IJCRT.ORG ISSN : 2320-2882

INTERNATIONAL JOURNAL OF CREATIVE RESEARCH THOUGHTS (IJCRT)

An International Open Access, Peer-reviewed, Refereed Journal

A Case Study On Paranoid Schizophrenia

P.S. MEDONNA SHAJINI, M.Sc.(N)

Professor, Bethlahem College of Nursing, Karungal

ABSTRACT

Schizophrenia is a serious mental illness that affects how a person thinks, feels, and behaves. People with schizophrenia may seem like they have lost touch with reality, which can be distressing for them and their family and friends. Schizophrenia is one of the most devastating psychiatric disorders that affects about 1% of the world population with respective age groups of 15-35 years. The symptoms of schizophrenia can make it difficult to participate in usual, everyday activities, but effective treatments are available. Many people who receive treatment can engage in school or work, achieve independence, and enjoy personal relationships.

Keywords: Schizophrenia, Paranoid schizophrenia, Delusion, Hallucination.

INTRODUCTION

Schizophrenia is a long-term mental health condition characterized by disturbances in thought (delusions), perception (hallucinations), and behavior (disorganized behavior) by a loss of emotional responsiveness, extreme apathy and noticeable deterioration in the level of functioning in everyday life.

Schizophrenia is a chronic, severe mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and relates to others. Schizophrenia affects approximately 24 million people or 1 in 300 people (0.32%) worldwide. This rate is 1 in 222 people (0.45%) among adults (2). It is not as common as many other mental disorders. Onset is most often during late adolescence and the twenties, and onset tends to happen earlier among men than women.

According to Global Burden of Disease 2019, Schizophrenia affects approximately 24 million people or 1 in 300 people (0.36%) worldwide. This rate is 1 in 222 people (0.45%) among adults. According to the global burden of disease study 1990-2017, in 2017 there were 197.3 million people with mental disorders in India, comprising 14.3% of the total population of the country.

The word “Paranoid Schizophrenia’ means “delusional”. Paranoid schizophrenia is at present the most common form of schizophrenia. It is characterized by the delusion of persecution, the delusion of reference, the delusion of jealousy, the delusion of grandiosity & hallucinatory voices like auditory hallucinations. Other features include disturbance in affect -blunt affect, volition, speech and motor behavior.

1. ETIOLOGY

The exact cause of schizophrenia is unknown. Several studies suggest that multiple factors are responsible for the causation of schizophrenia.

1.1. Biological theories

Biological explanations include biochemical, neurostructural, genetic and perinatal risk factors.

1.1.1 Biochemical Theories

Many studies hypothesize the functional increase of dopamine at the postsynaptic receptor.

1.1.2. Neurostructural Theories

Research has found abnormal brain structure in people with schizophrenia.

Computed tomography and magnetic resonance imaging (MRI) studies of brain structure show enlarged ventricles and mild cortical atrophy in some patients of schizophrenia.

A positron emission tomography scan shows hypofrontality and decreased glucose utilization in the dominant temporal lobe

1.1.3. Genetic Theories

Schizophrenia can run in families.

The disease is more common among people born of consanguineous marriages.

Studies show that relatives of schizophrenics have a much higher probability of developing the disease than the general population

1.1.4. Perinatal Risk Factors

Factors like Gestational diabetes, Pre-eclampsia, Birth complications, Maternal malnutrition and vitamin deficiency, Viral infections, and exposure to toxins like marijuana are associated with an increased risk of developing schizophrenia in people whose genes make them more likely to get the disorder.

1.2 **Psychological Theories**

The psychological explanation includes the stress vulnerability hypothesis, expressed emotions, family theories, and psychoanalytical theories.

1.2.1 Stress Vulnerability Hypothesis

According to this theory increased number of stressful life events before the onset or relapse probably has a triggering effect on the onset of schizophrenia among genetically vulnerable individuals. Stressful life events can precipitate the disease in predisposed individuals.

