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Case Report

Case Report of a Schizophrenic Patient: A Complex Case

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Abstract

In this work the clinical case of Mr. L., a 28-year-old male patient with schizophrenic disorder onset during adolescence 10 years earlier. From the beginning and taking charge of the Psychiatric Service he has little awareness of the disease with consequent compliance in the treatment plan. In these 10 years he has been requested to be admitted to the Psychiatric Diagnosis and Care Service (SPDC) and has alternated periods of intense malaise with repeated hospitalizations with periods of sufficient compensation. Persecutory and paranoid delusions, auditory and olfactory hallucinations and episodes of verbal and physical aggression towards objects and family members that occur above all at home are almost constant, albeit with varying intensity. The repercussions of the disease have been decisive on the scholastic, social and occupational functioning of L.

The cause of the description of this case is determined by the clinical history of the patient, which has lasted for 10 years and in which there has been no significant improvement. To date, care services have encountered failures in conceiving and implementing patient aid interventions, various pharmacological therapies and psycho-educational interventions have been tried but normal the patient has relapses with exacerbation of delusional symptoms and aggressive assistance for which he becomes necessary hospitalizations in SPDC and sometimes compulsory health checks or treatments (ASO or TSO).

Materials and Methods: It was possible to observe this case during the work experience and information through the clinical documentation - medical and nursing - of the ward in which the patient was hospitalized. The scientific-rehabilitative path of the treatment group was compared with the most recent evidence regarding the understanding of mental illness and the aid interventions of the schizophrenic patient.

All the necessary data have been collected in respect of privacy and previous anonymity consent from the patient, his parents, the Director and the Coordinator of the U.O. SPDC. I have personally witnessed patient care during the work experience at SPDC.

Results: Up to now it has not been possible to find effective care and treatment trajectories to allow L. to live in a functional way in the social context, despite the disease. Pharmacological therapy is effective only in the short term as the patient, adapting without conviction to the treatments, easily abandons them on his own initiative. Attempts at social and work reintegration did not lead to significantly positive results.

Conclusions: This case report confirms the complexity of schizophrenic disorder and the difficulty in its treatment. It highlights the need to enhance the range of non-pharmacological interventions, of a relational, psychological and educational type and allows intercepting the contribution of nursing care, in the evolution of the disease to the achievement of better living conditions through the development of empowerment and self-determination. of the patient and his family.

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Case Presentation

The idea of developing this analysis arose from the personal interest in the psychiatric area that I had the opportunity to cultivate during my work experience in the Psychiatric Diagnosis and Treatment Service. I decided to deal with the issue of assistance to the schizophrenic patient in the form of a case report, as I felt that presenting a real clinical case was the best way to depict the dimension of complexity in understanding and assisting the person affected by this psychiatric pathology. The case examined concerns the story of L., a 28-year-old boy, suffering from schizophrenia for 10 years, hospitalized numerous times in SPDC. During hospitalization he presents auditory and olfactory hallucinations, delusions of persecution and influence. His behavior is characterized by an evident social withdrawal, by a poor and difficult impulse control, especially of an aggressive nature and by a strong difficulty in managing the relationship with family members, which manifests itself in the form of physical and verbal fights from both set off. Other critical points are the marked difficulty of entering the world of work, the lack of awareness of the disease and the lack of adherence to each treatment project that is planned and proposed. Over the years, several interventions have been planned that have not proved effective in preventing relapses and improving the patient's well-being; the therapeutic scheme has been modified several times and an attempt has been made to reinsert L. in a satisfactory social, family and work context through rehabilitation and psycho-educational interventions.

The main goal that the care group has set itself is to keep the patient involved in the treatment project and increase his functional abilities by containing the positive symptoms of schizophrenia and limiting the negative consequences of stigma and social withdrawal as much as possible. In writing this report I wanted to emphasize the importance of medical and nursing care centered on the patient and his family and on the need to integrate drug therapy with relational and rehabilitative interventions that must be continuously verified and modified if necessary. Finally, since it is a disease that often accompanies the person for the rest of life, it is important to ensure continuity of care by strengthening the networks not only between the services of the Mental Health Department but also with social services and the community. Therefore, information, education, counseling and interception, strengthening or maintenance of networks in support of the patient and his family become important.

