CHAPTER 8

Schizophrenia and Other Psychotic Disorders

OVERVIEW

Schizophrenia

The schizophrenias are severe and persistent neurologic diseases. These serious disorders affect a person’s:

- Perceptions (hallucinations and delusions)
- Thinking (delusions, paranoia, disorganized thinking)
- Language (associative looseness, poverty of speech)
- Emotions (apathy, anhedonia, depression)
- Social behavior (aggressive, bizarre behaviors or extreme social withdrawal)

Schizophrenia affects approximately 1% of the population, and 95% of individuals who become schizophrenic have the condition throughout their lifetime. Schizophrenia is a relapsing psychotic disorder. A psychotic disorder is one in which people have difficulty with differentiating reality from fantasy (reality testing).

Major symptoms seen in psychotic disorders are hallucinations, delusions, and disorganized thinking. Hallucinations and delusions can be very frightening, often terrifying for individuals. They also can be very disconcerting initially and even frightening to nurses and other health care individuals. These are the positive symptoms
of schizophrenia. Nurses can greatly benefit from individual or peer supervision when dealing with these challenging phenomena. Communicating with clients who are delusional and hallucinatory and have disorganized thinking is a skill that is learned with guidance and practice.

The **negative symptoms** of schizophrenia are more subtle and are the most damaging to the client’s quality of life. **Negative symptoms** include feelings of emptiness, amotivational states, anhedonia, and apathy.

Cognitive symptoms (poor problem-solving, poor decision-making skills, illogical thinking) also need to be targeted when planning care.

The symptoms of schizophrenia usually become apparent during adolescence or early adulthood (15 to 25 for men, 25 to 35 for women). Paranoid schizophrenia has a later onset. The schizophrenias are severe, biologically based mental illnesses. Current theories of schizophrenia involve neuroanatomical and neurochemical abnormalities, which might be induced either genetically or environmentally (birth defects, viruses). Although the schizophrenias are not caused by psychological events, stressful life events can trigger an exacerbation of the illness. Therefore, psychoeducational and family treatment modalities can be crucial in helping clients in a number of ways. Psychoeducational, family, group, and behavioral approaches, for example, can help clients increase their social skills, maximize their ability in self-care and independent living, maintain medical adherence, and, most important, increase the quality of their lives. Client and family education greatly improves the management of schizophrenia.

Schizophrenia is not a single disease, but rather a syndrome that involves cerebral blood flow, neuroelectrophysiology, neuroanatomy, and neurobiochemistry. The *Diagnostic and Statistical Manual of Mental Disorders* (4th edition, text revision) (DSM-IV-TR) criteria for the diagnosis of schizophrenia are listed in Box 8–1.

Box 8–2 identifies five subtypes of schizophrenia.

### Other Psychotic Disorders

**Schizophreniform Disorder**

The essential features of this disorder are exactly those of schizophrenia except that:
### Box 8-1

**DSM-IV-TR Criteria for Schizophrenia**

1. **Characteristic symptoms:** Two (or more) of the following, each present for a significant portion of the time during a 1-month period (or less if successfully treated):
   - Delusions
   - Hallucinations
   - Disorganized speech (e.g., frequent derailment or incoherence)
   - Grossly disorganized or catatonic behavior
   - Negative symptoms, (i.e., affective flattening, alogia, or avolition)

   Note: Only one Criterion 1 symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person’s behavior or thoughts, or two or more voices conversing with each other.

2. **Social/occupational dysfunction:** For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning, such as work, interpersonal relations, or self-care, are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

3. **Duration:** Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion 1 (i.e., active-phase symptoms) and might include periods of prodromal or residual symptoms.

4. Symptoms are not caused by (a) another psychotic disorder; (b) a substance or general medical disorder; or (c) a pervasive developmental disorder, unless prominent delusions or hallucinations are also present for at least 1 month.

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- The total duration of the illness is at least 1 month, but less than 6 months.
- Impaired social or occupational functioning during some part of the illness is not apparent (although it might occur).

This disorder might or might not have a good prognosis.
Box 8-2  **Subtypes of Schizophrenia**

**Paranoid**
Onset usually in the late 20s to 30s. People who develop this disorder usually function well before the onset of the disorder (good premorbid functioning). Paranoia (any intense and strongly defended irrational suspicion) is the main characteristic; the main defense is projection. Hallucinations, delusions, and ideas of reference are dominant.

**Disorganized**
The most regressed and socially impaired of all the schizophrenias. The person has highly disorganized speech and behavior and inappropriate affect. Bizarre mannerisms include grimacing, along with other oddities of behavior.

**Catatonia**
The essential feature is abnormal motor behavior. Two extreme motor behaviors are seen in catatonia. One extreme is psychomotor agitation, which can lead to exhaustion. The other extreme is psychomotor retardation and withdrawal to the point of stupor. The onset is usually acute, and the prognosis is good with medications and swift interventions. Other behaviors might include autism, waxy flexibility, and negativism.

**Undifferentiated (Mixed Type)**
Clients experience active hallucinations and delusions, but no one clinical picture dominates (e.g., not paranoid, catatonic, or disorganized; rather the clinical picture is one of a mixture of symptoms).

**Residual**
A person who is referred to as having residual schizophrenia no longer has active symptoms of the disease, such as delusions, hallucinations, or disorganized speech and behaviors. However, there is a persistence of some symptoms—for example, marked social withdrawal; impairment in role function (wage earner, student, or homemaker); eccentric behavior or odd beliefs; poor personal hygiene; lack of interest, energy, initiative; and inappropriate affect.
Brief Psychotic Disorder
This is a disorder in which there is a sudden onset of psychotic symptoms (delusions, hallucinations, disorganized speech) or grossly disorganized or catatonic behavior. The episode lasts at least 1 day, but less than 1 month, and then the individual returns to his or her premorbid level of functioning. Brief psychotic disorders often follow extremely stressful life events.

Schizoaffective Disorder
This disorder is characterized by an uninterrupted period of illness during which there is a major depressive, manic, or mixed episode, concurrent with symptoms that meet the criteria for schizophrenia. The symptoms must not be due to any substance use or abuse or general medical condition.

Delusional Disorder
This disorder involves nonbizarre delusions (situations that occur in real life, such as being followed, infected, loved at a distance, deceived by a spouse, or having a disease) of at least 1 month’s duration. The person’s ability to function is not markedly impaired, nor is the person’s behavior obviously odd or bizarre. Common types of delusions seen in this disorder are delusions of grandeur, persecution, or jealousy, or somatic or mixed delusions.

Shared Psychotic Disorder (Folie à Deux)
A shared psychotic disorder is an occurrence in which one individual, who is in a close relationship with another who has a psychotic disorder with a delusion, eventually comes to share the delusional beliefs either in total or in part. Apart from the shared delusion, the person who takes on the other’s delusional behavior is not otherwise odd or unusual. Impairment of the person who shares the delusion is usually much less than the person who has the psychotic disorder with the delusion. The cult phenomenon is an example, as was demonstrated at Waco and Jonestown.
Induced or Secondary Psychosis

Psychosis can be induced by substances (drugs of abuse, alcohol, medications, or toxin exposure) or caused by the physiologic consequences of a general medical condition (delirium, neurologic conditions, metabolic conditions, hepatic or renal diseases, and many more). Medical conditions and substances of abuse must always be ruled out before a primary diagnosis of a schizophrenia or other psychotic disorder can be made.

