

CHAPTER 2

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Literature review

Literature review of self-concept of schizophrenic patients included the following contents (a) schizophrenia (b) self-concept (c) alterations of self-concept in schizophrenic patients.

Schizophrenia

Schizophrenia is a clinical syndrome that exacts enormous personal and economic costs worldwide. It is a disorder of mental that manifests movement and behavior. These manifestations combine in various ways and create considerable diversity among patients. The cumulative effect of the illness is always severe and usually long-lasting (Kaplan & Sadock, 1995).

Etiology

Detailed knowledge of causes of schizophrenia is lacking (Fortinash & Holoday-Wowet, 1996). Many authors suggested that multiple factors are causes of schizophrenia and no single theory can explain the disorder. Explanations

can be categorized broadly into biological and psychological (psychodynamic) causes.

Biological theorists postulated that schizophrenia is caused by anatomical and physiological abnormalities. Biological explanations include biochemical, neurostructural, and genetic theories. Biochemical theorists have postulated that a biochemical process accounts for the positive symptoms of schizophrenia, excessive dopaminergic activity in cortical areas causes acute positive symptoms of schizophrenia (Keltner, Schweclee, & Bostrom, 1995). Neurostructural theorists propose that schizophrenia, particularly negative schizophrenia, is a result of pathoanatomy. Lipids influence neural proteins and thus have an impact on neuronal behavior (Keltner, Schweclee, & Bostrom, 1995). Horrobin and his colleagues (1997, cited in Hillbrand, Spitz, & VandenBos, 1997) have proposed a theory of schizophrenia based on abnormalities in fatty acid and phospholipid metabolism.

Genetic theorists proposed that persons with schizophrenia seem to inherit a predisposition to the disorder. Their relatives have a greater incidence of schizophrenia than others. The genetic risk for schizophrenia are: identical twin affected 50 percent, fraternal twin affected 15 percent, brother or sister affected 10 percent, one parent affected 15 percent, both parents affected 35 percent, second-degree relative affected 2-3 percent, and no

affected relative 1 percent. Concordance rates are 50 percent for monozygotic twins, this is 50 times greater than the risk for general population (Keltner, Schweclee, & Bostrom, 1995).

Psychodynamic theories of schizophrenia focus on the individual responses to life events (Keltner, Schweclee, & Bostrom, 1995). The common theme of these theories is the internal reaction to life stressors or conflicts. Psychodynamic theories of schizophrenia include developmental theories and family theories of schizophrenia.

Developmental theories of schizophrenia proposed that the seeds of mental health and illness were shown in childhood. To understand the current functioning of individuals, it is important to understand their upbringing or development (Keltner, Schweclee, & Bostrom, 1995). Freudian (cited in Keltner, Schweclee, & Bostrom, 1995) focused on fantasy and Meyer (cited in Keltner, Schweclee, & Bostrom, 1995) focused on real-life events. An extension of their arguments is that events in early life can cause mental problems that are as severe as schizophrenia. Freudian concepts are still used meaningfully in discussion of schizophrenia. These concepts include poor ego boundaries, fragile ego, ego disintegration, inadequate ego development, super ego dominance, regressed or id behavior, love-hate (ambivalent) relationships, and arrested psychosexual development (Keltner, Schweclee, & Bostrom, 1995). The child

who is deprived of nurturing, loving environment, who is neglected or rejected, is vulnerable to mental disturbances. Sullivan (cited in Keltner, Schweclee, & Bostrom, 1995) used different terms to explain the same ideas. The lack of warm, nurturing attention during the early years could block the expression of affective responses in later years.

Family theories of schizophrenia are linked naturally to development theories. If early-life experiences are crucial in development, the argument is made that the family is significant to the development of mental health or illness. Lack of a loving and nurturing primary caregiver, inconsistent family behavior, and faulty communication patterns are thought to be responsible for mental problems in later life (Keltner, Schweclee, & Bostrom, 1995). It can be seen that psychodynamic development is very important. The nurses must take responsibility for the patients begin on the early life by teaching mothers how to take care of their children to be in a good mental health and prevent the mental problems in the later life including adolescent, adult, and old age. Person with a predisposition to schizophrenia may avoid serious mental disorder if they can cope with stressors of their life in appropriate mechanism.

