Schizophrenia and Other Psychotic Disorders

EILEEN TRIGBOFF

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schizophrenia, residual type 00
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LEARNING OUTCOMES
After completing this chapter, you will be able to:

1. Describe the central features of schizophrenia.
2. Distinguish among the subtypes of schizophrenia.
3. Compare and contrast the various biopsychosocial theories that address the possible causes of schizophrenia.
4. Compare and contrast the various theories for the causes of schizophrenia.
5. Explain how psychological and social pressures can influence the course of schizophrenia.
6. Discuss the major nursing implications in caring for clients with difficult and chronic illnesses such as schizophrenia.
7. Discuss the major nursing implications in supporting the families of persons with schizophrenia.
8. Describe methods to prevent or minimize relapses in schizophrenia.
9. Identify the personal characteristics you bring to the care of clients with schizophrenia that might cause you to distance yourself or fail to understand their experience and difficulties.

CRITICAL THINKING CHALLENGE
Like most individuals with schizophrenia, Alicia is extremely sensitive to her environment. When stressed, she often runs the risk that her symptoms will worsen. In the course of living in usual ways, everyone experiences stress related to conducting day-to-day activities. Alicia’s nurse at the mental health clinic has been preparing her to cope with working at a local store. Specific environmental features, such as noise and visual distractions, are particularly difficult for Alicia to deal with.

1. Why do mental health care providers advocate that people with schizophrenia interact with the larger community in treatment programs, jobs, and living in the community?
2. Would people with schizophrenia be better off in protected environments such as semistructured group homes or structured and sheltered workshops?
3. How would you help Alicia deal with noise and visual distractions?
4. How do most working people create an environment that suits their strengths and weaknesses? Can these methods be useful for Alicia?
Schizophrenia is a complex disorder with an extremely varied presentation of symptoms. It affects cognitive, emotional, and behavioral areas of functioning. According to the National Institute of Mental Health, the prevalence rate for schizophrenia is approximately 1.1% of the population over the age of 18. The age of onset is typically between the late teens and mid-thirties, although there are cases outside that range. For example, there is a rarely seen childhood schizophrenia as well as a late-onset schizophrenia (referred to as LOS) that is diagnosed after age 45 and seen more often in women. The illness is diagnosed most frequently in the early twenties for men and late twenties for women. The progression of the disease is as variable as its presentation. In some cases, the disease progresses through exacerbations and remissions; in other cases, it takes a chronic, stable course; while in still others, a chronic, progressively deteriorating course evolves. The National Institute of Mental Health website on schizophrenia (www.nlm.nih.gov/medlineplus/schizophrenia.html), which can be accessed through a direct link on the Companion Website for this book, will also serve as a resource on schizophrenia for you, your clients, and their families.

Symptoms of Schizophrenia

The diagnosis of schizophrenia requires not only the presence of distinct symptoms but also the persistence of those symptoms over time. Symptoms must be present for at least 6 months, and active-phase symptoms (called Criterion A symptoms in the DSM-IV-TR) must be present for at least 1 month during that time, before schizophrenia can be diagnosed. The diagnostic criteria for schizophrenia are presented in the DSM-IV-TR feature below.

The symptoms of schizophrenia are conceptually separated into positive symptoms, which represent an excess or distortion of normal functioning, or an aberrant response; and negative symptoms, which represent a deficit in functioning.

Positive Symptoms

Positive symptoms include the three most pronounced outward signs of the disorder: hallucinations, delusions, and disorganization in speech and behavior.

Hallucinations

Hallucinations are the most extreme and yet the most common perceptual disturbance in schizophrenia. A hallucination is a...
subjective sensory experience that is not actually caused by external sensory stimuli. One or more of the five senses are involved in hallucinations. Hallucinations may be auditory (heard), visual (seen), olfactory (smelled), gustatory (tasted), or tactile (touched). Figure 16-1 represents how someone with visual hallucinations may distort a scene.

The most common form of hallucination in schizophrenia, at least in the western hemisphere, is hearing voices or sounds that are distinct from the person’s own thoughts. If a voice is heard, it (or they) may be friendly or hostile and threatening. It is particularly characteristic of schizophrenia if the person hears two or more voices conversing with each other, or hears a voice that provides continuous comments on the train of thought.

Having auditory hallucinations does not necessarily mean that the individual hears human speech. As you will see in Table 16-3, several other sounds made by clocks, animals, insects, and so on may be hallucinated. Do not confuse hallucinatory experiences with synesthesia, which is the experience of having multiple senses involved in a single event; synesthesia is not a disease or disorder. Distinguishing between synesthesia and hallucinations can be accomplished by ensuring that there is no external stimulation to the sensations. Examples of synesthesia include seeing sounds, seeing colors when in pain, and hearing smells.

This knowledge must, necessarily, influence the way you gather information during assessment.

Hallucinations also occur in several other illnesses besides schizophrenia. Dementia (Chapter 14), substance abuse (Chapter 15), and depression (Chapter 17) are some of them. Table 16-1 links hallucinations with commonly associated disease processes. Hallucinations can also be experienced under extreme physiologic stress or as a side effect of medications.

Delusions

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 many forms. In delusions of persecution, the person may think that others are following him, spying on him, trying to damage or take something of value like a reputation, or trying to torment him (e.g., “They have misters in my apartment that spray LSD onto me when I walk around.”). In another common form, delusions of reference, the person thinks that public expressions, like a story on the television or a newspaper article, are specifically addressed to him or her or that the event occurred because of his or her thoughts or actions (e.g., “When the newscaster wears navy blue, she is speaking my thoughts to the world.”). Specific delusions are discussed in Table 16-2.

Disordered Speech and Behavior

Other positive symptoms represent excesses of language or behavior. Disorganized speech is the outward sign of disordered thoughts and may range from less severe forms (the person moves rapidly from one topic to another), to severe forms (the person’s speech cannot be logically understood). Positive symptoms include low-level behavioral responses to the environment characterized by such disorganized behavior as agitated, nonpurposeful, or random movements, and waxy flexibility (discussed and defined later in this chapter). The positive symptoms of schizophrenia are discussed in Table 16-3.
### TABLE 16-2 ■ Types of Delusions

<table>
<thead>
<tr>
<th>Disturbances in Thinking</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delusions of persecution</td>
<td>Belief that others are hostile or trying to harm the individual</td>
<td>A woman notices a man looking at her and believes that he is trying to follow her.</td>
</tr>
<tr>
<td>Delusions of reference</td>
<td>False belief that public events or people are directly related to the individual</td>
<td>A man hears a story on the evening news and believes it is about him.</td>
</tr>
<tr>
<td>Somatic delusions</td>
<td>Belief that one’s body is altered from normal structure or function</td>
<td>An elderly woman believes that her bowel is filled with cement and refuses to eat.</td>
</tr>
<tr>
<td>Thought broadcasting</td>
<td>Belief that one’s unspoken thoughts can be heard</td>
<td>A young client believes that everyone around him knows he’s attracted to a nurse although he has said nothing.</td>
</tr>
<tr>
<td>Delusions of control</td>
<td>Belief that one’s actions or thoughts are controlled by an external person or force</td>
<td>A woman believes that her neighbor controls her thoughts by means of his home computer.</td>
</tr>
</tbody>
</table>

### TABLE 16-3 ■ Positive Symptoms

<table>
<thead>
<tr>
<th>Positive Symptom</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hallucinations</td>
<td></td>
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<tr>
<td>Auditory</td>
<td></td>
</tr>
<tr>
<td>Human speech</td>
<td>(speaking clearly, mumbling, whispering, singing, yelling, screaming, one voice, several voices, voice speaking to client, voices speaking to each other, male, female, both, indistinguishable, imitating nonhuman sounds)</td>
</tr>
<tr>
<td>Mechanical sounds</td>
<td>(clocks, metal clanging, clicking)</td>
</tr>
<tr>
<td>Music</td>
<td></td>
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<tr>
<td>Animal sounds</td>
<td></td>
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<tr>
<td>Insect sounds</td>
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<tr>
<td>Wind through the trees</td>
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<tr>
<td>Grating sounds made by walking on sand</td>
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<tr>
<td>Crinkling sound from plastic or aluminum wraps</td>
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<tr>
<td>The sound of the earth moving or heaving as during an earthquake</td>
<td></td>
</tr>
<tr>
<td>Visual</td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td>People</td>
</tr>
<tr>
<td>Animals</td>
<td>Movement of large objects</td>
</tr>
<tr>
<td>Distortions of everyday sights</td>
<td>Auras</td>
</tr>
<tr>
<td>Olfactory</td>
<td></td>
</tr>
<tr>
<td>Green peppers</td>
<td>Blood</td>
</tr>
<tr>
<td>Fumes</td>
<td>Burning materials</td>
</tr>
<tr>
<td>Garlic</td>
<td>Urine or feces</td>
</tr>
<tr>
<td>Semen</td>
<td>Rotting meat</td>
</tr>
<tr>
<td>Sulfur</td>
<td></td>
</tr>
<tr>
<td>Gustatory</td>
<td></td>
</tr>
<tr>
<td>Metallic flavor</td>
<td>Blood</td>
</tr>
<tr>
<td>Urine or feces</td>
<td>semen</td>
</tr>
<tr>
<td>Tactile</td>
<td></td>
</tr>
<tr>
<td>Being pregnant</td>
<td>Giving birth</td>
</tr>
<tr>
<td>Being beaten</td>
<td>Electrocution</td>
</tr>
<tr>
<td>Being raped</td>
<td>Band around head</td>
</tr>
<tr>
<td>Grease on hands</td>
<td>Moving tumors</td>
</tr>
<tr>
<td>Internal movements</td>
<td></td>
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</table>

### Delusions

| Persecutory | “I cannot leave my apartment more than once a month. I have to have this cardboard in my pockets when I go out so the CIA can’t take pictures of me.” |
| Referential | “I didn’t mean to do it. I was just thinking what would happen if the train derailed. I’m sorry I killed all those people.” |

—Continued
### TABLE 16-3  Positive Symptoms—Continued

<table>
<thead>
<tr>
<th>Positive Symptom</th>
<th>Examples</th>
</tr>
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<tbody>
<tr>
<td>Delusions—Continued</td>
<td></td>
</tr>
<tr>
<td><strong>Somatic</strong></td>
<td>“I am going to be hemorrhaging, bleeding to death through my mouth.” Or: “I have an alien gestating in my belly. When he is mature he’ll drip from my palms like sweat.”</td>
</tr>
<tr>
<td><strong>Religious</strong></td>
<td>“My daughter is the devil, saturated with evil, because her age of ascendance is 666 (June 6, 2006).”</td>
</tr>
<tr>
<td><strong>Substitution</strong></td>
<td>“It looks just like my wife but it’s really a robot.”</td>
</tr>
<tr>
<td><strong>Thought insertion</strong></td>
<td>“These thoughts are being put in my head by the alien conspiracy.” Or: “When I get angry it’s because the NSA is altering my brain waves.”</td>
</tr>
<tr>
<td><strong>Nihilistic</strong></td>
<td>“Everything is falling apart. My insides are rotting away and so is everything else.”</td>
</tr>
<tr>
<td><strong>Grandiose</strong></td>
<td>“I made $7 million from a software program I developed and they’re keeping it from me until I tell them my secret programming wizardry.” Or: “I am not who you think I am. I work midnights at all the top law firms so I can get all their work done for them.”</td>
</tr>
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</table>

**Disorganized Speech**

<table>
<thead>
<tr>
<th>Disorganized Speech</th>
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</thead>
<tbody>
<tr>
<td><strong>Loose associations</strong></td>
<td>“I came here by bus, but bussing is kissing, I wasn’t kissing but if you keep it simple that is a business tenet for KISS. That was a great group that played on and on, but I’m not playing with you. You are youthful looking. Look out for yourself too.”</td>
</tr>
<tr>
<td><strong>Word salad</strong></td>
<td>“Wimple sitting purple which the twilighted cheshire, for then frames of silver ticking bubble and.”</td>
</tr>
<tr>
<td><strong>Clanging</strong></td>
<td>“I want to eat neat treat seat beat.” “I’m fine it’s a sign fine whine wine pine dine.”</td>
</tr>
<tr>
<td><strong>Echolalia</strong></td>
<td>Client repeats pieces of what is said or entire phrases: Nurse asks, “How are you today?” and the client states, “You today.” Or client states, “I love smelling roses. I love smelling roses.”</td>
</tr>
</tbody>
</table>

**Behavior**

<table>
<thead>
<tr>
<th>Behavior</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disorganized</strong></td>
<td>Client walks around aimlessly picking up everything available to him and touching all objects and surfaces.</td>
</tr>
<tr>
<td><strong>Catatonic</strong></td>
<td>Excited catatonia: A client in the ER is repeatedly assaultive, hyperactive, or cannot sit still. Waxy flexibility: Client maintains a rigid position, allows another to move him or her into new positions and maintains the new position.</td>
</tr>
</tbody>
</table>

**Thinking**

<table>
<thead>
<tr>
<th>Thinking</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lack of planning skills</strong></td>
<td>Indecisiveness</td>
</tr>
<tr>
<td><strong>Concrete thinking</strong></td>
<td>Blocking</td>
</tr>
<tr>
<td><strong>Lack of problem-solving skills</strong></td>
<td>Difficulty initiating tasks</td>
</tr>
</tbody>
</table>

### Negative Symptoms

Negative symptoms of schizophrenia are less dramatic but just as debilitating as positive symptoms. Table 16-4 gives examples of negative symptoms of schizophrenia. Negative symptoms include the “four As” of schizophrenia:

1. **Flat affect** and apathy
2. **Alogia**
3. **Avolition**
4. **Anhedonia**

**Flat Affect**

People with schizophrenia often appear to have unemotional or very restricted emotional responses to their experiences. **Flat affect** “is the absence or near absence of any signs of affective expression” as well as poor eye contact (American Psychiatric Association [APA], 2000). To see how flat affect differs from a normal range of affect, imagine someone responding to winning a prize (“This is great! I’m so happy!”). Now imagine that same person with much less emotion in her response and no emotion showing on her face (“Oh.”). The difference between the two responses is the flattening of affect.

