

CHAPTER 1

INTRODUCTION

Background and significance of research problem

Schizophrenia is a group of complex disorder with an extremely varied presentation of cognitive, perceptual, emotional and behavioral symptoms. Approximately, one percent of general population will have schizophrenia during their lifetime and it affects both sexes equally (Keltner, Schwechee, & Bostrom, 1995). In China, according to the collaborative survey in 12 areas in 1982, the annual incidence of schizophrenia was between 0.09 and 0.27 per 1,000 population, the lifetime prevalence was 5.69 per 1,000 and the point prevalence was 6.06 per 1,000 in urban and 3.42 per 1,000 in rural (San, Yang, Lian, Zhang, Huang, Lin, Ming, & Chai 1994). Chengdu, Si Chuan is one of these 12 areas in China which consists of 10 million population. It was estimated that there were about 56,900 people who suffered from schizophrenia (San, et al. , 1994).

The course of schizophrenia is difficult to define. Some courses progress rapidly, some slowly, and others are static. Some may run entire gamut and are called chronic

syndromes (Burgess, 1990). Normally, the process of schizophrenia can be divided into three phases. The early phase is a period of time just prior to the active (psychotic) phase in which there is a clear deterioration from one's previous levels of functioning (Suanum & Krause, 1991). The onset is insidious in about half of patients with earliest signs of involvement occurring many years before the more blatant manifestations of psychosis appear (Kaplan & Sadock, 1995). The active phase following the onset known as a period when symptoms are most pronounced and the person is usually recognized as ill by others and most of them are confined in the hospital (Kaplan & Sadock, 1995). The last phase is the residual phase, a time when patients experience the more subtle signs of illness. These symptoms are the residual, or leftover symptoms from the active phase. Usually, the patients in the first two phases are considered as acute patients and should be admitted in the hospital. The patients in residual phase are considered to be in a rehabilitation period. They are expected to stay at home or in community, and are also expected that their acute symptoms are subsided and they are able to perceive their self (Fortinash & Holoday-Wowet, 1996).

The symptoms of schizophrenia are conceptually separated into positive symptoms, which represent an excess distortion of normal functioning, and negative symptoms,

which represent a deficit in functioning (Chesla, 1996). Positive symptoms include distortions or exaggerations of inferential thinking and perception. False sensory perception is the most common perceptual disturbance in schizophrenia (American Psychiatric Association, 1994). Negative symptoms of schizophrenia are less dramatic but just as debilitating as positive symptoms of disorder. Negative symptoms include restricted range of facial and bodily expression of emotion, poor eye contact, brief and empty verbal responses which is thought to be symptomatic of diminished thoughts (Wilson & Kneisl, 1996). Patients with schizophrenia do not have the same symptoms. However, all patients will show signs of psychosis at times.

Schizophrenic patients exhibit marked changes in their affect, cognition, perception, behavior and socialization (Walker, 1992). In affective change, the person can not adapt his/her thinking to the common reality (Gundel & Rudolf, 1993, cited in Fortinash & Holoday-Wowet, 1996). Cognitive change, a major characteristic of schizophrenia, is the disruption of usual ways of thinking (Walker, 1992). Perceptual change in schizophrenic patients means that they have difficulty in receiving the correct sensory, stimulus or may have trouble understanding how others would respond to it (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992). Patients with perceptual disturbance will exhibit in hallucination,

illusion, altered internal sensation, distortion of behavioral body image and negative self-perception (Bendik, 1996). Behavioral change is a marked decrease in relations to the environment (Burgess, 1990). In social change schizophrenic patients exhibit a low level of social functioning and self-care (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992). All of these changes affect patients' understanding of the environment and self. Changes also affect their personality and coping mechanism. Therefore, their concept of self, as a whole are affected. In regard to rehabilitative schizophrenic patients, they are expected that their positive as well as negative symptoms had subsided. They gain their perception of self and they can manage their daily life and accept responsibility for self-care such as grooming, eating, dressing, etc. They are able to return to their previous social environment and to previous or equivalent occupation (Kolb & Brode, 1982). However, some leftover changes could affect patients' physical self and personal self and need to be explored.