Signs and symptoms

Schizophrenia is marked by significant disruptions in thought processes, behavior, and affect, each of which can become incapacitating. The primary symptoms of the disorder 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 the distortions or exaggerations of inferential thinking (delusion), perception (hallucination), language and communication (disorganized speech), and behavioral monitoring (grossly disorganized or catatonic behavior) (American Psychiatric Association, 1994). Hallucinations, the false sensory perception, are the most extreme and the most common perceptual disturbance in schizophrenia (Wilson & Kneisl, 1996). The most common form of hallucination in schizophrenia is auditory hallucination and visual hallucination. Delusions are mistaken or false beliefs about the self or the environment that are firmly held even in the face of disconfirming evidence. Delusions may take several forms such as persecutory delusion, grandeur delusion, and nihilistic delusion. Disorganized speech is the outward sign of disordered thoughts and may range from less severe forms, where the person moves rapidly from one topic to another, to more severe forms, where the person's speech

can not be logically understood. Disorganized behavior may present as agitated, nonpurpose, or random movements, and as catatonia (Wilson & Kneisl, 1996).

Negative symptoms of schizophrenia are less dramatic but just as debilitating as positive symptoms of the disorder. Negative symptoms include: flattened affect, alogia, avolition, anhedonia (American Psychiatric Association 1994). People with schizophrenia often appear to have nonemotional or restricted emotional response to their experience. Flattened affect describes this restricted range of facial and bodily expression of emotion, as well as poor eye contact. Brief, empty verbal responses are known as alogia. This poverty of speech is thought to be symptomatic of diminished thoughts and is different from a refusal to speak. A symptom that is frequently misunderstood by families and members of the larger community is avolition, an inability to pursue and persist in goal-directed activities. The schizophrenic patients who experienced of avolition is often misinterpreted as laziness or an unwillingness to support himself or herself, rather than as a symptom of this chronic disorder. Anhedonia, the inability to experience pleasure, does not define schizophrenia, but it is an important symptom that challenges many nurses. It is difficult to imagine and painful to empathize with someone who cannot see to enjoy even small aspects of life (Wilson &

Kneisl, 1996).

Patients with schizophrenia cannot contact with reality, communication may not make sense and they may engage in bizarre behavior. The use of symbols in actions and speech is predominant. Although there are many changes in the person's life, the major changes of schizophrenic patients are in their affect, perception, cognition, behavior and socialization (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992).

Affective change

Affect refers to feelings and emotions. In the normal state, feelings and emotions generally synchronize with the content of thoughts (Burgess, 1990). Because schizophrenic patients have impairment in affect, the synchronization does not occur. They are exhibited a split between thinking and feeling (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992). They may appear flattened, blunted or labile affects, apathy, ambivalence, and overreaction (Keltenr, Schwechee, & Bostrom, 1995). Affect change influence patients interaction with others and their ability to identify and label their emotion.

Cognitive change

Cognition refers to mental or thinking processes. It involves purposefully obtaining information and knowledge. This is the use of intellect, reason, and judgment. Cognitive impairment is one of the major characteristics of

schizophrenia. They are unable to think clearly and logically. They have difficulty to act reasonable. The differences in the ways schizophrenic patients think are autistic thinking, magical thinking, concrete thinking (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992). These signs and symptoms that schizophrenic patients exhibit in impaired cognition are: delusion, derealization, ideas of reference, errors in recall memory, difficult sustaining attention, incorrect use of language and flight of ideas (Fortinash & Holoday-Wowet, 1996). The patients have derealization loss of ego boundaries. They can not tell where own body ends and environment begins. They feel that world around them is not real or distorted.

Perceptual change

Schizophrenic patients have difficulty in perceiving reality and processing information. Patients with disturbances on perception may have difficulty receiving the correct sensory, stimulus, or may have trouble understanding how others would respond to it (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992). Patients have perceptual disturbance exhibit in hallucination, illusions, altered internal sensations, agnosia, distortion of body image and negative self-perception (Bendik, 1996).

Behavioral change

The characteristics of schizophrenic patients' behavior are catatonia, waxy flexibility, negativism, stereotype, and echopraxia (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992). They exhibit various disturbances in psychomotor behavior such as a marked decrease in reactions to the environment. They make purposeless and stereotyped, excited motor movements not influenced by external stimuli. In addition, bizarre grimacing and mannerisms may be observed along with pacing and rocking motions (Burgess, 1990). They are inability to cope with depression. About 50 percent of the depression patients are at risk for suicide (Bendik, 1996) and inability to manage anger.