**Alogia**

Brief, empty verbal responses are known as *alogia*. Rather than saying a few sentences in response to a question, clients with alogia reply with a single word or a very limited number of words. This **poverty of speech** is thought to be symptomatic of diminished thoughts and is different from a refusal...
to speak. Under these circumstances, the client does not use many words to express experiences or thoughts.

**Avolition**

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. You may see evidence of this negative symptom when a client fails to go for a job interview or fails to become involved in an easily available activity. The schizophrenic person’s experience of avolition is often misinterpreted as laziness or an unwillingness to support himself or herself, rather than as a symptom of this chronic disorder. This misunderstanding often affects the ability of family members and friends to stay involved in relationships with the client. They may feel frustrated, as if their efforts have been wasted, or personally rejected because their suggestions have gone unheeded.

**Anhedonia**

**Anhedonia**, the inability to experience pleasure, is an important symptom that challenges many nurses. It is difficult to imagine, and even more arduous to empathize with, someone who cannot seem to enjoy even small aspects of life. It is important to remember that people who have schizophrenia cannot enjoy experiences because of a physiologic reason over which they have no control.

Negative symptoms of schizophrenia are difficult to assess because they differ in degree, but not in form, from everyday experience. While few of us have experienced true hallucinations, many of us know what it is like to have a day without the energy to pursue goal-directed activities. Another difficulty in recognizing the presence of negative symptoms stems from the fact that people with schizophrenia often live in difficult situations that may lead to restricted emotional expression and disturbed goal-directed activities. Living in poverty or in unsettled circumstances—homelessness, for example—can induce feelings of desperation or despair, which may mimic the negative symptoms of schizophrenia. It is important to try to separate environmental influences on experience from the disease process, and to note the persistence of the symptoms over time across a variety of circumstances. For example, if a client is living in a rooming house where others around him are likely to steal, that client will not be safe talking excitedly about having received a gift from his parents. If, however, the client is not excited when in his own home in front of his parents and trusted others, the presence of a negative symptom of schizophrenia is likely.

Another important criterion for recognizing schizophrenia is detecting an impaired ability to perform and complete social and work obligations. It is diagnostic of schizophrenia when the person has difficulty performing in one or more areas of life including work, school, social relationships, and the maintenance of everyday activities such as dressing and providing food for oneself.

**Somatic Treatments**

Prior to the 1950s—which is referred to as the pre-neuroleptic age—insulin coma, drug or electrically induced shock treatments, and psychosurgery, including prefrontal lobotomies, were used to treat schizophrenia. The impact of these extreme somatic treatments did make a difference, for a time, in symptomatology but were not durable or beneficial and often not ethical. Many hoped these treatments were the long-sought-after cure for schizophrenia because they were relatively quick and inexpensive compared to lengthy and costly analytic therapies. This hope was not realized.

Contemporary psychosurgery has been refined from a gross assault on cranial tissue (the lobotomy of decades past) to procedures in which specific involved areas of the brain are delicately shaped to reduce repetitive and destructive behaviors (amygdalotomy, cingulotomy). Electroconvulsive therapy (ECT) has been improved upon and crafted to an impressive degree in the last 20 years. Effective treatment with minimal risks has been offered mostly for mood-disordered clients.

The introduction of psychoactive drugs in the 1950s provided new alternatives for the treatment of schizophrenia. Psychotropic medications, which influence the thoughts, mood, and behavior of clients, made previously uncontrolled symptoms manageable. In the period following the introduction of psychotropic medications, the use of seclusion and restraints declined dramatically, as did the duration of hospital stays and numbers of clients in state mental hospitals.

A new optimism arose regarding the possible outcomes of mental illness. Because they controlled the most difficult symptoms of psychosis, psychotropic medications made psychosocial or behavioral treatments possible for a much greater percentage of psychiatric clients. The major tranquilizers did not live up to their promise of providing a cure for schizophrenia and other chronic psychiatric illnesses. However, these drugs relieved the most debilitating symptoms for many clients and were the first step toward recovery or a higher level of functioning.

Refer to Chapters 5, 6, 7, and 32 for more details on the history and the science behind somatic treatments.
Ethical and legal aspects of somatic treatments are discussed in Chapter 13.

**Relapse**

A client with schizophrenia is vulnerable after a period of stability, however brief or extended, partial or complete, to a return of symptoms. This is referred to as a relapse, and the disease itself has a pattern of relapse and recovery. As a chronic disorder, schizophrenia is characterized by relapses alternating with periods of full or partial remission.

Although antipsychotic medication is effective in reducing relapse rates, 30% to 40% of clients relapse within 1 year after hospital discharge even if they are receiving maintenance medication. This is a tremendous difficulty for the client to overcome; therefore, acknowledge the sense of demoralization likely with such a recurrent and debilitating course that cannot be altered significantly. The current hope is that the relapse rate will be reduced from around 35% to about 15% to 20%. The need to improve methods for relapse prevention is clear (van Meijel et al., 2006). The following clinical examples detail how relapses can occur under certain circumstances.

**CLINICAL EXAMPLE**

Daryl, a 26-year-old with a diagnosis of paranoid schizophrenia, decided to stop taking his quetiapine (Seroquel) because he didn’t think he needed it anymore. Within a few days of stopping the medication, he was unable to leave the house for fear of someone harming him. Although he liked his job at the local cannery and knew that he had the chance to earn more money in the near future, he refused to go to work for fear that he would be hit by a bus on his way there. He was eventually fired because of poor attendance. The loss of a structured schedule furthered his deterioration and Daryl relapsed, requiring hospitalization.

In this instance, a decrease in medication increased Daryl’s biologic vulnerability, with marked behavioral, and eventually environmental, consequences. His relapse began with a medication issue and could have been prevented.

**CLINICAL EXAMPLE**

Jeanne, 22, lived with her divorced mother and younger sister Maura since her release from the hospital after her second psychotic episode. She found living alone too frightening and was more comfortable staying in her old room at home. When Maura began preparing to leave home for college, Jeanne became increasingly anxious, demanding to sleep in Maura’s room at night and hiding Maura’s belongings. As Maura’s departure grew near, Jeanne began actively hallucinating and withdrew to her room, refusing to talk to her mother or sister.

In this case, the client did not have sufficient coping skills to deal with her sister’s departure from the household, and her psychosis reemerged. Jeanne’s relapse may have been averted had she been taught coping skills and had the opportunity to practice them. However, learning is unfavorably affected by schizophrenia, motivation and energy are problems, and even a competent program of teaching cannot remove all the negative consequences in response to life stress. Subtypes of schizophrenia are used to designate which symptoms are prominent. The subtypes are discussed below and in the DSM-IV-TR Diagnostic Criteria feature on page 9.

**Paranoid Type**

Prominent hallucinations and delusions are present in the paranoid type of schizophrenia. Delusions are often persecutory or grandiose, and they often connect into a somewhat organized story. Delusions may also be varied and include somatic or religious delusions. Hallucinations often link with the delusions, although this is not necessary. For example, a person who believes he is being monitored by the FBI may hear the voices of people he identifies as FBI agents laughing at him or talking to him.

**Disorganized Type**

The central features present in the disorganized type of schizophrenia are disorganized speech and behavior and flat or inappropriate affect. The client appears disorganized and unkempt because basic everyday tasks like dressing oneself cannot be accomplished. The client may have all the necessary clothing on, but the order of putting on each item of clothing or the steps required to accomplish dressing (e.g., buttoning, zipping, tying) may be too much to handle. Emotional expression may be either inappropriate to the content of what the client is saying (e.g., laughing when discussing being thrown out of the house by roommates) or restricted and flat. Hallucinations and delusions are typically more fragmentary and disorganized than in the paranoid type. This subtype has been referred to as potentially being the most severe form of the disease.

**Catatonic Type**

Although not seen frequently in the United States, the catatonic type of schizophrenia is a distinctive type characterized by extreme psychomotor disruption. The client may display substantially reduced movement to the point of stupor, accompanied by negativism and resistance to any intervention. A client could display a type of posturing known as waxy flexibility, a feature of catatonic motor behavior in which, when clients are placed in peculiar positions, they remain almost completely immobile in the same position for long stretches of time. Alternatively, extremely active and purposeless movement (excitement) that is not influenced by what is going on around the person may be present. Additional signs of the catatonic type of schizophrenia are repeating what others say or mimicking their movements.

**Undifferentiated Type**

When a client is in an active psychotic state, meaning that Criterion A symptoms for schizophrenia are met and the client does not have prominent symptoms that match any of
the prior subtypes, then **undifferentiated type** is diagnosed. Remember that a client’s diagnosis may also change over the years as symptoms form and re-form. The particular subtype diagnosed at one point in time may not match what is currently happening to a client. The subtype of schizophrenia may have shifted, with the undifferentiated subtype now most representative of the course of the disease.

**Residual Type**

The **residual type** of schizophrenia is a subtype diagnosis reserved for a client who has had at least one documented episode of schizophrenia but now has no prominent positive symptoms of the illness. Negative symptoms such as flat affect and inability to work are present, but prominent hallucinations, delusions, and disorganized thoughts and behavior are not. When a client has these characteristics, the client is considered to have residual features of the illness and receives this subtype diagnosis.

**OTHER PSYCHOTIC DISORDERS**

Psychosis occurs in a number of disorders in addition to schizophrenia. The problems with symptoms can be short-lived or may extend into significant periods of time with disability.

**Schizophreniform Disorder**

Schizophreniform disorder is very similar to schizophrenia except the person has not been ill for very long. The diagnostic criteria are the same as the Criterion A symptoms for schizophrenia. The main difference is that the client has experienced the symptoms for at least 1 month and either recovered from the symptoms before 6 months, or 6 months have not yet elapsed since the original symptoms began. Under the latter set of circumstances, the diagnosis of schizophreniform disorder is provisional until the 6 months have elapsed and then a diagnosis is set. A second difference, besides duration, is that the client may show no impairment in social and work functioning.

Schizophreniform disorder may occur just prior to the onset of schizophrenia (i.e., be prodromal to [precede] schizophrenia), yet approximately one third of clients diagnosed with this disorder recover. The other two thirds go on to have either schizophrenia or schizoaffective disorder.

**Schizoaffective Disorder**

In **schizoaffective disorder**, two sets of symptoms—psychotic and mood symptoms—are present concurrently in the same period of illness episode: Criterion A symptoms of schizophrenia and symptoms of a mood disorder (either a major depressive or manic disorder; see Chapter 17). Schizoaffective disorder is less common than, and has a slightly better prognosis than, schizophrenia, but it has a substantially worse prognosis than mood disorders. Interacting with a client who has schizoaffective disorder may require the same skills you would employ with a client who has...
schizophrenia. Disorganized speech may be an expression of this client’s psychosis. The Rx Communication box provides examples of therapeutic communication with a client with the clang association form of disorganized speech.

One of the defining characteristics of schizoaffective disorder is when the hallucination or delusion occurs. A person who has schizoaffective disorder is likely to have hallucinations or delusions regardless of mood state. In other words, if the person were delusional only when he or she had extreme problems with mood (mania or depression), it is likely the diagnosis would be mood disorder with psychotic features rather than schizoaffective disorder.

**Delusional Disorder**

**Delusional disorder** is diagnosed when the client holds one or more nonbizarre delusions for a period of at least 1 month. The client must never have met the Criterion A symptoms for schizophrenia. Although it is sometimes difficult to differentiate bizarre from nonbizarre delusions, the key is that the nonbizarre delusions could conceivably arise in everyday life. A nonbizarre delusion is the focus of the clinical example that follows.

**CLINICAL EXAMPLE**

Martin holds the delusional belief that the police are trying to entrap him. He goes to extremes to protect his home with surveillance and security equipment. At the same time, he believes that the police won’t bother him at work because his boss, with whom he gets along well, is the son of a policeman.

People with delusional disorders may function quite well in areas of their life not affected by the delusion, yet behave oddly in activities touched by the delusion. Delusional disorders are not common and arise predominantly during middle and late adulthood.

A subtype of delusional disorder, the erotomaniac type, occurs when clients believe that another person is in love with them. Typically this other person has no relationship whatsoever to the client, or the relationship is superficial at best. Contacting the person, stalking the person, and displaying to impress the imagined lover, have involved celebrities, politicians, and even the man or woman next door.

