 25y Persists throughout life. Both patients and their families often suffer from poor care and social ostracism because of widespread ignorance about the disorder

HISTORY

Emil Kraepelin

Kraepelin translated Morel's demence pr'ecoce into dementia precox. A term that emphasized the change in cognition (dementia and early onset (precox) of the disorder. Patients with dementia precox were described as having a long-term deteriorating course and the clinical symptoms of hallucinations and delusions.

= psychosis in period of puberty

Eugene Bleuler

Bleuler coined the term schizophrenia. He chose the term to express the presence of schisms between thought, emotion, and behavior in patients with the disorder?"

النظام المنفرد عن السلوك !!

The Four As.

Bleuler identified specific fundamental (or primary) symptoms of schizophrenia to develop his theory about the internal mental schisms of patients. These symptoms included:

- Associational disturbances of thought, especially looseness.
- Affective disturbances.
- Autism.
- And ambivalence.
- Bleuler also identified accessory (secondary) symptoms:
- Hallucinations.
- Delusions.

خلل مصاحب في التفكير ومفهومه العصبية.

تناقض

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Definition:

((Schizophrenia))

Is disintegrative psychosis characterized by splitting of normal link between perception, mood, thinking, behavior and contact with reality.

OR-

انفصال الرابطة الطبيعية بين ادراك المحسوس والمزاج والتفكير والسلوك والارتباط مع الحقيقة.

Is a major psychotic disorders marked by profound withdrawal from interpersonal relationship and cognitive and perceptual disturbance that make dealing with reality difficult.

الانسحاب من العلاقات الشخصية.

Epidemiology:

According to DSM-IV-TR, the annual incidence of schizophrenia ranges from 0.5 to 5.0 per 10,000. With some geographic variation.

Gender and Age: Schizophrenia is equally prevalent in men and women. The two genders differ in the onset and course of illness: (10-25) for men (25-35) for women.

Etiology:-

1-Genetic Factors

Is Schizophrenia Inherited?

It has long been known that schizophrenia runs in families.

- The risk of schizophrenia in first-degree relatives of people with schizophrenia is 10%.
- If both parents have schizophrenia, the risk of schizophrenia in their child is 40%.
- Concordance for schizophrenia is about 10% for dizygotic twins and 40-50% for monozygotic twins.

2-Biochemical Factors

Dopamine Hypothesis:

The most notable theory is the dopamine hypothesis, which posits that schizophrenia is due to hyperactivity in brain dopaminergic pathway.

This excess activity may be related to production or release of the substance at

- ① ↑ sensitivity of nerves to dopamine.
- ② ↓ dopamine antagonist -

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nerve terminals increased receptor sensitivity or reduce activity of dopamine antagonists. مثال cocaine, amphetamines stimulate dopaminergic activity

This theory is consistent with the efficacy of antipsychotic (which block dopamine receptor) and the ability of the drugs (such as cocaine or amphetamines) that stimulate dopaminergic activity to induce psychosis

Serotonin:

نظريّة نقص السيروتونين

تنظيم النوم

درجة الحرارة

→ induce psychosis

Serotonin responsible for regulation of the sleep, temperature, pain sensitivity, appetite. It may be insufficient in schizophrenic patient.

Nor epinephrine:

نظريّة نقص النورإبينفرين

Norepinephrine leads to mobilization of the body to deal with stressful situation (fight or flight). It may be insufficient in schizophrenic patient.

Anatomical abnormalities

Many studies of people with schizophrenia have found abnormalities in brain structure (for example, enlargement of the fluid-filled cavities, called the ventricles, in the interior of the brain, and decreased size of certain brain regions) or function (for example, decreased metabolic activity in certain brain regions). It should be emphasized that these abnormalities are quite subtle and are not characteristic of *all* people with schizophrenia, nor do they occur *only* in individuals with this illness.

II- Psychological causes (psychoanalytic theory)

النظرية النفسية
الكلينيكية

1- Mother Child relationship:

الرعاية الأوفر + الاستبداد هيرويف الأكبر عند الطفل + مش صنفهم الواقع

- Cold overprotective and domineering mother lead to arrested ego development of child and inability to deal with demands and forced to retreat into a form of thinking characteristic of early childhood, being unable to interpret reality, and the individual is susceptible to a fantasy world in which hallucinations and delusions attempt to create a reality of wishful thinking or to express inner fears.

لا يكون معرض للعالم الخيالي مع المراهقين
والانفصالات الخلق واقع بتمناه أو لإلها - محاربه

- Sullivan believed that the illness stemmed from a parent child relationship brought intense anxiety and produces feeling of dread, loathing, and barrier leading the child to deny these feeling become (not me) but some one else this withdrawal from emotion or not me portion of the system is the basis for later development of schizophrenia

المرض الذي نتج من علاقة الأب بالطفل
سبب القلق والحزن والرهبة والاشد - والكواجز ← يتم لتسليم الشعور كزواجا

- Erikson stated that developing trust vs. mistrust in the mother figure is generalized to other interpersonal relationship. No achievement and fixation at this level result in suspiciousness of other, self isolation and difficulty of inner personal relationship.

