CHAPTER 14

Schizophrenic Disorders

OBJECTIVES
After reading this chapter, you will be able to:

- ASSESS the positive and negative symptoms of schizophrenic disorders.
- DESCRIBE the multiple etiologies of the schizophrenic syndrome.
- IDENTIFY the principles of psychiatric rehabilitation.
- APPLY the nursing process to clients who have schizophrenic disorders.

The gold star (religious imagery) is bursting through the blackness of my life.

—Carlos, Age 49

www.prenhall.com/fontaine
Schizophrenia is a disorder of the brain like epilepsy or multiple sclerosis. It is diagnosed in about 1 percent of the U.S. population and is a devastating disorder that affects not only the individual but family, friends, and the community as a whole. Although it is referred to as a single disease, it is more accurately a syndrome, characterized by a broad range of symptoms, physiological malfunctions, etiologies, and prognoses. Included in the syndrome of schizophrenia are schizotypal personality disorder, paranoid personality disorder, schizoaffective disorder, schizophreniform disorder, delusional disorder, brief psychotic disorder, shared psychotic disorder, and schizophrenia. Personality disorders are covered in Chapter 16. Relatives of people who have schizophrenia are often included in the spectrum since they are thought to have a genetic predisposition to schizophrenia but do not necessarily demonstrate full or any clinical manifestations of schizophrenia (Anders, 2000; Cadenhead, Swerdlow, Shafer, Díaz, & Braff, 2000).

**Schizophrenia** is a combination of disordered thinking, perceptual disturbances, behavioral abnormalities, affective disruptions, and impaired social competency. This means the person has difficulty thinking clearly, knowing what is real, managing feelings, making decisions, and relating to others. Typically, the person is fairly normal early in life, experiences subtle changes after puberty, and undergoes severe symptoms in the late teens to early adulthood. The early age of onset often shatters the lives of its victims and robs them of the opportunity for a productive adult life.

The onset and progression of schizophrenia is quite variable. It is believed that people with an abrupt onset of the illness suffer from a different form of schizophrenia than those whose onset is more insidious. The vast majority develops the disorder in adolescence or young adulthood, with only 10 to 15 percent of cases first diagnosed in people over the age of 45. In some cases, the disorder progresses through relapses and remissions; in other cases, it takes a chronic, stable course; while in still others, a chronic, progressively deteriorating course evolves. Much too often, the illness results in lifelong problems in coping with everyday living that reflect irreversible neurobiological deficits. Early diagnosis and treatment may reduce the chronicity and improve the prognosis of people suffering from schizophrenia. Women tend to have a later onset of illness, better treatment response, shorter and less frequent relapses, and an overall higher quality of life than do their male counterparts (Crespo-Facorro, Piven, & Schultz, 1999; Seeman, 2001).

In **schizoaffective disorder**, clients suffer from symptoms that appear to be a mixture of schizophrenia and the mood disorders. The person experiences one or more of the following psychotic symptoms: delusions, hallucinations, disorganized speech, disorganized behavior, or negative symptoms. In addition, the person experiences symptoms of the mood disorders, which may be major depressive symptoms, manic symptoms, or mixed symptoms. Schizoaffective disorder is most likely a distinct syndrome resulting from a high genetic liability to both mood disorders and schizophrenia. The age of onset, like schizophrenia, is typically late adolescence or early adulthood. Like
mood disorders, however, it is much more common in women than in men. Women are also much more likely than men to have their diagnosis switched from schizophrenia to schizoaffective disorder. Clients with schizoaffective disorder often have difficulty maintaining job or school functioning, experience problems with self-care, are socially isolated, and often suffer from suicidal ideation. The prognosis is somewhat better than for schizophrenia but significantly worse than the prognosis for mood disorders (American Psychiatric Association, [APA], 2000; Siris, 2000; Tsuang, Stone, & Faraone, 2000).

In brief psychotic disorder there is a rapid onset of at least one of the following psychotic symptoms: delusions, hallucinations, disorganized speech, or disorganized behavior. The episode lasts at least one day but less than one month, after which the person returns to the premorbid level of functioning. The symptoms of schizophreniform disorder are the same as but last at least one month but less than six months. One third return to their premorbid level of functioning while two thirds progress to the diagnosis of schizophrenia or schizoaffective disorder. In a shared psychotic disorder, a person who is in a close relationship with another person who is delusional comes to share the delusional beliefs. This most commonly occurs between two people but may involve more individuals such as when children adopt the parent's delusional beliefs (APA, 2000).

**KNOWLEDGE BASE**

The classic subtypes described in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., Text Revision) (DSM-IV-TR) (undifferentiated, catatonic, paranoid, disorganized, and residual) are difficult to apply and have many symptoms in common. Individuals often get diagnoses changed from one category to another as symptoms fluctuate and thus the classification is unstable (Liddle, 1999). The classic subtypes have given way to new systems of classification. The most widely used system is one of positive symptoms, negative symptoms, and thought disorganization. This arrangement represents symptom types that are probably semi-independent of each other. To make sense of these groups, you must understand that positive does not mean good, and negative does not mean bad.

**DSM-IV-TR CLASSIFICATIONS**

<table>
<thead>
<tr>
<th>Schizophrenia</th>
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<tr>
<td>Paranoid Type</td>
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<tr>
<td>Disorganized Type</td>
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<tr>
<td>Catatonic Type</td>
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<tr>
<td>Undifferentiated Type</td>
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<td>Residual Type</td>
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<th>Schizophreniform Disorder</th>
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<tr>
<td>Schizoaffective Disorder</td>
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<tr>
<td>Delusional Disorder</td>
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<tr>
<td>Brief Psychotic Disorder</td>
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<td>Shared Psychotic Disorder</td>
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<td>Psychotic Disorder due to general medical condition</td>
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<tr>
<th>Substance-induced psychotic disorder</th>
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<tr>
<td>Psychotic Disorder Not Otherwise Specified (NOS)</td>
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Rather, positive symptoms are excessive or added behaviors that are not normally seen in mentally healthy adults. For example, healthy adults do not experience delusions; therefore, delusions are a positive characteristic (see Table 14.1). Women are more likely to exhibit more positive than negative symptoms. Positive symptoms are most likely the result of physiological changes, including increased dopamine (DA) function in the subcortical areas of the brain and decreased glucose utilization in the brain. Medication is often successful in diminishing positive symptoms (Bryant, Buchanan, Vlader, Breier, & Rothman, 1999). Negative symptoms are the loss of normal function that is normally seen in mentally healthy adults. For example, healthy adults are able to complete their ADLs; therefore, an inability to care for oneself is a negative characteristic of schizophrenia (refer back to Table 14.1). Men are more likely to exhibit prominent negative symptoms. Negative symptoms are most likely related to anatomic changes as well as decreased DA function in the prefrontal cortex. These characteristics have been more treatment resistant.
A deficit syndrome has been proposed as a distinct subtype of schizophrenia characterized by significant and persistent negative symptoms. These individuals often experience an insidious onset of schizophrenia, a chronic deteriorating course, and a poor response to treatment. Evidence suggests that the deficit syndrome has important genetic and/or family environmental components (Ross et al., 2000).

**Behavioral Characteristics**

Positive behavioral characteristics include hyperactivity and bizarre behavior. Hyperactive behavior most typically occurs during a period of relapse. The excitement may become so great that it threatens the person’s safety or that of others. The behavior may also be very unpredictable. Schizophrenia can cause people to engage in bizarre behavior such as repeating rhythmic gestures, doing ritualistic postures, or demonstrating freakish facial or body movements. Some people will imitate other people’s movements (echopraxia) or words (echolalia) or may senselessly repeat the same word or phrase for hours or days. Another positive characteristic is a decreased awareness of one’s own behavior. It is not unusual to hear clients describe their behavior as being under the influence of alien forces or of other people (Franck et al., 2001).

Negative behavioral characteristics are decreased activity level, limited speech, and minimal self-care.
The decreased activity level includes a reduction of energy, initiative, and spontaneity. There is a loss of natural gracefulness in body movements that results in poor coordination; activities may be carried out in a robot-like fashion. People with schizophrenia often have limited speech, referred to as **alogia**, which makes it difficult for them to carry on a continuous conversation or say anything new. They may say very little on their own initiative or in response to questions from others; some may be mute for several hours to several days.

Another difficulty for individuals and their significant others is a deterioration in appearance and manners. Self-care may become minimal; they may need to be reminded to bathe, shave, brush their teeth, and change their clothes. Because of confusion and distraction, they may not conform to social norms of dress and behavior.

**AFFECTIVE CHARACTERISTICS**

Positive affective characteristics include inappropriate affect, overreactive affect, and hostility. Inappropriate affect occurs when the person's emotional tone is not related to the immediate circumstances. An overreactive affect is appropriate to the situation but out of proportion to it.

Negative affective characteristics include blunted or flat affect and anhedonia. A blunted affect describes a dulled emotional response to a situation, and a flat affect describes the absence of visible cues to the person's feelings. Schizophrenia can make it difficult for people to clearly express their emotions. They show less emotion, laugh less, and cry less (see Table 14.2).