**Brief Psychotic Disorder**

In a brief psychotic disorder, at least one of the Criterion A symptoms for schizophrenia are present (hallucinations, delusions, disorganized speech or behavior) for at least 1 day, but for less than 1 month. Upon remission of these symptoms, clients return to their level of functioning prior to the onset of the illness. This disorder may be brought on by a particular stressful event in the person’s life, including childbirth. In other instances, a stressful life event cannot be specifically identified. Brief psychotic disorder is an unusual and seldom-seen phenomenon.

**Additional Psychotic Disorders**

Several additional psychotic disorders are specified in the DSM-IV-TR:

- Shared psychotic disorder
- Psychotic disorder due to a general medical condition
- Substance-induced psychotic disorder
- Psychotic disorder not otherwise specified (NOS)

Consult the DSM-IV-TR for diagnostic criteria for these disorders. However, in diagnosing any psychotic disorder, the diagnostician must explore the alternative explanation that symptoms may be caused by an underlying medical disorder or by substance use.

**BIOPSYCHOSOCIAL THEORIES**

Beliefs about the causes of schizophrenia have changed over the centuries since schizophrenia was equated with early senility. Theories about the treatment for schizophrenia have also undergone change. For example, at one point it was erroneously believed (based on the writings of Sigmund Freud) that people with schizophrenia could not be treated because they were unable to form a therapeutic relationship with a psychoanalyst. At another point, a now discredited theory pointed to the behavior of parents, especially mothers, causing schizophrenia in their offspring. It is likely that several factors interrelate to cause schizophrenia and several forces influence the effectiveness of treatment. A multifactorial cause and a varied approach to treatment, responsive to the individual’s needs, seem to be the best approach.
**Biologic Theories**

It is unlikely that schizophrenia is caused by one specific biologic abnormality. Scientists have searched unsuccessfully for a unique biologic marker consistently present in people with schizophrenia but absent in healthy people. At the same time, evidence suggests that the disorder is not merely psychological and that biologic alterations are present. Particularly convincing is the fact that the symptoms associated with schizophrenia, such as delusions or hallucinations, are found in healthy people only when they are in a state of metabolic imbalance or suffer from organic diseases. Individuals who have brain tumors, have infections, or have ingested certain drugs, for example, may experience hallucinations.

**Genetic Theories**

People with schizophrenia inherit a genetic predisposition to the disease rather than inheriting the disease itself. What supports this theory is the fact that relatives of people with schizophrenia have a greater chance of developing the disease than does the general population. While 1.1% of the population develops schizophrenia, 10% of the first-degree relatives (parents, siblings, children) of persons with schizophrenia are diagnosed with the disease during their lifetimes (Brookes et al., 2006; Karayiorgou & Gogos, 2006; Kessler, Chiu, Demler, & Walters, 2005). The risk of developing schizophrenia increases with the closeness of one’s relationship to a diagnosed person. Siblings have a greater risk of developing the disease than do half-siblings or grandchildren, and these have a greater risk than more distant relatives, such as cousins.

There is no clear genetic marker for schizophrenia at this time, although several research projects are involved in the search for susceptibility genes. The most promising development has been the Human Genome Project. The Project’s completion of the sequence of the human genome has been guiding the study of the genetic variations implicated in human disease. The quest for the schizophrenia gene is exciting news for psychiatric-mental health nurses. On the other hand, Joseph and Leo (2006) make a strong argument that much of what we have assumed is genetic can also be explained by environmental factors. The risk of susceptibility may remain the same, but the notion that there is one specific schizophrenia gene may have weaker support than previously thought.

In fact, it is becoming obvious that a single gene is not responsible for schizophrenia (Paz et al., 2006; Riley & Kendler, 2006). This illness resists easy genetic codification due to its complexity and its variety of forms. It has been suggested that schizophrenia may be a collection of disorders rather than a single disease entity. The current front-runner among possible susceptibility genes for schizophrenia is neuregulin 1 (NRG1), a very complex gene (Harrison & Law, 2006). It has six known types but only two may be relevant to schizophrenia.

Research examining the occurrence of schizophrenia in twins indicates that both environmental and genetic factors are important. Rates of concordance (in which both twins either express or do not express the trait) for schizophrenia are consistently higher for monozygotic twins than for dizygotic twins.

Interestingly, monozygotic, or identical, twins need not both have schizophrenia, but the chance of both twins having schizophrenia is 25% to 39%. This finding supports the hypothesis of some level of genetic transmission. The fact that both twins are not always affected when they are genetically identical, however, indicates that environment plays a large part in the expression of the illness. If the disease were solely genetically determined, the concordance rates in this group would be close to 100%. (See also pages 000–000 in Chapter 6 for another discussion of genetics in schizophrenia.)

**Brain Structure Abnormalities**

As a group, people with schizophrenia differ in their brain structure from people who do not have schizophrenia. People with chronic schizophrenia show changes to their frontotemporal cortical gray matter, among other areas. Magnetic resonance imaging (MRI) studies show hippocampal structural differences between people who have schizophrenia and those who do not. When the hippocampus is formed, brain-derived neurotrophic factor (BDNF) is involved. Checking for abnormalities in BDNF may be able to tell us who is at risk for developing schizophrenia (Szeszko et al., 2005).

Altered brain structures may be genetically based and could represent a marker of vulnerability to schizophrenia that precedes any other symptomatology. How the brain structure abnormalities influence the progress of the disease is not well understood and requires further study. An example of PET scan differences between identical twins where one has schizophrenia and the other is unaffected is seen in Figure 16-2.

**Biochemical Theories**

The biochemical basis of schizophrenia is captured in the dopamine hypothesis, which states that schizophrenic symptoms may be related to overactive neuronal activity that is dependent on dopamine (DA). In other words, positive psychotic symptoms are associated with excessive DA transmission.

The hypothesis was supported by numerous studies demonstrating that DA blockers, which are medications that decrease DA activity, alleviate symptoms. The traditional antipsychotic medications were shown to be effective because of their ability to antagonize DA receptors; however, this causes undesirable side effects such as extrapyramidal symptoms. The relief of positive symptoms with these traditional agents was not complete, and the negative symptoms of the disorder were much less responsive to DA blockers. See Figure 16-3 for a graphic representation of this concept.

Research suggests that the relationships between DA activity and schizophrenic symptoms are much more complex than originally hypothesized. It is now known that there are multiple types of DA receptors, and different types of receptors are concentrated in different regions of the brain. Another feature of this theory is catechol-O-methyltransferase (COMT), a catecholamine-metabolizing enzyme involved in dopamine flux and the dopaminergic regulation problems seen in schizophrenia (Tunbridge, Weinberger, & Harrison, 2006; Meyer-Lindenberg et al., 2006). The regulation of DA activity
continues to be thoroughly studied, as DA dysregulation from every source is recognized as being inherently involved in the pathology of schizophrenia (Eastwood & Harrison, 2006). Further evidence that supports a biochemical theory is the physical impact that atypical antipsychotic agents have on clients with schizophrenia (Kelly et al., 2006; Kelly & Conley, 2006). These medications block DA as well as serotonin. This may help lessen extrapyramidal side effects such as dystonia and akathisia (uncomfortable or painful side effects, explained in detail in Chapter 32), and may be the reason they are so useful in reducing negative symptoms.

Psychological Theories
Most psychological theories focus on the processing of information as well as attention and arousal states in schizophrenia.

Information Processing
Many clients with schizophrenia have information-processing deficits. Two central types of information processing have been identified:

1. Automatic processing
2. Controlled or effortful processing

Automatic processing occurs when you take information in unintentionally. Automatic processing can occur without your being aware of it and does not interfere with conscious thought processes that occur at the same time. An example of automatic information processing is being aware of the physical features of a new environment, such as a room being large and spacious as opposed to small and confined.

People with schizophrenia are deficient in controlled information processing (Lee, Lee, Lee, & Kim, 2007; Nicode-
irritability, excitement, and anxiety rather than apathy and lethargy. These clients demonstrate symptoms of agitation that have been noted during both symptomatic and nonsymptomatic periods. These clients show a state of hyperarousal evidenced by elevated psychologic, physiologic, and behavioral alteration in the form of increased galvanic skin response, heart rate, and blood pressure. Hyperarousal is a striking feature for an example of an interaction with a client who is unfocused and having a problem processing information.

We do not know whether the inability of a person with schizophrenia to sustain conscious, directed thought is the primary problem or the result of a primary deficit in automatic thinking. If the primary deficit is in automatic processes, then the person is forced to complete automatic tasks at the conscious level, inhibiting and slowing controlled information processing. There is research support for the presence of attention and cognitive impairments (Donohoe et al., 2006) and the presence of negative impacts on working memory in the current literature. Sufficient evidence to resolve this question is not yet available.

Attention and Arousal

Attention and arousal are measured by physiologic states and alterations, such as galvanic skin response, heart rate, blood pressure, skin temperature, and pupillary response. Physiologic studies of attention and arousal in clients with schizophrenia show promise in identifying clinically significant subgroups.

One subgroup of clients exhibits abnormally low response levels to novel, or different, stimuli. This finding suggests that these clients are less adept than healthy people at attending to and responding to novel situations. An example of this state can be seen when a client with schizophrenia does not register that a ball is being thrown at him during a game of catch. The ball may even strike him, drop to the ground, and roll away before the client looks at it.

A second group of clients with schizophrenia demonstrates a state of hyperarousal evidenced by elevated electrodermal activity, heart rate, and blood pressure. Hyperarousal has been noted during both symptomatic and nonsymptomatic periods. These clients demonstrate symptoms of irritability, excitement, and anxiety rather than apathy and withdrawal. An example of this state occurs when a client with schizophrenia angrily and loudly criticizes someone for using incorrect grammar in a sentence.

Family Theories

Numerous theories implicating family interaction alone as a cause of schizophrenia have been proposed and unsupported. Research has failed to support the theory that dysfunctional family interaction alone causes the illness.

Suggestions have been supported that disordered family communication (the inability to focus on and clearly share an observation or thought) causes schizophrenia only in the presence of a genetic predisposition to the disease. For example, the communication taking place at the dinner table may be chaotic and constant. No one finishes a sentence and nothing is discussed to its logical conclusion. Living with this pattern of family communication during early development is thought to impair the ability of the person with schizophrenia to perceive the environment and communicate with others about it. People with schizophrenia are more likely to show symptoms of thought disorder when they are raised by people who have dysfunctional communication.

Individuals with schizophrenia who are raised by adoptive parents, who showed elevated levels of communication deviance, demonstrate as much thought disorder as those raised in birth families. In contrast, adoptees who were raised by adoptive parents with more functional communication were less likely to show thought disorder. In one study, this pattern was not evident in control adoptees—there was no discernible relationship between thought disorder in the adoptees and communication deviance in the adoptive parents. In other words, these findings did not detect the presence of a “schizophrenogenic” environment for individuals without a preexisting genetic liability. These examples support the view that genetic factors alone do not explain the development of schizophrenia, and that interactions with the environment are important. Individuals who live in aversive environments tend to have higher rates of schizophrenia, suggesting there may be a neighborhood and social context to development of the disease (Allardyce & Boydell, 2006).

A second theory is that the family’s emotional tone can influence the course of schizophrenia over time. Researchers...
found that individuals with schizophrenia from families who are highly critical, hostile, overprotective, or overinvolved tend to relapse more often. Families exhibiting such characteristics have been described as having high expressed emotion (EE). There is some evidence that family expressed emotion, life events, and biological factors combine with the individual’s genetic liability to the disorder to cause schizophrenia. In other words, the disorder is responsive to psychosocial attributes such as the emotional climate of the family (Kymalainen, Weisman, Rosales, & Armesto, 2006). Recent research on schizophrenia can be found on the National Alliance for Research on Schizophrenia and Depression website at www.mhsource.com/narsad/ and through a direct link on the Companion Website for this book.

**Humanistic–Interactional Theories**

An interactional model of schizophrenia integrates many of the biologic and psychosocial theories already discussed. In this view, schizophrenia is due to the interaction of a genetic predisposition or biologic vulnerability, stress or change in the environment, and the individual’s social skills and supports. In an interactional model, the influences are multidimensional. A biologic vulnerability may inhibit the individual’s capacity to cope with even minor stressors such as the loss of a primary source of support. Similarly, the symptoms of schizophrenia may worsen upon entering an environment that demands coping skills the person with schizophrenia may not have developed.

A precursor to present-day interactional theories is the enduring interpersonal-psychiatric theory of Harry Stack Sullivan (discussed in detail in Chapter 5). Sullivan, a psychiatrist, emphasized modes of interaction and the role of anxiety as the real focus of psychiatric inquiry in his work with people with schizophrenia. Hildegard Peplau (known as the “mother” of psychiatric nursing) based her interpersonal psychiatric nursing approach on the work of Sullivan. However, Peplau had more to say than Sullivan about the social and cultural conditions that influence behavior. The ideas of Sullivan and Peplau continue to influence our practice with clients who are schizophrenic.