1.2.2 Expressed Emotions

Increased expressed emotions such as hostility, critical comments, and emotional over- involvement of significant others in the family can lead to an early relapse.

1.3 **Family Theories**

These include schizophrenic mother (cold, over protective and domineering), lack of real parents, dependency anxious mother, parental marital schism or skew (hostility between parents), double-blind theory (parents convey two or more conflicting and incompatible messages at the same time).

1.4 Psychoanalytical Theories

According to Freud there is regression to the oral stage of psychosexual development with the use of defense mechanisms of denial, projection and reaction formation.

1.4 **Sociocultural Theories**

Sociocultural explanation includes economic and social mobility.

1.5.1 Economic Status

Some studies show that schizophrenia was found to be more common in people with very low socioeconomic status.

1.5.2 Social Mobility

Higher rates of schizophrenia have been found among some migrants.

2. ICD-11 Diagnostic Requirements

At least two of the following essential symptoms must be present for a period of 1 month or more. At least one of the qualifying symptoms should be from the item (a) through (d) below:

a. Persistent delusions (e.g., persecutory, grandiose, reference).

b. Persistent hallucinations (e.g., mainly auditory or any sensory modality).

c. Disorganized thinking (e.g., tangentiality and loose associations, irrelevant speech, neologism, incoherent, word salad).

d. Experiences of influence, passivity or control (i.e., an experience that one's feelings, impulses, actions or thoughts are not generated by oneself but are being placed in one's mind or withdrawn from one's mind by others or that one's thoughts are being broadcast to others).

e. Negative symptoms such as affective flattening, alogia or paucity of speech, avolition, asociality and anhedonia.

f. Grossly disorganized behavior that impedes goal-directed activity (e.g., bizarre or inappropriate emotional responses).

g. Psychomotor disturbances (e.g., catatonic restlessness, agitation, posturing, waxy

flexibility, negativism, mutism or stupor). If full symptoms of catatonia are present in the context of schizophrenia, the diagnosis of catatonia associated with another mental disorder should be assigned.

3. CASE STUDY OF Mr. X

A case study of a 48-year-old Male with Paranoid Schizophrenia is discussed with consent from his wife. Mr. X was admitted to the psychiatric ward on 3/4/2024 with complaints of muttering to himself, wandering behavior & throwing household things in the last 2 months, Decreased sleep, suspiciousness towards his wife & not taking food properly for 3 months. He had a history of similar episodes during 2018 and 2020. There is no significant past medical and surgical history. There is no significant family history except for the fact that his father is an alcoholic. On admission, vital signs are stable. The mental status examination was done and the findings show that blunt affect, thought broadcasting, the delusion of persecution, auditory and visual hallucination, disoriented to time, place & person, poor memory, and impaired judgment with grade I insight.

4. CLINICAL FEATURES

Schizophrenia symptoms are classified into positive, negative and cognitive symptoms.

4.1 Positive symptoms are those that cause an excess or distortion of normal function including:

4.1.1 Delusions: Delusions can be paranoid (beliefs of persecution), somatic (false beliefs about physical illness), grandiose (belief of self-importance and having special powers or abilities; belief that one is especially very powerful, rich, born with a special mission in life); delusion of reference (being referred to by others); delusion of control (being controlled by an external force).

4.1.2 Hallucinations: Most commonly auditory or visual characterized by experiences when there are no external stimuli.

4.1.3 Disorganized speech and behavior: Aggression, agitation, odd behavior.

4.1.4 Thought disorders: Thoughts can be blocked or withdrawn from the mind by others.

4.1.5 Ideas of reference: Occurs when a person believes that certain external phenomena such as TV, radio

4.1.6 Loss of pleasure or interest in life (anhedonia)

4.1.7 Reduced speech (alogia)

4.1.8 Ambivalence and poor newspaper articles are reporting about them or talking directly to them (ideas of reference can also be considered as delusions if there are beliefs that external happenings relate directly to the individual).

