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Case Raport

Case report on schizophrenia: Application of paplaus model theory in nursing care plan

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ABSTRACT

Introduction: The term schizophrenia was coined by Eugen Bleuler, it has been derived from the Greek word "schizo" meaning split, and "phren" meaning mind.[1]
The point prevalence of schizophrenia is about 1% with equal prevalence in both sexes. The onset of schizophrenia is bimodal in women and often runs a more benign course as compared to men and usually occurs in the late teens or early 20[2]
Most devastating disease as this disease strikes the people at the stage when they can show the growth and highest productivity in their lives, mostly in teens or early 20's, it affects people such a way unable them to return to normal lives: go to job, school to marry, etc.[3]
Conclusion: Understanding the severity of this disorder is very important because these clients are always Potential for violence self-directed or at others related to extreme suspiciousness so to Identify the level of suicide precautions needed. If there is a high-risk, does a hospitalization requires? Or if there is a low risk, will the client be safe to go home with supervision from a family member or a friend? For example, does client:
Admit previous suicide attempts.,Abuse any substances..Have no peers/friends.,Have any suicide plan.,Contact the family, arrange for crisis counseling. Activate links to self-help groups.,Check for the availability of required supply of medications needed,Initially, provide activities that require minimal concentration (e.g., drawing, playing simple board games),Involve the client in gross motor activities that call for very little concentration (e.g., walking,When the client is at the most depressed state, Involve the client in one-to-one activity.

1. Introduction

The disease process undergoes through four stages.

1.1. The premorbid stage

In this stage the person shows social mal-adjustment, social withdrawal, antagonist thoughts, and behavior, it also includes shyness and withdrawal.

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1.2. The prodromal stage

In this stage the client shows signs and symptoms which can determine either the onset or fully developed disease.

This stage can begin with slight change in premorbid functioning to full devastating disease.

This stage can range from few weeks to years. This stage is accompanied by functioning impairment and symptoms such as anxiety, sleep disturbance, fatigue, poor concentration, depressed mood.[4]

1.3. Active /Acute schizophrenia

This is main and active phase of disorder in which psychotic symptoms are present.

1.4. Residual stage

Schizophrenia is characterized by periods of remission and exacerbation. This phase comes after acute phase of illness. In this the symptoms of acute phase are either absent or not prominent.[5]

2. Clinical Features

2.1. Bleulers 4 As

1. A: Ambivalence
2. A: Affect Blunting
3. A: Autism
4. A: Apathy

Table 1: Schizophrenic mind contains the positive and the negative symptoms:

Positive symptoms:	**Negative Symptoms:**
Hallucinations: Auditory, visual, olfactory, gustatory and tactile.	Lack of pleasure and motivation. (anhedonia avolition)
Delusions	Paucity of speech / alogia.
Disorganized thinking	Social Withdrawal/ asociality
Disorganized speech	Blunted affect.
Grossly disorganized behavior	
Experiences of passivity and control	

2.2. Case diagnose: Schizophrenic

2.3. Presenting chief complaints

xx year old female, Divorced 8 yrs back ,9 yrs history of mental illness with 3 days exacerbation of

1. Aggressive behavior.
2. Excessive talking.
3. Irrelevant talking.
4. Hyper religiosity.
5. Multiple weeping episodes.
6. Suicidal attempt.
7. Excessive use of water.
8. Repeating checking, washing and cleaning ritual.

Table 2: Identification data

Name:	xxxxxx
Father:	xxxxx.
Age:	xx yrs old.
Sex:	xxxx.
Address:	xxxxx
Education:	xxxxx
Fathers Occupation:	xxxxxx
Family Income:	xxxxx
Marital status:	xxxxxx.
Religion:	xxxxx.
Informant:	Mother.

2.4. History of present illness

1. *Duration:* 3 days
2. *Mode of onset:* Insidious
3. *Course:* Fluctuating
4. *Intensity:* Increasing
5. *Precipitating Factors:* Attending religious ceremony.

3 days back ,patient was in her usual state of health when her family members noticed that her symptoms were worsening. She refused to take medications and on being persuade to do so, she refused and that I will not take medicine '*You don't believe me, I am possessed with a jinn that will get transferred'*.

2.5. Treatment history

1. Tab. Olanzepine 100mg BT.
2. Tab. Tropess 2mg BD.

2.6. Past psychiatric and medical history:

1. Previously treated as MDD with Psychotic features in 2009.
2. Acute Psychotic episodes in 2006.
3. F20 in 2007.
4. Brief Psychotic episodes in 2007.
5. Manic symptoms in 2016.
6. No significant medical/surgical history.
7. Substance use details: Nil.