**Stress–Vulnerability Model**

An interactional model for understanding schizophrenia that has received wide acceptance is the stress–vulnerability model, which suggests that people with schizophrenia have a genetically based, biologically mediated vulnerability to personal, family, and environmental stress. In this model, risk factors and protective factors interact in any of three ways:

1. Stressors, risk, and vulnerability factors combine and potentiate each other.
2. As long as stress is not excessive, it enhances competence.
3. Protective factors modulate or buffer the impact of stressors by improving coping and adaptation.

People with schizophrenia have a potentially increased vulnerability to stress. High-EE relatives may cause them great stress, resulting in an exacerbation of symptoms and/or a relapse. It is now almost standard practice to aim to reduce high EE and criticism in the family system of persons with schizophrenia. However, as one study indicates, while some families are identified by researchers as having a critical home environment, the clients themselves do not necessarily perceive their relatives as critical (Weisman, Rosales, Kymalainen, & Armesto, 2006).

As we know, the stressors a client with schizophrenia experiences can overwhelm the resources available, and symptoms result. Psychobiologic stressors include the stress of living with schizophrenia itself. Altered attention and perception, as well as problems with motivation and energy, create stresses for people with schizophrenia. Environmental and interpersonal stressors include those we all encounter; however, a person with schizophrenia is particularly sensitive to them. These include stressful life events, environments that are highly demanding or stimulating, and family or living environments that are highly negative.

It is not unusual for clients to make statements that point to the validity of the stress–vulnerability concept, especially the protective qualities. One client said, “I’m not saying it [referring to an antipsychotic medication] is a perfect solution. It’s not. There are painful side effects. But I know I can count on it when the going gets rough. If things get stressful it will help me through it.” A second client said: “I feel raw inside and out when I’m off it [referring to an antipsychotic medication]. Everything bothers me. So it cushions the blows that are my life.”

**Resources That Moderate Stress**

Resources that can moderate stress (and are thought to affect the development of symptoms in schizophrenia) include:

- Skill in symptom recognition and management
- Social support
- Antipsychotic medication

The capacities to self-monitor the waxing and waning of schizophrenia and to develop coping strategies to influence symptoms at the first sign of trouble show promise in influencing the longer-term course of the illness. An example of how you can help a client to self-monitor symptoms and develop coping strategies is in the Evidence-Based Practice feature that follows. This capacity to detect prodromal symptoms and acute symptoms and institute self-care before completely decompensating is a resource that may work to mitigate the stress that occurs in the person, family, or environment.

Social support has proven helpful in moderating stress for general populations and for people with schizophrenia in particular. Supportive others who provide empathy, interpersonal contact, financial aid, problem solving, and other forms of support help to mitigate the difficulties of schizophrenia (Montgomery, Tompkins, Forchuk, & French, 2006). Finally, antipsychotic medications moderate some, and sometimes most, symptoms of the disease, and thus some of the stressors induced by the disease.
Perceive that the walls of a hallway are closing in. The client with schizophrenia may mistake a chair for a person or ceives or exaggerates stimuli in the external environment. A physical contact. A sense of touch and therefore be extremely sensitive to any acutely sensitive to sounds. Another may have a heightened a client may see colors as brighter than normal or may be a client may misperceive or exaggerates stimuli in the external environment. A client with schizophrenia may mistake a chair for a person or perceive that the walls of a hallway are closing in. The perceptual changes are sufficient to cause the client to mistake the stimulus for something else (see the example of an illusion in Figure 10-1 on page 000). Hallucinations are the most extreme and yet the most common perceptual disturbance in schizophrenia. Auditory hallucinations are the most common form of hallucination. Although hallucinations are a hallmark of schizophrenia, their presence alone does not establish the presence of the disorder. Refer back to Table 16-1 on page 4, which lists various types of hallucinations.

Assess perceptual disturbances by asking the client about the experience and by observing for behaviors that indicate the client is frightened or attending to internal stimuli. Ask the client, “What are you seeing and hearing?” Note the degree to which this description differs from your perceptions of the environment.

Clients may be reluctant to discuss the extreme perceptual disturbance of hallucinations. One of the ways you can introduce the topic is to discuss physical symptoms such as pain or discomfort. Then ask about hearing and vision skills. From there it is a smooth transition to asking about unusual experiences with hearing and seeing.

A classic sign of auditory hallucinations is placing the hands over the ears when clients are frightened by the voices and attempt to block them out. Less obvious signs of hallucinations are inappropriate laughing or smiling, difficulty following a conversation, and difficulty attending to what is happening at the moment. Fleeting, rapid changes of expression that are not precipitated by events in the real world can be another sign. The degree to which clients believe the hallucinatory experience is real and their ability to verify the reality of the experience by checking with others have important implications for interventions. Note the client’s emotional response to hallucinations. Some clients experience depression or despair about the continued presence of voices; others may be comforted or kept company by their voices. Client coping

**EVIDENCE-BASED PRACTICE**

**ASSESSING THE PARENTING SKILLS OF A CLIENT WITH SCHIZOPHRENIA**

Jane is a 33-year-old female, mother of two small children, who has paranoid schizophrenia. She is one of the people with whom you work in an outpatient clinic for moderately ill people who have schizophrenia. Your education and experience have taught you that schizophrenia is a complex illness that requires more than just medications to address it adequately.

Jane typically hides her illness from her children. She wants to protect them from the stress and stigma of a mentally ill mother, and she wants her role as mother to be unsullied by illness and incapacitation. In order to achieve this, she watches what she says and masks her troubles. Jane has appointments at the clinic only when her children are otherwise occupied. They do not know she is in therapy or takes medications. What happens as a result is that Jane gets very symptomatic from the stress of pretending she is not ill.

This situation suggests the need to be sensitive to mothers who have a serious mental illness. Carefully and accurately assess and reassess the mothering skills needed to make sure the children are nurtured, their relationship is healthy, and the mother receives the care she needs. Action should be based on more than one study, but the following is a study that would be helpful in this situation.


**CRITICAL THINKING APPLICATION**

1. Is it possible for Jane to truly hide her illness from her children?
2. How will you know if Jane’s relationship with her children is a nurturing one?

**NURSING PROCESS**

**Clients with Schizophrenia**

Schizophrenia is a difficult and chronic illness requiring understanding and competent care in every facet of the client’s life. In addition to the discussion that follows, a nursing care plan for the client with schizophrenia is presented at the end of the chapter.

**Assessment**

Assessing clients who have schizophrenia occurs at individual, family, and environmental levels. Be aware of the client’s status and of changes in the client’s personal life, family situation, and environment in order to plan care and intervene effectively. In addition, care that addresses multiple levels of the client’s life is consistent with the interactional theory of schizophrenia because it is assumed that changes in any aspect of the client’s environment influence all other aspects of the personal environmental balance.

**Subjective Data**

These data describe the client’s inner experience of schizophrenia.

**Perceptual Changes**

The perceptions of clients with schizophrenia may be either heightened or blunted. These changes may occur in all the senses or in just one or two. For example, a client may see colors as brighter than normal or may be acutely sensitive to sounds. Another may have a heightened sense of touch and therefore be extremely sensitive to any physical contact. Illusions occur when the client misperceives or exaggerates stimuli in the external environment. A client with schizophrenia may mistake a chair for a person or perceive that the walls of a hallway are closing in.
strategies, and their effectiveness or ineffectiveness, are also an important aspect of assessment. Finally, clients may talk to themselves, presumably in answer to the voices they hear. Specific guidelines for assessing hallucinations are given in the Your Assessment Approach feature.

**Objective Data**
These data are the observable symptoms and manifestations of schizophrenia that you, as a nurse, will assess.

**Disturbances in Thought and Expression** Clients with schizophrenia find that their thinking is muddled or unclear. Their thoughts are disconnected or disjointed, and the connections between one thought and another are vague.

The clarity of the client’s communication often reflects the level of thought disorganization. Client responses may be simply inappropriate to the situation or conversation. They may have difficulty responding or stop in midsentence, as if they are stuck, a sign of thought blocking.

Note the rate and quality of the client’s speech. Is it unusually loud, insistent, and continuous? Does the client wander from topic to topic or have tangential communication (communication with only a slight or tenuous connection to the topic)? An example is, “You want to know how I came here? I came here by bus, but bussing is kissing, I wasn’t kissing but if you keep it simple that is a business tenet for KISS. That was a great group that played on and on but I’m not playing with you.” Does the client bring up minute details that are irrelevant or unimportant to the topic at hand (circumstantial communication)? An example is, “You want to know how I came here? I came here on a blue and yellow bus with a lady bus driver. There were three teenage kids and a blind man with a seeing-eye dog on the bus. It didn’t have to make a stop at the corner of Main and 9th.” Are the client’s responses slow and hesitant, reflecting difficulty in taking in stimuli and responding to them?

Clients with schizophrenia also have difficulty thinking abstractly. Their responses may be inappropriate because they interpret words literally rather than abstractly. For example, when told to prepare to have his blood drawn, a young man readied some paper and marking pens. You can assess abstract thinking by asking clients the meaning of proverbs, a test requiring the client to abstract a general meaning from a specific or metaphysical statement, for example, “People who live in glass houses shouldn’t throw stones.” Clients with schizophrenia are more likely to give concrete (“If you throw a stone the glass will break”) rather than abstract (“Don’t criticize someone else if you behave the same way”) responses.

**Disruptions in Emotional Responses** Tone of voice, rate of speech, content of speech, expressions, postures, and body movements indicate emotional tone. Many individuals with schizophrenia demonstrate inappropriate affect—emotional responses that are inappropriate to the situation. For example, a client may smile or laugh while relating a history of having been abused as a child. Or, a client may become angry or anxious when asked to join a group of other clients for dinner. The degree to which a client’s emotions are inappropriate is a prognostic indicator. Clients whose emotional response is preserved and generally appropriate have a more favorable prognosis than clients who demonstrate inappropriate affect.

A marked decrease in the variation or intensity of emotional expression is called blunted affect. The client may express joy, sorrow, or anger, but with little intensity. In flat affect, there is a total lack of emotional expression in verbal and nonverbal behavior; the face is impassive, and voice rate and tone are regular and monotonous. The absence of emotion and the presence of anhedonia are also often indicative of schizophrenia.

**Motor Behavior Changes** Disruptions seen in schizophrenia include disorganized behavior and catatonia. Disorganized behavior lacks a coherent goal, is aimless, or is disruptive. Catatonic behavior is manifested by unusual body movement or lack of movement. This activity disturbance includes catatonic excitement (the client moves excitedly but not in response to environmental influences), catatonic posturing (the client holds bizarre postures for periods of time), and stupor (the client holds the body still and is unresponsive to the environment).

**Changes in Role Functioning** An important factor in predicting the course of schizophrenia is the client’s level of functioning before the symptoms of the disease became pronounced. Assessment should therefore include a complete history of the client’s success at completing developmental tasks. The prognosis is best if the client functioned at a high level prior to the onset of schizophrenic disturbance. Assess how well the client fulfilled role responsibilities in the family, in school, in relation
to peers, and in work. Obtain a history of the rate of decline in these various roles. The onset of schizophrenia may be relatively acute, or degeneration may be slow.

**Drug Use** Clients with drug toxicity or withdrawal may have behavior disturbances similar to those seen in clients with schizophrenia. They may have auditory or visual hallucinations and may be confused, illogical, and highly anxious. For this reason, it is essential to obtain a detailed drug history. Assess both long-term and recent use of chemical substances. If the client is not a reliable historian, interview family or friends. In addition, both blood and urine should be tested for drugs if reliable information cannot be obtained.

**Family Health History** Part of a thorough and complete assessment is noting any history of mental disorder in the client’s family (Chafetz, White, Collins-Bride, Nickens, & Cooper, 2006). Of particular interest is a history of schizophrenia or any thought disorder, mood disorders (such as cyclical highs or depressions), or alcoholism in any family member. Note any report that family members had “nervous breakdowns” or any other colloquial descriptions of mental or emotional disorders.

**Family Cohesion and Emotion** In families of people with schizophrenia, enmeshment (see Chapter 30), combined with a negative emotional tone, is thought to be detrimental to the ill member’s well-being. However, the presence of acquaintances and family members showing emotional warmth in low expressed emotion (EE) situations can have a protective function.

Much of the nursing assessment of family cohesion and emotion can be carried out unobtrusively. Chapter 30 has specific guidelines for assessment of these and other family dynamics. The nursing staff, in conjunction with the interdisciplinary team, can also arrange formal family assessment interviews (also discussed in Chapter 30). When you are observing interactions, note signs of dysfunction.

**Family Overinvolvement and Negativity** At present there are no clear-cut clinical determinants of exactly how much overinvolvement and negative emotion in families is problematic. Note families who seem excessively bonded emotionally. The inability of family members to maintain emotional, social, or physical separateness is a clear sign of this problem. Also assess for the presence of a high level of criticism among family members. Discuss families that seem seriously enmeshed or hypercritical with the treatment team.

**Family Communication Problems** Unclear or incomplete communication is frequent in families of people with schizophrenia. This area requires nursing assessment. Unclear communication may result from continual interaction with the ill member or may contribute to the disorder. Clinicians must evaluate how effectively the family communicates to determine the potential need for intervention.