Phases of Schizophrenia

Schizophrenia has been divided into three phases:

Phase I—Onset. This phase (acute phase) includes the prodromal symptoms (e.g., acute or chronic anxiety, phobias, obsessions, compulsions, dissociative features) as well as the acute psychotic symptoms of hallucinations, delusions, and/or disorganized thinking.

Phase II—Years following onset. Patterns that characterize this phase are the ebb and flow of the intensity and disruption caused by symptoms, which might, in some cases, be followed by complete or relatively complete recovery.

Phase III—Long-term course and outcome. This is the course that the severely and persistently mentally ill client follows when the disease becomes chronic. For some clients, the intensity of the psychosis might diminish with age; however, the long-term dysfunctional effects of the disorder are not as amenable to change.

ASSESSMENT

Presenting Signs and Symptoms

1. Positive symptoms
   - Delusions
   - Hallucinations
   - Disorganized thinking/speech
   - Disorganized or catatonic behavior

2. Negative symptoms
   - Flat emotional affect
   - Sparse productivity of thought (Alogia)
   - Lack of goal directed activity (Avolition)
3. Cognitive symptoms
  - Memory and attention deficits
  - Language difficulties
  - Proteins monitoring personal behavior, establishing goals maintaining tasks, and so on

Assessment Tool
The Brief Psychiatric Rating Scale (BPRS) (Appendix D-5) is a useful tool for evaluating overall psychiatric functioning. It is particularly helpful in evaluating the degree to which psychotic symptoms affect a person’s ability to function.

Assessment Guidelines

Schizophrenias

Assessing Positive Symptoms
1. Assess for command hallucinations (e.g., voices telling the person to harm self or another). If yes:
   - Do you plan to follow the command?
   - Do you believe the voices are real?
2. Assess if the client has fragmented, poorly organized, well-organized, systematized, or extensive system of beliefs that are not supported by reality (delusions). If yes:
   - Assess if delusions have to do with someone trying to harm the client and if the client is planning to retaliate against a person or organization.
   - Assess if precautions need to be taken.
3. Assess for pervasive suspiciousness about everyone and their actions, for example:
   - Is on guard, hyperalert, vigilant
   - Blames others for consequences of own behavior
   - Is hostile, argumentative, or often threatening, in verbalization or behavior

Assessing Negative Symptoms
4. Assess for negative symptoms of schizophrenia (see Table 8-1 for definitions and suggested interventions).
5. Assess if client is on medications, what the medications are, and if treatment is adherent with medications.
6. How does the family respond to increased symptoms? Overprotective? Hostile? Suspicious?
7. How do family members and client relate?
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NURSING DIAGNOSES WITH INTERVENTIONS

People with schizophrenia often have multiple needs. Basic to these is safety. Refer to Chapters 16 and 17 for nursing care plans identifying nursing interventions for suicide intent and violence toward others. Suicide and threat of violence to others are basic to nursing interventions for all clients in all settings, not just for people with schizophrenia or the hospitalized person.

Relating to people with schizophrenia can be a challenge, especially in the acute phase; therefore guidelines for

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8. Assess support system. Is family well informed about the disease (e.g., schizophrenia)? Does family understand the need for medication adherence? Is family familiar with family support groups in the community, or where to go for respite and family support?

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Table 8-1  Negative (Deficit) Symptoms of Schizophrenia

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Clinical Findings</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apathy</td>
<td>Slow onset</td>
<td>The newer atypical (novel) antipsychotics might target some of the negative symptoms.</td>
</tr>
<tr>
<td>Poverty of speech or</td>
<td>Interferes with a person’s life</td>
<td>The most used interventions include:</td>
</tr>
<tr>
<td>content of speech</td>
<td>Positive premorbid history</td>
<td>1. Skill training interventions:</td>
</tr>
<tr>
<td>Poor social</td>
<td>Chronic deterioration</td>
<td>• Identify areas of skill deficit person is willing to work on.</td>
</tr>
<tr>
<td>functioning</td>
<td>Family history of schizophrenia</td>
<td>• Prioritize skills important to the person.</td>
</tr>
<tr>
<td>Anhedonia</td>
<td>Cerebellar atrophy and lateral and third ventricular enlargement on computed tomography scan</td>
<td>2. Working with person to identify stressors:</td>
</tr>
<tr>
<td>Social withdrawal</td>
<td>Abnormalities on neuropsychologic testing</td>
<td>• Identify which stressors contribute to mal-adaptive behaviors.</td>
</tr>
<tr>
<td></td>
<td>Poor response to antipsychotics</td>
<td>3. Work with person on increasing appropriate coping skills.</td>
</tr>
</tbody>
</table>
Impaired Verbal Communication are included. Again, during the acute phase, relating to others is difficult. Guidelines for interacting and gradually adding social skills are included in Impaired Social Interaction. Working with clients who are hallucinating (Disturbed Sensory Perception), delusional (Disturbed Thought Processes), and paranoid (Defensive Coping) can be a great challenge. Therefore, these are included.

Also, importantly, often the families are left to cope with the exhaustive needs of their family member. Interrupted Family Processes should always be assessed, and referrals and teaching should be readily available.

Nonadherence to medications or treatment is a huge challenge for mental health professionals. Nursing care plans for Nonadherence/Noncompliance are found in Chapter 20. Table 8-2 provides a list of potential nursing diagnoses.

Selected Nursing Diagnoses and Nursing Care Plans

IMPAIRED VERBAL COMMUNICATION

Decreased, delayed, or absent ability to receive, process, transmit, or use a system of symbols

Related To (Etiology)

▲ Psychologic barriers (e.g., psychosis, lack of stimuli)
▲ Side effects of medication
▲ Altered perceptions
● Biochemical alterations in the brain of certain neurotransmitters

As Evidenced By
(Assessment Findings/Diagnostic Cues)

▲ Inappropriate verbalization
▲ Difficulty expressing thoughts verbally
▲ Difficulty in comprehending and maintaining the usual communication pattern
● Poverty of speech

▲ NANDA International accepted; ● In addition to NANDA International
### Table 8-2 Potential Nursing Diagnoses for Schizophrenia

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Nursing Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive Symptoms</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Hallucinations:</strong></td>
<td>Perception: Auditory/Visual</td>
</tr>
<tr>
<td>• Hears voices (loud noises) that others do not hear.</td>
<td>Risk for Violence: Self-Directed and Other-Directed</td>
</tr>
<tr>
<td>• Hears voices telling them to hurt self or others (command hallucinations).</td>
<td></td>
</tr>
<tr>
<td><strong>Distorted thinking not based in reality, for example:</strong></td>
<td>Disturbed Thought Processes</td>
</tr>
<tr>
<td>• <strong>Persecution:</strong> thinking others are trying to harm them.</td>
<td>Defensive Coping</td>
</tr>
<tr>
<td>• <strong>Jealousy:</strong> thinking spouse or lover is being unfaithful, or thinks others are jealous when they are not.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Grandeur:</strong> thinking they have powers they do not possess, or they are someone powerful or famous.</td>
<td></td>
</tr>
<tr>
<td>• <strong>Reference:</strong> believing all events within the environment are directed at or hold special meaning for them.</td>
<td></td>
</tr>
<tr>
<td>• Loose association of ideas (looseness of association).</td>
<td>Impaired Verbal Communication</td>
</tr>
<tr>
<td>• Uses words in a meaningless, disconnected manner (word salad).</td>
<td>Disturbed Thought Processes</td>
</tr>
<tr>
<td>• Uses words that rhyme in a nonsensical fashion (clang association).</td>
<td></td>
</tr>
<tr>
<td>• Repeats words that are heard (echolalia).</td>
<td></td>
</tr>
<tr>
<td>• Does not speak (mutism).</td>
<td></td>
</tr>
<tr>
<td>• The person delays getting to the point of communication because of unnecessary and tedious details (circumstantiality).</td>
<td></td>
</tr>
<tr>
<td>• Concrete thinking: The inability to abstract; uses literal translations concerning aspects of the environment.</td>
<td></td>
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</tbody>
</table>