The Anglo-Saxon term "insight", which can be translated into the Italian language with the expression "to see inside" things, a situation, is a term that has entered the psychiatric lexicon to define the degree of awareness that a person has of being sick and to need care and assistance. Freud affirmed that even in the most severe forms of psychosis a normal person remains "hidden", who observes "as an impartial spectator the passing of the disease and its tumult" (Freud, 1938). This represents the starting point for a reflection that opens up to the possibility of recognizing in the schizophrenic subject the persistence of parts preserved by the pathology and with them the presence of a certain capacity to judge oneself and one's illness.

In this perspective, insight also assumes a clinical as well as psychopathological value: the therapist can grasp what has not completely disappeared, he can strengthen the patient's conscious part in order to allow him to "appropriate" his illness and therefore to access to a more active and solid adherence to treatment resulting in an improvement in the prognosis of the disorder [1]. In a systematic review, Lincoln, Lullmann and Rief [2] showed that between 50% and 80% of schizophrenic patients were shown to have partial or totally absent insight. Some aspects related to disease awareness are compliance with treatment, the ability to recognize some symptoms attributable to psychosis as pathological and dysfunctional and the social consequences of such disorders. In particular, good insight correlates with compliance with treatment, with fewer rehospitalizations and with a better quality of life of the schizophrenic patient [3]. Although there are numerous data confirming the important role played by insight in determining a better course and outcome of schizophrenic disease, it should not be overlooked that there is also a high correlation between insight, the development of post-psychotic depression and the risk of suicide. ; consequently, the absence of insight does not necessarily have negative effects on prognosis but can instead play an important defensive function implemented by the subject to try to develop a more functional adaptation to the disease [4].

Treatment

The main effect of antipsychotic drugs is the reduction of the "positive" symptoms of the disease, ie delusions, hallucinations and dysphoria. However, taking neuroleptics worsens "negative" symptoms, increasing episodes of apathy, lack of emotional affection, lack of interest in social interactions, disordered thoughts and a reduced ability to plan and execute activities [5].

Prolonged use of neuroleptics interferes with other dopaminergic pathways, generating in some cases the neuroleptic malignant syndrome, in which there is a reduction of spontaneous movements, and the extrapyramidal syndrome, which determines a symptom picture similar to that of Parkinson's disease with tremor, bradykinesia and rigidity.

Extrapyramidal effects include: muscle stiffness, lack of facial expression, slowing of ideation and reflexes and other movement disorders [6].

The most common side effects are: heaviness of the head, numbness, weakness, fainting, dry mouth and difficulty in visual accommodation, impotence, constipation, difficulty in passing urine, skin rash, altered menstrual cycle, increased blood pressure weight, increased body temperature, unstable blood pressure.

Poor adherence to physician prescriptions is the main cause of ineffectiveness of pharmacological therapies and is associated with an increase in health care interventions, morbidity and mortality, representing damage both for patients and for the health system and for the society.

Adherence to therapy means compliance by the patient with the doctor's recommendations regarding the timing, doses and frequency of drug intake for the entire course of therapy. In the schizophrenic patient, compliance refers to the number of drug intakes compared to the number of therapeutic prescriptions [7].

There is a difference between the two concepts of compliance and adherence: the first refers to the patient's passive obedience to follow the prescribed therapeutic scheme, while the second refers to the therapeutic alliance that occurs according to consensual decisions between patient (and family) and doctor.

Statistics have shown that approximately 50% of schizophrenic patients are non-adherent to therapy and a large proportion of patients who adhere to doctor's prescriptions drop out of treatment after one year [8].

The correlation between inadequate compliance and an increase in psychotic relapses, emergencies and re-hospitalizations in schizophrenic patients is widely demonstrated in the literature.

Compliance, being a complex and multifactorial phenomenon, should not be understood simply as the assumption of therapy but also involves a series of changes in behavior and lifestyle and includes, for example, compliance with outpatient visits, the execution of blood chemistry tests for monitoring the plasma level of the drugs taken, the acceptance of hospitalization when necessary [9].

Conclusions

Schizophrenia is a form of mental illness characterized by complexity and peculiarities that are unique from time to time, causing difficulties in the care groups in understanding the needs and related aid interventions for a better quality of life, more aware and self-determined, of the patient and of his family.

The purpose and purpose of this retroactive case report is to improve - through the comparison of clinical data and scientific data - the understanding of the needs of a psychotic patient and his perceptions of the disease, from a "patient-centered" perspective, of the triggering factors which determine the relapses and exacerbation of malaise and the influence of the stigma of mental illness in the treatment path. Observe how the nurse can contribute, through the assistance process, to providing help and identifying the most suitable and viable solutions taking into account the history of the patient and his family, the possibilities offered by the social context.

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