Assess these aspects of family communication:

- Ability to focus on a topic
- Ability to discuss a topic in a meaningful way with other family members

- Ability to maintain the discussion without wandering from the subject or becoming distracted
- Use of language and explanations that are generally understandable (not peculiar to that family alone)

Also note who in the family seems to do the talking, who talks to whom, and whether members talk for, or interrupt, one another. Communication problems that commonly occur with the diagnosis of schizophrenia and interfere with interpersonal relationships, especially family communication, are discussed in Box 16-1.

**Family Burden** Most families of individuals with schizophrenia report that caring for the ill member places a burden on the family unit. Ask about the challenges the family is facing so that you can determine the information and support needs to be met. See Chapter 30 for examples of common family burdens.

**Environment** Assess the availability of support and services beyond the bounds of the family, including extended family and friends, as well as community groups and organizations that support people with schizophrenia. Assess also the availability of mental health programs that address the specific mental health needs of people with schizophrenia.

**Nursing Diagnosis: NANDA**

Nursing diagnoses with clients with schizophrenia focus on alterations in the patterns of activity, cognition, emotional processes, interpersonal processes, and perception. Alterations

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**Box 16-1 Problematic Communication Patterns Common in Schizophrenia**

**Blocking**

The client has trouble expressing a response or stops in midsentence, as if stranded without a thought.

**Clang Associations**

Words that rhyme or sound alike are distributed throughout conversations without necessarily making sense.

**Echolalia**

Phrases, sentences, or entire conversations said to the client are repeated back by the client.

**Neologisms**

Words or meanings are invented by the client. This can include multisyllabic, pseudo-scientific words or simple words.

**Perseveration**

The client maintains a particular idea regardless of the topic being discussed or attempts to change the subject.

**Word Salad**

An incoherent medley of words is emitted in conversation as if it was a sensible and articulate phrase.
in ecologic, physiologic, and valuation processes are assessed as well; however, the central nursing problems relate to the former five processes.

**Impaired Communication**

Schizophrenia interferes with the ability to communicate, a complex and demanding function.

**Verbal** Clients with schizophrenia may communicate in a disorganized, sometimes incomprehensible fashion. Some clients, because their thinking is disorganized, speak very little (alogia, or poverty of speech). Also note there may be a poverty of content in speech, in that the client converses but actually says very little.

Often, clients with schizophrenia communicate in ways that are overly concrete (a sign of an inability to think and communicate abstractly) or overly symbolic (a sign of preoccupation with unreal or delusional material). The symbols are usually difficult to decipher because their meanings are idiosyncratic to that particular individual.

**Nonverbal** The facial and bodily expressions that accompany the verbal communication of people with schizophrenia frequently do not match the content of the verbal message. This lack of congruence is primarily due to the blunting of emotions found in schizophrenia. Expected facial expressions—smiles, looks of concern or disgust—may not accompany the client’s statements. In addition, clients with motor or behavioral abnormalities—posturing, unusual movements, or grimacing—convey a confusing mix of verbal and nonverbal messages.

**Self-Care Deficits**

People with schizophrenia frequently appear indifferent to their personal appearance. They may neglect to bathe, change clothes, or attend to minor grooming tasks such as combing their hair. Some show little awareness of current fashion styles, and many wear clothing that makes them look out of place. Of greater concern are those who wear clothing that is inappropriate to the current season and weather conditions.

Although lack of attention to grooming might be a simple annoyance to those who must live in close proximity to the person with schizophrenia, health risks related to prolonged poor hygiene can arise. Assess immediate problems, such as inadequate nutrition, fluid intake, and elimination, as well as long-term problems, such as dental caries and increased susceptibility to infections.

Disregard for appearance and hygiene may extend to the client’s environment. The client may fail to maintain a clean and safe living space. He or she may not take good care of personal belongings and may misplace them. Self-care deficiencies may result from consistently disturbed thought and perceptual processes. For example, a client whose chronic hallucinations are only partly relieved by medication may have difficulty concentrating for long periods and paying attention to grooming.

**Activity Intolerance**

The emotional disturbances of ambivalence and apathy, common in schizophrenic disorders, can result in lack of interest and inactivity. Inactivity induced by ambivalence is associated with higher levels of emotion. Anxious about choosing one course of action and rejecting another, the client is immobilized. The following clinical examples describe the experience of intolerance to activity.

**CLINICAL EXAMPLE**

Jim is ambivalent about taking a pass to go out alone from the inpatient unit for the first time. He is undecided about taking the risk of leaving the hospital setting without a staff member, yet yearns for the freedom of walking the streets alone. Indecision leaves him standing, immobilized, by the doorway to the unit.

Extreme ambivalence can manifest itself in even the most automatic of behaviors.

**CLINICAL EXAMPLE**

Melissa cannot eat because of ambivalence about where to sit or what to eat. She stands in the center of the dining room, turning first to one chair and then another, unable to choose a place to sit so that she can begin eating.

Clients who are inactive because of apathy demonstrate little emotional tone. Such clients may spend long hours lying in bed staring into space or listening to music. Often, but not always, apathetic individuals prefer isolation. You might find several clients sitting in the same room, engaged in no apparent activities, and interacting with one another only when absolutely necessary.

**Social Isolation**

Extreme anxiety about relating to others often leads clients with schizophrenia to withdraw from interaction and to isolate themselves. Some clients tolerate only a few moments of direct communication, whereas others can manage extended periods of contact. Assess the client’s tolerance of brief periods of contact with staff and other clients. Document patterns of relating and withdrawal, also noting in which activities the client engages when in contact with others and which activities the client undertakes when alone. Nurses who work in skilled nursing facilities also need to be able to diagnose social isolation as a symptom of schizophrenia (see the What Every Skilled Facility Nurse Should Know feature).

**Decisional Conflict**

Decisional conflict in schizophrenia is probably due to biochemical alterations in the brain that make it difficult for clients to take in, synthesize, and respond to information. Decisional conflict may be evident both in the mundane activities of daily life (e.g., selecting one’s diet) and in major life decisions. This can be frustrating for caregivers and for clients. The following clinical example shows how decisional conflict can remove what is a pleasant aspect of life from the client.
**DISTurbed Sensory Perception**

Alterations in the five senses (sound, sight, smell, taste, touch) create an altered perception of the world.

**Hallucinations** Hallucinations are both a clinical diagnostic sign of schizophrenia and a focus for nursing care. You need to know the extent and nature of clients’ hallucinations so that you can document the hallucinatory experience. Discuss with the client, if the client is able to, the details of his or her symptoms. Look for major themes in the content of the hallucinations, particularly whether the hallucinations command the client to take action. Command hallucinations such as “Jump up and down. Jump up and down. Don’t look at her, she has cancer and you’ll catch it.” can be difficult for the client to cope with and can affect the client’s behavior. The client may not be able to withstand pressured commands to say things or perform acts that could include violence or a refusal to remain in a housing situation (which could lead to homelessness).

**Illusions** Illusions make the client vulnerable to emotional and physical injury. The level of misperception may vary from day to day and even throughout the day. Misperceptions of the social environment make the client vulnerable to inappropriate responses that may be ridiculed by others. Misperceptions of the physical environment, such as misjudging the speed of an oncoming car, may lead to physical harm.

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**WHAT EVERY SKILLED NURSING FACILITY NURSE SHOULD KNOW**

A skilled nursing facility (SNF) nurse needs to be familiar with the primary symptoms of schizophrenia—delusions, hallucinations, agitation, and general decompensation. There are two reasons SNF nurses should be familiar with these symptoms:

1. **These symptoms are part of a disease process that require treatment.**
2. **The presence of these symptoms can distort or mask the presentation of symptoms of physical illnesses, and severe psychiatric distress can impair healing from medical and surgical procedures and injuries.**

When an SNF resident represents symptoms that appear to include behavioral and psychiatric features, the SNF nurse should be prepared and able to document, classify, and report these symptoms correctly, and to help ensure the resident receives necessary treatment. Knowing the interventions, pharmacological and nonpharmacological, can speed stabilization and improve the quality of life your residents experience.

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**Disturbed Body Image**

A body image disturbance is common in people with schizophrenia. Clients may lose the sense of where their bodies leave off and where inanimate objects begin. They may become dissociated from various body parts and believe, for example, that their arms and legs belong to someone else. They may worry about the normalcy of their sexual organs. Clients often verbalize this altered sense of self directly, saying “I don’t feel like myself” or “I feel like I am looking at my body from somewhere else in the room.”

**Excess Fluid Volume**

Excess fluid intake, or water intoxication, is a problem that is observed primarily in clients who reside in institutions such as state mental hospitals. This physiologic state is brought on by excessive drinking, characterized by hyponatremia, confusion, and disorientation, and progresses to apathy and lethargy. In severe cases, seizures and death may result. This behavior can lead to irreversible brain damage. Polydipsia appears to be significantly associated with male gender, smoking, celibacy, and psychiatric chronicity. Polydipsia in schizophrenia has been treated effectively with clozapine (Margetic, Aukst-Margetic, & Zarkovic-Palijan, 2006). For clients suspected to be at risk because of frequent drinking, preventive measures include regular measures of urine specific gravity, and regular weights designed to screen for increases in the body’s fluid volume.

**Disturbed Thought Processes**

Schizophrenia changes the way thoughts are processed by distorting logic and organization.

**Delusions** Clients express delusional thinking in direct interactions and, to a lesser extent, through behaviors. When asked, many clients willingly describe their delusional beliefs in detail. They seldom withhold this information because they believe firmly in the validity of the delusion, no matter how bizarre it seems to others. Clients’ actions reflect the fixedness of their beliefs.

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**Clinical Example**

Gerry has the somatic delusion that her body is riddled with holes. She flatly refuses to drink, convinced that the fluid will flow directly out of the holes and soil her dress.

The content of delusions varies: delusions of persecution, reference, and so on (see Table 16-3). Reality-based delusions may seem plausible because they could, under some circumstances, actually occur. Bizarre delusions, more common among clients with schizophrenia, have no possible basis in reality. On the other hand, the false belief that one’s husband is having an affair with a neighbor has a possible basis in reality, and is called a reality-based delusion. In contrast, the belief that one’s thoughts are directed by a television announcer, or that one’s unspoken thoughts can be heard by others, are known as bizarre delusions.
Delusions often reflect the client’s fears, particularly about personal inadequacies. For example, a man’s grandiose delusion that he is the mayor of New York City could be a defense against feelings of inferiority. Similarly, persecutory delusions defend against the person’s own feelings of aggression. Aggressive feelings are projected onto a person or organization—for example, the police, whom the client then fears.

**Magical Thinking** Magical thinking is the belief that events can happen simply because one wishes them to. Some people with schizophrenia claim they can exert their will to make people take certain actions or make specific events occur, like winning the lottery.

**Thought Insertion, Withdrawal, and Broadcasting** Hallmarks of schizophrenic thought are the beliefs that others can put ideas into one’s head (thought insertion) or take thoughts out of one’s head (thought withdrawal). In addition, some clients believe that their thoughts are transmitted to others via radio, television, or other means but not directly by the client. This belief is known as thought broadcasting.

**Dysfunctional Family Processes**
When a family has a member with a significant illness, regardless of whether it is a mental or physical illness, that family’s functioning and dynamics change. The operations of the family must change to accommodate the ill family member as well as how the rest of the family deals with the illness. The symptoms of the illness may be alien to family members, and they may not know how they should respond. See the Partnering with Clients and Families feature for guidelines on how to teach families about the negative symptoms of schizophrenia.

**Interrupted Family Processes**
Families burdened with the long-term responsibility of caring for a relative with schizophrenia may suffer disruptions in their household routine, work, social interactions, and physical well-being. The household may be disrupted by the client’s insistence that the family act on and accommodate delusional beliefs. The family may bend to the client’s wish, fearing an increase in the client’s anxiety and possible fighting or shouting if they do not comply.

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**Clinical Example**

The Walker family built an extra bathroom rather than fight with Tim, their son with schizophrenia, who spends hours in the bath completing elaborate washing rituals.

The Sherman family must eat out several times a week because Suzanne, their daughter with schizophrenia, refuses to allow anyone in the room when she eats.

The family social life may be disrupted. For instance, the family may fear leaving the ill person alone, or they may fear that the ill person will embarrass visitors if friends are invited in. Some families are willing to be open about the adjustments they make in living with a loved one with schizophrenia, whereas others choose to live isolated lives.

Family members’ work can suffer because of the emotional strain of living with an ill member. They must take time off to accompany the schizophrenic person to doctors’ appointments, make hospital visits, and help during interviews with social agencies or the police. Family health may suffer because of general inattention or because of prolonged stresses within the home.

**Outcome Identification: NOC**
The outcome criteria established for a client with schizophrenia need to be flexible and include the option to acknowledge a partial behavior change as success. For example, the out-
Can Culturally Adapted Interventions Make a Difference in Outcome?

Schizophrenia is a difficult illness with many presentations. The distress people experience during symptom exacerbation motivates the search for treatments that are effective and useful in fulfilling the needs of the client. The search for answers has taken a variety of pathways, including the realm of spirituality and cultural sensitivity.

The quality of mental health services available to people who have schizophrenia are greatly enhanced when the relevant content of both psychoeducational and mental health interventions are culturally linked. Think about the last time you spoke with somebody about a problem you were having. If that person had an understanding of both your culture and your value system, such as spirituality, you probably had an easier time explaining your problem. Now think about a time when you spoke with somebody about a problem you were having and that person had no idea what you were talking about. How would you describe that experience? As you can imagine, this happens quite often with people who have schizophrenia when their symptoms are unusual or they are not able to articulate them clearly.