لوما في تمت ← الاربعاء
والعزلة و صعبون العلاقات بين الناس

2- Family theories

- Dysfunctional family system

صراع العلاقة بين الأم والأب

• conflict of maternal relationship (continuous fight between parents) lead to grater deal of anxiety

• Scapegoat: one or both parents may blame the child when things go wrong rather than blame themselves or one another

كبش
الضاد

لوص الطفل على السب
بدل من لوم أنفسهم

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? Signs and Symptoms of Schizophrenia:

? **Positive symptoms of schizophrenia:** The positive symptoms appear early in the first phase of the illness and added to the patient's personality traits. These are the symptoms that get people's attention and often precipitate hospitalization. The positive symptoms are presented in terms of alteration in thinking, perception, and behaviors such as Delusions, Hallucinations, and Bizarre Behaviors.

? **Negative symptoms:** The negative symptoms of schizophrenia develop over a long time. These are the symptoms that most interfere with the individual's adjustment and ability to survive included;

- نقط
من معرفه معناه للمجانبه
تجيب (فقد الحاضر)
علة الحكي
علة الطامة
عزلة اجتماعية
من مفهوم معناه حابيه
- ? **Anhedonia:** loss of interest in pleasurable activities.
 - ? **Avolition:** loss of motivation.
 - ? **Alogia:** poverty of speech.
 - ? **Anergia:** loss of energy.
 - ? **Asociality:** social withdrawal.
 - ? **Affect flattening or Apathy**

? Subtypes of Schizophrenia:

كثيرا مرضنا الدكر !!

1- Paranoid Schizophrenia:

FFB

A- Preoccupation with one or more delusion typically organized into a coherent framework or frequent auditory hallucination (content frequently persecutory and/or grandiose).

إظهار مجموع !!

انطهادي

عظمة

B- None of the following is prominent: disorganized speech disorganized behavior, flat or inappropriate affect, catatonic behavior. The key feature of

الناس غير موجود

this subtype of schizophrenia is the combination of false beliefs (delusions) and hearing voices (auditory hallucinations).



2- Disorganized/ hebephrenic Schizophrenia:

A- Disorganized schizophrenia (hebephrenic schizophrenia) is marked by disorganized speech (word salad, incoherent speech, and clanging), thinking (concrete thinking), and behavior (grimacing, posturing, stereotyped behaviors, and sexual behaviors such as masturbating in public), coupled with flat affect or inappropriate emotional responses to a situation.

B-Does not meet criteria of catatonic types.

3-Catatonic Schizophrenia:

A-Catatonic schizophrenia is characterized by disturbances of movement that may include rigidity, stupor, agitation, bizarre posturing, and repetitive imitations of the movements or speech of other people. These patients are at risk for malnutrition, exhaustion, or self-injury.

B-At least two of the following are present:

- ☐ A-Motor immobility, waxy flexibility or stupor
- ☐ B-Excessive motor activity (purposeless)
- ☐ C-Peculiar movements, stereotype of movements, prominent mannerisms, or prominent grimacing.
- ☐ E- Echolalia or echopraxia.

تقلد الآخرين
لغة تكرار الكلام التي يسمعها الآخرين
طردان غير عالوفة
سلوكيات وامنية

4- Undifferentiated Schizophrenia:

Schizophrenia

Patients in this category have the characteristic positive and negative symptoms of schizophrenia but do not meet the specific criteria for the paranoid, disorganized, or catatonic subtypes. (none of the above)

5-Residual Schizophrenia:

This category is used for patients who have had at least one acute schizophrenic episode but do not presently have such strong positive psychotic symptoms as delusions and hallucinations. They may have negative symptoms, such as withdrawal from others, or mild forms of positive symptoms, which indicate that the disorder has not completely resolved.

Other thought disorders: Psychotic disorders

• Schizophreniform disorder: 1 - 6 months

Symptoms are the same as schizophrenia but of shorter duration, specifically, symptoms that last at least 1 month But less than 6 months.

• Schizoaffective disorder:

During an uninterrupted period of illness, there is either a mood episode at the same time as active symptoms of schizophrenia, preceded or followed by 2 weeks of delusions or hallucinations without mood symptoms.



• Delusional disorder:

The person has non bizarre delusions of 1 month's duration, and functioning is not impaired outside of the delusion. Types include jealous, persecutory, somatic, grandiose, and erotomanic."