4.2 Negative symptoms are those that lead to a decrease or loss of normal function including:

4.2.1 Lack of emotions or restricted range and intensity of emotions (affective flattening)

4.2.2 Poor or non-existent social functioning

4.2.3 Lack of motivation, self-care

4.2.4 It is common for people with schizophrenia to lack insight to such an extent that they do not believe they are ill

4.3 Cognitive symptoms are nonspecific and hence must be severe enough for another individual to notice them. These include:

4.3.1 Problems in attention, concentration and memory.

4.3.2 Having trouble processing information to make decisions.

4.3.3 Having trouble using information immediately after learning it.

5. INVESTIGATIONS

No diagnostic test definitively confirms schizophrenia. Tests may be ordered to rule out disorders that cause psychosis including vitamin deficiencies, uremia, thyrotoxicosis and electrolyte imbalances.

CT scan and MRI show enlarged ventricles, enlargement of the sulci on the cerebral surface and atrophy of the cerebellum.

6. TREATMENT MODALITIES

6.1 Pharmacotherapy

Conventional antipsychotics are now used less frequently because of their only partial efficacy and adverse effects. These are long-acting IM doses that release the drug gradually over several weeks.

Chlorpromazine: 300-1500 mg/day PO; 50-100 mg/day IM

Fluphenazine decanoate: 25-50 mg IM every 1-3 weeks

Haloperidol: 5-100 mg/day PO; 5-20 mg/day IM

Trifluoperazine:15-60 mg/day PO;1-5 mg/day IM

Atypical antipsychotics control a wider range of signs and symptoms than conventional agents do and cause few or no adverse motor effects.

Clozapine: 25-450 mg/day PO

Risperidone: 2-10 mg/day PO

Olanzapine: 10-20 mg/day PO

6.2 Electroconvulsive Therapy (ECT)

6.3 Psychological Therapies-Group therapy, Behavior therapy, Cognitive therapy, Family therapy, social skill training.

6.4 Psychosocial rehabilitation

7. NURSING MANAGEMENT

Nursing management for schizophrenia includes assessing symptoms, establishing rapport, enhancing communication, improving general and social functioning levels, promoting medication compliance and educating family members.

7.1. Nursing Assessment

Data may be obtained from patients, family members, other people familiar with the
patient, and also from old records. Nursing assessment includes information regarding any previous incidence of mental illness or psychotic episodes.

1. Observe behavior patterns, posturing, psychomotor disturbance, appearance, and hygiene.
2. Identify the type of disturbance the patient is experiencing.
3. Ask the patient about feelings while thought alterations are evident.
4. Note the effect and emotional tone of the patient and whether they are appropriate in relation to the thought or present situation.
5. Assess for the theme and content of delusional thinking. If the delusion is persecution-oriented,
assess the nature of threat and risk for violence.
6. Assess speech patterns associated with delusions.
7. Assess for the ability to perform self-care activity, i.e., sleep pattern and interaction with other patients.
8. Determine any suicidal intent or recent attempts that may have been made.

7.2 Nursing Diagnosis

Disturbed thought process related to the inability to trust evidenced by delusional thinking and extreme suspiciousness of others.

7.2.1 Objective: The patient will eliminate delusional thinking and demonstrate trust in others

7.2.2 Nursing interventions

1. Assess the content of delusion without appearing to probe
2. Initially clarify meanings, for example, "Who do you think is trying to hurt you?"

3. Misinterpretations of patients are clarified, and arguments are avoided

4. Avoid physical contact in the form of touching the patient

5. Educate the patient and family or significant others about the patient's symptoms, the importance of medication Compliance, and follow-up visits.

7.2.3 Evaluation

The patient was able to establish trust with family members and reduced his suspicions.

7.3 Nursing Diagnosis

Disturbed sensory perception (auditory/ visual) related to panic anxiety evidenced by inappropriate responses, poor concentration, disorientation, withdrawn behavior.