Change in social

Schizophrenic patients often experience a low level of social functioning and self-care. They appear isolated behavior, avoiding contact with others. Some patients have poorly formed body ego boundaries, which makes contact with others as frightening. Schizophrenic patients may have an impaired ability to trust others and some may be unsure of themselves because of impaired reality orientation. The above factors make it difficult to establish relationship, provide for adequate self-care, and maintaining their employment (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992).

These changes affect patients understanding of the environment and self and affect their personality and coping style. Patients find out it's too hard to distinguish themselves from others, and often their own body has strange and unreal quality to it.

The phase of schizophrenia

The phase of schizophrenia can be divided into three general phases (Suanum & Krause, 1991). The first phase of schizophrenia is an early phase. This phase is the period of time just prior to the active (psychotic) functioning. Specific characteristics of this early phase are as follows: social withdrawal, impairment in role functioning, peculiar behaviors, impairment in personal hygiene and grooming, blunted or inappropriate affect, disturbance in communication, bizarre ideas, and unusual perceptual experiences. Patients themselves are likely to recognize and report several of the following symptoms in the early phase such as tension and nervousness, trouble concentrating, reduced appetite, trouble sleeping, reduced enjoyment, restlessness, difficulty remembering, depression, and preoccupied by one or several ideas.

The second phase is an active phase. The active phase is a period when symptoms are most pronounced and the person is usually recognized as ill by others. This phase consists

of the overtly psychotic symptoms, which usually include delusions, hallucinations, and problems in thinking, feeling, and behavior. When experiencing the active phase, many but not all patients require hospitalization and are considered "psychotic". The active phase is also what mental health professionals often refer to as a "relapse", when it is not the first time a person actively experiences these psychotic symptoms.

The last phase is residual phase. The residual phase is the stage that follows the active phase, a time when patients experience more subtle signs of illness. These symptoms are the residue, or leftover symptoms, from the active phase. They are likely to include social withdrawal, blunted affect, impaired social functioning, and periods of depression.

From the three phases, it appears that some people with schizophrenia do not experience a full remission, recovery, or disappearance of all their psychotic symptoms. Many patients continue to experience a few symptoms in a less intense manner for several years after the onset of their condition. However, it does not mean that persons who continue to have residual symptoms cannot find a way to manage life in a reasonable manner. Two-thirds of patients with schizophrenia return to their communities and can function with the normal range (Suanum & Krause, 1991). The

favorable outcome should be characterized as "social recovery" rather than as "cured" or as full recovery. This means that the patients are able to return to his previous social environment and to previous of equivalent occupation (Kolb & Brode, 1982).

In general, the patients in the first two phases are considered as acute patients and should be admitted in the hospital. Most of schizophrenic patients in hospitalization get effective treatment. Their positive symptoms as well as negative symptoms will subside and continue to the rehabilitation period. The patients in the residual phase may be considered as rehabilitation period and are expected that they should stay in their home or community. They are expected that their acute symptoms are subsided and they are able to perceive their self (Fortinash & Holoday-Wowet, 1996). At this time, patients' psychical symptoms are disappeared or with a few minor negative symptoms such as irritability, shyness, or shallowness of affective responses (Kolb & Brode, 1982). Their insight are restored or partly restored and have good orientation (person, place, and time). They are able to communicate with others and can manage their daily life and accept the responsibility for self-care. Discharge criteria is used to evaluate patients for the rehabilitation period. It may vary according to each hospital. In the psychiatric department of West China

University of Medical Sciences and The Fourth Mental Hospital of Chengdu City, Si Chuan, China, the discharge criteria include: positive symptoms as well as negative symptoms are subsided, insight are restored or partly restored, has good orientation, accept responsibility of self-care, can manage his/her daily life, accept the follow up and continue medical treatment.