*Continued*
Table 8-2  Potential Nursing Diagnoses for Schizophrenia—cont’d

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Nursing Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negative Symptoms</strong></td>
<td></td>
</tr>
<tr>
<td>Uncommunicative, withdrawn, no eye contact.</td>
<td>Social Isolation</td>
</tr>
<tr>
<td>Preoccupation with own thoughts.</td>
<td>Impaired Social Interaction</td>
</tr>
<tr>
<td>Expression of feelings of rejection or of aloneness (lies in bed all day; positions back to door).</td>
<td>Risk for Loneliness</td>
</tr>
<tr>
<td>Talks about self as “bad” or “no good.”</td>
<td>Chronic Low Self-Esteem</td>
</tr>
<tr>
<td>Feels guilty because of “bad thoughts”; extremely sensitive to real or perceived slights.</td>
<td>Risk for Self-Directed Violence</td>
</tr>
<tr>
<td>Lack of energy (<em>anergia</em>).</td>
<td>Ineffective Coping</td>
</tr>
<tr>
<td>Lack of motivation (<em>avolition</em>); unable to initiate tasks (social contact, grooming, and other aspects of daily living).</td>
<td>Self-Care Deficit (bathing/hygiene, dressing/grooming)</td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td>Families and significant others become confused, overwhelmed, lack knowledge of disease or treatment, feel powerless in coping with client at home.</td>
<td>Compromised Family Coping</td>
</tr>
<tr>
<td><strong>Nonadherence to medications and treatment:</strong> Client stops taking medication (often because of side effects), stops going to therapy groups.</td>
<td>Disabled Family Coping</td>
</tr>
<tr>
<td></td>
<td>Impaired Parenting</td>
</tr>
<tr>
<td></td>
<td>Caregiver Role Strain</td>
</tr>
<tr>
<td></td>
<td>Deficient Knowledge</td>
</tr>
<tr>
<td></td>
<td>Nonadherence (Noncompliance)</td>
</tr>
</tbody>
</table>

- Disturbances in cognitive associations (e.g., looseness of association, perseveration, neologisms)
- Inability to distinguish internally stimulated thoughts from actual environmental events or commonly shared knowledge

- In addition to NANDA International
Outcome Criteria

- Communicates thoughts and feelings in a coherent, goal-directed manner (to client’s best ability)
- Demonstrates reality-based thought processes in verbal communication (to client’s best ability)

Long-Term Goals

Client will:
- Be able to speak in a manner that can be understood by others with the aid of medication and attentive listening by discharge
- Learn two diversionary tactics that work for him/her to lower anxiety, thus enhancing ability to think clearly and speak more logically by (date)

Short-Term Goals

Client will:
- Spend three 5-minute periods with nurse sharing observations in the environment within 4 days
- Spend time with one or two other people in structured activity involving neutral topics by (date)

Interventions and Rationales

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess if incoherence in speech is chronic or if it is more sudden, as in an exacerbation of symptoms.</td>
<td>1. Establishing a baseline facilitates the establishment of realistic goals, the cornerstone for planning effective care.</td>
</tr>
<tr>
<td>2. Identify how long client has been on antipsychotic medication.</td>
<td>2. Therapeutic levels of an antipsychotic helps clear thinking and diminishes looseness of association (LOA).</td>
</tr>
<tr>
<td>3. Plan short, frequent periods with client throughout the day.</td>
<td>3. Short periods are less stressful, and periodic meetings give client a chance to develop familiarity and safety.</td>
</tr>
</tbody>
</table>

*In addition to NANDA International*
Intervention

4. Use simple words, and keep directions simple.
5. Keep voice low and speak slowly.

6. Look for themes in what is said, even though spoken words appear incoherent (e.g., anxiety, fear, sadness).
7. When you do not understand a client, let him/her know you are having difficulty understanding (e.g., “I want to understand what you are saying, but I am having difficulty.”)
8. Use therapeutic techniques to try to understand client’s concerns (e.g., “Are you saying . . . ?” “You mentioned demons many times. Are you feeling frightened?”).
9. Focus on and direct client’s attention to concrete things in the environment.
10. Keep environment quiet and as free of stimuli as possible.
11. Use simple, concrete, and literal explanations.

Rationale

4. Client might have difficulty processing even simple sentences.
5. High pitched/loud tone of voice can raise anxiety levels; slow speaking aids understanding.
6. Often client’s choice of words is symbolic of feelings.
7. Pretending to understand (when you do not) limits your credibility in the eyes of your client and lessens the potential for trust.
8. Even if the words are hard to understand, try getting to the feelings behind them.
9. Helps draw focus away from delusions and focus on reality-based things.
10. Keeps anxiety from escalating and increasing confusion and hallucinations/delusions.
11. Minimizes misunderstandings and/or incorporating those misunderstandings into delusional systems.
**Intervention**

12. When client is ready, introduce tactics that can lower anxiety and minimize voices and “worrying” thoughts. Teach client to do the following:

- Take time out.
- Read aloud to self.
- Seek out staff, family, or other supportive person.
- Listen to music.
- Learn to replace irrational thoughts with rational statements.
- Learn to replace “bad” thoughts with constructive thoughts.
- Perform deep breathing exercises.

**Rationale**

12. Helping client to use tactics to lower anxiety can help enhance functional speech.

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**IMPAIRED SOCIAL INTERACTION**

The state in which an individual participates in an insufficient or excessive quantity or ineffective quality of social exchange

**Related To (Etiology)**

- Impaired thought processes (hallucinations or delusions)
- Self-concept disturbance (might feel “bad” about self or “no-good”)
- Difficulty with communication (e.g., associative looseness)
- Inappropriate or inadequate emotional responses
- Feeling threatened in social situations
- Exaggerated response to stimuli
- Difficulty with concentration

▲ NANDA International accepted; ◆ In addition to NANDA International
As Evidenced By
(Assessment Findings/Diagnostic Cues)

▲ Verbalized or observed discomfort in social situations
▲ Observed use of unsuccessful social interactions behaviors
▲ Dysfunctional interaction with peers
● Spends time alone by self
● Inappropriate or inadequate emotional response
● Does not make eye contact, or initiate or respond to social advances of others
● Appears agitated or anxious when others come too close or try to engage him in an activity