According to the Roy Adaptation Model for Nursing (Andrews & Roy, 1991), the person as an adaptive system is affected by environment known as stimuli. Based on the ability of the person to cope with the changing environment or the current adaptation level, the person makes a response. Responses, then, are the person's behaviors as an adaptive

system. In this model, the goal of nursing is to help persons achieve adaptation in all aspects of their life, with the emphasis on health and quality of life. Understanding the coping mechanisms of the person is important to nursing practice.

The result from coping mechanisms can be observed in four categories or adaptive modes, developed by Roy to serve as a framework for assessment (Roy, 1988). These four modes have been termed the physiological, the self-concept, the role function, and the interdependence modes. Although these modes of adaptation should be assessed by nurses to understand the whole person, the typical mode, which can be seen in a specific problem or disease, should be considered. Schizophrenic patients, be described above, have disturbances in perception of self, thus understanding their self-concept mode is necessary.

Self-concept was defined by Driever (1976, cited in Andrews & Roy, 1991, p.270) as the composite of beliefs and feelings that one holds about oneself at a given time. This definition was accepted to use with Roy Adaptation Model. The self-concept mode is viewed in Roy Adaptation Model as having two subareas, physical self and personal self. The physical self is further subdivided into body sensation and body image. The personal self is subdivided into three areas called self-consistency, self-ideal/self-expectancy, and

moral-ethical-spiritual self. The assessment of body sensation involves asking persons about physical sensation they are feeling. In contrast, assessment of body image focuses on persons' perception of how their body looks. In self-consistency, the person's response to new situations such as illness and hospitalization is assessed. Self-ideal/self-expectancy which is the person's goal and expectations of self. The last one is moral-ethical-spiritual self which is the person's value and belief and how it can affect their level of wellness.

Understanding the rehabilitative schizophrenic patients' self-concept will benefit for nurses in assessing appropriate diagnosing and effective care planning. Self-concept of rehabilitative schizophrenic patients reflects their coping mechanisms that will affect their rehabilitation. Patients with positive self-concept can expose their world openly and honestly that will benefit their recover and cope to the stresses in their life. Patients with positive self-concept function more effectively, which is evident in interpersonal competence, intellectual efficiency, and environment mastery (Stuart & Sundeen, 1987). In contrast, patients with negative or low self-concept will feel helpless, worthless, and depress that will increase their anxiety and the risk of suicide. In addition, patients with low self-concept appear withdrawal,

lack competence in work and life that will affect their recovering and increase the impairment of social functioning and the relapse of the disease. A few studies focused on this knowledge having been found in western countries, while no study is reported in China. This descriptive study was conducted to describe the self-concept of those rehabilitative schizophrenic patients in China.

Objective of the study

To describe self-concept of rehabilitative schizophrenic patients.

Research question

What is self-concept of rehabilitative schizophrenic patients?

Definition of terms

Schizophrenic are Chinese persons who have been diagnosed of patients having schizophrenia and were in rehabilitation period and admitted in psychiatric department of West China University of Medical sciences and The Fourth Mental Hospital of Chengdu City, Si Chuan, China.

Self-concept is the composite of beliefs and feeling that one holds about oneself at a given time. It consists of two components named physical self and personal self. Physical self is subdivided into body sensation and body image while personal self is subdivided into three areas called self consistency, self-ideal/self-expectancy, and moral-ethical-spiritual self. This concept is measured by the Self-concept Scale developed by the researcher.

Rehabilitation the phase that the acute symptoms as well as period negative symptoms of schizophrenia are expected to be subsided after the treatment. The patients are considered by a psychiatrist to be in good orientation (person, place, and time) and can manage their daily life and perform their self-care activities.