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Coping with Symptoms of Relapse in Schizophrenia

Shuba Kumar[1], R. Thara[1], and S. Rajkumar[2]

[1] Schizophrenia Research Foundation, C-46, 13th Street, Annanagar (East), Madras 600102, India
[2] Department of Psychiatry, Government General Hospital, Madras 600003, India

Summary. A pilot study is reported of 30 chronic schizophrenic patients at the psychiatric out-patient facility of Government General Hospital, Madras, India. The objectives of the study were to assess the patients' perception of prodromata of relapse and their coping mechanisms. Patients were questioned on these aspects, using a semi-structured interview guide. The study showed a high degree of perception of prodromal signs amongst the cohort. Only 4 patients were unable to perceive any prodromata of relapse. Most commonly noted prodromal symptoms were disturbed sleep and slowness and underactivity. Patients had also resorted to various coping measures such as internal dialogue and talking to a close relative or friend. The study has clearly proved that Indian schizophrenic patients are perceptive of prodromata of relapse and developed self-help methods. These methods, if properly identified, could be incorporated in psychosocial intervention programmes.

Key words: Schizophrenic relapse – Perception – Prodromal symptoms – Coping strategies

Introduction

To most of us, coping occurs unconsciously or else is only marginally attended to. But how do schizophrenic patients deal with relapses which contribute to chronicity and disability? In the process of coping to they perceive early prodromal symptoms likely to lead to relapses?

Häfner and Thurm (1987), Heinrichs et al. (1985) and Herz and Melville (1980) have all reported a high perception of prodromal signs. Brenner et al. (1987) and Brier and Strauss (1983) also elaborated on various coping mechanisms of schizophrenic patients. In India this is an area which has not been very widely researched; thus the impetus arose for conducting a study on Indian schizophrenic patients. The aims of this study were (1) to assess patients' perception of prodromata of relapse, and (2) to ascertain the mechanism of coping with early symptoms of relapse.

Offprint requests to: S. Kumar

Methods

Thirty outpatients regularly attending the psychiatric out-patient department of the Government General Hospital, Madras, India were included. The group comprised 20 males and 10 females, the average age being 29.57 years, and mean duration of illness being 7.67 years. Their socio-economic status ranged from low to middle class, and many patients were literate.

Criteria for inclusion were that the patients satisfied DSM III criteria for schizophrenia, were aged between 15–45 years, had relapsed at least once after stabilization of the first episode, and were in a state of total or partial remission at the time of the interview.

Remission meant absence of major psychotic disturbances such as formal thought disorders, auditory/visual hallucinations and others for a period of at least 1 month before the interview. This was considered essential, as only then could the patient comprehend and respond to the questions asked.

The absence of any existing instrument to measure prodromata of relapse necessitated the use of a semi-structured guided interview. Initial informal interviews were conducted with patients who were urged to talk freely about their symptoms. Based on this, a more organized and semi-structured interview guide was designed, modelled largely on the format used in the Mannheim study (Häfner and Thurm 1987). The questions focused on two main areas: one recorded the early symptoms of relapse as perceived by the patients and the other aimed at ascertaining the various coping strategies used by them. Essentially the symptoms were grouped into four broad

areas: disturbance in vegetative functions, behavioural changes, affective changes and mild psychotic changes.

The questions asked included:

1. Are you aware of any indicators that warn you about an impending relapse?
2. Do you sense any changes in your behaviour, mood eating or sleep pattern?
3. If so, how do you cope with these symptoms?
4. Are you able successfully to use these coping mechanisms in controlling further deterioration?

As an illustrative example, patient X suffering from chronic undifferentiated schizophrenia, used to feel a strong desire to hit his superiors while at work, and sometimes even to tear up currency notes. He used to cope by withdrawing from that situation as quickly as possible and taking on more work to divert his attention, which proved quite effective.

Results

All but 4 of the 30 patients interviewed were able to perceive prodromata of relapse. The chi-square analysis revealed no significant association between socio-demographic variables such as age, sex, socio-economic status, duration of illness and the perception of prodromal symptoms. Table 1 gives the frequency ranking of the prodromal symptoms as cited by the patients. In general, patients detected between 6 and 10 symptoms.

Table 1. Perception of prodromal signs

	No. of patients	%
I. *Vegetative functions*		
1. Disturbed sleep	20	67
2. Work impairment	12	40
3. Low appetite	11	37
II. *Affective changes*		
1. Depression	13	43
2. Irritability	12	40
3. Anxiety, fear	7	23
III. *Behavioural changes*		
1. Slowness and underactivity	16	53
2. Poor hygiene	8	27
3. Embarrassing behaviour	6	20
4. Restlessness and agitation	5	17
5. Talking to self	4	13
6. Excessive talking and singing	3	10
IV. *Psychotic changes*		
1. Confusion inability to think clearly	15	50
2. Ideas of reference	9	30
3. Auditory hallucination	8	27
4. Feelings of unreality	2	7
5. Sensitivity to noise	1	3

The coping measures resorted to ranged from internal dialogue (43%), talking to a close relative or friend (23%), seeking psychiatric help (7%), adjusting medication (13%) and engaging in work (10%). The mechanism of internal dialogue which many patients employed essentially entailed a form of self-reassurance which the patients gave to themselves. For instance patient Y, suffering from paranoid schizophrenia, initially becomes aware of an imminent relapse when he starts having disturbed sleep, and becomes irritable and mildly suspicious. Sensing this disturbance, he reassures himself by saying that he should not get upset over small issues, that this is a feature of his illness which he must try to ignore, because if he were to give in to it, he would once again relapse seriously. This had quite a positive affect on the patient, as he was able to prevent further deterioration.

Discussion

Some of the easily perceived symptoms were: disturbances in sleep pattern, slowness of movement and thought, confusion and difficulty in concentration and depression. In fact 37.8% of the sample in Häfner's study also noted changes in their vegetative functioning, as indicators warning them of a relapse. Changes in affect, where patients were able to sense an increasing tendency towards depression and irritability, were also cited by patients. This is in accord with the findings of Herz and Melvile (1980).

With regard to how patients coped with these symptoms, the study revealed that many patients had resorted to the mechanism of internal dialogue, as one of the means of combating the disturbances that assailed them before a relapse. Talking to a close friend or relative was also found to be helpful. Internal dialogue was also resorted to by patients when experiencing auditory hallucinations. Withdrawing to a quiet place proved effective, as it helped to diminish the disturbing effect of excessive external stimuli. In their study on 40 chronic schizophrenic patients with persistent auditory hallucinations, Falloon and Talbot (1981) found that their patients resorted to changes in activity, interpersonal contact, manipulation and physiological arousal and attentional control. A few patients in our study preferred to engage in work, as this process helped the voices to fade.

By virtue of being preliminary, this study has been on a limited sample, but the finding that Indian patients do employ coping strategies offers hope that this potential in them can be more effectively used in their management. A larger sample, use of controls and in-

clusion of many more variables would be the logical consequence of this study.

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