Culture, spirituality, and a value system are intricately interwoven. They form the fabric for a system of meaning. Symptom expression, stressors, coping mechanisms, and interactions with others arise from this system. Keeping the cultural and spiritual context of a client’s experience in mind while interacting around psychiatric symptoms and treatment reduces the client’s frustrations and increases the effectiveness of your communication.

Preventing Relapse

Combining maintenance antipsychotic medication therapy with psychosocial approaches has been found to be more effective than pharmacotherapy alone in delaying or preventing relapse. It has been suggested that early intervention would be effective in preventing relapse in clients with schizophrenia. This could be accomplished through close clinical or family monitoring for the client’s particular prodromal symptoms (those symptoms that occur early in the relapse process for that client). Once identi-

Planning and Implementation: NIC

Nursing interventions are most effective when they focus on the needs and wants of the client to maximize functioning. In order to accomplish this, you must attend to the issues that are important to the client. The client’s perspective is the most valuable tool you have to create competent and meaningful treatment interventions. Box 16-2 discusses the issues most important to the client with schizophrenia, from the unique perspective of the client.

When planning care for any client with a chronic illness, nurses must be careful to set realistic goals for client change. Particular care must be taken with clients who are schizophrenic because they are extremely sensitive to change and failure. Deterioration in all aspects of functioning is characteristic of the disease. Focus on the most troublesome areas of client functioning and set incremental, short-term goals that pave the way for successes in achieving long-term goals. Answering the questions in the Your Self-Awareness: Working with Clients Who Have Schizophrenia feature on page 22 will increase your effectiveness in working with a psychotic client.

Important Issues for the Client with Schizophrenia

People who have schizophrenia have to deal with an illness different from any other disease. The symptoms are unlike anything else, and anosognia (unawareness of the illness) can further complicate their lives. Imagine not knowing you have an illness and not, therefore, needing help. It makes accepting treatment and staying in treatment particularly challenging. Developing meaningful treatment and conducting effective interventions incorporate these vital aspects into effective nursing care:

- Personal power and efficacy
- Interpersonal relationships
- Social expectations
- Differences between what one hoped for oneself and what one has now
- Connecting with people
- Personal growth
- Stability
- Coping with relapses
- Expression of spirituality
- Understanding the symptoms of the illness
fied, prompt clinical intervention with antipsychotic medication may reduce the overall frequency of the relapse event.

Programs for relapse prevention typically combine standard doses of maintenance antipsychotic medication with psychosocial treatment and result in lower relapse rates. Weekly group therapy for clients is an opportunity to monitor prodromal symptoms. Such clinical scrutiny may prevent or minimize relapse and rehospitalization. A multi-family group component is helpful to support and educate the families as well as provide peer contacts and here-and-now experiences.

For clients residing with their families, educational and supportive family interventions have an important effect on relapse prevention. Those clients who live more independently and experience relapses could benefit from a community treatment contact. Prevention is more effective when clients and their families understand the likely relapse triggers, as outlined in Table 16-5.

Other aspects of relapse prevention have been implemented clinically with good results. Clients with a psychosis that is not responsive to pharmacotherapy may benefit from specific cognitive–behavioral therapies (see Chapter 31), while persons with persistent negative symptoms and limited social competence may find social skills training useful. In addition, new programs of supported employment may enable some clients to maintain competitive employment. The impacts of regularly scheduled employment and improved skills can be

<table>
<thead>
<tr>
<th>TABLE 16-5</th>
<th>Relapse Triggers in Schizophrenia</th>
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<tbody>
<tr>
<td><strong>Physiological Stressors</strong></td>
<td><strong>Personal Stressors</strong></td>
</tr>
<tr>
<td>Infection</td>
<td>Pain</td>
</tr>
<tr>
<td>Acute illness</td>
<td>Fatigue</td>
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<tr>
<td>Chronic illness</td>
<td>Side effects of medications</td>
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<tr>
<td>Dehydration</td>
<td>Appetite changes</td>
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<tr>
<td>Insomnia</td>
<td>Injury</td>
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<tr>
<td>Rape</td>
<td>Surgery</td>
</tr>
<tr>
<td><strong>Perceived rejection/abandonment</strong></td>
<td>Financial difficulties</td>
</tr>
<tr>
<td>Conflict, anger</td>
<td>An increase in responsibility</td>
</tr>
<tr>
<td>Relationship changes (family, intimate relationships, friendships, etc.)</td>
<td>A decrease in access to resources</td>
</tr>
<tr>
<td><strong>Interpersonal Stressors</strong></td>
<td>Recreational activity choice/access</td>
</tr>
<tr>
<td>Loss of job or status within a job</td>
<td>Maturational/developmental changes</td>
</tr>
<tr>
<td>High expressed emotion</td>
<td>Community Stressors</td>
</tr>
<tr>
<td><strong>Community Stressors</strong></td>
<td>Disruption of living situation</td>
</tr>
<tr>
<td>Difficulties making living arrangements</td>
<td>Transportation</td>
</tr>
<tr>
<td>Roommate/family stressors</td>
<td></td>
</tr>
<tr>
<td>Community disruption</td>
<td></td>
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a helpful distractor from the onslaught of psychosis if it does not tax the client’s coping abilities.

**Promoting Adequate Communication**

Clients with schizophrenia try to communicate, even though their statements may be difficult to understand. Close attention to what the client is saying and honest attempts to understand the real and symbolic aspects of the message are important. The client will perceive nuances of your behavior. Therefore, one of the most direct and successful ways to demonstrate caring and respect is to attend seriously to the client (this is discussed in depth in Chapter 10). Clients make valid observations about their environment, needs, and concerns. Some, if not all, of their observations and sensations exist in reality and are not to be treated as if they are all totally psychotic symptoms. The sensitivity to the environment that can overwhelm someone with schizophrenia also clues him or her into aspects to which others may not have access. A client may make observations about events or situations that are beyond your awareness. For example, take seriously a client’s statement about another client’s drug use or suicidal threats. If a client complains of a physical symptom such as stomach distress, consider the symptom as real until there is evidence otherwise. It is easy to dismiss a client’s statements, particularly those of a delusional client. Doing so, however, shows lack of respect for the client’s intact capacities to see and respond to what is happening in the environment.

**Promoting Adherence with Medication Regimen**

Psychotropic medications play an important part in the treatment of schizophrenic disorders. Drugs that diminish focal symptoms (hallucinations and delusions) and yet produce relatively few untoward effects are now available. Complying with treatment, which for schizophrenia means medications, is a complex demand. You will need to be creative and ever-mindful of your client’s specific barriers to learning and maintaining specific behaviors. The disease itself causes difficulty in adhering to a treatment regimen when a client lacks the ability to recognize the illness. This is called poor insight and can be compared to the unawareness or lack of insight into neurological deficits following a stroke. Recognize that individuals respond to their illness, their circumstances, and their medications in different ways.

The idea of adherence can be expressed through a number of terms such as treatment adherence, role reliability, collaboration for health behaviors, and cooperation. Interviews and clinical contacts tell us that clients are able to participate in the treatment if they are included and made an integral part of the design of their care (Haynes et al., 2006; Isherwood, Burns, & Rigby, 2006; Rosenberg & Rosenberg, 2006). See Box 16-3 for a description of the barriers and challenges to treatment adherence.

Consistent adherence in taking medications as prescribed is not common among this client population. Researchers estimate that as few as 68% of psychiatric clients adhere to medication regimens while in the hospital (Uko-

**Box 16-3 Challenges to Adherence**

- Difficulties with prescribed psychotropic medications
- Severe level of symptomatology
- Cognitive difficulties secondary to thought disorder
- Motivational problems secondary to negative symptoms
- Motivational problems secondary to flight into health (wanting to be “normal”)
- Unpleasant side effects
- Persistence of positive symptoms (delusions) mitigating against adherence
- Financial issues
- Misperceptions and misunderstanding of the information presented in medication teaching
- Cursory or minimal medication teaching that lacks relevance to all areas of the client’s life
- Unresolved issues with treatment providers
- Cultural impacts

Ekpenyong, 2006). When these clients return to the community, 37% or fewer adhere to drug regimens. Clients may stop taking their medications for these reasons:

- They don’t understand the administration instructions.
- They are too disorganized to follow the instructions.
- The side effects of major tranquilizers are too uncomfortable.
- They do not wish to be stigmatized as having schizophrenia so they reject treatment.
- They begin to feel better and believe the medication is no longer necessary.
- They don’t have easy access to pharmacies because of transportation, financial, or interpersonal difficulties.

Clients who do not take medications are more vulnerable to stressors and risk more frequent relapse of symptoms. Efforts to educate clients about their medications and to have them practice self-medication prior to discharge have increased the rate of adherence only marginally. Client attitudes toward the medications prescribed also influence their willingness to comply. You must be an active participant in assessing adherence and fostering a positive attitude toward medications. Commonly used antipsychotic medications and side effects are presented in Chapter 32.

Clients are often ambivalent about taking medications. Maintaining adequate blood levels of therapeutic medications is important for clients with schizophrenia. To help them overcome ambivalence, give them time to think about taking the medications. Set a time limit. For an inpatient who fails to comply, come back later and try again. Two useful strategies are reminding clients of the positive effects of the medication and framing the action as a way for them to help themselves get better. The Your Intervention Strategies: Adherence Enhancers feature on page 24 is a compendium for increasing treatment adherence for clients with schizophrenia.
Assisting with Grooming and Hygiene

Helping clients establish and maintain personal care habits is a complex process. If the client clearly lacks the skills, then teach the skills. If, however, the client has learned grooming skills but does not practice them, focus on ways to motivate the client. Intervention begins by establishing clear expectations and each feature a spoke in the wheel or a target with each feature/strategy as an arrow hitting the center of the target.

- Involve the family.
- Match the degree of client autonomy in treatment to the needs of the individual client.
- Financial assistance might be available.
- Have clients teach about their medications (after they have learned sufficiently) to other recipients or to significant others. Nothing speeds learning as much as teaching others.

Promoting Organized Behavior

Clients whose behavior is disorganized require direction and limits to make their actions more effective and goal-directed.
In working with a disorganized client, proceed slowly and remain calm. The client’s perception of the environment may be distorted, but your calmness can help calm the client. Try to direct the client in simple, safe activities. Nursing goals and interventions for a disorganized client must focus on manageable steps. A clinical example of one such intervention follows.

**CLINICAL EXAMPLE**

George is moving quickly yet aimlessly from the refrigerator to the cupboard. He pulls a box of cereal from the cupboard, opens it, and then wanders away. Next he goes to the refrigerator, opens the door, peers in, and closes the door. Rummaging through all his pockets, he locates a comb, combs through his hair, sets the comb on the counter, and wanders back to the cupboard. This effortful yet unproductive behavior continues for several minutes when the nurse enters.

Nurse: George, are you trying to get some cereal for yourself?

George: Sort of. I was going to . . . brush . . . no . . . comb . . . no . . . eat something. Yeah, I wanted something to eat.

Nurse: Try to concentrate on one thing. First, put the comb back in your pocket. (He does so.) Now, come over here and get the cereal box. Here’s a bowl. Here’s a spoon. (She hands him the utensils.) Why don’t you sit right here? (She seats him so that he has his back to the rest of the activity in the room.) Can you sit still for a bit?

George: I think so.

Nurse: Pour yourself some cereal. I’ll get the milk for you. (She does so.)

George begins to eat his cereal quietly. The nurse stays with him for a few minutes and directs him to continue eating each time he becomes distracted by others who come into the room.

**Promoting Social Interaction and Activity**

The client’s efforts to withdraw from social contact stem from past relationship failures and fear of rejection. Clients often find their internal world less risky and therefore more attractive than a world that requires interpersonal relating. When making efforts to help the client become less withdrawn, respect the client’s sometimes overwhelming anxiety about human contact.

After establishing a basic level of trust, encourage the client to try out new behaviors within the relationship. The goal is to have the client experience success; therefore, encourage even small increments of change. If, for example, the client has difficulty initiating conversation, encourage the client to practice this skill once a day. Similarly, if the client avoids any activity in the environment because of fear of relating to groups, structure an activity involving the client, yourself, and one other client. Reinforce the client when he or she approaches you to communicate, even if that communication contains problematic patterns (refer back to the Rx Communication feature on page 000).

**Promoting Social Skills and Activities**

Address social skills that are essential to functioning in the environment: introducing oneself, starting a conversation, ending a conversation, saying no, asking for assistance, and listenening. Staff members can model these skills and help clients role-play each skill. Focus discussion on situations in which clients might need the skill. If they see its applicability to their altered perceptions of the disease, they will be motivated to learn the skill. Praise and, if available, material rewards can also motivate clients. Social skills training can also be done in small groups (see Chapter 30).

Schizophrenia can disturb a person’s will and capacity to accomplish meaningful activity. Clients with distorted perceptions and thinking expend considerable energy merely taking in and interpreting their immediate worlds. In addition, major tranquilizers, which control the positive symptoms of the disease, can further inhibit a client’s active involvement and interest in activities. Be aware of how much work it takes to cope with schizophrenic symptoms. Do not assume that periods of quiet or inactivity are due to laziness or lack of interest. Rather, assess each individual’s need for quiet periods in which to organize perceptions and thoughts.