Treatment of schizophrenia

Schizophrenia is considered to be one of the most devastation of psychiatric disorders and severely affect patients and their family. Therefore, comprehensive and appropriate treatments are needed to reduce patients suffering from symptoms, to offer the best chance at rehabilitation, and to help those who are close to patients (Kaplan & Sadock, 1995). The treatment includes:

(a) using antipsychotic medications. By means of appropriate medications, patients able to engage in human interactions that make rehabilitation possible (Janosik & Davies, 1986). The antipsychotic medications are useful in treating acute and exacerbation of schizophrenia (Kaplan & Sadock, 1995). Antipsychotic medications cause the schizophrenic person to be less out of touch with reality, less withdrawn, less delusional, and less anxious (Kline & Davies, 1973 cited in Janosik & Davies 1986). However, most

of antipsychotic medications are not very benefit to negative symptoms and have side effect, such as allergic reactions, contact dermatitis, autonomic nervous system reactions, endocrine reactions, neurologic reaction, akathisia, dystonias, tardive dyskinesia, etc (Janosik & Davies, 1986).

(b) using augmenting agents added to antipsychotic medication in persistently psychotic patients. Psychiatrists are interested in combining medications to achieve optimal response such as combining lithium, carbamazepine, benzodiazepines, reserpine, and electroshock therapy (Kaplan & Sadock, 1995).

(c) family therapy has been used in recently years. The family interventions focus on two major outcome areas: symptom reduction and societal (family) reactions to the illness.

(d) relationship therapy is the establishment of a one-to-one therapeutic relationship between nurses and patients in which the nursing process is used to meet the clients' needs. Interpersonal communication and therapeutic relationship are areas in which schizophrenic patients are likely to experience problems and in which nurses can be especially helpful (Janosik & Davies, 1986).

(e) milieu therapy is a variation of relationship therapy offered on a larger scale. The basic principle of milieu therapy is that all of the patients' surroundings,

physical and interpersonal, constitute part of the therapeutic environment. The purpose of milieu therapy is to oppose regression and to foster patients a sense of personal worth, to enhance their ability to interact with others, and to increase their social competence so that a return to a rewarding life style is possible. Group interaction is an effective way of modifying maladaptive behaviors. In group meetings patients learn to communicate with others, to become aware of how they appear to others, and to improve their communication skills (Janosik & Davies, 1986).

(f) rehabilitation has the dual primary objectives of reducing functional disabilities through support for the patients' social environment and advocacy for needed resources and opportunities for them. Rehabilitation programs and services include vocational rehabilitation, services, residential treatment and housing and psychosocial rehabilitation (Kaplan & Sadock, 1995).

In summarize, schizophrenia is complex disorder with marked changes in individual's affective, cognitive, perceptual, behavior, and social. The phase of schizophrenia can be divided in to three phases, the early phase, active phase, and residual phase. Residual phase is considered as rehabilitation period. Patients are expected that their positive as well as negative symptoms are subsided. They gain their perception of self and they can manage their daily life

and accept responsibility for self-care. The treatment of schizophrenia usually include using antipsychotic medication, using augmenting agents added to antipsychotic medication, family therapy, relationship therapy, milieu therapy, and rehabilitation.

Self-concept

Definition of self-concept

Coomb and Snygg's theory (1959 cited in Driever, 1976) viewed self-concept as a map that each individual consults in order to understand himself/herself, especially during moments of crisis and/or decision.

Self-concept was defined by Driever (1976, cited in Andrews & Roy, 1991, p.270) as the composites of beliefs and feelings that one holds about oneself at a given time. It was formed from internal perceptions and perceptions of others' reactions, and directed the person's behavior. This definition was accepted to use with Roy Adaptation Model.

Stuart and Sundeen (1987) defined self-concept as all the notions, beliefs, and convictions that constitute on individuals knowledge of himself/herself and influence his/her relationship with others.

Sideleau (1992) viewed self-concept as the sum of perceptions, feelings, and beliefs about oneself. It includes

characteristics and personality traits and evaluation of the worth or desirability of these traits. It is a totality of a person's attitudes, beliefs, judgments, and values held in relation to one's behavior, abilities, and worth.

Andrews and Roy (1991) defined self-concept as the composite of beliefs and feelings that a person holds about him or herself at a given time, and is formed from internal perceptions and perceptions of others' reactions, self-concept directs one's behavior. It consists of two components: the physical self including body sensation and body image and the personal self comprised of self-consistency, self-ideal/self-expectancy, and moral-ethical-spiritual self.

Component of self-concept

Physical self

Physical self is defined as the individual's appraisal of one's physical attributes, appearance, functioning, sensation, sexuality and wellness-illness status (Driever, 1976; Andrews & Roy, 1991). It includes two components, body sensation and body image.