Outcome Criteria

● Improves social interaction with family, friends, and neighbors
● Engages in social interactions in goal directed manner
● Uses appropriate social skills in interactions

Long-Term Goals
Client will:
● Engage in one or two activities with minimal encouragement from nurse or family members by (date)
● Use appropriate skills to initiate and maintain an interaction by (date)
● State that he or she is comfortable in at least three structured activities that are goal directed by (date)
● Demonstrate interest to start coping skills training when ready for learning

Short-Term Goals
Client will:
● Engage in one activity with nurse by the end of the day
● Attend one structured group activity within 1 week
● Maintain an interaction with another client while doing an activity (drawing, playing cards, cooking a meal)
## Interventions and Rationales

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess if medication has reached therapeutic levels.</td>
<td>1. Many of the positive symptoms (paranoia, delusions, and hallucinations) will subside with medications, which will facilitate interactions.</td>
</tr>
<tr>
<td>2. Ensure that the goals set are realistic, whether in the hospital or community.</td>
<td>2. Avoids pressure on client, and sense of failure on part of nurse/family. This sense of failure can lead to mutual withdrawal.</td>
</tr>
<tr>
<td>3. Keep client in an environment as free of stimuli (loud noises, high traffic areas) as possible.</td>
<td>3. Client might respond to noises and crowding with agitation, anxiety, and increased inability to concentrate on outside events.</td>
</tr>
<tr>
<td>4. Avoid touching the client.</td>
<td>4. Touch by a “stranger” can be misinterpreted as a sexual or threatening gesture. This is particularly true for a paranoid client.</td>
</tr>
<tr>
<td>5. If client is unable to respond verbally or in a coherent manner, spend frequent, short periods with client.</td>
<td>5. An interested presence can provide a sense of being worthwhile.</td>
</tr>
<tr>
<td>6. Structure times each day to include planned times for brief interactions and activities with the client on a one-on-one basis.</td>
<td>6. Helps client to develop a sense of safety in a nonthreatening environment.</td>
</tr>
</tbody>
</table>
Intervention

7. If client is delusional/hallucinating or is having trouble concentrating at this time, provide very simple concrete activities with client (e.g., looking at a picture book with nurse, drawing, painting).

8. Structure activities that work at the client’s pace and ability.

9. Try to incorporate the strengths and interests the client had when not as impaired into the activities planned.

10. If client is very paranoid, solitary or one-on-one activities that require concentration are appropriate.

11. If client is very withdrawn, one-on-one activities with a “safe” person initially should be planned.

12. As client progresses, provide the client with graded activities according to level of tolerance e.g., (1) simple games with one “safe” person; (2) slowly add a third person into “safe”

Rationale

7. Even simple activities help draw client away from delusional thinking onto reality in the environment.

8. Client can lose interest in activities that are too ambitious, which can increase a sense of failure.

9. Increases likelihood of client’s participation and enjoyment.

10. Client is free to choose his level of interaction; however, the concentration can help minimize distressing paranoid thoughts or voice (e.g., chess).

11. Learns to feel safe with one person, then gradually might participate in a structured group activity.

12. Gradually the client learns to feel safe and competent with increased social demands.


**Intervention**

activities; (3) introduce simple group activities; and then (4) groups in which clients participate more.

13. Eventually engage other clients and significant others in social interactions and activities with the client (card games, ping-pong, sing-a-longs, group outings, etc) at client’s level.

14. Identify with client symptoms he experiences when he/she begins to feel anxious around others.

15. Teach client to remove himself briefly when feeling agitated and work on some anxiety-relief exercises (e.g., deep breathing, thought stopping).

16. Provide opportunities for the client to learn adaptive social skills in a nonthreatening environment. Initial social skills training could include basic social behaviors (e.g., maintain good eye contact, appropriate distance, calm demeanor, moderate voice tone).

**Rationale**

13. Client continues to feel safe and competent in a graduated hierarchy of interactions.

14. Increased anxiety can intensify agitation, aggressiveness, and suspiciousness.

15. Teaches client skills in dealing with anxiety and increasing a sense of control.

16. Social skills training helps client adapt and function at a higher level in society, and increases clients quality of life. These simple skills might take time for a client with schizophrenia, but can increase self confidence as well as more positive responses from others.
**Intervention**

17. As client progresses, Coping Skills Training should be available to him/her (nurse, staff, or others). Basically the process is:
   a. Define the skill to be learned.
   b. Model the skill.
   c. Rehearse skills in a safe environment, then in the community.
   d. Give corrective feedback on the implementation of skills.

18. Useful coping skills that client will need include conversational and assertiveness skills.

19. Remember to give acknowledgment and recognition for positive steps client takes in increasing social skills and appropriate interactions with others.

**Rationale**

17. Increases client’s ability to derive social support and decrease loneliness. Clients will not give up substances of abuse unless they have alternative means to facilitate socialization and feel they belong.

18. These are fundamental skills for dealing with the world, which everyone uses daily with more or less skill.

19. Recognition and appreciation go a long way to sustaining and increasing a specific behavior.

**Hallucinations**

**Presenting Signs and Symptoms**

- Clients state they hear voices.
- Client denies hearing voices, but observer notes client(’s):
  - Eyes following something in motion that observer cannot see
  - Staring at one place in room
  - Head turning to side as if listening
Mumbling to self or conversing when no one else is present
- Inappropriate facial expressions, eye blinking
- If hallucinations are from other causes (e.g., drugs, alcohol, delirium), the underlying cause needs to be treated as soon as possible using accepted medical and nursing protocols.

Assessment Guidelines

Hallucinations
1. Assess for command hallucinations (e.g., voices telling the person to harm self or another).
2. Assess when hallucinations seem to occur the most (e.g., times of stress, at night).

Selected Nursing Diagnoses and Nursing Care Plans

DISTURBED SENSORY PERCEPTION: AUDITORY/VISUAL

Change in the amount or patterning of incoming stimuli accompanied by a diminished, exaggerated, distorted, or impaired response to such stimuli

Related To (Etiology)
- Altered sensory reception: transmission or integration
- Biochemical imbalance
- Chemical alterations (e.g., drugs, electrolyte imbalances)
- Altered sensory perception
- Psychologic stress
- Neurologic/biochemical changes
As Evidenced By
(Assessment Findings/Diagnostic Cues)

▲ Disorientation to time/place/person
▲ Auditory distortions
▲ Hallucinations
● Tilting the head as if listening to someone
● Frequent blinking of the eyes and grimacing
● Mumbling to self, talking or laughing to self
▲ Altered communication pattern
▲ Change in problem-solving pattern
▲ Reported or measured change in sensory acuity
▲ Inappropriate responses

Outcome Criteria

• Maintains social relationships
• Maintains role performance
• States that the voices are no longer threatening, nor do they interfere with his or her life
  ■ Learns ways to refrain from responding to hallucinations

Long-Term Goals

Client will:
• Demonstrate techniques that help distract him or her from the voices by (date)
• Monitor intensity of anxiety

Short-Term Goals

Client will:
• State, using a scale from 1 to 10, that “the voices” are less frequent and threatening when aided by medication and nursing intervention by (date)
• State three symptoms they recognize when their stress levels are high by (date)

▲ NANDA International accepted; ● In addition to NANDA International
■ Adapted from NOC Objective Distortive Thought Self-Control
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- Identify two stressful events that trigger hallucinations by (date)
- Demonstrate one stress reduction technique by (date)
- Identify two personal interventions that decrease or lower the intensity or frequency of hallucinations (e.g., listening to music, wearing headphones, reading out loud, jogging, socializing) by (date)

*Interventions and Rationales*

**Intervention**  
1. If voices are telling the client to harm self or others, take necessary environmental precautions.
   a. Notify others and police, physician, and administration according to unit protocol.
   b. If in the hospital, use unit protocols for **suicidal** or **threats of violence** if client plans to act on commands.
   c. If in the community, evaluate need for hospitalization. Clearly document what client says and, if he/she is a threat to others, document who was contacted and notified (use agency protocol as a guide).