7.3.1 Objective: The patient will demonstrate decreased hallucinations

7.3.2 Nursing interventions

1. Assess for type of hallucinations and characteristics of hallucinations

2. Observe the patient for hallucinating behavior like talking to self, laughing to self, stopping in mid-sentence

3. Provide a busy schedule of activities to prevent being all alone. Engage in conversation or a concrete activity of interest to the patient

4. Show acceptance of the patient's behavior and of the patient as a person

5. Educate the patient and family/significant others about the patient's symptoms and importance of medication compliance

7.3.3 Evaluation

The patient's hallucinatory behavior was reduced.

7.4 Nursing Diagnosis

Ineffective health maintenance related to inability to trust; extreme suspiciousness evidenced by inadequate food and fluid intake, and difficulty in falling asleep.

7.4.1 Objective: The patient will maintain adequate nutrition, hydration, sleep and rest

7.4.2 Nursing interventions

1. Monitor food and fluid intake

2. Provide a less stimulating environment (dim light, comfortable bed, less noise, etc.) to suspicious patients as they find it difficult to fall asleep due to nightmares or severe anxiety

3. Prevent daytime naps by involving the patients actively in physical exercises or day treatment programs.

4. If the patient is suspicious or is reluctant to take medications, allow the patient to open the sealed medication packet

5. If toileting needs are not being met, establish a structured schedule for the patient

7.4.3 Evaluation

The patient maintained proper food intake, and adequate sleep and rest.

7.5 Nursing Diagnosis

Social isolation related to the inability to trust, panic anxiety, and delusional thinking evidenced by withdrawal, sad, dull affect, preoccupation with own thoughts, expression of feelings of rejection of aloneness imposed by others.

7.5.1 Objective:

The patient will voluntarily spend time with other patients and staff members in group activities on the unit.

7.5.2 Nursing interventions

1. Convey an accepting attitude by making brief, frequent contacts. Show unconditional positive regard
2. Offer to be with the patient during group activities that he finds frightening or difficult.
3. Involve the patient gradually in different activities on the unit
4. Give recognition and positive reinforcement for the patient's voluntary interaction with others
5. Involve the patient's family members also in therapeutic processes.

7.5.3 Evaluation

The patient was involved in ward activities and demonstrated his willingness to engage in the company of others.

8. CONCLUSION

Schizophrenia is frequently associated with significant distress and impairment in personal, family, social, educational, occupational, and other important areas of life. People with schizophrenia are 2 to 3 times more likely to die early than the general population. This is often due to physical illnesses, such as cardiovascular, metabolic, and infectious diseases. People with schizophrenia often experience human rights violations both inside mental health institutions and in community settings. This contributes to discrimination, which in turn can limit access to general health care, education, housing, and employment. The WHO Special Initiative for Mental Health aims to further progress towards the objectives of the Comprehensive Mental Health Action Plan 2013-2030 by ensuring 100 million more people have access to quality and affordable care for mental health conditions.

References

1. Sreevani R. A guide to Mental Health & Psychiatric Nursing. 4th ed. New Delhi: Jaypee Brothers Medical Publisher (P) Ltd; 2018.
2. Ahuja N. A Short Textbook of Psychiatry. 7th ed. New Delhi: Jaypee Brothers Medical Publisher; 2011.
3. Sadock JB, Sadock AV, Ruiz P. Synopsis of Psychiatry: Behavioral sciences/clinical psychiatry. 11th ed. New Delhi, India: Wolters Kluwer; 2015.
4.Laursen TM, Nordentoft M, Mortensen PB. Excess early mortality in schizophrenia. Annual Review of Clinical Psychology, 2014;10, 425-438.
5. WHO. Mental health systems in selected low- and middle-income countries: a WHO-AIMS cross-national analysis. WHO: Geneva, 2009
6.Jaeschke K et al. Global estimates of service coverage for severe mental disorders: findings from the WHO Mental Health Atlas 2017 Glob Ment Health 2021;8-27.
7.Kumari S, Das A. A case study on paranoid schizophrenia. Southeast Asian J Health Prof 2022;5(2):52-55