Anhedonia, the inability to experience pleasure, causes many people with schizophrenia to feel emotionally barren. They also have an inability to express emotion. These two difficulties may lead to eccentric social interactions and social withdrawal. Consumers may not take much interest in the things around them, even things they used to find enjoyable. If the world feels "flat as cardboard," they may not feel that it is worth the effort to get out and do things.

People with schizophrenia have a normal ability to experience unpleasant emotions and often experience worries and fears. With little warning, some people with schizophrenia become hostile as anger turns into aggression with the intent to do harm.

**PERCEPTUAL CHARACTERISTICS**

Positive perceptual characteristics include hallucinations and sensory overload. A **hallucination** is the occurrence of a sound, sight, touch, smell, or taste without an external stimulus to the corresponding sensory organ. Hallucinations are very real to the person and may be triggered by anxiety and by functional changes in the central nervous system. Researchers, observing brain function through magnetic resonance imaging (MRI), found that the same brain area was activated when clients listened to audible speech as when they were experiencing auditory hallucinations. In other words, the brain reacts as if unable to distinguish between its own internally generated speech and actual, audible speech (Murray, 1999).

### Table 14.2

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Example</th>
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<tbody>
<tr>
<td>Inappropriate</td>
<td>When told it's time to turn off the TV and go to bed, Joe begins to laugh uproariously.</td>
</tr>
<tr>
<td>Overreactive</td>
<td>When Kathy wins at cards, she jumps up and down and does a cheer for herself.</td>
</tr>
<tr>
<td>Blunted</td>
<td>Tom has been looking forward to his wife's visit. When she arrives on the unit, he is only able to give her a small smile.</td>
</tr>
<tr>
<td>Flat</td>
<td>When Juanita's mother tells her that her favorite dog has died, Juanita simply says, &quot;Oh,&quot; and does not give any indication of an emotional response.</td>
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The most common type is auditory hallucination, or the hearing of voices or unusual noises. The voice is often that of God, the devil, a neighbor, or a relative; the voice may say either bad or good things; and the voice seems to be coming from an external source. Auditory hallucinations occur in 50 to 80 percent of people with schizophrenia. The next most common type is visual hallucination, which is usually nearby, clearly defined, and moving. Visual hallucinations are often accompanied by auditory hallucinations. Tactile, olfactory, and gustatory hallucinations are uncommon and are more likely to occur in people who are undergoing substance withdrawal or abuse.

Hallucinations may considerably control the person's behavior. It is not unusual for people having auditory hallucinations to carry on a conversation with one of the voices. After a period of time, many people realize that if they admit they hear voices, they will be labeled “sick” or “crazy.” To avoid being labeled, they may be very evasive about their hallucinations.

Kari, a nurse, is on a home visit with Lisa, a 44-year-old client who lives in supervised housing. Lisa is filling out a piece of paper that Kari gave her yesterday.

Kari: How are you doing with the self-image exercise?

Lisa: He tells me what to say. [laughing softly]

Kari: Who tells you what to say?

Lisa: He does. I never tell anyone about him. I've only told a couple of people. [makes brief eye contact]

Kari: Is he here right now?

Lisa: Yes, he just walked around the corner. [looks across the room]

Kari: How do you feel when this voice talks to you?

Lisa: I'm used to it. I've known him since I was little. Let's see. What do I value the most? Myself. No, he said I can't put that. He says I have to put my loved ones. [looking down at piece of paper]

Kari: You value yourself the most, but the voice won't let you write that down?

Lisa: Yes.

Our sensory systems receive information from the environment and from our bodies through stimuli transmitted to the brain. However, we do not consciously perceive much of this sensory information. Sensory information is processed in a series of relay stations within the brain where irrelevant stimuli are inhibited. This allows us to filter out unnecessary and distracting information—a process called selective perception—and focus on what is important at the given moment. Schizophrenia often disrupts the filtering process, causing sensory overload. When there are too many messages arriving at the cortex at the same time, thinking becomes disorganized and fragmented (see Figure 14.1).

The negative perceptual characteristic in schizophrenia is the inability to understand sensory information. People with schizophrenia sometimes have a hard time making sense of everyday sights, sounds, and feelings. Their perception of what is going on around them may be distorted so that ordinary things appear distracting or frightening. They may be overly sensitive to background noises and colors and shapes.

COGNITIVE CHARACTERISTICS

Schizophrenia impairs many cognitive functions, such as thought formation, memory, language, attention,
and executive functions. Positive cognitive characteristics of schizophrenia are delusions, disorganized thinking, and loose associations.

**Delusions** are false beliefs that cannot be changed by logical reasoning or evidence. When there is an extensively developed central delusional theme from which conclusions are deducted, the delusions are termed *systematized*. There are a number of delusional types: grandiosity (delusions of grandeur), persecution, control, somatic, religious, erotomanic, ideas of reference, thought broadcasting, thought withdrawal, and thought insertion (see Table 14.3).

Delusions represent dysfunctions in the information-processing circuits within and between the hemispheres. The severity of delusions can be a valuable indicator in monitoring the course of the illness.

**Grandiosity**, also known as delusions of grandeur, is an exaggerated sense of importance or self-worth. It is often accompanied by beliefs of magical thinking.

People with schizophrenia may experience delusions of persecution. They may believe someone is trying to harm them and, therefore, any personal failures in life are the fault of these harmful others.

Vanessa believes she is a victim of a plot. She states that people live in her attic and that they followed her on a recent trip to Florida. She believes these people are spraying her with a toxic chemical that creates somatic symptoms. “They have somehow chosen me to be a victim in an attempt to disrupt the water waves.”

**Delusions of control** occur when the person believes that feelings, impulses, thoughts, or actions are not one’s own but are being imposed by some external force.

Samuel believes that a group of doctors are doing long-distance laser surgery on his back. He says his back twitches when they do the surgery, and he can hear the voices of the doctors talking. “I have computer chips in my brain, and the computer sends out electrical impulses and tells me what to do. I really shouldn’t be telling you this because now the security people are going to follow you.”

Religious delusions involve false beliefs with religious or spiritual themes.
The case manager has been called by Miguel’s family to make a home visit. He has been sitting in front of a homemade altar and prays with a rosary to God all day long. He has been fasting intermittently for seven weeks and has lost 30 pounds. He tells the case manager that he is being controlled by the devil, needs to be freed by God, and is fasting to atone for his sins. He states, “I don’t eat because God is nourishing me.”

Erotomanic delusions are beliefs that a person, usually someone famous and of higher status, is in love with her or him. Preoccupation with the “fantasy” lover may lead to stalking. Occasionally, the stalker turns violent, not because of hatred of the person, but because the person cannot fulfill the romantic delusions.

Mandi believes that she is engaged to Brad Pitt and that they will be getting married next month. She is busy planning for the wedding and discussing who, among the rich and famous, will be at the wedding.

Table 14.3

<table>
<thead>
<tr>
<th>Delusion</th>
<th>Example</th>
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<tbody>
<tr>
<td>Grandiosity (delusions of grandeur)</td>
<td>“I’ve been a member of the president’s cabinet since the Kennedy years. No president can do without me. If it weren’t for me, we would probably be in World War IV by now.”</td>
</tr>
<tr>
<td>Persecution</td>
<td>“The CIA and the FBI are both out to get me. I am constantly being followed. One of the other patients in here is really a CIA agent and is here to spy on me.”</td>
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<tr>
<td>Control</td>
<td>“I have this wire in my head, and my family controls me with it. They make me wake up and make me go to sleep. They control everything I say. I can’t do anything on my own.”</td>
</tr>
<tr>
<td>Religious</td>
<td>“As long as I wear these 10 religious medals and keep all these pictures of Jesus pinned to my clothes, nothing bad can happen to me. No one can hurt me as long as I do this.”</td>
</tr>
<tr>
<td>Erotomanic</td>
<td>“Julia Roberts is really my wife. We got married last week. She adores me and will be here soon to visit.”</td>
</tr>
<tr>
<td>Sin and guilt</td>
<td>“I know I often hurt my parents’ feelings when I was growing up. That’s why I can’t ever keep a job. When I get a job and start doing good, I have to quit it to make up for my bad behavior.”</td>
</tr>
<tr>
<td>Somatic</td>
<td>“My esophagus is being torn apart. I have this rat in my stomach, and sometimes he comes all the way up to my throat. He’s eating away at my esophagus. Look in my throat now—you can probably see the rat.”</td>
</tr>
<tr>
<td>Ideas of reference</td>
<td>“People on TV last night told me I was in charge of saving the environment. That’s why I’m telling everyone to stop using their cars. It’s my job because that’s what they told me last night.”</td>
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<tr>
<td>Thought broadcasting</td>
<td>“I’m afraid to think anything. I know you can read my mind and know exactly what I’m thinking.”</td>
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<tr>
<td>Thought withdrawal</td>
<td>“I can’t tell you what I’m thinking. Somebody just stole my thoughts.”</td>
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<tr>
<td>Thought insertion</td>
<td>“You think what I’m telling you is what I’m thinking, but it isn’t. My father keeps putting all these thoughts in my head. They are not my thoughts.”</td>
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Somatic delusions occur when people believe something abnormal and dangerous is happening to their bodies.