Body sensation is the ability to feel and experience one self as physical being (Andrews & Roy, 1991). The first impression of self and the world is experienced physically through body sensation. Throughout the stages of life, each

person is challenged to integrate the changing physical as well as emotional, spiritual, and social aspects of being human. Mastering the first stage of maturational development, trust versus mistrust (Erikson, 1963, cited in Andrews & Roy, 1991), is dependent on how body sensations are managed by the nurturing person and the kind of touch the infant received. The body sensation behaviors are the observations listed as the individual's responses to the questions. The assessment of body sensation involves asking the person about physical sensation they are feeling, such as " I feel...(strong, weak, sexually responsive, faint, and pained)".

Body image is how one views about the appearance and function of one's body. Assessment of body image focuses on the person's perception of how the body looks and functions (Andrews & Roy, 1991). Behavioral statements such as " I need to lose some weight", " I feel I'm rather attractive", or " I am not very physically fit" are related to body image. Negative feeling or perceptions about characteristics, functions, or limits of the body or a body part are body image disturbance.

Personal self

Andrews and Roy (1991) viewed personal self as the individual's appraisal of one's own characteristics, expectations, values and worth. Each human being must have some sense of self to be able to function as an individual in

the world. Consideration of the individual's personal self in the promotion of adaptation is of primary importance. Adaptation problems in the area of the self-concept mode and specifically the personal self may interfere with the person's ability to heal and to do what is necessary to maintain health. In Roy Adaptation Model, personal self is divided into self-consistency, self-ideal/self-expectancy, and moral-ethical-spiritual self (Roy, 1976; Andrews & Roy, 1991).

Self-consistency is one's actual performance, one's response to a situation, and one's personality traits (Andrews & Roy, 1991). It is the part of the person which strives to maintain a consistent self-organization and thus to avoid disequilibrium (Driever, 1976). The notion of self-consistency is drawn from the theory of personality described by Lecky (1969, cited in Driever, 1976). Lecky theorized that the person has a need, and therefore motivation, to maintain a consistent or stable self-image, whatever that self-image may be for the person. According to this aspect of self, anything that threatens the consistency of the self-image causes the person to experience anxiety. In self-consistency, the person's response to new situations such as illness and hospitalization are assessed.

Self-ideal/self-expectancy is what one would like to be, related to what one is capable of being (Andrews & Roy,

1991). It is that aspect of personal self which relates to what the person expects himself to be and do (Driever, 1976). It is also the person's ideal of what he wants to become. Each person achieves his self-ideal/self-expectancy by incorporating into himself the perceptions of what significant others expect of him. The person takes these images into himself/herself so that the images become what he sees as his self-ideal/self-expectancy. These images of what a person expects of himself/herself, and wishes to become, guide his/her behavior toward achieving the identified goal (Driever, 1976).

The moral-ethical-spiritual self is an aspect of the personal self which functions as observer, standard-setter, dreamer, comparer, and most of all, evaluator of who this person says that he or she is (Driever, 1976). It is the person's belief system, morals, and the evaluator of who one is (Andrews & Roy, 1991). The moral-ethical-spiritual self is the person's value and belief and how it can effect their level of wellness. The moral-ethical-spiritual self judges the desirability or undesirability of perceptions. It also evaluates the person's behavior in terms of how the person's behavior measures up against the person's consist image of self. The judgment that the moral-ethical-spiritual self makes influence the value or esteem the individual feels about himself (Driever, 1976).

Measurement of self-concept

Several instruments have been used to measure self-concept in different populations. Fitts' (1965) Tennessee Self-concept Scale, consisted of 100 self descriptive statements which the subject used to portray his/her own picture of him/her self including physical self, moral-ethical self, personal self, family self, and social self. Piers and Harris' self-concept scale had 80-item, designed by Piers and Harris (1964) to assess how children (between age of 6 to 16) perceive themselves. It yielded a full-scale score as well as six sub concept scores including social behavior, academic competence, physical appearance and attribute, anxiety, popularity, and happiness and satisfaction.

Although these instruments had been used to measure one's sense of self, they were not fitted for this study, because this study focused on a group of rehabilitative schizophrenic patients. Fitts' self-concept scale had 100 items that may be too long and difficult for schizophrenic patients to answer all questions and Piers and Harris' self-concept scale was appropriate for children. Thus, the researcher developed a self-concept scale based on self-concept adaptive mode of Roy Adaptation Model of Nursing. Self-concept adaptive mode is one typical mode among the four

adaptive modes of Roy Adaptation Model. It can be seen in a specific problem or disease like schizophrenia which has disturbances in perception of self. The instrument used in this study focused on individual's self-concept including physical self and personal self. According to Roy's self-concept adaptive mode, the physical self is further divided into body sensation and body image and the personal self is further divided into self-consistency, self-ideal/self-expectancy, and moral-ethical-spiritual self. Therefore, the instrument would measure schizophrenic patients' self-concept involving five components.