2. Decrease environmental stimuli when possible (low noise, minimal activity).

**Rationale**  
1. People often obey hallucinatory commands to kill self or others. Early assessment and intervention might save lives.

2. Decrease potential for anxiety that might trigger hallucinations. Helps calm client.
Intervention

3. Accept the fact that the voices are real to the client, but explain that you do not hear the voices. Refer to the voices as “your voices” or “voices that you hear.”

4. Stay with clients when they are starting to hallucinate, and direct them to tell the “voices they hear” to go away. Repeat often in a matter-of-fact manner.

5. Keep to simple, basic, reality-based topics of conversation. Help client to focus on one idea at a time.

6. Explore how the hallucinations are experienced by the client.

7. Help the client to identify the needs that might underlie the hallucination. What other ways can these needs be met?

Rationale

3. Validating that your reality does not include voices can help client cast “doubt” on the validity of his or her voices.

4. Clients can sometimes learn to push voices aside when given repeated instruction, especially within the framework of a trusting relationship.

5. Client’s thinking might be confused and disorganized; this intervention helps client focus and comprehend reality-based issues.

6. Exploring the hallucination and sharing the experience can help give the person a sense of power that he or she might be able to manage the hallucinatory voices.

7. Hallucinations might reflect needs for:
   a. Power
   b. Self-esteem
   c. Anger
   d. Sexuality
Intervention
8. Help client to identify times that the hallucinations are most prevalent and frightening.
9. Engage client in simple physical activities or tasks that channel energy (writing, drawing, crafts, noncompetitive sports, treadmill, walking on track, exercise bike).
10. Work with the client to find which activities help reduce anxiety and distract the client from hallucinatory material. Practice new skills with client.
11. Be alert for signs of increasing fear, anxiety, or agitation.
12. Intervene with one-on-one, seclusion, or PRN medication (as ordered) when appropriate.

Rationale
8. Helps both nurse and client identify situations and times that might be most anxiety producing and threatening to client.
9. Redirecting client’s energies to acceptable activities can decrease the possibility of acting on hallucinations and help distract from voices.
10. If clients’ stress triggers hallucinatory activity, they might be more motivated to find ways to remove themselves from a stressful environment or try distraction techniques.
11. Might herald hallucinatory activity, which can be very frightening to client, and client might act upon command hallucinations (harm self or others).
12. Intervene before anxiety begins to escalate. If client is already out of control, use chemical or physical restraints following unit protocols.

Delusions
Presenting Signs and Symptoms
- The client has fragmented, poorly organized, well-organized, systematized, or extensive system of beliefs that are not supported by reality.
- The content of the delusions can be grandiose, persecutory, jealous, somatic, or based on guilt.
Part II  Diagnosis and Care Planning

Assessment Guidelines

Delusions

1. Assess if delusions have to do with someone trying to harm the client, or if the client is planning to retaliate against a person or organization.
   a. If client is a threat to self or others, notify person and authorities.
   b. Confer with physician and administration if precautions need to be taken.
2. Assess when delusional thinking is the most point (e.g., when under stress, in the presence of certain situations or people, at night).

Selected Nursing Diagnoses and Nursing Care Plans

DISTURBED THOUGHT PROCESSES

Disruption in cognitive operations and activities

Related To (Etiology)

- Biochemical/neurologic imbalances
- Panic levels of anxiety
- Overwhelming stressful life events
- Chemical alterations (e.g., drugs, electrolyte imbalances)

As Evidenced By

(Assessment Findings/Diagnostic Cues)

- Inaccurate interpretation of environment
- Memory deficit/problems
- Egocentricity
- Inappropriate non-reality-based thinking
- Delusions

¬ NANDA International accepted; ● In addition to NANDA International
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Outcome Criteria

- Refrains from acting on delusional thinking
- Demonstrates satisfying relationships with real people.
- Delusions no longer threaten or interfere with his or her ability to function in family, social, and work situations.
  - Perceive environment effectively

Long-Term Goals

Client will:
- Demonstrate two effective coping skills that minimize delusional thoughts by (date)

Short-Term Goals

Client will:
- State that the “thoughts” are less intense and less frequent with aid of medications and nursing interventions by (date)
- Talk about concrete happenings in the environment without talking about delusions for 5 minutes by (date)
- Begin to recognize that his or her frightening (suspicious) “thinking” occurs most often at times of stress and when he or she is anxious

Interventions and Rationales

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Utilize safety measures to protect clients or others, if clients believe they need to protect themselves against a specific person. Precautions are needed.</td>
<td>1. During acute phase, client’s delusional thinking might dictate to them that they might have to hurt others or self in order to be safe. External controls might be needed.</td>
</tr>
<tr>
<td>2. Attempt to understand the significance of these beliefs to the client at the time of their presentation.</td>
<td>2. Important clues to underlying fears and issues can be found in the client’s seemingly illogical fantasies.</td>
</tr>
</tbody>
</table>

- NOC objective Distance Thought Self-Control
Intervention
3. Be aware that client’s delusions represent the way that he or she experiences reality.
4. Identify feelings related to delusions. For example:
   a. If client believes someone is going to harm him/her, client is experiencing fear.
   b. If client believes someone or something is controlling his/her thoughts, client is experiencing helplessness.
5. Do not argue with the client’s beliefs or try to correct false beliefs using facts.
6. Do not touch the client; use gestures carefully.
7. Interact with clients on the basis of things in the environment. Try to distract client from their delusions by engaging in reality-based activities (cards, simple board games, simple arts and crafts projects, cooking with another person, etc.).

Rationale
3. Identifying the client’s experience allows the nurse to understand the client’s feelings.
4. When people believe that they are understood, anxiety might lessen.
5. Arguing will only increase client’s defensive position, thereby reinforcing false beliefs. This will result in the client feeling even more isolated and misunderstood.
6. A psychotic person might misinterpret touch as either aggressive or sexual in nature and might interpret gestures as aggressive moves. People who are psychotic need a lot of personal space.
7. When thinking is focused on reality-based activities, the client is free of delusional thinking during that time. Helps focus attention externally.
**Intervention**
8. Teach client coping skills that minimize “worrying” thoughts. Coping skills include:
   - Talking to a trusted friend
   - Phoning a helpline
   - Singing
   - Going to a gym
   - Thought-stopping techniques

9. Encourage healthy habits to optimize functioning:
   - Maintain regular sleep pattern.
   - Reduce alcohol and drug intake.
   - Maintain self-care.
   - Maintain medication regimen.

**Rationale**
8. When client is ready, teach strategies client can do alone.
9. All are vital to help keep client in remission.