2.7. Family history:

3. Personal History

3.1. History

Full term normal vaginal delivery, No history of maternal infections, birth defect, cyanosis, jaundice. Normal cry at

Table 3: No. of family members: 07 (Seven), there are children of her brother and her son too.

Age	Education	Occupation	Health status	Relationship with patient	Age at Death	Mode of Death
60yrs	Illiterate	Laborer	Normal	Father	X	X
60yrs	Illiterate	Home maker	Normal	Mother	X	X
35yrs	11^{th} pass	Govt. employee	Normal	Brother	X	X
33yrs	Illiterate	Private job	F20	Client	X	X
30yrs	8th class	Home maker	Normal	Sister	X	X
27yrs	Illiterate	Carpenter	Normal	Brother	X	X
25yrs	Illiterate	Home maker	Normal	Sister	X	X

History of psychiatric illness in mothers cousin (aggressive and wondering behavior).

birth.

3.2. Child hood history

1. Primary caregiver: Mother
2. Feeding: Breastfed.
3. Developmental milestones: Normal
4. Behavioral & emotional Problems: Nil.
5. Illness during childhood: Met with an accident with no significant cause.
   (a) *Educational history:* Illiterate never went to school.
   (b) *Play history:* Not good.
   (c) *Emotional problems during adolescence:* Not significant.
   (d) *Puberty:* 14 yrs old with the appearance of secondary sexual characteristics.
   (e) *Marital History:* Married in 2003, divorced in 2009 because of her mental illness.
   (f) *Pre-morbid personality:* Excessively concerned with cleanliness. Frequent washing of clothes and utensils.

3.3. Interpersonal relationships: Introvert

1. Family & Social relationships: Preferred Solitude, Handled criticism.
2. Use of leisure time: Didn't have any specific hobbies, spent most time in household work.
3. Habits: Home work (Cleaning).
4. Eating pattern: Regular
5. Elimination: Regular.

3.4. Application of interpersonal relations theory

Basic elements:

1. The patient
2. The nurse
3. The interaction between them
4. The kind of nurse each person becomes makes a substantial difference in what each client will learn as she or he is nursed throughout his or her experience with illness
5. Fostering personality development in the direction of maturity is a function of nursing and nursing education; it requires the use of principles and methods that permit and guide the process of grappling with everyday interpersonal problems or difficulties.
6. Nursing can take as its unique focus the reactions of clients to the circumstances of their illnesses or health problems.
7. Since illness provides opportunity for learning and growth, nursing can assist clients to gain intellectual and interpersonal competencies, beyond those that they have at the point of illness, by gearing the nursing practices to evolving such competencies through nurse-client interactions[6]

3.5. Relationships have four phases

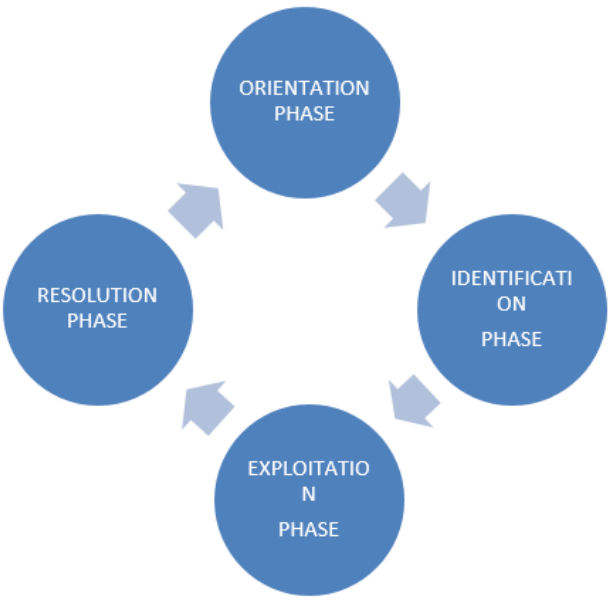

Fig. 1: Phases of relationships

Table 4:

Nursing Diagnosis	Planning	Nursing interventions	Rationale	Evaluation
Impaired verbal communication related to altered perception	Patient will express thoughts and feelings in a coherent, logical, goal-directed manner.	Assess if incoherence in speech is chronic or if it is more sudden, as in an exacerbation of symptoms.	Establishing a baseline facilitates the establishment of realistic goals, the foundation for planning effective care.	By the implementation of all interventions, the clients communication levels are improved.
	Patient will demonstrate reality-based thought processes in verbal communication	Identify the duration of the psychotic medication of the client.	Therapeutic levels of an antipsychotic aids clear thinking and diminishes derailment or looseness of association.	
	Patient will spend time with one or two other people in structured activity neutral topics.	Keep voice in a low manner and speak slowly as much as possible.	High-pitched/loud tone	
		Keep environment calm, quiet and as free of stimuli as possible.		
		Plan short, frequent periods with a client throughout the day.		