Rachel, looking at an orange she is holding, says: “I had a bowel movement yesterday. It looked like this. It was one of my ovaries or it might have been a tumor.”

Ideas of reference are remarks or actions by someone else in no way related to the person but that are interpreted as related to her or him. Thought broadcasting occurs when people believe that their thoughts can be heard by others. Thought withdrawal is the belief that others are able to remove thoughts from one’s mind. Thought insertion is the belief that others are able to put thoughts into one’s mind.

Sumidra believes that other people can smell a “bad odor coming from her private parts.” She says when she sees two people walking down the street together, they stare at her and she knows they are talking to each other about her terrible smell.

Further information about delusions is found in Chapter 9.

Disorganized thinking is another effect of schizophrenia. Adaptation to the environment and effective coping depend not only on learned responses but also on the flexibility of the brain in organizing this incoming information. Thought disorder is abnormalities in the form of thought and is experienced by the listener as disorganized speech. Because speech is a reflection of cognitive functioning, loose association is an indication of disorganized thinking. The person is described as having loose association when verbal ideas shift from one topic to another, there is no apparent relationship between thoughts, and the person is unaware that the topics are unconnected. At times, the person may change topic and direction so frequently that she or he is incoherent or impossible to understand (Goldberg et al., 1998).

Ming Lee states: “The thing in the ozone level is going away and people aren’t told about it. Do you know why my bed is so soft? It doesn’t matter. Everybody’s got to die and the babies are going away. God bless America.”

The negative cognitive characteristics of schizophrenia are concrete thinking, attention impairment, memory deficits, impaired problem solving, lack of motivation, and lack of insight. These symptoms are most likely related to dysfunctions in the cerebral cortex. Concrete thinking is characterized by a focus on facts and details and an inability to generalize or think abstractly. If you ask a client what brought him to the hospital, he is likely to say “a car.” Attention impairment interferes with the processing of information and the response to such information. The person has poor concentration and is easily distracted. Disturbances include responding to irrelevant external stimuli and difficulty completing tasks.

You will recall from Chapter 7 that there are two types of long-term memory: declarative and procedural. Declarative memory is memory for people and facts, is consciously accessible, and can be verbally expressed. Procedural memory does not require conscious awareness and involves the memory of motor skills and procedures. Memory deficits in schizophrenia are one of the most severely impaired functions, which explains the day-to-day difficulties encountered by people with schizophrenia. The deficit is primarily in the area of declarative memory. The processes of responding emotionally, forming impressions about people, drawing inferences, and many other high-level cognitive functions are supported by declarative memory. Thus, a person may display inappropriate behavior or make poor judgments when memory is impaired by the disorder (D’Elia et al., 2001).

Impaired problem solving may occur for a number of reasons. The person may be unaware that a problem exists, have impaired judgment, be unable to think logically, be unable to make a decision, or be unable to plan or follow through on a decision. Since one of the problems with this disorder is faulty information processing, a person with schizophrenia needs more time to think and problem-solve.

Lack of motivation, referred to as avolition, is the inability to persist in goal-directed activities. People may have trouble starting projects or following through with things once begun. Their inability to persist at work or school activities gets them into sig-
significant employment or academic difficulties. At the extreme, they may have to be reminded to do simple things like taking a bath or changing clothes. Poor insight, or lack of awareness of one's own mental illness, is more common in people with schizophrenia than in those with schizoaffective disorder or with major depressive disorder. Poor insight means that individuals have difficulty identifying their symptoms, which has implications for agreeing with treatment plans and for recognizing early signs of relapse (Kennedy, Schepp, & O'Connor, 2000).

**SOCIAL CHARACTERISTICS**

The primary positive social characteristic of schizophrenia is one of aloof and stilted interactions with others. People with schizophrenia may use outdated or very formal language and may have difficulty carrying on a conversation.

Nurse: Hi, my name is Tonya. I am your nurse today.

Client: I must say, Miss Tonya, I am very pleased to make your acquaintance. Your profession is certainly to be admired.

The negative social characteristics of schizophrenia are social withdrawal/isolation, a poor rapport with others, and inadequate social and occupational skills. Social withdrawal/isolation may result from paranoid delusions, from severe difficulty participating in conversations, or an inability to experience feelings of friendship or intimacy. Inadequate social skills can interfere with the ability to develop rapport with others. These ineffective skills may drive away friends and family members who do not understand the behavior, further increasing the sense of isolation. People with schizophrenia may be socially incompetent in part because they are unable to perceive the subtle cues that are critical to interpersonal interactions. In order to understand body cues during an interaction, one must be able to think abstractly. People with schizophrenia understand concrete cues better than abstract cues. For example, while they can identify and recall what someone said and did, they are less able to identify the emotional tone behind the words or comprehend the motivation for the interaction. Occupational skills may be inadequate because of cognitive disruptions, behavioral abnormalities, inability to manage feelings, or inadequate social skills.

Most people with schizophrenia experience cycles of relapse and remission. Families who have a loved one suffering from a chronic medical illness, such as debilitating heart disease, usually receive social support and sympathy. But members of families with a loved one suffering from schizophrenia are often avoided. Many families are drained financially from the expense of long-term therapy, medications, and intermittent hospital stays. Mental health services are poorly covered in most medical insurance policies.

People suffering from schizophrenia are not indifferent to their emotional and social environments. The emotional climate of the family has been shown to play a role in the relapse of the disorder. Clients who live in families that are highly critical, hostile, and overinvolved (referred to as high expressed emotion) have a significantly higher relapse rate than those who live in a supportive and caring family system. Families who are highly negative or excessively intrusive to the client can accelerate the time to relapse by causing physiological arousal and increased symptoms. On average, the relapse rate among clients who are in family therapy is 24 percent as compared to 64 percent among those not in family therapy (Bustillo, Lauriello, Horan, & Keith, 2001; Paris, 1999).

Approximately one third of the homeless population suffers from psychiatric disability, many of these with schizophrenia. The figures rise to 66 percent when chemical dependence is included in the estimate. In addition, all people, if left homeless for a sufficient period, will develop less effective coping skills and demonstrate some type of mental disorder or disability (Mueser, Bond, & Drake, 2001). Perhaps nothing is more upsetting than the sight of an individual who is homeless and clearly experiencing severe psychiatric problems. The image of a disheveled man angrily responding to voices only he can hear is an example of society's failure to address the problem of both homelessness and psychiatric disability. Homeless mentally ill women represent one of the most vulnerable segments of our society. They frequently face a choice between the dangers of life on the street and the hazards of overcrowded, unsafe, and poorly supervised shelters. Rape and physical battery are a daily risk for these women.
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Homeless psychiatrically disabled people are often fearful and distrustful of the mental health system. In community health nursing, you must be prepared to work with homeless people in nonclinical settings, including streets, shelters, subways, bus terminals, and other public areas. You will need a combination of patience, persistence, and understanding. Depending on the needs and wants of a particular person, providing food, clothing, or simply company can be essential in developing a therapeutic relationship.

CULTURE-SPECIFIC CHARACTERISTICS

A person’s cultural and religious background must be considered when assessing individuals from cultures that are different than your own. In some cultures, experiences that we label as delusional or hallucinatory are expected, normal experiences. In addition, differences in styles of expression of feelings may be misunderstood and labeled as pathologic when in fact they are completely normal for that cultural group (APA, 2000).

Schizophrenia is recognized worldwide and affects about 1 percent of the population in different cultures. For unknown reasons, there are small areas of population with increased incidence, such as second-generation African Caribbeans living in the United Kingdom. The symptoms tend to be universal, with minimal influence by the specific culture (APA, 2000; Harvey, 2001).

AGE-SPECIFIC CHARACTERISTICS

Childhood schizophrenia is diagnosed when the onset of psychotic symptoms occurs before 12 years of age and before the completion of brain maturation. This form of schizophrenia is very severe and may have a stronger genetic predisposition (Sowell et al., 2000).

Most children who develop schizophrenia appear normal at birth and during the first years of life. Subtle behavioral and cognitive characteristics often precede the first psychotic episode. These signs include higher than expected rates of abnormal speech and motor abnormalities such as clumsiness and abnormal movements. In addition, they experience social withdrawal and isolation, decline in IQ over several years, and diminishing school performance. Prior to developing psychotic symptoms there is a high rate of special education placement and failed grades (Nicolson et al., 2000; Nicolson & Rapoport, 2000).

Symptomatology is similar to that seen in adults, although the content of children’s hallucinations and delusions comes from their experiences. For example, rather than believing that the FBI is following them, children may believe that a cartoon villain is out to get them.

The majority of older adults who have schizophrenia have had the disorder since they were young. A number of these people show substantial improvement in symptoms, especially the positive symptoms, over the course of their lifetimes.