At the same time, clients with schizophrenia live in a culture in which action and accomplishment are highly prized and rewarded. They are not immune to the pressure for personal productivity as a measure of personal worth (Thomas, Seebohm, Henderson, Munn-Giddings, & Yasmeen, 2006). For this reason, they feel better about themselves when they are involved in meaningful activities. Your task is to help clients find activities that are intrinsically rewarding or that bring some social or tangible reward, yet are within their capacities.

Learning clients’ personal interests is a first step. Providing opportunities for the client to actively engage in an activity of interest (by providing records, books, craft materials, or access to newspapers and television) is the next intervention. In addition, activities within the therapeutic milieu, such as attending groups and completing unit “jobs,” can provide the external rewards of praise from staff and peers (Connor & Wilson, 2006). These activities give clients confidence and develop and promote their work habits. Success in these activities can lead to success in volunteer or paid work in the community after discharge.

**Intervening with Hallucinations and Delusions**

Delusions or hallucinations often frighten clients. You can intervene by:

- Reassuring clients that they are safe
- Protecting them from physical harm as they respond to their altered perceptions
- Validating the feelings they are having in response to their experience
- Validating reality
- Helping them distinguish what is real from what is a hallucination or a delusion
Hallucinations are especially frightening if the client has never experienced them before or if their content is threatening or angry. Attempt to alleviate this anxiety by describing your perception of the frightened behavior and asking clients to discuss what they are experiencing. Make simple reassuring remarks, such as “I hear what you’re telling me. This sounds very frightening. No one means to harm you.” See the Your Intervention Strategies feature above for suggested nursing interventions that help a client manage hallucinations.

Protect clients from harm and reassure them about safety. A client may take impulsive action to escape the frightening experience or to obey voices in the hallucination. Prevent this by:

- Closely observing client behavior during active hallucinations
- Using calming techniques and one-to-one interactions to shape and guide the situation
- Reducing excess noise and distractions. One person speaks to the client at a time.
- Intervening quickly by giving additional doses of psychotropic medications or placing the client in a quiet room
- If necessary, securing the unit so that the client cannot leave and take self-destructive or impulsive action

Make every effort to help the client attend to real rather than internal stimuli, orient the client to the real situation, and encourage the client to focus on you rather than on the hallucination (England, 2006; Grant, 2006). “George, listen to me rather than to the sounds you hear. Remember, you are in the hospital and I am your nurse. I will help you find your shoes. Come with me.” Active involvement in some activity, such as finding shoes, will help the client maintain a focus on real events and perceptions.

General guidelines for working with delusional individuals are to avoid arguing with their false beliefs, to focus on the reality-based aspects of their communication, and to protect them from acting on their delusions in a way that might harm themselves or others (Hunt et al., 2006). It may also be important to teach clients that sharing their delusional content directly with others in community settings such as the workplace or the social club may frighten others and lead to stigmatization. Keeping delusional content to oneself in these situations can improve interpersonal relationships. See the Your Intervention Strategies feature above for suggested nursing interventions that contain or manage delusions.

Promoting Congruent Emotional Responses

Working with clients who display blunted or flat affect can be confusing for nurses who are accustomed to reading emotional responses that fall within a more normal range. Be aware that these clients have feelings about events around them, including their interaction with you and other staff members, yet may have difficulty expressing those feelings.

Note any lack of congruence between the person’s affect and the content of the message. If your relationship with the client is well established, you might comment on the incongruity and explore it with the client. (“Malcolm, what you are telling me is sad but you are laughing. What shall I pay attention to?”) Modeling clear, congruent communication is helpful. Little can be done to change the client’s anhedonia, yet empathic listening might comfort the client.

Ambivalence, the simultaneous experience of contradictory feelings about a person, object, or action, can trouble clients with schizophrenia. Ambivalence can become great enough to immobilize a client. Such clients cannot express...
You may be able to partially alleviate the client’s unease by identifying aloud the emotions the client may be experiencing. (“Lily, I think you might be feeling both very happy to see your father and at the same time very angry.”) Naming the conflicting emotions gives the client the opportunity to talk about them, although many times he or she may not be able to do so.

Immobility due to ambivalence is extremely uncomfortable. One way of intervening is to limit the number of choices the indecisive client has to make. For example, a man may be immobilized by his inability to decide whether to go out alone for the first time. You can help by telling him that it seems too soon for him to go out alone and that, for today, he must be accompanied. Another example is a young woman who is undecided about where to sit. You can remove extra chairs at the table in the dining room so that she has only one choice.

**Partnering with Clients and Families**

**Teaching About Schizophrenia**

To assist families, you need to evaluate the family’s current responses to living with and caring for a family member with schizophrenia. The following suggestions apply to the time period shortly after the disorder has been diagnosed.

**Suggestions**

Discuss the basic nature of the disorder: Schizophrenia is a disease of the brain, like any other biologic disease.

Help families identify their responses to the early ambiguous signs of the illness and notice how their responses have changed now that the diagnosis has been made.

Reinforce families for supporting the ill member in seeking treatment.

Refer families to structured educational or psychoeducational programs in which they can learn about the disease and its treatment, as well as receive support.

Inform families about how to reach the local branch of the National Alliance on Mental Illness (NAMI). Hand out fliers that provide telephone numbers and people to contact.

Provide families with access to information such as:


**Rationale**

Families misunderstand mental illness to be a personal failing and are comforted by the fact that it has a biologic basis.

Families often misinterpret early signs of the disorder as acting out or developmentally appropriate behavior. On learning that these signs are part of the illness, they feel guilty for not seeking help sooner.

Stigma about mental illness persists, and families need support for taking action and engaging with treatment systems.

Schizophrenia is extremely complex, and its treatment is multifaceted. Families can benefit from structured classes. Programs that offer support to families in addition to education have proven efficacy in improving the illness course for the ill member.

NAMI is a nationwide family support organization that provides peer support, education, and advocacy for the seriously mentally ill and their families.

**Promoting Family Understanding and Involvement**

When a person with schizophrenia is hospitalized, encourage the family and help them remain involved in the client’s care. Except for unusual circumstances, share information on the client’s status, treatment program, and future treatment plans, including discharge plans. Nurses may need to be active advocates for families’ rights to information about, and involvement in, the care of their loved one with schizophrenia. Of course, nurses need to comply with the client’s wishes and with the laws governing disclosure of information, which vary by state and by institution.

**Referral to Psychoeducation Programs**

If assessment suggests that family members need information about the disease and treatment, refer the family to education programs, if they are available. Family psychoeducation programs are preferable to direct teaching because they often combine education with mutual support. In such groups, families can meet others who share their life difficulties. These peers can provide informal support and information to help the family deal with the tasks that lie ahead. You can reinforce the formal teaching that occurs in such programs when you meet with individual families. See the Partnering with Clients and Families: Teaching about Schizophrenia feature above.

**Referral to NAMI**

Without exception, families should know about a national family support group with many local and state affiliates. The National Alliance on Mental Illness (NAMI) serves families through educational programs, local support groups, and political activism. Most local organizations are listed in telephone directories or can be reached through the local community mental health agency responsible for information and referral. For a resource link to NAMI, go to the Companion Website for this book.
The Oldstads were worried about their daughter’s failing grades at college for the last semester and were surprised to learn that she had ended a relationship with her boyfriend. When she came home for spring break, she seemed disinterested and uncommunicative and wouldn’t eat or socialize with the family. Her parents found her burning incense and chanting to herself in the mirror at 3:00 A.M. In a panic, they took her to the local emergency room. After a complete workup, they were shocked to learn that the probable diagnosis was schizophrenia. Furthermore, the physician wanted their daughter to begin taking medication.

The rapidity of the decline in their daughter’s functioning, and the fact that she had hidden many of her symptoms from them, left the Oldstads feeling guilty, sad, and disbelieving. They could not fathom how this had happened to their beautiful daughter. A nurse at the emergency room had given them the number of a local NAMI support group and hotline. In their anguish, they called and were able to speak with other parents, who helped them begin to deal with their emotions and directed them to helpful books that explained schizophrenia and its treatment.

The importance of NAMI to families and the NAMI education program are discussed in detail in Chapter 30.

Promoting Community Contacts
An awareness of a client’s community supports and potential treatment programs can guide nurses in preparing clients for discharge. For example, the client’s most important peer support group might be the clientele at a local day treatment program or social club. If so, several visits prior to discharge will help the client make the transition back to the community.

Preparing clients for the residence they will enter after hospital discharge is a central nursing task. Often, placement depends on how the client functions in the hospital (Stroup et al., 2006). If the client is able to manage medications, participate in a variety of groups, and live cooperatively with other clients, then placement in a residential care facility that supports independent functioning is appropriate. In contrast, clients who need assistance with structuring free time, resist taking medications, or cannot be responsible for self-care require a more structured and supervised environment (Wilson, 2006).

Nurses work with clients to help them achieve their highest level of functioning. They document clients’ abilities to perform various tasks and make recommendations to the treatment team about appropriate placements.

Evaluation
To complete the nursing process, nurses evaluate changes in client status and behavior in response to nursing interventions. Evaluation criteria are linked to nursing goals and reflect an understanding of the limitations of clients with schizophrenia. However, you must keep the concept of recovery in mind, as every client can improve and recover to a certain extent. The National Library of Medicine MEDLINEplus website at www.nlm.nih.gov/publicat/schizmenu.cfm offers search options on schizophrenia and other topics.

Communication
Clients will, with greater regularity, express their thoughts clearly and congruently. They will feel sufficient trust to talk to the nurse about troublesome symptoms or experiences. Because clients will probably continue to experience some symptoms even after medications have taken effect, this trust allows them to express what has changed and what is still troublesome.

Self-Care
Clients will consistently appear clean and well groomed and will independently manage personal grooming and hygiene. Clients will have clean and reasonably appropriate clothes, in terms of both fashion and season. Individual styles of dress, which are the client’s way of expressing or presenting the self, will be supported by nurses. The means for maintaining self-care after discharge from acute care are identified.

Activity Intolerance
Clients will participate in goal-directed activities with minimal intervention. Clients will complete the activities they begin. Clients will demonstrate a broader range of interest and activities than they did on admission.

Social Isolation
Clients will demonstrate the capacity to interact, at least for brief periods, with nursing staff, with other clients, and in small groups. They will consistently demonstrate socially required interactions, such as greeting and starting a conversation with a stranger, asking for assistance, saying no, and listening to another’s conversation. Clients will be inactive for shorter periods and spend more time engaged in interesting or meaningful activity. They will demonstrate the capacity to function outside the protective environment of acute or sheltered care.

Sensory/Perceptual Alterations
Clients will have fewer episodes of attending to internal stimuli. If hallucinations or delusions persist, clients will begin to identify stressors or situations that precipitate them. Clients will identify and practice personal coping strategies that decrease the hallucinations, delusions, or their effects, such as going to a quiet room, engaging in social activities, and performing activities that demand concentration.

Thought Processes
Clients will engage in reality-based discussions. If delusions persist, clients will not act on delusions in ways that are harmful or detrimental to themselves or others. They will also identify significant others in their current living environment who can help them limit their hallucinations via distraction or social contact.
**Emotional Responses**

Clients will have increased awareness that their emotional expressions at times do not match their verbal communications. They will monitor others’ responses to them to learn cues about how they are varying their emotional expressions. Clients will experience fewer episodes of extreme discomfort due to ambivalence about people, events, or actions.

**Family Functioning**

Families will be involved in all aspects of client care, including assessment, planning and carrying out interventions, inpatient treatment choices, and planning for discharge. Family understanding of the illness trajectory and the client’s capacities and limits will improve (Segrin, 2006). Family difficulties in caring for clients will be considered in treatment and discharge planning, and adequate resources will be identified to support family needs. Families will report that their questions about the schizophrenic disease process, and about varying modes of treatment for the disorder, have been answered.

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**CASE MANAGEMENT**

Knowledge of the impact schizophrenia has on the way an individual thinks and functions is the underpinning of a competent case management program. In order to carry out any particular task, an individual with this illness must have specific duties coupled with realistic expectations. The case management strategies that work best with schizophrenia and other psychotic disorders include:

1. Tasks broken into manageable steps
2. Concrete actions
3. Structured environment
4. Routines and schedules
5. Dependable professionals
6. Flexibility to accommodate the shifts of the illness

Intensive Case Management (ICM) assists people with schizophrenia in outpatient settings (discussed in Chapter 12). With a smaller caseload, you have greater involvement with clients who require more supervision and care. You would orchestrate appointments and daily functioning issues to enhance the client’s abilities to remain in the community and to foster a more independent lifestyle. Whether your assignment involves case management or intensive case management, the difficulties with thought processing and communication mentioned earlier in the chapter will shape your management of the case.

**COMMUNITY-BASED CARE**

People who have schizophrenia can have repetitive inpatient hospitalizations. The transition from an inpatient unit back to the community setting must begin prior to the client’s discharge from the inpatient setting, forming a bridge from inpatient to outpatient care.