In summary, self-concept is composite of beliefs and feelings that one holds about oneself at a given time. It is formed from internal perceptions and perceptions of others' reactions. Self-concept composes of physical and personal self. Physical self is further divided into body sensation and body image. Personal self is further divided into self-consistency, self-ideal/self-expectancy, and moral-ethical-spiritual self. The assessment of self-concept focused on these five components by using the Self-concept Scale developed by the researcher based on self-concept mode of Roy Adaptation Model.

Alteration of self-concept in schizophrenic patients

Schizophrenia is considered as a complex disorder with presentation of cognitive, perceptive, emotional, behavioral, and social changes (Walker, 1992). All of these disorders affect patients' understanding of the environment and self. Burgess (1990) mentioned that schizophrenia relinquishing control in a key area of the self.

Disturbances of self-concept in schizophrenic patients always appear in physical self and personal self. Patients may have some disturbances in the way one perceives one's body image, perception of one's worth, and mistrust themselves (Beck, Rawlins, & Willams, 1988). Patients distort on body image with respect to size, facial, expression, activity, amount and nature of detail, exaggeration or diminution of body's parts. They consider their body's parts as no longer in proportion. Severe schizophrenic patients may be unable to recognize photographs of themselves or even identify their own body parts (Beck, Rawlins, & Willams, 1988).

Patients who exhibit low self-concept felt worthless. Low self-concept was derived from negative appraisals of their rejecting relationships, and actual failures in relationships, school, work, or independent functioning (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992). Poor self-concept pervaded patients' experiences and prevents them from

incorporating positive feedback and expressing their personal strengths and weakness. Mistrust is occurred because patients loss of ego boundaries, inability to separate self from others or the environment. Anxiety, inconsistent feedback and loss of reality testing skills inhibit the person's ability to formulate an integrated self-concept and define themselves as a separate person (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992).

Janosik and Divies (1986) viewed schizophrenic patients often experience distortions in how the self is perceived. These distortions may affect body image. For many schizophrenic patients, body image is not a stable concept. Parts of the body are subjected to imagine change. In addition, they viewed that weight gain may be a source of trouble of body image. Weight gain may be related to the side effects of medications that involve the endocrine system.

Tayler (1994) viewed that schizophrenic patients have distorted self-perception and poor self-concept. The negative symptoms will let patients to poorly defined concept of who one is and what the meaning of one's life is (Tayler, 1994). In addition, they often have distorted image of their appearance and are often preoccupied with body's parts, such as the nose or breasts.

Fabrega (1989) reviewed the self and schizophrenia in a cultural perspective which suggested that schizophrenia

alter and disturb an individuals customary sense of self, sense of boundaries between self and others (of the behavioral environment), and the ability of the self to relate meaningfully to the cultural world. Culture, the symbolic system, orders and organizes the way individuals conceptualize themselves and the world, and in this way, shapes or constructs the very symbolic environment and objects in which individuals live. The different cultures may give a different content to orientations of the self and provide different meanings and emphases about the self.

Estroff's (1989) studied on self, identity, subjective experiences of schizophrenia, analysis the self and identity in relation to schizophrenia. He viewed that having schizophrenia includes not only the experience of profound cognitive and emotional upheaval, but also resulted in a transformation of self. Concepts of self and identity have been central concerns of schizophrenia. He emphasized the transformation of self that result from serious mental illness, especially schizophrenia.

Dzurec (1990) investigated self-perception and functioning for people with 15 chronic schizophrenia, the results showed that patients gave themselves higher scores (mean=25.9, SD=5.2) than the caretaker scores (mean=22.2, SD=6.5) on the progress evaluation scale which measured aspects of their daily functioning. Most patients perceived

themselves as mental well. The results also showed that the perception of mental health did not significantly influence their functioning ($r=0.14$, $P<0.64$). This was in opposition to findings reported by others people that suggested patients with schizophrenia tended to have negative self-perception. The positive self perception might be the function of respondents' expressed satisfaction with their housing situation.