**Paranoia**

**Presenting Signs and Symptoms**
- Pervasive suspiciousness about one or more persons and their actions
- On guard, hyperalert, vigilant
- Blames others for consequences of own behavior
- Hostile, argumentative, often threatening verbalizations or behavior
- Poor interpersonal relationships
- Has delusions of influence, persecution, and grandiosity
- Often refuses medications because “nothing is wrong with me”
- Might refuse food if believes it is poisoned

**Assessment Guidelines**

**Paranoia**
1. Assess for suicidal or homicidal behaviors.
3. Assess need for hospitalization.
Selected Nursing Diagnoses and Nursing Care Plans

**DEFENSIVE COPING**

Repeated projection of falsely positive self-evaluation based on a self-protective pattern that defends against underlying perceived threats to positive self-regard

**Related To (Etiology)**
- Perceived threat to self
- Suspicions of the motives of others
- Perceived lack of self-efficacy/vulnerability

**As Evidenced By (Assessment Findings/Diagnostic Cues)**
- Projection of blame/responsibility
- Grandiosity
- Denial of obvious problems
- Rationalization of failures
- Superior attitude toward others
- Hostile laughter or ridicule of others
- Difficulty in reality testing of perceptions
- Difficulty establishing/maintaining relationships
- Hostility, aggression, or homicidal ideation
- Fearful
- False beliefs about the intentions of others

**Outcome Criteria**
- Interacts with others appropriately
- Maintains medical compliance
- Demonstrates decreased suspicious behaviors interacting with others

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▲ NANDA International accepted; ● In addition to NANDA International
■ NOC outcome for Impulse Self-Control
**Long-Term Goals**

Client will:
- Acknowledge that medications help lower suspiciousness
- State that he/she feels safe and more in control in interactions with environment/family/work/social gatherings by (date)
- Be able to apply a variety of stress/anxiety-reducing techniques on own by (date)

**Short-Term Goals**

Client will:
- Remain safe with the aid of medication and nursing interventions (either interpersonal, chemical, or seclusion), as will others in the client’s environment
- Focus on reality-based activity with the aid of medication/nursing intervention by (date)
- Demonstrate two newly learned constructive ways to deal with stress and feelings of powerlessness by (date)
- Demonstrate the ability to remove himself or herself from situations when anxiety begins to increase with the aid of medications and nursing interventions by (date)
- Identify one action that helps client feel more in control of his or her life

**Interventions and Rationales**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Use a nonjudgmental, respectful, and neutral approach with the client.</td>
<td>1. There is less chance for a suspicious client to misconstrue intent or meaning if content is neutral and approach is respectful and nonjudgmental.</td>
</tr>
<tr>
<td>2. Be honest and consistent with client regarding expectations and enforcing rules.</td>
<td>2. Suspicious people are quick to discern dishonesty. Honesty and consistency provide an atmosphere in which trust can grow.</td>
</tr>
</tbody>
</table>
### Intervention

3. Use clear and simple language when communicating with a suspicious client.

4. Explain to client what you are going to do beforehand and minimize the opportunity for miscommunication and misconstruing the meaning of the message.

5. Be aware of client’s tendency to have ideas of reference; do not do things in front of client that can be misinterpreted:
   a. Laughing
   b. Whispering
   c. Talking quietly when client can see but not hear what is being said

6. Diffuse angry and hostile verbal attacks with a nondefensive stand.

7. Assess and observe client regularly for signs of increasing anxiety and hostility.

8. Provide verbal/physical limits when client’s hostile behavior escalates: *We won’t allow you to hurt anyone here. If you can’t control yourself, we will help you.*

### Rationale

3. Minimize the opportunity for miscommunication and misconstruing the meaning of the message.

4. Prepares the client beforehand and minimizes misinterpreting your intent as hostile or aggressive.

5. Suspicious clients will automatically think that they are the target of the interaction and interpret it in a negative manner (e.g., you are laughing at them, whispering about them, etc.).

6. When staff become defensive, anger escalates for both client and staff. A nondefensive and nonjudgmental attitude provides an atmosphere in which feelings can be explored more easily.

7. Intervene before client loses control.

8. Often verbal limits are effective in helping a client gain self-control.
**Intervention**

9. Set limits in a clear, matter-of-fact way, using a calm tone. *Threatening John is not acceptable. Let's talk about appropriate ways to deal with your feelings.*

10. Maintain low level of stimuli and enhance a nonthreatening environment (avoid groups).

11. Initially, provide solitary, noncompetitive activities that take some concentration. Later a game with one or more clients that takes concentration (e.g., chess, checkers, thoughtful card games such as bridge or rummy).

**Rationale**

9. Calm and neutral approach may diffuse escalation of anger. Offer an alternative to verbal abuse by finding appropriate ways To deal with feelings.

10. Noisy environments might be perceived as threatening.

11. If a client is suspicious of others, solitary activities are the best. Concentrating on environmental stimuli minimizes paranoid rumination.

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**Providing Support to Family/Others**

**INTERRUPTED FAMILY PROCESSES**

Change in family relationships and/or functioning

**Related To (Etiology)**

▲ Shift in health status of a family member
▲ Situational crisis or transition
▲ Family role shift
▲ Developmental crisis or transition
● Mental or physical disorder of family member

▲ NANDA International accepted; ● In addition to NANDA International
As Evidenced By
(Assessment Findings/Diagnostic Cues)

▲ Changes in participation in decision making
▲ Changes in mutual support
▲ Changes in stress reduction behavior
▲ Changes in communication patterns
▲ Changes in participation in problem solving
▲ Changes in expression of conflict in family
● Inability to meet needs of family and significant others (physical, emotional, spiritual)
● Knowledge deficit regarding the disease and what is happening with ill family member (might believe client is more capable than they are)
● Knowledge deficit regarding community and healthcare support

Outcome Criteria

Family members/significant others will:
• State they have received needed support from community and agency resources that offer support, education, coping skills training, and/or social network development (psychoeducational approach)
• Demonstrate problem-solving skills for handling tensions and misunderstanding within the family environment
• Recount in some detail the early signs and symptoms of relapse in their ill family member, and know whom to contact

Long-Term Goals

Family members/significant others will:
• Know of at least two contact people when they suspect potential relapse by (date)
• Discuss the disease (schizophrenia) knowledgeably by (date):
  ○ Understand the need for medical adherence
  ○ Support the ill family member in maintaining optimum health

▲ NANDA International accepted; ● In addition to NANDA International
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- Know about community resources (e.g., help with self-care activities, private respite)
- Have access to family/multiple family support groups and psychoeducational training by (date)

**Short-Term Goals**

Family members/significant others will:
- Meet with nurse/physician/social worker the first day of hospitalization and begin to learn about this neurologic/biochemical disease, treatment, and community resources
- Attend at least one family support group (single family, multiple family) within 4 days from onset of acute episode
- Problem-solve, with the nurse, two concrete situations within the family that all would like to change
- State what the medications can do for their ill member, the side effects and toxic effects of the drugs, and the need for adherence to medication at least 2 to 3 days before discharge
- Be included in the discharge planning along with client
- State and have written information identifying the signs of potential relapse and whom to contact before discharge
- Name and have complete list of community supports for ill family member and supports for all members of the family at least 2 days before discharge