Between 15 and 32 percent of people with schizophrenia have a late onset type, which occurs after age 45 and affects more women than men. The clinical picture is somewhat different than in earlier onset schizophrenia. People with late-onset have more delusions, which are often persecutory and bizarre. They are more likely to exhibit vivid hallucinations but have fewer cognitive disruptions and negative symptoms. It is thought that late-onset schizophrenia may be a less severe form of the disorder (Crespo-Facorro et al., 1999; Zorrilla & Zeste, 2000).

Sensory impairment, such as hearing loss or cataracts, may increase the severity of the symptoms since environmental stimuli are often misinterpreted. In addition, people with hearing and vision loss tend to decrease social contacts and become socially isolated, which may increase suspicious thoughts.

PHYSIOLOGICAL CHARACTERISTICS

Velocardiofacial syndrome is a congenital defect related to chromosome 22. The predominant clinical signs include cleft palate, cardiac abnormalities, minor facial anomalies, and learning disabilities. Among adults with this syndrome, there is an increased incidence of schizophrenia and schizoaffective disorder. These anomalies are considered to develop during the first 16 weeks of gestation and coincide with early brain development. People with velocardiofacial syndrome demonstrate neuroanatomical abnormalities in the temporal lobe as well as decrease total cerebral volume, both of which occur in people with schizophrenia (Eliez et al., 2001; Ismail, Cantor-Graae, & McNeil, 1998).

In comparison to men, women develop schizophrenia several years later and experience less severe symptoms. Research shows that estrogens protect against nerve cell loss and preserves connections between neurons. Estrogens also enhance the efficacy of antipsychotic medications.
As estrogens decrease in the menopausal years, we find more women than men developing late-onset schizophrenia (Seeman, 2001). People with schizophrenia have much higher rates of cigarette smoking (58 to 88 percent) compared with the general population (25 percent) and twice as high as those with other psychiatric diagnoses. There are three possible reasons for this heavy dependence on nicotine. First, clients may self-medicate with nicotine to improve cognition, lessen auditory hallucinations, and moderate the side effects of medications. Nicotine, like other drugs of addiction such as cocaine and amphetamine, appears to stimulate the reward center of the brain. It does this through stimulation of nicotinic receptors, which increases DA synthesis and decreases DA metabolism. Thus, smoking may be a way to self-medicate a disturbance in the reward center. Second, smoking may be a risk factor for a person who has the genetic vulnerability to schizophrenia. This is supported by the data that those who start smoking at a young age have an earlier onset of their schizophrenia. Third, genetic or environmental factors might work together, contributing to the co-occurrence of nicotine use and schizophrenia (George et al., 2000; Kelly & McCreedie, 1999).

Smoking places clients at greater psychiatric risk because components in cigarette smoke stimulate hepatic enzymes, increasing the rate of metabolism of psychotropic medications. Smoking also places them at increased risk for cardiovascular and respiratory diseases (Weiner et al., 2001).

Abnormalities in the ability to identify smells may be a marker of cerebral dysfunction in schizophrenia. Research shows that people with schizophrenia are unable to identify when smells have a pleasing scent, just as they are unable to experience pleasure. The prefrontal brain regions used to assess emotional pleasure and olfactory pleasure appear to have a dysfunction in their circuitry. Just as clients can experience unpleasant emotions, they can identify unpleasant odors. Normally, the limbic system is activated in response to unpleasant odors. Significantly different, people with schizophrenia use their prefrontal regions to recognize unpleasant stimuli, leading to overactivation of these areas. The awareness of unpleasant and potentially dangerous external stimuli may cause individuals to feel threatened and may give rise to paranoid thinking (Crespo-Facorro et al., 2001).

CONCOMITANT DISORDERS

Many who suffer from schizophrenia use alcohol or drugs in an effort to self-medicate and feel better. More than 50 percent of people with schizophrenia have problems with alcohol or drugs at some point during their illness. Prompt recognition and treatment of this dual diagnosis problem is essential for effective treatment. Substance-related disorders are discussed in Chapter 15.

Suicide accounts for the majority of premature deaths among people with schizophrenia. It is estimated that as many as half of this population experience suicidal ideation, make suicide attempts, or both. Ten percent are successful suicides. Risk factors include more severe illness, frequent relapses, and significant depressive symptoms, especially hopelessness (Radomsky et al., 1999).

Twenty-five percent of people with schizophrenia also experience obsessions and compulsions and of this group, 8 percent can be diagnosed with obsessive-compulsive disorder. Most typically, people are preoccupied with the content of their delusions and may ruminate for hours over their upsetting thoughts. Twenty-five percent of people with schizophrenia also experience depressive episodes. These depressive symptoms are more likely to occur early in the course of the schizophrenic disorder (Nahas, Molloy, Risch, & George, 2000).

CAUSATIVE FACTORS

Schizophrenia is not a single disorder but rather a syndrome with multiple variations and multiple etiologies, both of which are complex and inadequately understood. In some, a genetic defect may contribute to abnormal development of the brain or a neurochemical malfunction, while in other cases factors such as nutrition, toxins, or trauma might interact in a genetically vulnerable person, resulting in schizophrenia. In other cases the cause may be completely environmental, such as viral infections or birth complications.

Genetic Factors

That there is a genetic component in schizophrenia is well recognized, and it is thought that 85 percent of the susceptibility to schizophrenia may be genetic in origin. However, the exact genetic vulnerability is not known, as no single gene has been identified as a risk
factor for schizophrenia. It is likely that a number of genes are involved and that different families may have different genes involved. There may also be a different pattern of inheritance in early-onset versus late-onset type. It is likely that the early-onset type has a higher genetic load for schizophrenia (Paris, 1999).

A person has an 8 percent risk of schizophrenia if a sibling has the disorder, a 13 percent risk if one parent is affected, a 10 to 15 percent risk if both parents are affected, and a 50 percent risk if one monozygotic twin has schizophrenia. In addition, 21 percent of first-degree relatives have schizotypal personality disorder or other traits in the schizophrenic syndrome (Cadenhead et al., 2000; Harvey, 2001) (see Figure 14.2).

In monozygotic twins, prenatal factors do not always affect each twin to the same extent. Because the hands are formed at the same time cells are migrating to the cerebral cortex during the second trimester of pregnancy, they have been a site for indirectly studying brain development. In studying sets of twins in which one has schizophrenia and the other does not, it was found that affected twins had a number of small deformities in their hands and greater differences in their fingerprints compared to their siblings. There was also a significant prenatal size difference between the twins during the second trimester. Conditions that could result in brain injury at this stage of development include anemia, anoxia, ischemia, maternal alcohol or drug abuse, toxin exposure, or viral infection (Tarrant & Jones, 2000).

Neurobiological Factors

Neurodevelopment studies demonstrate evidence of abnormal brain development. The basic flaw seems to be that certain nerve cells migrate to the wrong areas when the brain is first taking shape, leaving small regions of the brain permanently out of place or miswired. In some cases, the neurons of the cortex may be deficient. From a developmental perspective we do not know whether these cells form normally and then fail to thrive or whether they are malformed from the beginning.

Studies also show higher than expected occurrences of prenatal disruptions and obstetrical complications with increased risk of psychiatric disorders in childhood and adult life. One hypothesis is that exposure to nutritional deficiency during fetal life may be a risk factor for schizophrenia. Other risk factors include fetal hypoxia, exposure to infections during gestation, and fetal growth retardation. It is believed that these risk factors may be related to brain damage (Flashman, McAllister, Andreason, & Saykin, 2000; Harvey, 2001; Rosso, et al., 2000).

You may be wondering why, if schizophrenia begins in utero, does it not manifest for 20 years. Recent studies show that some people with schizophrenia may have early signs that are overlooked or misunderstood. For example, a child might sit up a month later than other children or speak three months later. These signs may indicate a slight maturational lag in brain function that is later associated with schizophrenia. Later in childhood, there may be evidence of lagging development and cognitive perceptual abnormalities.

**FIGURE 14.2** Average Risk of Developing Schizophrenia

One factor related to the delay in the appearance of significant symptoms may be the myelin sheath, which does not form on the outside of many brain cells until late adolescence. Between the ages of 16 and 22, there are also progressive changes in cortical interactions, especially between the left prefrontal and temporal regions. This failure of the cortex to reorganize during adolescence may be the final neurodevelopmental failure of schizophrenia (Sowell et al., 2000).

Neurochemical factors likely involve dopamine (DA), serotonin (5-HT), norepinephrine (NE), glutamate (glu), and gamma-aminobutyric acid (GABA) neurotransmission. At times, neurotransmitters work together (synergistically) to trigger the same biochemical reaction, while at other times they act as antagonists, with one inhibiting the action of another. Glu, involved in learning and memory, may be responsible for some of the cognitive symptoms. In addition, glu is necessary for the breakdown of DA and other transmitters, which affects the efficiency of prefrontal information processing. Glu receptors have a role in regulating the migration and pruning of neurons during brain development and thus may play a role in structural abnormalities that have been seen in schizophrenia. Excessively high levels of NE are associated with positive symptoms, while paranoid symptoms have been related to increased DA activity. No single neurotransmitter is clearly responsible for schizophrenia. The important concept may be homeostasis: the absolute level of any neurotransmitter being much less important than its relative level with respect to all other transmitters. There may also be an undiscovered neurochemical factor yet to be found. It will be a long time before this is understood clearly (Goff & Coyle, 2001; Volk, Austin, Pierri, Sampson, & Lewis, 2001).