McCay, Ryan, and Amey (1996), on their study of mitigating engulfment: recovering from a first episode of psychosis, viewed schizophrenia as having a profound impact on an individual's self-concept. Therapeutic modalities can help individuals work out a positive self-concept in the context of this disease. Group therapy help patients to build confidence and improve self-concept.

In rehabilitation period, schizophrenic patients' positive symptoms as well as negative symptoms are subsided, their insight is restored or partly restored. They have good orientation, know themselves, the where, and the time. They are able to return to their social environment and to previous or equivalent occupation (Kolb & Brode, 1982). There are few studies focus on rehabilitative schizophrenic patients' self-concept. The self-concept of rehabilitative schizophrenic patients may be positive or negative. In nursing practice it was found that many schizophrenic

patients have negative self-concept and some authors viewed that schizophrenic patients have tendency of negative self-concept (Haber, Mchahn, Price-Hoskins, & Sideleaa, 1992; McCay, Ryan, & Amey, 1996). Sullivan (cited in Stuart & Sundeen, 1987) viewed the development of self-concept as a continue learning process. He called this process as learning about self from the mirror or other people, the significant others as the key to formulate the self-concept. Culture and socialization also affected the self-concept and personality development (Stuart & Sundeen, 1987). Some mentally ill patients have grown up in a social environment that contributed to the development of negative concept of self (Haber, McMahn, Price-Hoskins, & Sideleaa, 1992). The development theory of schizophrenia mentioned the lacking of warm, nurturing attention during the early year, blocks the expression of self in the later years. Lack of loving and nurturing primary caregiver, inconsistent family behavior and faulty communication patterns are thought to be responsible for mental problem in the later life (Keltner, Schweclee, & Bostrom, 1995). Therefore, the alteration of self-concept in schizophrenic patients are not developed only during the sick period. The developmental tasks and crisis also affect the self-concept development (Deriver, 1976). The rehabilitative schizophrenic patients' self-concept may be negative or positive, and may have alliterated before schizophrenia or

after the disorder.

In conclusion, schizophrenia is a complex mental disorder with marked changes in affective, perceptive, cognitive, behavior, and social. These changes make patients difficult to understand environment and self. They have disturbance in their self-concept such as they feel their body is no longer in appropriation and feel worthless or useless. In rehabilitation period, patients may have alteration in their self-concept. What they feel or see themselves are very important for their rehabilitation and their life. If they have positive self-concept, they will feel themselves as worthy persons and have competence in rehabilitation of social functioning. In contrast, if they have negative self-concept, they will feel unworthiness and helpless, lack competence for recover their social functioning. Thus, knowing about self-concept in rehabilitation period of schizophrenic patients will facilitate nurses to plan rehabilitation strategies and help patients to understand themselves which can direct their own life in a more satisfied way.

Conceptual framework

Schizophrenia is considered as a complex disorder with presentation of cognitive, perceptive, emotional, behavioral and social changes (Walker, 1992). All of these

disorders affect patient's understanding of the environment and him/herself and disturb their self-concept. Schizophrenia is divided into three phases. Patients in the residual phase are considered as rehabilitation period and are expected that they should stay in their home or community. They are also expected that their acute symptoms are subsided and able to perceive themselves (Fortinash & Holoday-Wowet, 1996).

Self-concept according to Andrews and Roy (1991) as the composite of beliefs and feelings that one holds about oneself at a given time. It consists physical self and personal self. The physical self is subdivided into body sensation and body image. The personal self is subdivided into self-consistency, self-ideal/self-expectancy, and moral-ethical-spiritual self (Andrews & Roy, 1991). To understand person's self-concept, it is necessary to assess all of their components. The assessment of body sensation involves asking the person about the sensation he/she is feeling. The assessment of body image focuses on the person's perception of how the body looks. In self-consistency, the person's response to new situation will be assessed. The assessment of self-ideal/self-expectancy involves asking person about his/her expectation or goal of self. Finally, the moral-ethical-spiritual self can be assessed by asking person about his/her value and belief (Andrews & Roy, 1991).

This descriptive study was conducted to identify self-concept of rehabilitative schizophrenic patients based on self-concept mode of Roy Adaptation Model. Knowing about self-concept in rehabilitation period of these patients will facilitate nurses to plan nursing intervention to enhance their positive self-concept.