Schizophrenia NCLEX Review

Schizophrenia

- Combination of disordered thinking, perceptual disturbances, behavioral abnormalities, affective disruptions, and impaired social competency
- Disturbances in affect, mood, behavior, and thought processes occur

Major Symptoms:

1. Delusional ideation:a false belief brought about without appropriate external stimulation and inconsistent with the individual's own knowledge and experience
2. Hallucinations: false sensory perceptions that may involve any of the five senses (auditory, visual,tactile, olfactory, and gustatory)
3. Disorganized speech patterns
4. Bizarre behaviors

    - At least two of these symptoms must be present for a significant portion of the time during a 1-month period
    - Duration: Continuous signs of the disturbance persist for at least 6 This 6-month period mustinclude at least 1 month of symptoms

Types of Schizophrenia:

1. Paranoid - characterized by persecutory (feeling victimized or spied on) or grandiose delusions, hallucinations, and, occasionally, excessive religiosity (delusional religious focus) or hostile and aggressive behavior
2. Disorganized - grossly inappropriate or ?at affect, incoherence, loose associations, and extremely disorganized behavior
3. Catatonic - characterized by marked psychomotor disturbance, either motionless or excessive motor
4. Undifferentiated - mixed schizophrenic symptoms of others
5. Residual - characterized by at least one previous, though not a current, episode; social withdrawal; ?at affect; and looseness of associations

Related Disorders:

1. Schizophreniform disorder: The client exhibits the symptoms of schizophrenia but for less than the 6 months necessary to meet the diagnostic criteria for Social or occupational functioning may or may not be impaired.
2. Schizoaffective disorder: The client exhibits the symptoms of psychosis and, at the same time, all the features of a mood disorder, either depression or
3. Delusional disorder: The client has one or more non-bizarre delusions—that is, the focus of the delusion is Psychosocial functioning is not markedly impaired, and behavior is not

obviously odd or bizarre.
4. Brief psychotic disorder: The client experiences the sudden onset of at least one psychotic symptom,such as delusions, hallucinations, or disorganized speech or behavior, which lasts from 1 day to 1 The episode may or may not have an identi?able stressor or may follow childbirth.
5. Shared psychotic disorder **(folie à deux)**: Two people share a similar The person with this diagnosis develops this delusion in the context of a close relationship with someone who has psychoticdelusions

II. Etiology

1. Biologic Factors
    - overactive basal ganglia
    - enlarged ventricles, cerebral atrophy, decreased cerebral blood flow, decreased brain volume, and reduced glucose metabolism in the frontal and temporal lobes as seen on imaging studies (CT, MRI, and PET scans)
    - Imbalance between dopamine and serotonin neurotransmitter systems, usually with an excess of dopamine
    - Low levels of the neurotransmitter GABA (gamma-aminobutyric acid)
2. Genetic Factors
    - increased risk for the development of schizophrenia with a positive family history of schizophrenia
    - risk increases for those with first-degree relatives diagnosed with schizophrenia
    - no specific genetic defect identified that causes schizophrenia
3. Psychological Factors
    - no specific studies that indicate that stress causes schizophrenia, but stress does affect relapse and exacerbation to schizophrenic manifestations
    - genetic predisposition + presence of stressful events = schizophrenia
4. Environmental factors

    - exposure to infectious agents such as viruses in early infancy may contribute to the development of schizophrenia
    - association between schizophrenia and complications during pregnancy or labor such as oxygen deprivation, short gestation periods, and low birthweights

III. Assessment

1. **Positive symptoms** indicate a distortion or excess of normal functioning: they often occur as the initial symptoms of schizophrenia and precipitate the need for hospitalization:

    - **Delusions** – fixed, false belief

Types of Delusions:

- *Persecutory/paranoid delusions* - involve the client's belief that "others" are planning to harm the client
- *Grandiose delusions* - characterized by the client's claim to

association with famous people or celebrities, or the client's belief that he or she is famout

- *Religious delusions* - often center around the second coming of Christ or another signi?cant religious figure or prophet.
- *Somatic delusions* - generally vague and unrealistic beliefs about the client's health or bodily functions.
- *Referential delusions or ideas of reference* - involve the client's belief that television broadcasts, music, or newspaper articles have special meaning for him or her.

