Unit 7: Schizophrenia Spectrum and Other Psychotic Disorders



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Mental Health Nursing

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Learning Outcomes

1. Describe the positive and negative symptoms of schizophrenia.
2. Discuss the etiology of schizophrenia.
3. Discuss the effectiveness of antipsychotic medications for clients with schizophrenia.
4. Apply the nursing process to the care of a client with schizophrenia.
5. Provide teaching to clients, families, caregivers, and community members to increase knowledge and understanding of schizophrenia.
6. Describe the supportive and rehabilitative needs of clients with schizophrenia who live in the community.

Introduction

- The term schizophrenia (which literally means split mind ”) was first used by Swiss psychiatrist Eugen Bleuler.
- Schizophrenia is a serious, chronic, psychiatric disorder characterized by impaired reality testing, hallucinations, delusions, and limited socialization.
- It is a psychotic thought disorder where hallucinations and delusions dominate the patient’s thinking, leading to confusing and bizarre behaviors.

CONT.

- People with schizophrenia have a “ between their thoughts and their feelings and between their reality and society’s reality, which can lead to unusual and frightening behaviors.
- Schizophrenia is a frequent cause for long psychiatric hospitalizations.
- The suffering of patients with schizophrenia and their families can last a lifetime as this crippling condition continues.
- The first psychotic break often responds well to treatment, but the relapse rate is high and the person may become increasingly disabled.

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- Schizophrenic individuals are vulnerable to substance abuse as they self medicate to control their symptoms.
- These patients can also be at risk for suicide, which may be manifested as voices telling the person to kill her/himself or a means to end suffering.
- **DSM-5** now categorizes schizophrenia under the global title of **schizophrenia spectrum disorders** (2013). In the past, schizophrenia was divided into five subtypes of catatonic, delusional, disorganized, undifferentiated, and residual, but in 2013 these were eliminated.
- The new term of **schizophrenia spectrum disorders** reflects a gradient of psychopathology that a patient can experience from least to most severe. Disorders such as schizophreniform and schizoaffective would be the less severe forms.

Categorizes the Schizophrenia Spectrum and Other Psychotic Disorder according the DSM-5

1. Schizotypal personality disorder.
2. Delusional disorder.
3. Brief psychotic disorder.
4. Schizophreniform disorder.
5. Schizophrenia spectrum.
6. Schizoaffective disorder.
7. Substance/drug induced psychotic disorder.
8. Psychotic disorder due to a medical condition.
9. Catatonia.
10. Other Specified Schizophrenia Spectrum and Other Psychotic Disorder.
11. Unspecified Schizophrenia Spectrum and Other Psychotic Disorder.

CONT.

- In addition, psychoses can occur in bipolar disorder and major depression. Another psychotic disorder is brief psychotic disorder, which includes postpartum psychosis as well as psychosis due to substance abuse or medical conditions.
- Medical conditions that can contribute to psychoses include brain tumors, CNS infections, delirium, and endocrine disorders. All of these disorders, though not schizophrenia, have some of the same symptoms but different etiology and duration of disability
- Frequently, schizophrenia is initially diagnosed in adolescents and younger adults between the ages of 16 and 35 with the occurrence of the first psychotic break, though later onset does occur.

Symptoms of Schizophrenia

1. The presence of delusions, hallucinations, and/or disorganized speech for a significant portion of time during a 1-month period. At least one of these must be present for the diagnosis.
2. Grossly abnormal motor behavior and/ or negative symptoms.
3. One or more areas of functioning, such as school, work, personal relationships, or self-care, are impaired. Some disturbance needs to be evident for at least 6 months.
4. Schizophrenia can also have features of catatonia, which include any of the following: motor immobility to stupor, excessive motor activity, peculiar voluntary movements, and echolalia or echopraxia.