• Brief psychotic disorder: 1 day → 1 month

For more than 1 day but less than 1 month, the person has delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior but no negative symptoms. Client then returns to premorbid level of functioning. This may occur in the postpartum period.

• Shared psychotic disorder (formerly called folie a deux):

Two people in a close relationship (e.g., twins, mother and child) hold similar delusions. Same delusion occurs in two persons, one of whom is less intelligent or more dependent on the other (also called shared paranoid disorder)

واحد يتوهم
آخره ذبا من الوهم

• Psychotic disorder not otherwise specified (NOS):

The person has persistent non bizarre delusions with periods of overlapping mood episodes or auditory hallucinations.

وهم متد + هالوسيات

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? **Diagnosis of Schizophrenia:**

Diagnostic and Statistical Manual of Mental Disorders 4th edition, text revised (DSM IV) diagnostic criteria for schizophrenia include:

(A) Characteristic symptoms: Two or more of the following symptoms:

- ≥ 2
1. Delusions.
 2. Hallucination.
 3. Disorganized speech.
 4. Grossly disorganized or catatonic behavior.
 5. Negative symptoms, i.e. affective flattening, impaired volition, anhedonia and withdrawal.

(B) Marked deterioration in social, self-care and occupational functions since onset of illness

(C) Duration: at least 6 months of persistent symptoms or negative symptoms.

(D) Symptoms of **schizoaffective and mood disorder are ruled out.**

(E) **Substance abuse and medical conditions are ruled out as etiology.**

(F) **Absence of history of autistic or pervasive developmental disorder in childhood.**

Treatment

Both pharmacologic and psychosocial interventions are necessary to safeguard the client and promote his/her recovery, in addition, continuity of care, including discharge plan and ongoing care within community, are essential interventions for client with schizophrenia.

Overall goals of treatment include:

- ✗ Safety in all setting.
- ✗ Stabilization and compliance on antipsychotic medication. الاستقرار - على الدواء
- ✗ Client and family education about schizophrenia and its tt.
- ✗ Physical care of client.
- ✗ Psychosocial support of client and family.

Treatment of a person with schizophrenia includes the following:

1- Pharmacologic interventions

Antipsychotic (neuroleptic) medications are needed to treat the symptoms of schizophrenia during both the acute and long-term phases of illness. There are two types of antipsychotic:

1- Traditional (conventional) antipsychotic:

They treat the positive symptoms of schizophrenia such as Hallucinations and delusions.

The traditional antipsychotic includes the following:

- Chlorpromazine (Thorazine)
- Fluphenazine (Prolixin)
- Haloperidol (Haldol)
- Trifluoperazine (Stelazine)
- Thioridazine (Mellaril)
- Thiothixene (Navane)
- Perphenazine (Trilafon)

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2- Atypical (novel) antipsychotic:

They relieve both the positive and negative symptoms (avoilation, social withdrawal).

They include the following:

- Clozapine (Clozaril)
- Risperidone (Risperdal)
- Olanzapine (Zyprexa)
- Quetiapine (Seroquel)
- Ziprasidone (Geodon)



2- Psychosocial interventions

- Milieu management
- Individual and group therapy:
- Cognitive-behavioral therapy.
- Vocational rehabilitation: *إعادة التأهيل*
- Continuity of care. *متابعة*



- Nursing process for Schizophrenia.

Nursing Diagnosis (Actual or Potential)

- Altered thought process.
 - Sensory/perceptual alterations.
 - Impaired verbal communication.
 - Social isolation.
 - Ineffective Individual coping.
 - Self care deficit (bathing/hygiene/grooming/ feeding/ toileting)
 - Altered family process.
- Violence, risk for: self/other directed

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(1) Altered thought process:

Related factors:

- 1- Impaired ability to process and synthesize internal and external stimuli.
- 2- Biological factors.
- 3- Sensory perceptual alteration.
- 4- Psychosocial/ environmental stressors.

Evidenced by:-

Inability to distinguish internally stimulated irrational ideas leading to faulty conclusion. (1)

- Perceives that others in the environment can hear his thoughts. (2)

Demonstrated neologisms, word salad, thought blocking, thought insertion, thought withdrawal, poverty of speech or mutism. Believes that his thoughts are responsible for world events. (3)

الأعراض السابقة

Goals:

- demonstrate reality based thinking in verbal and non verbal ; behavior.
- Demonstrate absence of psychosis (delusion, incoherent, illogical speech, magical thinking, ideas of reference)

Nursing intervention:

- Approach the client in a slow, calm matter-of-fact manner, to avoid distorting the client's sensory perceptual field, which could foster altered thoughts and perception.
- Maintain facial expressions and behaviors that are consistent with verbal statement. Patients are very sensitive to other responses to their symptoms.
- Continue to assess the client's ability to think logically and to utilize realistic judgment and problem solving abilities.
- Listen attentively for key themes and reality oriented phrases of thoughts.
- Interpret client misconception and misperceived environmental events in calm ,matter of fact. اعرفي سوء تفاهه بحدود
- Distract client from delusion by engaging him in less threatening or more comforting topic. الهيه عن ربه
- Refrain from touching a client who experiencing if it is persecutory type .touch may interpreted as physical or sexual assault. نوع الاضطراب
لا تلمس لانه يحكم فيها اغتصاب

(2) Sensory perceptual alteration:-

Related factors:-

- psychological stressors.
- withdrawal from environment.
- lack of adequate support system.
- Altered thought process.
- Disorientation.