- **Hallucination** – false sensory perceptions, or perceptual experiences that do not exist in reality

Types of Hallucination:

- Auditory hallucinations - the most common type, involve hearing sounds, most often voices, talking to or about the client. There may be one or multiple voices; a familiar or unfamiliar person's voice may be speaking.
- Command hallucinations - are voices demanding that the client take action, often to harm self or others, and are considered dangerous
- Visual hallucinations - involve seeing images that do not exist at all, such as lights or a dead person.
- Olfactory hallucinations - involve smells or They may be a speci?c scent, such as urine or feces, or more general such as a rotten or rancid odor.
- Tactile hallucinations refer to sensations such as electricity running through the body or bugs crawling on the skin.
- Gustatory hallucinations - involve a taste lingering in the mouth or the sense that food tastes like something else. The taste may be metallic or bitter or may be represented as a speci?c taste.
- Cenesthetic hallucinations - involve the client's report that he or she feels bodily functions that are usually undetectable. Examples would be the sensation of urine forming or impulses being transmitted through the brain.
- Kinesthetic hallucinations - occur when the client is motionless but reports the sensation of bodily movement. Occasionally the bodily movement is something unusual such as ?oating above the ground.
- Referential delusions or ideas of reference - involve the client's belief that television broadcasts, music, or newspaper articles have special meaning for him or her. Examples: The client may report that the president was speaking directly to him on a news broadcast or that special messages are sent through newspaper articles.

- **Abnormal Motor Activity**

- Catatonic posturing - Holding bizarre postures for long periods
- Catatonic excitement - Moving excitedly, with no environmental stimuli present

- Echopraxia - Repeating the movements of another person
- Waxy ?exibility - maintaining any position in which they are placed, even if the position is awkward or uncomfortable.

- **Unusual Speech Pattern**

  - Clang associations - are ideas that are related to one another based on sound or rhyming rather than meaning
    - Example: “the train brain rained on me.”; “that boat hope floats”
  - Neologisms - are words invented by the
    - Example: Grittiz: “I’m afraid of grittiz. If there are any grittiz here, I will have to leave. Are you a grittiz?”
  - Verbigeration - is the stereotyped repetition of words or phrases that may or may not have meaningto the listener.
    - Example: “I want to go home, go home, go home, go home.”
  - Echolalia is the client’s imitation or repetition of what the nurse
    - Example:
      - Nurse: “Can you tell me how you’re feeling?”
      - Client: “Can you tell me how you’re feeling, how you’re feeling?”

      - Stilted language - is use of words or phrases that are ?owery, excessive, and
        - Example: “Would you be so kind, as a representative of Florence Nightingale, as to do me the honor of providing just a wee bit of refreshment, perhaps in the form of some clear spring water?”
      - Perseveration - is the persistent adherence to a single idea or topic and verbal repetition of a sentence, phrase, or word, even when another person attempts to change the topic.
        - Example:
          - Nurse: “How have you been sleeping lately?”
          - Client: “I think people have been following me.”
          - Nurse: “Where do you live?”
          - Client: “At my place people have been following me.” Nurse: “What do you like to do in your free time?” Client: “Nothing because people are following me.”

      - Word salad - is a combination of jumbled words and phrases that are disconnected or incoherentand make no sense to the listener.
        - Example: “Corn, potatoes, jump up, play games, grass, cupboard.”

  - **Abnormal Thought Processes**
    - Tangential Thinking - veering onto unrelated topics and never answering the original question
      - Example:

        - Nurse: “How have you been sleeping lately?”
        - Client: “Oh, I try to sleep at night. I like to listen to music to help me sleep. I really like country-western music best. What do you like? Can I have something to eat pretty soon? I’m hungry.”
    - Circumstantial thinking - the client gives unnecessary details or strays from the topic but eventually providesthe requested information:
        - Example:
            - Nurse: “How have you been sleeping lately?”
            - Client: “Oh, I go to bed early, so I can get plenty of rest. I like to listen to music or read before bed. Right now I’m reading a good mystery. Maybe I’ll write a mystery someday. But it isn’t helping, reading I mean. I have been getting only 2 or 3 hours of sleep at night.”

    - Flight of ideas - Constant flow of speech in which client jumps from one topic to another in rapid succession;a connection between topics exists, although it is sometimes difficult to identify
        - Example: A man starts talking about his business, but quickly shifts to discussing the economy, the government, and other countries.

    - Associative looseness - Fragmented or poorly related thoughts and ideas
        - Example: "The next day when I'd be going out you know, I took control, like uh, I put bleach on my hair in California."

    - Thought blocking - An abrupt stop in the middle of a train of thought; the individual may or maynot be able to continue the idea.
        - Example: the client may suddenly stop talking in the middle of a sentence and remain silent for several seconds to 1 minute

- **Illusions: inaccurate perception or misinterpretation of sensory impressions**
- **Agitation**
- **Hostility**
- **Bizarre behaviors**

2. Negative symptoms indicate a loss or lack of normal functioning; they develop over time and hinder the person's ability to endure life tasks

- Anhedonia - diminished ability to experience pleasure or intimacy
- Apathy - lack of interest, enthusiasm, or concern
- Alogia - poverty of speech
- Anergia - lack of energy
- Avolition - lack of motivation and goals
- Ambivalence - inability to make a decision because of conflicting emotions
- Affect disturbances
    1. Blunted
    2. Flat
    3. Inappropriate
- Restricted emotion

- Social withdrawal
- Dependency
- Lack of ego boundaries
- Concrete thought processes
- Lack of self-care
- Sleep disturbances

IV. Nursing Responsibilities

A. Implementing Interventions for Delusional Thoughts

Be sincere and honest when communicating with the client

- Delusional clients are extremely sensitive about others and can recognize

Avoid vague or evasive remarks.