A new area of research involves the fat composition of cell membranes. The neuronal membrane consists of two layers of fatty molecules, which determines the flexibility of the membrane. Soft and pliable membranes communicate more smoothly than do stiff and rigid membranes. People with schizophrenia are depleted of both DHA (docosahexaenoic acid found in omega-3-type fish oil) and AA (arachidonic acid). These deficiencies may be related to the negative symptoms of schizophrenia (Carper, 2000).

On a larger scale, new brain imaging studies have revealed abnormalities of brain structure in schizophrenia. Although no single brain region has been found to be involved in the pathology of schizophrenia, the areas most noted for abnormalities include the prefrontal cortex, the temporal lobes, the hippocampus, the limbic system, the thalamus, and the ventricles. The reason people with schizophrenia may not "look the same" clinically may be a function of individual deviations in brain structure. In some cases, there is decreased tissue volume in specific areas, in others there is disrupted cerebral blood flow, in some cases there is decreased utilization of glucose and oxygen, and in others there is increased ventricular size (Gilbert et al., 2001; Perelstein, Carter, Noll, & Cohen, 2001). See Box 14.1 for a list of brain abnormalities.

An example of one deviation is that decreased blood flow to the thalamus may affect the ability of the brain to filter sensory signals, causing the person to be flooded with sensory information (refer back to Figure 14.1). Changes in cerebral blood flow suggest abnormalities in the density, size, or configuration of blood vessels in the person with schizophrenia. Structural abnormalities are really only the end result of some

**BOX 14.1**

**Structural Abnormalities in Schizophrenia**

- **Decreased Volume**
  - Temporal lobes
  - Hippocampus
  - Prefrontal cortex
  - Limbic system
  - Thalamus

- **Decreased Cerebral Blood Flow**
  - Temporal lobes
  - Basal ganglia
  - Thalamus

- **Decreased Blood Glucose and Oxygen Utilization**
  - Frontal lobes
  - Basal ganglia

- **Decreased Activity**
  - Prefrontal cortex

- **Increased Ventricular Size**
abnormal process and do not tell us much about what that process may be (Sigmundsson et al., 2001).

For some people with schizophrenia, there is a deficiency of nicotinic receptors in the hippocampus, an area of the brain important in attention to new sensory stimuli and memory formation. Clients who smoke may be self-medicating with nicotine, which improves their attentiveness and ability to lay down memories.

The diathesis-stress model shows the psychosis of schizophrenia as a final common path of neurodevelopmental, neurochemical, and structural decompensation. This is a multiple hit model. In other words, there must be a genetic vulnerability and environmental risk factors, which are then combined with maturational changes or life events that trigger the onset of schizophrenia. The more protective factors a person has, the less the chance he or she has of developing the disorder. It is believed that only a very small number of people have such a strong vulnerability that schizophrenia is virtually inevitable. The majority of the population has such a slight vulnerability that the risk for schizophrenia is virtually negligible. In between, are the people who may develop the disorder if stressed enough but who could also survive without schizophrenia if not sufficiently stressed (Siris, 2000; Zorrilla & Zeste, 2000).

**PSYCHOPHARMACOLOGICAL INTERVENTIONS**

Negative symptoms impose great suffering on people by interfering with their psychosocial functioning. Newer or atypical antipsychotic medications are characterized by:

- Effectiveness in decreasing the negative as well as eliminating the positive symptoms of schizophrenia
- Effectiveness for many people who are not responsive to conventional antipsychotic agents
- Effectiveness for people who also experience depressive symptoms
- A significantly lower incidence of extrapyramidal side effects, which increases clients’ ability to continue on the medication.

When added to antipsychotic medications, mood-stabilizing agents such as lithium carbonate, Tegretol (carbamazepine), and Depakote (valproate) enhance the effectiveness of the response and improve negative symptoms specifically. They are also effective for people experiencing affective symptoms. Benzodiazepines may also be used as adjuncts to antipsychotic medications. Studies have demonstrated reductions in anxiety, agitation, and psychotic symptoms with the use of these agents. See Chapter 8 for a more detailed explanation of these ancillary medications.

The addition of estrogen in women with acute psychotic episodes often provides a more rapid decrease in positive symptoms as well as a decrease in overall symptoms.

The use of medications in older clients is problematic at times. These individuals are likely to have other medical illnesses and to be taking multiple medications. Because of their age, they are at increased risk for drug interactions and side effects. Low doses of the atypical antipsychotics are the drugs of choice.

**MULTIDISCIPLINARY INTERVENTIONS**

**Psychiatric Rehabilitation**

The field of psychiatric or psychosocial rehabilitation grew out of a need to create opportunities for people suffering from psychiatric disabilities. The rehabilitation approach emphasizes the development of skills and supports necessary for successful living, learning, and working in the community. This approach creates collaborative partnerships with all interested people—consumers, families, friends, and mental health providers. It is assumed that the consumer will be “in charge” with regard to setting goals for where and how to live, work, learn, socialize, and recreate (see Box 14.2). Rehabilitation is a process, not a quick fix. It is also different than the traditional approach to long-term clients, which assumed that people with schizophrenia could not make decisions and would continue to deteriorate in spite of interventions. We now know that a substantial number of people with schizophrenia make good adjustments and lead satisfactory lives.

People with mental illness differ little from the general population. They want work that is meaningful and self-enhancing and the opportunity to socialize with others. Psychiatric rehabilitation is anchored in the values of hope and optimism that people can grow, learn, and make changes in their lives. Other values include the promotion of choices, self-determination, and individual responsibility. The essential element of self-help is power. People who are psychiatrically dis-
I need power and control in their relationships with professionals, in their own lives, and in the way resources are allocated. This allows them to take personal responsibility for where they are in their lives and where they are going.

As a nurse who functions as a resource for clients, you must not only be competent but also compassionate and caring. This includes searching for talents and skills until you find them, even when they are obscured by multiple relapses and low self-esteem. Your role is to teach skills, to coach skills as needed in a variety of social and work situations, and to identify supports in the community of choice. In this way you will promote independent living and successful coping for people with psychiatric disabilities (Carling, 1995; Farrell & Deeds, 1997; Palmer-Erbs, 1996).

Group Therapy

Group therapy is an effective psychosocial treatment modality for persons with schizophrenia. It helps prevent the withdrawal and social isolation that may occur for people who are psychiatrically disabled. For people who live alone, the group may be their primary opportunity to relate to others. The group setting also provides an opportunity to discuss and help each other solve problems in everyday living, employment difficulties, or interpersonal conflicts. There are several types of group therapy. Some groups are highly structured, while others may be more spontaneous. Some may have a very narrow topic range such as assertiveness training, while others may have a broader range such as general problems in living in the community. Groups focus on peer support, with an emphasis on development skills and changing behavior. Groups are also used for teaching and social support. See Chapter 10 for more information on group therapy.

Assertive Community Treatment (ACT)

People who are psychiatrically disabled are often ill-prepared to find and maintain the multiple services they need in order to function in the community. A new approach to help clients is the assertive community treatment (ACT) program. Clients are assigned to a specific multidisciplinary team that delivers all services when and where the client needs them. The main goal of the program is to prevent rehospitalization through provision of comprehensive integrated community services. The ACT program provides 24-hour coverage, including emergencies. Studies show that ACT reduces time spent in the hospital, improves housing stability, decreases symptoms, and improves quality of life (Mueser et al., 2001). Various other treatment settings within the community are discussed in Chapter 4.

ALTERNATIVE THERAPIES

Transcranial Magnetic Stimulation

Transcranial magnetic stimulation (TMS) is the use of a magnetic field that passes through the skull, which causes cells in the cerebral cortex to fire. More studies have been conducted in the use of TMS for depression than for schizophrenia. Initial studies indicate that TMS of the left temporoparietal area may decrease the frequency and duration of auditory hallucinations and may modulate other symptoms of schizophrenia (Nahas et al., 2000).

Omega-3 Fatty Acids

Those individuals who may have a deficiency of omega-3 fatty acids will find the addition of fish oil helpful. It may not be that people with schizophrenia have a low intake but rather that they need more to

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**Beliefs and Values in Psychiatric Rehabilitation**

**Beliefs**
- The most severely disabled psychiatric client has a potential for productivity.
- The opportunity to be gainfully employed is a generative force in human beings.
- Work can enhance self-esteem and reduce symptoms of mental illness.
- People require opportunities to be together socially.

**Values**
- Hope, optimism
- Wellness
- Choices
- Self-determination
- Individual responsibility
- Compassion

---
overcome a metabolic disorder that uses up essential fatty acids at a faster rate. The recommended dose is 5 grams per day, which is usually seven or eight capsules. The maximum dose is 15 grams daily. Taking the capsules at night and with orange juice cuts down on the fishy aftertaste (Carper, 2000).