There are a number of services necessary and available in the community to maximize both quality of life and more independent functioning for people with schizophrenia and other psychotic disorders. Examples are:

1. Continuing day treatment programs
2. Independent living centers
3. Day hospitals
4. Community mental health centers
5. Social clubs
6. Wellness centers

These various settings are described in Chapter 12.

Counseling, psychotherapy, medication management, and other treatments are part of the care delivered in the community. In addition, remember that recreation is a quality-of-life issue. Community-based care can be instrumental in providing the guidance needed for clients to integrate into community living with an illness that can be debilitating and difficult.

**HOME CARE**

You may conduct different roles in delivering clinical services and care to clients with schizophrenia in a home setting. For example, you may function as a case manager and make home visits. This can be particularly important for clients with schizophrenia who often have great difficulty successfully meeting daily responsibilities and maintaining independence in a healthy home environment.

An important function of the nurse, whether or not you are a case manager, is to assist clients who have schizophrenia with medication adherence. Clients with schizophrenia are at high risk for relapse because they may stop taking their antipsychotic medications. This can happen because of side effects (those reported and not reported to the prescriber), confusion about medication administration schedules, environmental factors that do not encourage adherence to a medication regimen, or any number of other factors. You can play an important role in reducing the likelihood of relapse during home care visits. The home will shape adherence practices because the home is the environment in which most doses of their medications are taken.

Home interventions by nurses, however, are not limited to case management or medication adherence issues. Some people with schizophrenia can benefit from supportive psychotherapeutic interventions delivered by you in the client’s home. These interventions can help generalize what they have learned beyond the confines of the nurse’s office or the clinic. When people who have schizophrenia live with significant others, it is sometimes possible for you to deliver psychoeducational interventions for everyone living together as a unit. This allows the significant others and the client the opportunity to increase their skills in living together and coping with this serious illness in a way that lowers the probability of client relapse.
**Identifying Information**

Jack May is a 24-year-old single male who lives with his mother and supports himself with SSI. He is brought to the psychiatric emergency service by his mother. He currently attends a structured work program 5 days a week, but stopped attending 8 days ago.

Jack says that he does not need to be hospitalized and that his mother is the one with the problem. He wants to be left alone to work on his computer projects. He admits that he has been hearing multiple voices in his head for the past week. For the past 2 weeks, Jack has been increasingly isolated, working on his personal computer in his room. He will not tell anyone what the work is about, but his mother has seen printouts that suggest it is a plan to soundproof and secure his room. Jack stopped attending his work program a week ago, saying that he had “more important work” to do at home. He refuses to eat or talk with his mother. His mother believes he stopped taking his medications approximately 2 weeks ago. Evidence that Jack may have stopped taking medications and follow-up treatment at the community mental health center.

**NURSING CARE PLAN**

**Client with Schizophrenia**

**Expected Outcome:** Client will demonstrate the ability to cope competently with delusions.

**Nursing Diagnosis:** Disturbed Thought Processes

**Short-Term Goals**

- Client able to function in a variety of settings without intrusive delusional thought content.

**Interventions**

- Make frequent, supportive, and brief contacts.
- Allow description of delusional thoughts and acknowledge emotional impact of same.
- Focus discussions on the client’s feeling level concerning the delusions, and not the content.
- Teach client how to cope with delusional thinking through engagement in activities for distraction, active self-talk promoting his efforts, support from others, treatment.
- Reinforce adaptive efforts.

**Rationales**

- Some contacts can be overwhelming for a client with schizophrenia and need to be of a manageable length.

  - The client must be taught how to cope with the symptoms of the illness in an effective manner.

**Psychosocial History**

Jack has completed high school and a few courses at the local community college. He was an above-average student and was always involved in school and extracurricular activities, until about 9 months before his first psychotic episode. Since that time, he has socialized primarily with his mother and rarely with a few acquaintances from the client support group. He smokes a pack of cigarettes a day and drinks beer occasionally. He denies any illicit drug use. Jack has a keen interest in computers. He took extensive coursework in computers in school and has collected considerable equipment and software, primarily gifts from his father. Other pastimes are listening to rock music and watching television.

**Medical History**

No notable medical problems.

**Current Mental Status**

Jack is a healthy-looking 24-year-old who is anxious, somewhat guarded, but cooperative in the interview. He is oriented to person, time, and place, and demonstrates good memory and recall. Judgment is impaired. His affect is anxious. Speech is rapid, pressured, tangential. He is hyperalert to his environment and is notably startled by a siren outside. Persecutory delusions about people trying to take over his home and work are present, and he has hallucinations of unrecognizable voices and the voice of his father. No command hallucinations. Some loosening of associations present. Abstractions are concrete and self-referential. Insight poor; believes that his mother is “sick” and that she should not impede him in his important projects.

**Other Clinical Data**

Evidence that Jack may have stopped taking medications approximately 2 weeks ago. Suicide/violence potential minimal.
Nursing Diagnosis: Anxiety related to delusions

Expected Outcome: Client will demonstrate decreased anxiety.

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<thead>
<tr>
<th>Short-Term Goals</th>
<th>Interventions</th>
<th>Rationales</th>
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<tr>
<td>Client able to describe a reduction in his anxiety. Client participates in his treatment.</td>
<td>Make frequent, supportive, and brief contacts.</td>
<td>Some contacts can be overwhelming for a client with schizophrenia and need to be of a manageable length. People with schizophrenia often do not have their feelings acknowledged. Reassurance validates their feelings.</td>
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<td>■ Reassure client verbally, with a structured routine, and by giving explanations congruent with client’s ability to understand.</td>
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<td>■ Prompt client to interact with others when able to reduce feelings of isolation and alienation.</td>
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<td>■ Provide an array of coping skills client may use when anxious.</td>
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Concept Map

Client with Schizophrenia: Disturbed Thought Processes

Mr. Jack May
24 y.o. male
Schizophrenia

generates nursing diagnosis

Disturbed Thought Processes

expected outcome

Client will demonstrate the ability to cope competently with delusions.

short-term goal

Client able to function in a variety of settings without intrusive delusional thought content.

intervention

by Monitoring

Teaching

through Reinforce adaptive efforts.

- Allow description of delusional thoughts and acknowledge emotional impact of same.
- Focus discussions on the client’s feeling level concerning the delusions, and not the content.

Some contacts can be overwhelming for a client with schizophrenia and need to be of a manageable length.

- Teach client how to cope with delusional thinking through engagement in activities for distraction, active self-talk, promoting his efforts, support from others, treatment.

The client must be taught how to cope with the symptoms of the illness in an effective manner.
Concept Map
Client with Schizophrenia: Anxiety Related to Delusions

Mr. Jack May
24 y.o. male
Schizophrenia

generates nursing diagnosis

Anxiety related to delusions

expected outcome

Client will demonstrate decreased anxiety

short-term goal

Client able to describe a reduction in his anxiety.
Client participates in his treatment.

Monitoring

intervention

by

Make frequent, supportive, and brief contacts.

rationale

Some contacts can be overwhelming for a client with schizophrenia and need to be of a manageable length.

Teaching

intervention

by

Provide an array of coping skills client may use when anxious.

rationale

You must teach a variety of coping skills to suit various situations.

Monitoring

intervention

by

People with schizophrenia often do not have their feelings acknowledged. Reassurance validates their feelings.

Teaching

intervention

by

• Reassure client verbally, with a structured routine, and by giving explanations congruent with client’s ability to understand.

rationale

• Prompt client to interact with others when able to reduce feelings of isolation and alienation.

rationale

You must teach a variety of coping skills to suit various situations.
EXPLORE  MEDIA LINK
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For NCLEX-RN® review questions, case studies, and other resources for this chapter see the Prentice Hall Nursing MediaLink CD-ROM that accompanies this book and the Companion Website at www.prenhall.com/kneisl.

Prentice Hall Nursing MediaLink CD-ROM
• Audio Glossary
• NCLEX-RN® Review Questions
• Critical Thinking Exercise
  • Client with Schizophrenia
• Videos and Animations
  • PET/SPECT Schizophrenia
  • Dystonia (Blepharospasm, Cervical Torticollis)
  • Bradykinesia (Shuffling Gait)
  • Akathisia (Legs)
  • Akinesia & Pill Rolling
  • Tardive Dyskinesia (Mouth, Trunk, Ambulation)

Companion Website
• Audio Glossary
• NCLEX-RN® Review Questions
• Case Study
  • Schizophrenia with Auditory Hallucinations
• Care Plan
  • Paranoid Schizophrenia
• Video
  • Learning from Clients
• MediaLinks
  • MediaLink Application

NCLEX-RN® REVIEW QUESTIONS

1. Which of the following client statements demonstrates the major symptoms of schizophrenia?
   1. “You can read my mind. This light of mine will shine, fine; blinding world will end at nine.”
   2. “I’ve been depressed ever since our house was destroyed by fire.”
   3. “I had too much to drink last night, started feeling all-powerful, and stupidly drove my truck into a tree.”
   4. “ ‘A stitch in time saves nine’ means that prevention is easier than fixing a real problem.”

2. A family member asks you, “Since both of my siblings have schizophrenia, why is my brother’s presentation so different from my sister’s? He withdraws when there’s a change in his environment or routine. She starts cursing and yelling about the Mafia and the CIA when I do something that’s less than perfect.” Based on your knowledge, your response should address the:
   1. Differences in information processing among clients with schizophrenia.
   2. Differences in presentation between subtypes of schizophrenia.
   3. Typical progression of symptoms within an individual over time.
   4. Effect of gender on clinical presentation in schizophrenia.
   5. Significance of paranoid content in the differential diagnosis of paranoid schizophrenia.

3. Which family member statements demonstrate recognition of the effects of social pressures associated with schizophrenia?
   1. “I’m going to help my family member figure out what to tell other family members, friends, and business associates about why he’s been on medical leave.”
   2. “I’ll attend a support group, but I’m afraid my family member will not go . . . she would rather try to ‘pass’ as not mentally ill.”
   3. “Maybe my family member can identify somebody who’s believable when that person says, ‘Your symptoms are worse. Let’s go to the psychiatrist.’”
   4. “If my family member would just move in with me, it would be a lot easier for me to maintain my household and care for my children.”
   5. “I used to protect my family member from a lot of the big interpersonal conflicts in the family, but we need to increase our expressed emotion.”

4. Which client statements demonstrate acknowledgment of the effects of psychological pressures associated with schizophrenia? Select all that apply.
   1. “If I can’t stand the side effects, how will I ask my psychiatrist to change my medication?”
   2. “I’m going to look for a job where I can use my college degree but have less day-to-day stress.”
3. “I have designed a weekly schedule so that I can get tasks done and have planned time to relax.”
4. “Next month, my sister and I are going to write a grant proposal for a psychiatric day treatment/social center.”
5. “I just want to get back to what I was doing and put this whole episode behind me.”

5. You have presented your client with written aftercare medication directions: “Take one capsule three times per day.” Your client informs you that s/he has reviewed the material. Which response specifically addresses the nurse’s concern for adherence?
1. “What might get in the way of taking your medications?”
2. “If you forget one dose, you can double the next one.”
3. “This medication really works best if you take one capsule three times per day.”
4. “Do you understand everything?”

6. The client with schizophrenia is preparing for discharge. To minimize relapse, which outcomes are the most important in planning the client’s care?
1. Describes medication regimen accurately and has a specific plan for obtaining refills
2. Identifies three new methods of spending leisure time
3. Lists three potential sources of social support
4. Identifies two new ways to bolster self-esteem

7. While you are employed as a charge nurse on an inpatient psychiatric unit, you recognize that you are choosing to spend less time interacting with the clients with schizophrenia. Your first action is to:
1. Reflect on your behavior.
2. Force yourself to interact with the clients with schizophrenia.
3. Discuss your observation with your clinical supervisor.
4. Request a transfer to another unit.

8. A peer approaches you and shares her frustration with her older brother, who has had multiple hospitalizations with schizophrenia. “He used to show interest in me, but since his discharge 5 days ago, he just stares into space. I cannot get a reaction out of him.” Which of the following statements impart accurate information? Select all that apply.
1. “He may be demonstrating flattening of affect and anhedonia.”
2. “He may have sedation or masked facial expressions from his medications.”
3. “Maybe he’s depressed about having a chronic illness.”
4. “It’s sad when a loved one does not reciprocate.”
5. “Have you confronted him with this?”

9. A nurse is designing a relapse-prevention inpatient group for clients with schizophrenia. Which statements address the two main categories of nursing activities?
1. “If you can increase your self-assessment skills, you’ll be able to tell when you’re getting more stressed.”
2. “We’re going to discuss current events.”
3. “Let’s go around the room and have each person say something positive about our group.”
4. “We will go around the room and each person will state a personal goal for today.”

10. You overhear a family member discussing medication adherence with your client. Which of the following statements do you want to encourage the family member to reiterate?
1. “Your support group encourages you to make healthy choices. Taking your meds is a healthy thing you can do every day, just like brushing your teeth.”
2. “Your children are getting tired of watching you get sick every time you stop your meds.”
3. “If you stop taking your medication, I’ll take custody of your children.”
4. “You should let these healthcare providers get you well. Why do you fight that?”

See Appendix C for answers.

REFERENCES