**Interventions and Rationales**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identify family’s ability to cope (e.g., experience of loss, caregiver burden, needed supports).</td>
<td>1. Family’s needs must be addressed to stabilize family unit.</td>
</tr>
<tr>
<td>2. Provide opportunity for family to discuss feelings related to ill family member and identify their immediate concerns.</td>
<td>2. Nurses and staff can best intervene when they understand the family’s experience and needs.</td>
</tr>
</tbody>
</table>
**Intervention**

3. Assess the family members’ current level of knowledge about the disease and medications used to treat the disease.

4. Provide information on disease and treatment strategies at family’s level of knowledge.

5. Inform the client and family in clear, simple terms about pharmacologic therapy: dosage, the need to take medication as prescribed, side effects, and toxic effect. Written information should be given to client and family members as well. **Refer to the client and family teaching guidelines in Chapter 21 under Antipsychotic Medication.**

6. Provide information on family and client community resources for client and family after discharge: support groups, organizations, day hospitals, psycho-educational programs, respite centers, etc. **See list of associations and Internet sites at end of chapter.**

**Rationale**

3. Family might have misconceptions and misinformation about schizophrenia and treatment, or no knowledge at all. Teach at client’s and family’s level of understanding and readiness to learn.

4. Meet family members’ needs for information.

5. Understanding of the disease and the treatment of the disease encourages greater family support and client adherence.

6. Schizophrenia is an overwhelming disease for both the client and the family. Groups, support groups, and psychoeducational centers can help:
**Intervention**

- Develop family skills
- Access resources
- Access support
- Access caring
- Minimize isolation
- Improve quality of life for all family members

**Rationale**

- Rapid recognition of early warning symptoms can help ward off potential relapse when immediate medical attention is sought.

**MEDICAL TREATMENT**

**Psychopharmacology**

Antipsychotic medications are indicated for nearly all psychotic episodes of schizophrenia. To delay medication therapy too long can put the client at risk for suicide or other dangerous behaviors.

Medications used to treat schizophrenia are called antipsychotic medications. Two groups of antipsychotic drugs exist: standard (traditional/conventional) and the newer atypical (or novel) medications. Many physicians urge the use of the atypical medications initially because of their better side effect profile and the fact that the atypical medications target the negative symptoms (apathy, lack of motivation) and anhedonia (lack of pleasure in life), thereby increasing the quality of life for clients.

**Atypical (Novel) Antipsychotic Medications**

During the early 1990s, new types of antipsychotics began appearing on the market, and they are currently used as first-line medications. (Clozapine [Clozaril] is the exception because of its tendency to cause agranulocytosis and its high incidence for seizures.) These drugs not only target the acute and disturbing symptoms seen in acute active episodes of schizophrenia (hallucinations, delusions, associative
looseness, paranoia), called positive symptoms, but also target the negative symptoms, which allows improvement in the quality of life for clients (increased motivation, improved judgment, increased energy, ability to experience pleasure and ↑ cognitive Function). These drugs also have a very low extrapyramidal symptom (EPS) profile and, in general, have a more favorable side-effect profile.

**Pros**
- Target negative and positive symptoms
- Lower risk of EPS
- Lower SE profile, ↑ compliance
- May improve symptoms of:
  - Anxiety
  - Depression
  - ↓ Suicidal behavior

**Cons**
- ↑ Weight gain
- Metabolic abnormalities (glucose dysregulation, hypercholesterolemia)
- Are more expensive

Table 8-3 provides a list of atypical antipsychotics, their dosages, and the side effects.

**Standard Medications**

The standard antipsychotic drugs target the more flagrant symptoms of schizophrenia (hallucinations, delusions, suspiciousness, associative looseness). These drugs can:
- Reduce disruptive and violent behavior
- Increase activity, speech, and sociability in withdrawn clients
- Improve self-care
- Improve sleep patterns
- Reduce the disturbing quality of hallucinations and delusions
- Improve thought processes
- Decrease resistance to supportive therapy
- Reduce rate of relapse
- Decrease intensity of paranoid reactions

Antipsychotic agents are usually effective 3 to 6 weeks after the regimen is started.

**Side Effects** There are some troubling side effects of these drugs that can at times limit medical adherence. Some of
# Table 8-3 Antipsychotic Medications

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range (mg/day)</th>
<th>EPS</th>
<th>ACH</th>
<th>OH</th>
<th>SED</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clozapine (Clozaril)</td>
<td>300–900</td>
<td>No</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Used in treatment-refractory clients—non–first-line (Clozaril)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.8%–0.1% incidence of agranulocytosis—weekly WBC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>High seizure rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Weight gain significant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Doses &gt;6 mg might see TD</td>
</tr>
<tr>
<td>Risperidone (Risperdal)</td>
<td>2–16</td>
<td>Low</td>
<td>Very</td>
<td>Low</td>
<td>Mod</td>
<td>Weight gain significant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Doses &gt;6 mg might see TD</td>
</tr>
<tr>
<td>Olanzapine (Zyprexa)</td>
<td>2.5–20</td>
<td>Low</td>
<td>Low</td>
<td>Mod</td>
<td>Low</td>
<td>Weight gain significant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Once-daily dose (long half-life)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Interaction with SSRIs might occur</td>
</tr>
</tbody>
</table>

*P.O.* By mouth  
*I.M.* Injectable  
*L.A.I.* Long-acting injectable  
*O.D.T.* Orally disintegrating tablets

Continued
Table 8-3 *Antipsychotic Medications—cont’d*

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose Range (mg/day)</th>
<th>EPS</th>
<th>ACH</th>
<th>OH</th>
<th>SED</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quetiapine (Seroquel)</td>
<td>150–750</td>
<td>Low</td>
<td>Low-None</td>
<td>Mod</td>
<td>Low</td>
<td>Risk of TD and NMS very low</td>
</tr>
<tr>
<td>Ziprasidone (Geodon)</td>
<td>40–160</td>
<td>Low</td>
<td>Mild-Mod</td>
<td>Mild</td>
<td>Low</td>
<td>ECG changes-QT prolongation; not to be used with other drugs known to prolong QT interval</td>
</tr>
<tr>
<td>P.O/IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Effective with the depressive symptoms of schizophrenia</td>
</tr>
<tr>
<td>Aripiprazole (Abilify)</td>
<td>10–30</td>
<td>Low</td>
<td>Low-None</td>
<td>Low-Mild</td>
<td>Low-</td>
<td>Teach about and check for akathisia; reported in some children</td>
</tr>
<tr>
<td>F.O/IM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>TD and sedation dose related NMS rare</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Little or no weight gain or increase in glucose, HDL, LDL, or triglycerides</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>First of a new class of atypical antipsychotics</td>
</tr>
</tbody>
</table>
### Table 8-3 Antipsychotic Medications