Schizophrenia's symptoms are typically described as (negative or positive)

1- Negative symptoms: Represent a loss or a decrease in the ability to initiate plans, speak, express emotion, or find pleasure in everyday life. These symptoms are harder to recognize as part of the disorder and can be mistaken for laziness or depression. The term "negative symptoms" refers to reductions in normal emotional and behavioral states. **These include the following:**

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1. **Alogia:** Tendency to speak little or to convey little substance of meaning (poverty of content)
2. **Anhedonia:** Feeling no joy or pleasure from life or any activities or relationships
3. **Apathy:** Feelings of indifference toward people, activities, and events
4. **Asociality:** Social withdrawal, few or no relationships, lack of closeness
5. **Blunted affect:** Restricted range of emotional feeling, tone, or mood
6. **Catatonia:** Psychologically induced immobility occasionally marked by periods of agitation or excitement; the client seems motionless, as if in a trance
7. **Flat affect:** Absence of any facial expression that would indicate emotions or mood
8. **Avolition or lack of volition:** Absence of will, ambition, or drive to take action or accomplish tasks
9. **Inattention:** Inability to concentrate or focus on a topic or activity, regardless of its importance

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2- Positive symptoms

Positive symptoms are easy-to-spot behaviors not seen in healthy people and usually involve a loss of contact with reality. Positive symptoms can come and go. Sometimes they are severe and at other times hardly noticeable, depending on whether the individual is receiving treatment.

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2- Positive or Hard Symptoms can include:

1. **Ambivalence:** Holding seemingly contradictory beliefs or feelings about the same person, event, or situation
2. **Associative looseness:** Fragmented or poorly related thoughts and ideas
3. **Delusions:** Fixed false beliefs that have no basis in reality
4. **Echopraxia:** Imitation of the movements and gestures of another person whom the client is observing
5. **Flight of ideas:** Continuous flow of verbalization in which the person jumps rapidly from one topic to another
6. **Hallucinations:** False sensory perceptions or perceptual experiences that do not exist in reality
7. **Ideas of reference:** False impressions that external events have special meaning for the person
8. **Perseveration:** Persistent adherence to a single idea or topic; verbal repetition of a sentence, word, or phrase; resisting attempts to change the topic
9. **Bizarre behavior:** Outlandish appearance or clothing; repetitive or stereotyped, seemingly purposeless movements; unusual social or sexual behavior

Most schizophrenics have a mixture of both positive and negative symptoms.

❑Onset

- Onset may be abrupt or insidious, but most clients slowly and gradually develop signs and symptoms such as social withdrawal, unusual behavior, loss of interest in school or at work, and neglected hygiene.
- The diagnosis of schizophrenia is usually made when the person begins to display more actively positive symptoms of delusions, hallucinations, and disordered thinking (psychosis).
- Those who experience a gradual onset of the disease (about 50%) tend to have a poorer immediate- and long-term course than those who experience an acute and sudden onset.
- Approximately one-third to one-half of clients with schizophrenia relapse within 1 year of an acute episode.
- Higher relapse rates are associated with nonadherence to medication, persistent substance use, caregiver criticism, and negative attitude toward treatment.

❑Immediate-Term Course

✓ **who typical clinical patterns emerge.**

- In one pattern, the client experiences ongoing psychosis and never fully recovers, though symptoms may shift in severity over time.
- In another pattern, the client experiences episodes of psychotic symptoms that alternate with episodes of relatively complete recovery from the psychosis.

❑Long-Term Course

- The intensity of psychosis tends to diminish with age. Many clients with longterm impairment regain some degree of social and occupational functioning.
- Over time, the disease becomes less disruptive to the person's life and easier to manage but rarely can the client overcome the effects of many years of dysfunction. In later life, these clients may live independently or in a structured family-type setting and may succeed at jobs with stable expectations and a supportive work environment. However, many clients with schizophrenia have difficulty functioning in the community, and few lead fully independent lives.