- Evasive comments or hesitation reinforces mistrust or delusions.

Be consistent in setting expectations, enforcing rules, and so forth

- Clear, consistent limits provide a secure structure for the client

Do not make promises that you cannot

- Broken promises reinforce the client’s mistrust of others

Encourage the client to talk with you, but do not pry or cross-examine for information

- Probing increases the client’s suspicion and interferes with the therapeutic relationship

Explain procedures, and try to be sure the client understands the procedures before carrying them out

- When the client has full knowledge of procedures, he or she is less likely to feel tricked by the staff

Give positive feedback for the client’s successes

- Positive feedback for genuine success enhances the client’s sense of well-being and helps to make non-delusional reality a more positive situation for the client

Recognize the client’s delusions as the client’s perception of the environment

- It is important to recognize the client’s environmental perceptions to understand the feelings he or she is experiencing.

Initially, do not argue with the client or try to convince the client that the delusions are false or unreal

- Logical argument does not dispel delusional ideas and can interfere with the development of trust

Interact with the client on the basis of real things; do not dwell on the delusional material

- Interacting about reality is healthy for the client

Engage the client in one-to-one activities at ?rst, then activities in small groups, and gradually activities in larger groups.

- The client who is distrustful can best deal with one person Gradual introduction of others when the client can tolerate it is less threatening.

Recognize and support the client's accomplishments (activities or projects completed, responsibilities ful?lled, interactions initiated).

- Recognition of accomplishments can lessen the client's anxiety and the need for delusions as a source of self-esteem.

Show empathy regarding the client's feelings; reassure the client of your presence and acceptance

- The client's delusions can be Empathy conveys your acceptance of the client and your caring and interest.

Do not be judgmental or belittle or joke about the client's belief

- The client's delusions and feelings are not funny to him or The client may feel rejected by you or feel unimportant if approached by attempts at humor.

Never convey to the client that you accept the delusions as reality

- You would reinforce the delusion (thus, the client's illness) if you indicated belief in the delusion

Directly interject doubt regarding delusions as soon as the client seems ready to accept (e.g., "I ?nd that hard to believe.") Do not argue with the client, but present a factual account of the situation as you see it.

- As the client begins to trust you, he or she may become willing to doubt the delusion if you express your doubt.

Attempt to discuss the delusional thoughts as a problem in the client's life; ask the client if he or she can see that the delusions interfere with his or her life.

- Discussion of the problems caused by the delusions is a focus on the present and is

reality

B. Implementing Interventions for Hallucinations

1. Help present and maintain reality by frequent contact and communication with client.
    - focus on what is real and to help shift the client's response toward reality
2. Elicit description of hallucination to protect client and The nurse's understanding of the hallucinationhelps him or her know how to calm or reassure the client.
    - Initially the nurse must determine what the client is experiencing—that is, what the voices are saying or what the client is seeing
3. Engage client in reality-based activities such as card playing, occupational therapy, or listening to music
    - this technique of distracting the client is often useful
4. Identify certain situations or a particular frame of mind that may precede or trigger auditory hallucinations
    - Intensity of hallucinations often is related to anxiety levels; therefore, monitoring and interveningto lower anxiety may decrease the intensity of hallucinations
5. Teaching the client to talk back to the voices forcefully
    - Being able to verbalize resistance can help the client feel empowered and capable of dealing withthe hallucinations

C. General Interventions for Schizophrenia

V. Pharmacology

Antipsychotic Medications

- Improve the thought processes and the behavior of the client with psychotic symptoms, especiallyclients with schizophrenia
- Affect dopamine receptors in the brain, reducing the psychotic symptoms
- Typical antipsychoticsare more effective for positive symptoms of schizophrenia, such as hallucinations, aggression, and delusions; typical antipsychotic medications also block the chemoreceptor trigger zone and vomiting center in the brain, producing an antiemetic
- Atypical antipsychoticsare more effective for the negative symptoms of schizophrenia, such as avolition, apathy, and
- The effects of antipsychotic medications are potentiated when given with other medications acting onthe

Side effects:

1. Anticholinergic Effects
    - Dry mouth
    - Increased heart rate
    - Urinary retention
    - Constipation
    - Hypotension
2. Extrapyramidal Side Effects