<table>
<thead>
<tr>
<th>Drug</th>
<th>Routes of Administration</th>
<th>Acute (mg/day)*</th>
<th>Maintenance (mg/day)*</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol (Haldol)</td>
<td>PO, IM</td>
<td>5–50</td>
<td>2–20</td>
<td>Has low sedative properties; is used in large doses for assaultive patients, thus avoiding the severe side effect of hypotension. Appropriate for the elderly for the same reason as above; lessens the chance of falls from dizziness or hypotension. High incidence of extrapyramidal side effects.</td>
</tr>
<tr>
<td>Trifluoperazine (Stelazine)</td>
<td>PO, IM</td>
<td>10–60</td>
<td>5–30</td>
<td>Low sedation—good for withdrawn or paranoid symptoms. High incidence of EPS. NMS might occur.</td>
</tr>
<tr>
<td>Fluphenazine (Prolixin)</td>
<td>PO, IM, SC</td>
<td>2.5–20</td>
<td>2–20</td>
<td>Among the least sedative. High incidence of akathisia. Possibly associated with weight reduction.</td>
</tr>
<tr>
<td>Thiothixene (Navane)</td>
<td>PO, IM</td>
<td>6–30</td>
<td>5–40</td>
<td>Possibly associated with weight reduction.</td>
</tr>
<tr>
<td>Loxapine (Loxitane)</td>
<td>PO, IM</td>
<td>60–100</td>
<td>20–200</td>
<td>Can help control severe vomiting. Increases sensitivity to sun (as with other phenothiazines).</td>
</tr>
<tr>
<td>Molindone (Mobic)</td>
<td>PO</td>
<td>50–100</td>
<td>20–200</td>
<td></td>
</tr>
<tr>
<td>Perphenazine (Trilafon)</td>
<td>PO, IM, IV</td>
<td>12–32</td>
<td>8–64</td>
<td></td>
</tr>
<tr>
<td>Chlorpromazine (Thorazine)</td>
<td>PO, IM, R</td>
<td>200–1600</td>
<td>200–1000</td>
<td></td>
</tr>
</tbody>
</table>

*Continued*
Table 8-3 *Antipsychotic Medications—cont’d*

<table>
<thead>
<tr>
<th>Drug</th>
<th>Routes of Administration</th>
<th>Acute (mg/day)*</th>
<th>Maintenance (mg/day)*</th>
<th>Special Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine (Thorazine)</td>
<td>PO, IM</td>
<td>50-600</td>
<td>75-600</td>
<td>Highest sedation and hypotension effects; least potent</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Can cause irreversible retinitis pigmentosa at 800 mg/day</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Weight gain common</td>
</tr>
<tr>
<td>Thioridazine (Mellaril)</td>
<td>PO</td>
<td>200-600</td>
<td>200-600</td>
<td><strong>Not recommended as first-line antipsychotic</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dose-related severe ECG changes; might cause sudden death</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Among the most sedative; severe nausea and vomiting might occur in adults</td>
</tr>
<tr>
<td>Mesoridazine (Serentil)</td>
<td>PO, IM</td>
<td>75-300</td>
<td>100-400</td>
<td></td>
</tr>
</tbody>
</table>

* Au: MS not clear?
Decanoate: Long-Acting

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage Range</th>
<th>Administration</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haloperidol a-IM (Haldol) LAI</td>
<td>0-50-300</td>
<td>Given deep muscle z-track IM</td>
<td>Give every 3-4 weeks</td>
</tr>
<tr>
<td>Fluphenazine deca-IM LAI (Prolixin)</td>
<td>0-12.5-50</td>
<td>Given deep muscle z-track IM</td>
<td>Give every 2-4 weeks</td>
</tr>
</tbody>
</table>


*Dosages vary with individual responses to antipsychotic agent used.*

ACH, Anticholinergic side effects (e.g., dry mouth, blurred vision, urinary retention, constipation, agitation); ECG, electrocardiograph; EPS, extrapyramidal side effects; HDL, high-density lipoprotein; IM, intramuscular; IV, intravenous; LDL, low-density lipoprotein; OH, orthostatic hypotension; NMS, neuroleptic malignant syndrome; PO, oral; R, rectal; SC, subcutaneous; IM-intramuscular L.A.I.-Long acting injection O.D.T.-Orally disintegrating tablets. SED, sedation; SSRI, selective serotonin reuptake inhibitor; TD, tardive dyskinesia; WBC, white blood cell count.
these side effects can be managed with other medications. EPS, cardiac side effects, and toxic effects of these drugs are discussed further in Chapter 21.

One of the most disturbing side effects to clients are the EPS; medication is used to treat the EPS caused by these standard antipsychotics. Refer to Chapter 21 for a client and family medication teaching plan.

PSYCHOSOCIAL APPROACHES

Treatment of Comorbid Conditions

There are many treatment approaches that can help clients with schizophrenia better adjust to their environment and increase their quality of life when used in conjunction with medications. Some of the psychotherapeutic approaches that seem to be useful for many people with these disorders are discussed here. However, treatment should not only be aimed at the symptoms of schizophrenia but also need to target some of the comorbid conditions that a client might exhibit. Some of the more common comorbid conditions in people with schizophrenia include:

- Substance use problems
- Depressive symptoms or disorders
- Risk for suicide
- Violent behaviors

If a comorbid condition is identified, it must be treated, if overall adherence to a second treatment approach is followed and/or successful.

Specific Psychosocial Treatments

Individual Therapy

There is evidence that supportive therapy that includes problem-solving techniques and social skills training helps reduce relapse and enhance social and occupational functioning when added to medication treatment for schizophrenic individuals who are treated in an outpatient environment. Cognitive behavioral therapy (CBT), cognitive rehabilitation, and social skills training (SST) are particularly helpful in people with chronic schizophrenia who have cognitive impairments.
**Family Intervention**

Families with a schizophrenic member endure considerable hardships while coping with the psychotic and residual symptoms of schizophrenia. Often families are the sole caretakers of their schizophrenic member and need education, guidance, and support as well as training to help them manage (APA, 2000b). A **Psychoeducational family approach** provides support, education, coping skills training, and social network expansion and has been proven very successful with both decreasing family stress and increasing client adherence to treatment. Families can be helped by:

- Understanding the disease and the role of medications
- Setting realistic goals for their schizophrenic member
- Developing problem-solving skills for handling tensions and misunderstanding within the family environment
- Identifying early signs of relapse
- Having knowledge of where they can go for guidance and support within the community and nationally

**Group Therapy**

The goals of group therapy for individual members are to increase problem-solving ability, to enable realistic goal planning, to facilitate social interactions, and to manage medication side effects (Kanas, 1996). Groups can help clients develop interpersonal skills, resolution of family problems, utilization of community supports as well as increase medication compliance by learning to deal with troubling side effects.

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**NURSE, CLIENT, and FAMILY RESOURCES**

**ASSOCIATIONS**

**National Alliance for the Mentally Ill (NAMI)**
Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
(800) 950-NAMI (check this one out!)
http://www.nami.org
Schizophrenics Anonymous
403 Seymour Avenue, Suite 202
Lansing, MI 48933
(517) 485-7168;(800) 482-9534 (consumer line) (check this one out!)

Recovery, Inc.
802 North Dearborn Street
Chicago, IL, 60610
(312) 337-5661

INTERNET SITES

Doctors Guide to the Internet
http://www.pslgroup.com/schizophr.htm
Many articles; good site for schizophrenia information

Internet Mental Health
http://www.mentalhealth.com
Vast amount of information/booklets/articles and general information

National Alliance for Research on Schizophrenia and Depression
http://www.narsad.org

Schizophrenia.com
http://www.schizophrenia.com