❑ RELATED DISORDERS

- **Schizoaffective disorder was described earlier. Other disorders are related to but distinguished from schizophrenia in terms of presenting symptoms and the duration or magnitude of impairment. Mojtabai et al. (2017) identify:**

1. Schizophreniform disorder: The client exhibits an acute, reactive psychosis for less than the 6 months necessary to meet the diagnostic criteria for schizophrenia. If symptoms persist over 6 months, the diagnosis is changed to schizophrenia. Social or occupational functioning may or may not be impaired.

❑ RELATED DISORDERS

2. Catatonia: is characterized by marked psychomotor disturbance, either excessive motor activity or virtual immobility and motionlessness.

- Motor immobility may include catalepsy (waxy flexibility) or stupor. Excessive motor activity is apparently purposeless and not influenced by external stimuli.
- Other behaviors include extreme negativism, mutism, peculiar movements, echolalia, or echopraxia.
- Catatonia can occur with schizophrenia, mood disorders, or other psychotic disorders.

❑ RELATED DISORDERS

3. Delusional disorder: The client has one or more non bizarre delusions— that is, the focus of the delusion is believable. The delusion may be persecutory, erotomanic, grandiose, jealous, or somatic in content. Psychosocial functioning is not markedly impaired, and behavior is not obviously odd or bizarre.

4. Brief psychotic disorder: The client experiences the sudden onset of at least one psychotic symptom, such as delusions, hallucinations, or disorganized speech or behavior, which lasts from 1 day to 1 month. The episode may or may not have an identifiable stressor or may follow childbirth.

❑ RELATED DISORDERS

5. Shared psychotic disorder (folie à deux): Two people share a similar delusion. The person with this diagnosis develops this delusion in the context of a close relationship with someone who has psychotic delusions, most commonly siblings, parent and child, or husband and wife. The more submissive or suggestible person may rapidly improve if separated from the dominant person.

6. Schizotypal personality disorder: This involves odd, eccentric behaviors, including transient psychotic symptoms. Approximately 20% of persons with this personality disorder will eventually be diagnosed with schizophrenia.

❑Biologic Theories

➢Genetic Factors

- Identical twins have a 50% risk of schizophrenia; that is, if one twin has schizophrenia, the other has a 50% chance of developing it as well.
- Fraternal twins have only a 15% risk.
- Other important studies have shown that children with one biologic parent with schizophrenia have a 15% risk
- the risk rises to 35% if both biologic parents have schizophrenia.

➢ Neuroanatomic and Neurochemical Factors

- Findings have demonstrated that people with schizophrenia have relatively less brain tissue and cerebrospinal fluid than those who do not have schizophrenia; this could represent a failure in the development or a subsequent loss of tissue.
- Computed tomography scans have shown enlarged ventricles in the brain and cortical atrophy.
- Positron emission tomography studies suggest that glucose metabolism and oxygen are diminished in the frontal cortical structures of the brain. The research consistently shows decreased brain volume and abnormal brain function in the frontal and temporal areas of persons with schizophrenia.
- Intrauterine influences, such as poor nutrition, tobacco, alcohol, and other drugs, and stress are also being studied as possible causes of the brain pathology found in people with schizophrenia.
- Currently, the most prominent neurochemical theories involve dopamine and serotonin. One prominent theory suggests excess dopamine as a cause.
- Some believe that excess serotonin itself contributes to the development of schizophrenia.
- Newer atypical antipsychotics, such as clozapine (Clozaril), are both dopamine and serotonin antagonists.

➢Immunovirologic Factors

- Popular theories have emerged, stating that exposure to a virus or the body's immune response to a virus could alter the brain physiology of people with schizophrenia.
- It is believed that cytokines may have a role in the development of major psychiatric disorders such as schizophrenia
- Recently, researchers have been focusing on infections in pregnant women as a possible origin for schizophrenia.

