Schizophrenia Spectrum Disorders

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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.

Introduction Cont.

- People with schizophrenia have a “split” 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 for a schizophrenic patient and his/her family can last a lifetime as this crippling condition continues

Introduction Cont.

- The first psychotic break often responds well to treatment, but the relapse rate is high and the person may become increasingly disabled.
- 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 Categorizes of Schizophrenia

- According to DSM-IV, schizophrenia was divided into five subtypes; **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.

DSM-5 Categorizes of Schizophrenia

- Delusional Disorder: Delusions without the other symptoms or disabilities of schizophrenia.
- Schizoaffective: Symptoms of schizophrenia along with symptoms of major depression or manic episode that requires treatment of both disorders.
- Schizophreniform: Schizophrenia symptoms without the level of impairment of functioning usually seen in schizophrenia and lasting more than 1 month and fewer than 6 months

DSM-5 Categorizes of Schizophrenia

- Schizotypal: A personality disorder characterized by odd and eccentric behavior that does not decompensate to the level of schizophrenia

Note: Disorders such as **schizophreniform** and **schizoaffective** would be the less severe forms.

Symptoms Cont.

- The presence of delusions, hallucinations, and/or disorganized speech for a significant portion of time during a one month period. At least one of these symptoms must be present for the diagnosis.
- Grossly abnormal motor behavior and/ or negative symptoms.
- One or more areas of functioning, such as work, school, personal relationships, or self-care, are impaired.
- Some disturbance needs to be evident for at least 6 months.

Symptoms Cont.

- Schizophrenia can also have features of catatonia, which include any of the following: **motor immobility, stupor, excessive motor activity, peculiar voluntary movements, and echolalia or echopraxia.**

Negative Symptoms

Loss of normal functions.

- Avolition: lack of desire or motivation to accomplish goals.
- Lack of desire to form social relationships,
- Inappropriate social behavior

Mood& Affect

- Inappropriate affect
- Bland or flat affect
- Apathy
- Emotional ambivalence
- Anhedonia
- Regression

Negative Symptoms

Impaired Interpersonal Functioning and Relationship to the External World

- Autism
- Deteriorated appearance

Psychomotor Behavior

- Lack of energy
- Waxy flexibility
- Posturing
- Pacing and rocking
- *Associated Features*

Note: Negative symptoms, poorer response to treatment, relatively poor outcome

Positive Symptoms

Positive symptoms are those that are found among people with schizophrenia but not present among those who do not have the disorder.

Content of Thought

- Delusions
- Religiosity
- Paranoia
- Magical thinking

Perception

- Hallucinations
- Illusions

Positive Symptoms Cont.

Sense of Self

- Echolalia
- Echopraxia
- Identification and imitation
- Depersonalization

Form of Thought

- Associative looseness
- Neologisms
- Concrete thinking
- Clang associations
- Word salad
- Circumstantiality
- Tangentially
- Mutism
- Perseveration

Note: Positive symptoms, good response to treatment, relatively better outcome

Etiology of Schizophrenia

- Schizophrenia is known as a brain disorder, but no single cause has been identified.
- Disruption of neurotransmitters, including dopamine, has been identified.
- Some dysfunction in neuron functioning .
- Some cerebral changes in the brain have also been suggested in the limbic system and prefrontal cortex.
- Genetic predisposition, and the most significant risk factor is having a close relative with schizophrenia

Psychiatric Treatment Of Schizophrenia

A comprehensive, multidisciplinary treatment plan including:

- Pharmacotherapy
- Social support
- Social/life skills training
- Self-help groups

Psychiatric Treatment Of Schizophrenia

A comprehensive, multidisciplinary treatment plan including:

- Family therapy can be helpful to maintain the patient effectively.
- Gaining life skills to deal with everyday challenges, occupational training, and family education have been helpful.
- Intensive individual psychotherapy is generally not as effective, but reality-based therapy to promote trust can be incorporated into the plan.
- Ongoing support can promote compliance with antipsychotic medications. Management of antipsychotic medications is generally the primary treatment.

Psychiatric Treatment of Schizophrenia Cont.

- *Typical antipsychotics* have been around since the 1950s and work by blocking postsynaptic dopamine receptors.
- *Typical antipsychotics* generally used to treat the positive symptoms of schizophrenia.
- Atypical antipsychotics have been available since the 1990s and are weaker dopamine receptor antagonists but more potent antagonists of serotonin receptors.

Psychiatric Treatment of Schizophrenia Cont.

- These 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 a long-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 useful 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 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

- **Dystonia**: muscle rigidity, torticollis (neck turned in awkward angle)
- **Pseudoparkinsonism** or dyskinesia: **stiffness, tremors, shuffling gait**
- **Akathisia**: restlessness, inability to sit still
- **Tardive dyskinesia**: late onset 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 OF THE SCHIZOPHRENIC PATIENT

The nursing care of the schizophrenic patient requires knowledge and compassion.

Common nursing diagnoses for the schizophrenic patient include:

- Self-care deficit
- Sensory perception, disturbed
- Social isolation
- Thought processes, disturbed
- Violence, risk for

GENERAL NURSING INTERVENTIONS

1. Watch for clues that patient is hallucinating, e.g., darting eyes, mumbling to self, staring at a vacant wall for long periods. You can also ask the patient if he is hearing voices.
2. If the patient is hallucinating, your response could be, "I don't see the devil standing there, but I understand how upsetting this is for you." In this way you are acknowledging what the patient is experiencing without reinforcing it as your reality.
3. If your patient is delusional, reinforce reality, "that man works for the hospital not the FBI," "Yes, there was a man at the nurse's station, but I did not hear him talk about you." Remind the patient he has some control to look at alternative ways to view reality
4. Work to slowly build trust in small ways. Avoid overreacting to patient's bizarre behavior or appearance
5. Maintain a calm, consistent environment with a regular routine
6. Even though he/she appears to be in another world, continue to include the patient in conversations and activities. Acknowledge his/her presence and importance.
7. Focus on reality, e.g., rather than listen to a long monologue about a delusion, talk about the schedule for the day.

GENERAL NURSING INTERVENTIONS CONT.

1. Never argue with the patient about what he or she is experiencing.
2. Incorporate Quality and Safety Education for Nurses (QSEN) competencies to maintain a safe environment for the psychotic patient (qsen.org), e.g., remove sharp objects, provide adequate supervision.
3. Take action to provide medications before agitation escalates.
4. Make sure there are orders for prn medications for agitation.
5. Never reinforce hallucinations, delusions, or illusions. An example of an inappropriate response is, “Jesus wants you to take these pills," That response reinforces the delusion about Jesus.
6. Avoid whispering or laughing when the patient cannot hear the whole conversation; such behavior can promote paranoia.
7. Avoid putting the patient into situations that are competitive or embarrassing.
8. Build trust by using therapeutic communication skills.
9. If the patient is catatonic, provide for basic physical needs and safety, and make brief supportive contacts with the patient without pressuring the patient to communicate.

24 REFERENCE

- Neeb's Fundamentals *of* Mental Health Nursing

4TH EDITION

Any Questions?