Table 5:

Nursing diagnosis	Planning	Nursing Interventions	Rationale	Evaluation
Impaired social interaction related to difficulty in communication	Patient will seek out supportive social contacts.	Assess if the medication has reached therapeutic levels.	Many of the positive symptoms of schizophrenia (hallucinations, delusions, racing thoughts) will subside with medications, which will facilitate interactions.	By implementing the interventions, the client social interaction will increase.
	Patient will improve social interaction with family, friends, and neighbors.	Identify with client symptoms he experiences when he or she begins to feel anxious around others.	Increased anxiety can intensify agitation, aggressiveness, and suspiciousness.	
	Patient will use appropriate social skills in interactions.	Keep client in an environment as free of stimuli (loud noises, crowding) as possible.	Client might respond to noises and crowding with agitation, anxiety, and increased inability to concentrate on outside events.	
	Patient will engage in one activity with a nurse by the end of the day.	Avoid touching the client.	Touch by an unknown person can be misinterpreted as a sexual or threatening gesture. This particularly true for a paranoid client.	
	Patient will maintain an interaction with another client while doing an activity (e.g., simple board game, drawing).			

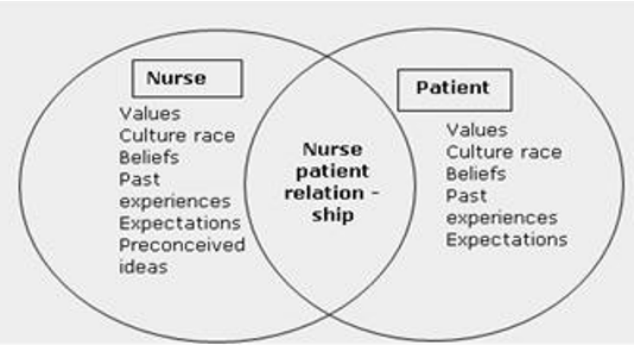

Fig. 2:

4. Influenced Psychobiological Experiences

1. Within personalities, there are needs, frustrations, conflicts, and anxieties that are influential
2. Every human has basic needs and goals exerting tensions within the relationship
3. Nurse's own self-understanding helps nurse to respond to these tensions and coping mechanisms
4. Nurse guides patient towards healing; tension and anxiety are converted into purposeful action as the result of the therapeutic relationship[7]

Nursing care plan according to interpersonal model which will increase interpersonal relation ship and by which patients tension and anxiety gets reduced[8]

5. Conclusion

The application of nursing care as per the specific theoritical framework which improves the quality of nursing care. In paplaus theory the healthy nurse patient relationship enhances the quality of care while caring for the client. Focusing on different areas while caring for the client through different stages of relationship can help the client to solve different problems.

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7. Conflict of Interest

None.

References

1. Salit SA, Kuhn EM, Hartz AJ, Vu JM, Mossa AL. Hospitalization costs associated with homelessness in New York City. *N Engl J Med*. 1998;338:1734–40.
2. Mushtaq B, Mir J. Psychiatric rehabilitation. Drug Design, Development and Therapy. *Schizophrenia Bull*. 2018;12(4):542–59.
3. Mir J, Mushtaq A. Crisis as psychiatric emergency and Role of psychiatric nurse. *J Nurs Administrator*. 2018;1(2):6.
4. Mushtaq B. Assertiveness in Nursing. *COJ Nurs Healthcare*. 2018;1(2):6.
5. Mir J, Mushtaq B, Mushtaq OA. Mental illness vs mental retardation. *Int J Med Paediatr Oncol*. 2022;8(1):10–4.
6. Hull JW, Smith TE. Anthony DT et al Patterns of symptom change: A longitudinal analysis. *Schizophr Res*. 1997;24(1):17–8.
7. Mushtaq B. Anxiolytics and Anti-Depressants and Psychiatry Nursing Management. *Adv Pharm Clin Trials*. 2018;3(2):1–3.
8. Mushtaq B. Role of psychiatric nurse for client receiving anti-psychotic drugs. *Pharma Pharmacol Int J*. 2018;6(3):223–3.

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