Psychiatric Treatment Of Schizophrenia

A comprehensive, multidisciplinary treatment plan including:

- Pharmacotherapy
- Social support
- Social/life skill straining
- Self-help groups
- Family therapy can be helpful to maintain the patient effectively.
- Gaining life skills to deal with every day challenges, occupational training, and family education have been help ful.
- Intensive individual psychotherapy is generally not as effective, but reality based therapy to promote trust can be incorporated in to the plan.
- Ongoing support can promote compliance with antipsychotic medications. Management of antipsychotic medications is generally the primary treatment.

❖ Pharmacotherapy

- Atypical antipsychotic drugs treat both the positive and negative symptoms and generally have fewer side effects.
- Most of these agents are available only in oral form.
- A few are available as along- acting injection that is given every few weeks. These include haloperidol ,fluphenazine ,and risperidone.
- Some medications come in liquid forms or quick dissolving tablets, which can also be use full if the patient is not cooperative with taking oral medication.

❖ Managing the Side Effects of Antipsychotics

•The atypical are generally less associated with extrapyramidal symptoms (**EPS**) than the typical agents ,but there is a wide range of other side effects, so close monitoring of the prescribed drug is essential.

•Some atypical are disposed to anticholinergic effects.

•Serious side effects in specific atypical can include: reduced **seizure threshold, blood dyscrasias, and cardiac arrhythmias**.

•One of the most serious is **agranulocytosis**, which is a rare blood complication of **clozapine** requiring close monitoring of the white blood cell count.

❖ Extrapyramidal symptoms

- Extrapyramidal symptoms can be devastating to quality of life. Close monitoring to treat these and prevent long-term consequences must be part of the treatment plan.

Extrapyramidal Side Effects can be include:

1. **Dystonia**: muscle rigidity, torticollis (neck turned in awkward angle).
2. **Pseudo parkinsonism** or dyskinesia: **stiffness, tremors, shuffling gait.**
3. **Akathisia**: restlessness, inability to sit still.
4. **Tardive dyskinesia**: late on set movement disorder that includes lip smacking, grimacing, tongue protrusion.

- **Extrapyramidal symptoms** are generally managed with anticholinergic drugs such as *benztropine, biperiden, trihexyphenidyl*, dopaminergic agonists such as amantadine, or antihistamines such as diphenhydramine.

❖ NURSING CARE FOR SCHIZOPHRENIC PATIENT

The nursing care for patients with schizophrenia not requires compassion.

❖ **Common nursing diagnoses for the schizophrenic patient include:**

- Self-care deficit.
- Sensory perception disturbed.
- Social isolation.
- Thought processes disturbed.
- Risk for violence.

❖ NURSING INTERVENTIONS

➢ For Clients with Schizophrenia

- ❑ Promoting safety of client and others and right to privacy and dignity.
- ❑ Establishing therapeutic relationship by establishing trust.
- ❑ Using therapeutic communication (clarifying feelings and statements when speech and thoughts are disorganized or confused).

❑ Interventions for delusions:

1. Do not openly confront the delusion or argue with the client.
2. Establish and maintain reality for the client.
3. Use distracting techniques.
4. Teach the client positive self-talk, positive thinking, and to ignore delusional beliefs.

❑ Interventions for hallucinations:

1. Help present and maintain reality by frequent contact and communication with client.
2. Elicit description of hallucination to protect the client and others.
3. The nurse's understanding of the hallucination helps him or her know how to calm or reassure the client.
4. Engage client in reality-based activities, such as card playing, occupational therapy, or listening to music.

❑ Coping with socially inappropriate behaviors:

1. Redirect the client away from problem situations.
2. Deal with inappropriate behaviors in a nonjudgmental and matter of fact manner; give factual statements; and do not scold the client.
3. Reassure others that the client's inappropriate behaviors or comments are not his or her fault (without violating client confidentiality).
4. Try to reintegrate the client into the treatment milieu as soon as possible.
5. Do not make the client feel punished or shunned for inappropriate behaviors.
6. Teach social skills through education, role modeling, and practice.
7. Client and family teaching.
8. Establishing community support systems and care.


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