Aromatherapy

Olfactory receptors are the only sensory pathways that open directly to the brain. Nerve cells relay this information directly to the limbic system, influencing emotions and behavior. Inhaling essential oils through the use of a diffuser or using essential oils in massage may be beneficial in inducing a sense of calmness. The following oils are the most helpful: basil, bergamot, chamomile, frankincense, juniper, lavender, lemon balm, and sandalwood. Coriander increases memory and mental function.

Acupuncture

The Chinese claim to have successfully treated schizophrenia with acupuncture. Research in Western medical practice is just beginning in this area. A six-month study in Texas showed a drop in the length of hospital stays for acupuncture-treated individuals (Gerber, 2000).

CRITICAL THINKING

Ricardo is a 24-year-old client who is being treated for schizoaffective disorder. He is depressed, withdrawn, and disheveled. He often looks upward and listens intently. He does not offer conversation and reacts in a hostile manner when spoken to, while retreating to the corner of his room.

Mohammed is a 19-year-old client on the same psychiatric unit who is being treated for schizophrenia. Mohammed has a flat affect, paces his room for hours, stampds on spiders that are not present, seldom socializes, and often accuses others of trying to steal his clothing.

1. In what ways does Ricardo’s illness differ from Mohammed’s?
2. What are the positive and the negative symptoms of schizophrenia?
3. What data support the positive symptoms of schizophrenia for Ricardo? For Mohammed?
4. What data support the negative symptoms of schizophrenia for Ricardo?
5. Both Ricardo and Mohammed are being treated with antipsychotic drugs that can produce tardive dyskinesia. How will you know if either of these clients is developing this drug side effect?
6. If you were Ricardo’s or Mohammed’s nurse, how would you intervene during their chronic hallucinatory episodes?

Assessment

The assessment of clients’ responses to their illness and their functional status includes assessment of clients’ reports, family or caregiver reports, and direct observation of performance. Clients who are not acutely ill are usually able to provide accurate information about their past history with mental illness and their current experiences. It is helpful to ask consumers under what conditions the symptoms improve or worsen. Ask clients how they cope with their symptoms so you can help them maintain and strengthen their effective solutions. Identification of functional abilities and disabilities leads to the formulation of nursing diagnoses (Hagen & Mitchell, 2001).

If clients are acutely ill, it may be difficult to obtain information directly from them. This is especially true for those who are experiencing delusions and hallucinations. Family members, roommates, friends, group home supervisors, or case managers may be the initial data source when there is an admission to the acute care setting. The Focused Nursing Assessment table provides questions that can be used in the home, the residential or group home setting, or in the acute care setting.

Diagnosis

There are many potential nursing diagnoses for clients suffering from schizophrenia. In synthesizing the assessment data, consider how well clients are functioning in daily life, what their skills and talents are, how stable their affect is, how well they are able to communicate, how well they are getting along with others, and how well they function at work. See the NANDA, NOC, NIC box for some of the more common nursing diagnoses you may be applying to your clients.

Outcome Identification and Goals

Based on the assessment data, you select outcomes appropriate to the nursing diagnoses. See the NANDA, NOC, NIC box for outcomes associated with the nursing diagnoses.

Client goals are specific behavioral measures by which you, clients, and significant others identify as realistic and attainable. The following are examples of some of the goals appropriate to people with schizophrenia:

- Communicates clearly
- Completes activities of daily living (ADLs) appropriately
- Exhibits increased attention span
- Makes appropriate decisions
- Affect is appropriate to the situation
- Denies hallucinations
- Verbalizes logical thought processes
- Interacts well with others
- Develops occupational skills

Nursing Interventions

Nurses have many opportunities to assist people with schizophrenia in a variety of settings as previously described. These contacts may be long-term relationships or may be during crisis periods of time. It is important that clients identify their priority concerns if the plan of care is to be effective. Change is more likely to happen when clients are invested in the treatment process.

Families, significant others, or caregivers should be actively involved in the plan of care and be taught to implement many of these interventions. See the NANDA, NOC, NIC box for interventions associated with the diagnoses and outcomes.

Behavioral: Communication Enhancement

Complex Relationship Building

The nature of the nurse-client relationship is one of the most effective nursing interventions. With rapport, communication, and trust, we are able to help our clients meet the outcome criteria they have identified. Review the material on communicating with clients in Chapter 2. When we listen to clients, accept them for who they are, and understand their perspective, we are more likely to help empower them and thereby help them achieve their highest level of functioning.
## Focused Nursing Assessment

### Clients with Schizophrenic Disorders

<table>
<thead>
<tr>
<th>Behavior Assessment</th>
<th>Affective Assessment</th>
<th>Cognitive Assessment</th>
<th>Sociocultural Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe your usual pattern of activities throughout the day.</td>
<td>What kinds of activities/situations give you pleasure? Anxiety? Anger? Guilt?</td>
<td>Have you ever heard voices? Are you hearing voices now? What do the voices say to you? What feelings are associated with the voices?</td>
<td>Who are the people most significant to you?</td>
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<tr>
<td>What are your responsibilities at home? At work? At school?</td>
<td></td>
<td>Have you ever seen things other people don’t see? What things do you see? What feelings are associated with seeing things?</td>
<td>When do you prefer to be alone?</td>
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<tr>
<td>What do you do for leisure activities?</td>
<td></td>
<td>Do you believe that you are someone very important?</td>
<td>When do you prefer to be with others?</td>
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<td>Do you feel anyone is trying to harm you?</td>
<td>How do you relate to others?</td>
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<td>Do you feel anyone is controlling you?</td>
<td>How do you resolve conflict with others?</td>
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<td>Do you think about religion a lot?</td>
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<td>Do you believe that you are very guilty for something you have done?</td>
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<td>Do you think anything abnormal is happening to your body?</td>
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<td>Do you think people are talking about you often?</td>
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<td>Do you believe others can hear your thoughts?</td>
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<td>Do you believe others can take away your thoughts?</td>
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<td></td>
<td>Do you believe others can put thoughts into your head?</td>
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<td></td>
<td>Do you have thoughts of harming yourself? Harming others?</td>
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<td></td>
<td></td>
<td>Have you ever thought you have special powers that other people do not have?</td>
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</tbody>
</table>
### Part 4: Mental Disorders

#### NURSING DIAGNOSES with NOC & NIC

**Clients with Schizophrenia**

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>OUTCOMES</th>
<th>INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altered thought process related to disruptions in cognitive processes such as delusions, loose association, concrete thinking</td>
<td>Distorted thought process: Self-restraint of disruption in perception, thought processes, and thought control</td>
<td>Complex relationship building, Active listening, Delusion management</td>
</tr>
<tr>
<td>Social isolation related to withdrawal, preoccupation with symptoms, lack of a supportive network, negative reaction by others to client’s social behavior.</td>
<td>Social interaction skills: An individual’s use of effective interaction behaviors</td>
<td>Socialization enhancement</td>
</tr>
<tr>
<td>Self-esteem disturbance related to feeling different from others, chronic nature of the disorder</td>
<td>Self-esteem: Personal judgment of self-worth</td>
<td>Self-esteem enhancement</td>
</tr>
<tr>
<td>Anxiety related to environmental stimuli, reduced contact with reality</td>
<td>Anxiety control: Personal actions to eliminate or reduce feelings of apprehension and tension from an unidentifiable source</td>
<td>Anxiety reduction</td>
</tr>
<tr>
<td>Knowledge deficit related to not understanding disease process; inability to stay on medications</td>
<td>Knowledge: Disease Process: Extent of understanding conveyed about a specific disease process. Knowledge: medication: Extent of understanding conveyed about the safe use of medication</td>
<td>Teaching: disease process, Teaching: Prescribed medications</td>
</tr>
<tr>
<td>Fatigue related to hyperactivity</td>
<td>Knowledge: Energy conservation: Extent of understanding conveyed about energy conservation techniques</td>
<td>Energy management</td>
</tr>
</tbody>
</table>

**Active Listening**

Sometimes clients are not able to hold thoughts together enough for you to comprehend what is being said. They may not remember how they started a sentence or where their thoughts were taking them (loose association). They are often more able to understand others than to make themselves understood. When this occurs, interrupt politely but firmly and ask a question that will help them communicate in a more direct manner. Say something like, “I’m not understanding what you are saying. Could we try that again?” Listening for themes in the conversation may help you understand
### Chapter 14  Schizophrenic Disorders

#### DIAGNOSIS

<table>
<thead>
<tr>
<th>DIAGNOSIS</th>
<th>OUTCOMES</th>
<th>INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing/hygiene self-care deficit related to an inability to remember steps in self care; low motivation</td>
<td><strong>Self-care</strong>: Activities of daily living (ADL): Ability to perform the most basic physical tasks and personal care activities</td>
<td><strong>Self-care assistance</strong></td>
</tr>
<tr>
<td>High risk for violence, self-directed, related to command hallucinations</td>
<td><strong>Suicide self-restraint</strong>: Ability to refrain from gestures and attempts at killing self.</td>
<td><strong>Suicide prevention</strong></td>
</tr>
<tr>
<td>Sensory-perceptual alterations related to disruptions in temporal lobe causing command hallucinations</td>
<td><strong>Distorted thought control</strong>: Self-restraint of disruption in perception, thought processes, and thought content</td>
<td><strong>Hallucination management</strong></td>
</tr>
<tr>
<td>High risk for violence, directed at others related to suspiciousness, fear</td>
<td><strong>Aggression control</strong>: Self-restraint of assaultive, combative, or destructive behavior toward others.</td>
<td><strong>Violence prevention</strong></td>
</tr>
<tr>
<td>Caregiver role strain related to fear of unknown, lack of social support, need to care for family member, inappropriate behavior on part of client</td>
<td><strong>Caregiver well being</strong>: Primary care provider's satisfaction with health and life circumstances.</td>
<td><strong>Family integrity promotion</strong></td>
</tr>
</tbody>
</table>

#### SOURCES


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the current concerns of the person. When you try to understand the world the client is experiencing, the person is more likely to feel you are being helpful.  