Evidenced by :-

- inattentive to surrounding. *عدم الانتباه للحيز*
- Appears to be listening to voices or sound.

Goals:-

- able to hold conversation without hallucination.
- remain in group activity.
- state that hallucination under control.

Nursing Intervention:-

- Continuously orient patient to actual environment events or activates, to present reality.
- Call the client and staff members by their names to reinforce reality. *تأريه باسمه*
- Utilize clear, concrete statements. *عمل واضح*
- Utilize clear, direct verbal communication rather than non verbal gestures. *تواصل بالقل*
- Focus on real events or activities to reinforce reality and divert client from the hallucinating experiences. *ركزي على الحيز الحقيقي*
- Reassure the client that he is in safe and won't be harmed.
- Attempt to determine precipitants of the sensory alteration (stressors that may trigger the hallucination). *كثير اسباب الخلل الحسي*
- When danger or violence is imminent; protect the client and others by the following procedures and policies or mechanical restrain to prevent harm to the client.
- Teach client techniques that will help stop the hallucination.

(3) Impaired verbal communication:

Related factors:

- Disturbance in the form of thinking (autistic). *توهم*
- Altered thought processes (delusion, magical thinking)
- Poverty of speech/mutism.
- Sensory perceptual alteration (hallucination).

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وهي في البيئة الحسية
↓

Disturbance in structure of association (e.g. neologism, word salad, clang association, perseveration).

Evidenced by:

- Loose association, neologism, word salad, clang association.

Goals

- Communicate thoughts and feelings in a coherent, goal directed manner.

Demonstrate reality based thought processes in verbal communication

Nursing Intervention:-

• Assess the extent to which the client impaired verbal communication interfere with his ability to get others understand the meaning, behind the message and clarify and to clarify communication.

• Demonstrate a calm, patient behavior, rather than attempting to face client to speak coherently, to decrease the clients fear and anxiety about inability to communicate needs and to demonstrate acceptance of client.

• Actively listen to and observe verbal and non verbal cues and behavior during the communication process.

• Praise the client's attempts to speak more coherently and to engage in more meaningful conversation with others, to increase self esteem & promote continued functional speech pattern.

• Use communication strategies such as clarification, restatement, validation to help to reveal the intent of client message.

(4) Social isolation:-

Related to:

- Altered sensory perception (hallucination or illusions, which may result in mistrust of or rejection by other clients in the environment)

- Altered thought processes (delusions, magical thinking, ideas of reference, thought blocking, thought insertion).

- Impaired verbal communication (neologisms, word salad, loose associations, tangentiality, incoherence, poverty speech, and mutism).

- Long-term illness, hospitalization, or environmental deprivation.

evidenced by:-

-Withdrawal from the environment and from others in the environment isolates self in room or bed for most of the day and night.

-Difficulty in establishing bonds or relationship with others in the environment(fails to seek out or respond to others)

-Verbalizations that indicate feelings of rejection from others in the environment.

- Inability to engage in social interactions or milieu activities. Inability to share or express feelings with others in groups or one-to-one

Goals:-

- Verbalizes willingness to engage in social interaction and activities with others in the environment.

Nursing interventions and rationale:-

❖ Assess the extent of the client's self-imposed isolation, to plan strategies to break the pattern of withdrawal with interactions and activities.

❖ Assist the client to meet basic needs during times of social withdrawal (sleep, nutrition, personal hygiene) to promote the client's physical health and well-being.

❖ Structure each day to include planned time for brief interaction and activities with the client to help the client organize times to engage with others and to let the client know participation is expected and that he or she is a worthwhile member of the community.

❖ Spend brief intervals with the client each day, engaging in meaningful, non challenging interactions, to ease the client out into the community by first developing trust, rapport, and respect.

❖ Discuss with the client anything of interest to him or her, such as items in the client's room, favorite activities, or hobbies, to encourage the client's social skills and decrease social Isolation.

❖ Provide the client with stimulation from recreational and other milieu activities to expose the client to social activities and increase opportunities for socialization.

❖ Encourage the client to engage in social activities that are within his or her physical capabilities and tolerance, to provide the client with successful social experiences that are likely to be repeated.