- Pseudo-parkinsonism or neuroleptic-induced parkinsonism
    - symptoms usually appear in the ?rst few days after starting or increasing the dosage of an antipsychotic medication
    - Tremors
    - Mask-like faces
    - Rigidity
    - Shuffling gait
    - Dysphagia
    - Drooling
- Dystonia - appear early in the course of treatment and are characterized by spasms in discrete muscle groups such as the neck muscles (torticollis) or eye muscles (oculogyric crisis)
    - spasms also may be accompanied by protrusion of the tongue, dysphagia, and laryngeal/pharyngeal spasm that can compromise the client's airway, causing a medical emergency
    - Acute treatment consists of diphenhydramine (Benadryl) given eitherintramuscularly or intravenously, or benzotropine (Cogentin) given
- Akathisia - restless movement, pacing, inability to remain still, and the client's report of inner restlessness
    - usually develops when the antipsychotic is started or when the dose is increased
    - Betablockers such as propranolol have been most effective in treating akathisia
- Tardive Dyskinesia - irreversible once it has appeared, but decreasing or discontinuing the medication can arrest the progression
    - Protrusion of the tongue
    - Chewing motion
    - lip smacking
    - blinking and grimacing
    - involuntary, choreiform movements of the limbs and feet

3. Neuroleptic Malignant Syndrome

- potentially fatal syndrome that may occur at any time during therapy with neuroleptic (antipsychotic) medications
- more commonly occurs at the initiation of therapy, after the client has changed from one medication to another, after a dosage increase, or when a combination of medications is used
- characterized by muscle rigidity, high fever, increased muscle enzymes (particularly CPK), andleukocytosis (increased leukocytes)
- Dyspnea or tachypnea; Tachycardia or irregular pulse rate; Fever; High or low blood pressure; Increased sweating; Loss of bladder control; Skeletal muscle rigidity; Pale skin; Excessive weakness or fatigue; Altered level of consciousness; Seizures

Interventions for Neuroleptic Malignant Syndrome

- Notify the physician.
- Monitor vital signs.
- Initiate safety and seizure precautions.
- Prepare to discontinue the medication.
- Monitor level of consciousness.
- Administer antipyretics as prescribed.
- Use a cooling blanket to lower the body temperature.
- Monitor electrolyte levels and administer fluids intravenously as prescribed.

4. Agranulocytosis

- failure of the bone marrow to produce adequate white blood cells, potentially fatal side effect of Clozapine
- develops suddenly and is characterized by fever, malaise, ulcerative sore throat, and leukopenia
- drug must be discontinued immediately

Note: Clients taking this antipsychotic must have weekly white blood cell counts. Currently, clozapine is dispensed every 7 days only, and evidence of the white cell count is required before a re?ll is furnished.

5. Other Side Effects

- Drowsiness
- Blood dyscrasias
- Pruritus
- Photosensitivity
- Elevated blood glucose level
- Increased weight
- Impaired body temperature regulation
- Gynecomastia
- Lactation

General Interventions for Antipsychotic Medications

1. Monitor vital signs
2. Monitor for symptoms of neuroleptic malignant syndrome (can occur with antipsychotic medications).
3. Monitor urine output
4. Monitor serum glucose level
5. The client taking an antipsychotic medication may require long-term medication for parkinsonian symptoms.
6. Administer the medication with food or milk to decrease gastric irritation
7. For oral use, the liquid form might be preferred because some clients hide tablets in their mouths to avoid taking them.

8. The absorption rate is faster with the liquid form of oral medication.
9. Avoid skin contact with the liquid concentrate to prevent contact dermatitis
10. Protect the liquid concentrate from light.
11. Dilute the liquid concentrate with fruit juice.
12. Inform the client that a full therapeutic effect of the medication may not be evident for 3 to 6 weeks after initiation of therapy; however, an observable therapeutic response may be apparent after 7 to 10 days.
13. Inform the client that some medications may cause a harmless change in urine color to pinkish to red-brown.
14. Instruct the client to use sunscreen, hats, and protective clothing when outdoors
15. Instruct the client to avoid alcohol or other CNS depressants
16. Instruct the client to change positions slowly to avoid orthostatic hypotension
17. Instruct the client to report signs of agranulocytosis, including sore throat, fever, and malaise.
18. Instruct the client to report signs of liver dysfunction, including jaundice, malaise, fever, and right upper abdominal pain.

VI. Psychotherapy

- Milieu therapy: a method of psychotherapy that controls the environment of the client to provide interpersonal contacts in order to develop trust, assurance, and personal autonomy

    1. Provide for the client's safety and the safety of others in the milieu
    2. Provide a supportive environment that is structured and predictable
    3. Collaborate with the multidisciplinary team regarding the client's plan of care
    4. Collaborate with the client regarding his or her plan of care
    5. Encourage the client to participate in milieu groups and activities that promote socialization
    6. Assist client with ADLs as needed, but encourage independence as client progresses