Sensory overload or the inability to screen out unimportant stimuli is frustrating and disorienting to clients and interferes with their abilities to listen and communicate. You can teach clients to decrease environmental stimuli by avoiding noise and confusion, including large crowds or large family gatherings. 

**Socialization Enhancement**  
Social difficulties frequently accompany schizophrenia, and social skills training is an appropriate nursing inter-
Part 4  Mental Disorders

vention. Because of the stigma attached to mental disorders and especially schizophrenia, consumers have had fewer opportunities to develop and practice social skills. This inexperience contributes to inappropriate responses when interacting with others. Poor social functioning has been found to be an important predictor of relapse and rehospitalization (Mueser et al., 2001).

After specific skill deficits are identified, training strategies are designed to reduce these deficits and improve the level of functioning. Social skills training is a series of highly structured and organized sessions of practice in basic skills usually conducted in a group format. Specific skills include nonverbal behaviors (facial expression, eye contact), paralanguage (voice loudness, sounds that are not words), verbal content (appropriateness of what is said), and interactive balance (amount of time each person spends talking).

Group leaders model the appropriate skills. Through role-play and social reinforcement, members learn the same behaviors, step by step. Social skills training includes such areas as how to initiate a conversation, how to express ideas and feelings appropriately, how to avoid topics that are not appropriate for a casual conversation, how to ask about job openings, and how to interview for a job. The goal of social skills training is to improve social functioning by decreasing problems of daily living, employment, leisure, and relationships. The ability to enjoy interpersonal relationships is a dimension of quality of life that is very important to address with people suffering from schizophrenia. Repeat practice can result in improvements in important areas of social adjustment, leading to less withdrawal and isolation. See Chapter 10 for more information on social skills training.

Behavioral: Coping Assistance

Self-Esteem Enhancement

Many people with schizophrenia desperately desire to be "normal" and thus suffer from low self-esteem. Self-esteem exercises can be implemented one to one and in group settings. In a one-to-one exercise, you might ask clients to write out or verbalize their positive qualities. Keeping a self-esteem journal is appropriate for some clients. Look for opportunities to give positive reinforcement. In a group setting, clients may be asked to share their own positive qualities as well as to recognize those of their peers. Group experience is an opportunity to learn how to give and receive positive feedback.

A number of group exercises promote self-esteem. One is having clients make a collage. Materials include magazines, scissors, glue, and blank paper. Have clients look for pictures that tell something about themselves and their interests, cut them out, and glue them on the paper. Have each person take a turn in describing the significance of the collage to the other group members. You can highlight the positive qualities each collage reveals.

Behavioral: Psychological: Comfort Promotion

Anxiety Reduction

Some persons with schizophrenia experience periodic symptoms of anxiety. Since anxiety can be contagious, remain calm and reassuring as you interact with clients. Your presence may help the anxious person feel more secure. Using relaxation techniques or meditation, reducing or eliminating caffeine intake, and moderating environmental stimuli, often lower levels of anxiety. You may encourage clients to go for a walk, work at a simple concrete task, or play a noncompetitive game such as catch. Further interventions are found in Chapter 11.

Behavioral: Patient Education

Teaching: Disease Process

Nursing believes that clients should be actively involved in the management of their illness. Thus, a psychoeducation program is an extremely important nursing intervention. The goal is to teach consumers about their illness and to cover the important behavioral, affective, cognitive, perceptual, and social problems they commonly experience. Another facet of psychoeducation is teaching clients to identify early signs of relapse. What exactly those early warning signs are vary from person to person but are repetitive for any one individual. Since early intervention may prevent a relapse, this self-surveillance strategy allows people to influence the course of the disease (McCann, 2001).
**Teaching: Prescribed Medication**

Some consumers will be unhappy or frustrated with their medication. Discontinuation of medication is a significant factor in relapse. Helping clients understand the need for medication is an important nursing intervention. Your may have clients explore the pros and cons of continuing or discontinuing medication. Help them review how medication may be useful in helping them make progress toward personal goals.

The most common reasons for stopping medications include denial of the disorder and the desire to be “normal,” an unwillingness to take the amount prescribed when they feel better, self-medicating with drugs or alcohol, and the distress associated with side effects. A recent study indicates that clients’ attitudes toward medication may be more positive than health care professionals have previously thought. The majority of consumers recognize that medications are important for their mental health and are necessary for functioning within the community (Mueser et al., 2001). Assist clients in developing a routine for taking their medication that fits into their daily habits. It may be using a weekly medication box with places for morning, noon, and evening medications. It may be using meal times as natural prompts to remind them of medication. It may be a chart on the wall. Whatever system the client believes will help can usually be adapted for self-management.

**Physiological: Basic: Activity and Exercise Management**

**Energy Management**

Some clients pace much of the day and are in danger of exhaustion and must be monitored for evidence of excessive physical fatigue. Set limits on hyperactivity by providing firm direction in taking short, frequent rest breaks. They often will manage this better if you stay with them for the designated rest time. Limit environmental stimuli to facilitate relaxation. Design diversional activities that are calming and restful. Clients should monitor their nutritional intake to ensure they have adequate energy resources (McCloskey & Bulechek, 1996).

**Physiological: Basic: Self-Care Facilitation**

**Self-Care Assistance**

Some clients will need assistance with self-care because of a change in activity level, confusion, or a perceptual impairment. They may need reminding or assistance with bathing, grooming, personal hygiene, and dressing. This assistance may be in the form of a list of step-by-step directions in the bathroom or bedroom, or gentle reminders such as “It’s time for you to brush your teeth,” “I think the dress you have chosen is not appropriate for work,” or “Did you shower this morning?” Other self-care activities might involve household tasks such as cleaning, cooking, shopping, or money management. As clients progress toward their goals, they are rewarded with greater responsibility and more privileges. Although some clients may never live independently they often can improve the quality of their lives through increased autonomy.

**Safety: Crisis Management**

**Suicide Prevention**

An important priority of care is client safety. Command hallucinations may order clients to harm, mutilate, or kill themselves or others. Others have suffered from delusions so intensely for so long that suicide seems like the only way to escape the pain of being persecuted or controlled by others. You must carefully assess for evidence of self-harm and direct care toward protecting clients until they can protect themselves. See Chapter 20 for care of a client who is suicidal.

**Safety: Risk Management**

**Hallucination Management**

The experience of hallucinations can be especially troublesome for the person who does not have anyone to talk to about them. Discussion of hallucinations is important to the development of reality-testing skills. Look and listen for clues that the person may be hallucinating, such as grinning or laughing inappropriately, talking to someone whom you cannot see, or slowed verbal responses. Ask the person to describe what is happening. If the person asks you, point out simply that you are not experiencing the same stimuli. The goal is to guide the person through the experience and let them know what is actually happening in the environment. Help the individual describe needs that may be reflected in the content of the hallucination. These needs may include having power and control of decisions that affect daily life, the ability to express anger, and self-esteem. For chronic hallucinations, the person might keep a calendar of when hallucinations occur and how long they last in an effort to identify the trigger.
The person experiencing acute hallucinations has no voluntary control over the brain malfunction that is causing this symptom and needs immediate nursing interventions. Do not leave the client alone since the inability to sort out reality may overwhelm her or his ability to cope. You may need to talk slightly louder than usual, but use very short, simple phrases using the person’s first name. The person may not be able to hear you but will see that your mouth is moving and know that you are trying to communicate. See Chapter 9 for further information on reduction of hallucinations.

Ask clients what coping methods they have developed for hallucination management so that you can support their efforts. Some people talk with family members, friends, or professionals, some get busy with other activities to take their mind off the hallucinations, and some exercise as a form of distraction. Ineffective coping behaviors include eating or smoking more than usual, using drugs or alcohol, or acting out against other people. Help clients identify effective coping strategies to replace the ineffective strategies. More important than the presence of hallucinations is the ability or inability to effectively cope with the experience.

Clients may wish to become involved in an international self-help movement called “voice hearer groups.” The goal of the group is to provide support and share practical ways to cope with problems related to experiencing hallucinations. For example, members in one group suggested using a cell phone (real or fake) to respond to the voices when out in public. Rather than being ridiculed for hallucinating, they blend in with others who are using cell phones. See Community Resources for more information on this group (Hagen & Mitchell, 2001).

Delusion Management

Persons experiencing delusions have difficulty processing language; therefore, nonverbal communication is critically important. Approach the person with calmness and empathy. It is very normal to feel confused by a delusion. You must carefully assess the content of the delusion without appearing to probe or patronize the client. Do not attempt to logically explain the delusion nor underestimate the power of a delusion and the person’s inability to distinguish the delusion from reality. Assess the duration, frequency, and intensity of the delusion. Since delusions are often triggered by stress, correlate the onset of the delusion with the onset of stress. See Chapter 9 for further information on management of delusions.

Fleeting delusions often will disappear in a short time frame. Fixed delusions may have to be temporarily avoided. Respond to the underlying feelings rather than the illogical nature of the delusion. This will encourage discussion of fears, anxieties, or anger without judging the person. Quietly listen and then give guidance for the immediate task at hand. The client may find it helpful to engage in distracting activities as a way to stop focusing on the delusion.

Environmental Management: Violence Prevention

Some clients may be at high risk for violence directed at others when they misperceive communication from others or when they perceive that they themselves are being threatened. Encouraging clients to talk out rather than act out feelings will assist in maintaining control over behavior. Clients often can identify triggering factors such as a noisy environment, unfamiliar people, or other anxiety-provoking situations. If clients begin to escalate and become more agitated, it helps to remain calm, use a low tone of voice, give them personal space, and avoid physical contact with them. Set limits on aggressive behavior. Depending on the clinical setting, seclusion may become necessary. See Chapter 9 for further interventions with clients who are at high risk for violence.

The suspicious client is always on the lookout for danger and functions at a steady level of hyperalertness. Avoid frightening these individuals, who may strike out to protect themselves from perceived danger. Always give them plenty of personal space and never touch them without specific permission. Because they are hyperalert to everything in the environment, be careful not to behave in ways that could be misinterpreted. A suspicious client could misperceive two people talking together in a soft tone of voice as “They’re talking about me.” A group of nurses sharing a laugh could be misperceived as “They’re all laughing at me.” Among the client population, African Americans are more likely to be perceived as being violent or dangerous than clients from other ethnic groups. This is true even when independent assessment of violent behavior showed they were significantly less likely to be violent. As a result of this misperception, African American clients receive more doses, more injections,
Schizophrenic Disorders

Chapter 14

Family: Life Span Care

Family Integrity
Schizophrenia often strikes adolescents or young adults, leaving their parents confused and frightened. Whether the child was living at home or away, employed or unemployed, all of the parents in one study reported feeling a never-ending sense of responsibility for their child, which was at times overwhelming. Parents are likely to experience sorrow and grief as they begin to deal with the impact of their child’s illness. Knowing that this is likely to occur, nurses can offer anticipatory guidance and interventions. Parents desire information and some level of involvement in their child’s treatment plan. They often seek advice on how to cope with the day-to-day challenges they face, what they might expect in the future, and sources of community support. The question that health care professionals have to answer is how to include the family within the context of client confidentiality.

Family Involvement
Because so many people are afraid of and uninformed about schizophrenia, many families try to hide it from friends and deal with it on their own. We must reach out to these families and offer them support and education. Family education often is conducted in a group setting, which enables families to begin to build a support network. You must help them understand that they are not responsible for causing their loved one to develop schizophrenia and have no reason to feel guilty. They need to learn about the nature of schizophrenia and the variety of available treatment programs. They need practical solutions on how to manage on a day-to-day basis. You can assist families in achieving a balance between being protective and encouraging independence. For example, families should try to do things with them rather than for them, so that clients are able to regain their sense of self-confidence. Increased family education often decrease caregiver burden and improves the quality of life for all family members (Czuchta & McCay, 2001). See Box 14.3 for family education.

Families can encourage their loved ones to stick with the treatment program, take their medications, and avoid alcohol and drugs. It is important to recognize early signs of relapse to prevent acute episodes and rehospitalizations. Family members can ask the person with schizophrenia to agree that, if they notice warning signs of a relapse, it is okay for them to contact the physician so that the medication can be adjusted in an effort to stabilize the condition. All threats of suicide should be taken very seriously. Families should have an identified contact person they can call for help. If the situation becomes desperate, the family should call 911.

The family may need help in setting expectations and limits on inappropriate behavior. The positive symptoms of schizophrenia can cause a great deal of family stress. That is also true of the negative symptoms, which are often misinterpreted as laziness or uncooperativeness.

To prevent or delay relapse, it is critical to intervene with families who have high expressed emotion (EE), that is, those who are highly critical, hostile, and overinvolved. Consumers who live in high EE situations have much higher relapse rates than those living in low EE environments. Teach family members to moderate displays of all emotion in an effort to provide a neutral emotional climate. They may need assistance in defining and reshaping appropriate boundaries (McCann, 2001).

It is totally within the rights of a family to decide that a member who has an illness must get treatment for it. The family should also establish appropriate rules that must be followed. If the client is unwilling to comply, the family may choose to look for alternative living arrangements. For more information, see Box 14.3 and the Community Resources section at the end of this chapter.

BOX 14.3

Family Education
- Information about the disorder
- Managing symptoms
- Expectations during recovery
- Role of medications
- Handling crises
- Warning signs of suicide
- Early signs of relapse
- Housing and social resources
- Self-help groups

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and higher 42-hour doses of psychotropic drugs than do Euro-Americans (Lawson, 2000).
Part 4  Mental Disorders

Consumers who are discharged from an acute hospitalization with medication as the primary intervention have a 50 percent rehospitalization rate within six to nine months. In contrast, consumers discharged with medication and continuing family therapy only have a 2 to 10 percent rehospitalization rate. Family therapy moves beyond family education and helps people cope with the disorder of schizophrenia. Families learn how to manage conflict, avoid criticizing one another, decrease overprotective behaviors, and develop appropriate expectations of one another. Often, this is best accomplished with the help of a family therapist.

Evaluation

To complete the nursing process, you evaluate clients' responses to nursing interventions based on the outcomes you selected. You determine the appropriate intervals for measurement and document the condition of clients according to each individual's status. Johnson, Maas, & Moorhead (2000) is the resource for identifying measurement scales and specific indicators for each outcome.

Distorted Thought Control

Individuals are able to identify triggers to delusions. They verbalize a decrease in the duration, frequency,
and intensity of delusions. They utilize distractions techniques to limit their focus on delusions.

**Social Interaction Skills**

Social skill deficits are identified and new skills are practiced within a group format. They are able to initiate conversations, express ideas and feelings appropriately, and avoid inappropriate topics.

**Self-Esteem**

Clients with schizophrenic disorders choose leisure activities that are consistent with their physical, emotional, and social capabilities. They develop a list of pleasurable activities to which they can refer when necessary. 

**Anxiety Control**

Individuals demonstrating improved anxiety control, plan and implement effective coping strategies. They rehearse and use techniques such as slow, deep breathing, muscle relaxation, guided imagery, distraction techniques, and a quiet environment to manage their feelings of anxiety.

**Knowledge: Disease Process**

Individuals and families acknowledge the reality of schizophrenic disorders. They seek and act on information obtained from reliable sources. Clients are able to manage their disorder by identifying barriers to self-management and problem-solving solutions to these barriers. They develop their own mental health file with information about their diagnoses, medications, self-help strategies, and resources.

**Knowledge: Medications**

Individuals identify their medications by name and describe usual side effects they experience. They verbalize an understanding of the need for continued medication. They cite examples of how the medications make their life more functional. They avoid self-medication with alcohol or drugs. They implement a routine for taking their medications.

**Knowledge: Energy Conservation**

Clients limit the extent of episodes of hyperactivity and monitor themselves for signs of excess physical fatigue.

**Self-Care Activities of Daily Living (ADLs)**

Clients respond to environmental cues for ADLs. They live in the least restrictive setting possible.

**Suicide Self-Restraint**

Individuals who are suicidal develop a list of reasons to live or die and goals they hope to achieve with suicide. They develop a list of alternative solutions to their problems. They discuss their beliefs regarding death and the impact of suicide on family members. They participate in developing and maintaining a no-suicide contract. Clients formulate a written list of support systems and community resources and remain safe.

**Aggression Control**

Clients refrain from violating others' personal space and refrain from harming others or destroying property. They identify feelings of anger, frustration, hostility, and aggression. They identify alternatives to aggression and maintain self-control without supervision. They communicate their needs appropriately and verbalize control of impulses.

**Caregiver Well-Being**

Family members acknowledge clients' dependency issues for those who are psychiatrically disabled. They provide appropriate supervision in the least restrictive environment. They seek suggestions on how to cope with the day-to-day challenges they face. If relevant, they utilize respite services to maintain their own sense of well-being. They participate in self-help groups with the community and interact with extended family and friends on a regular basis.

To build a care plan for a client with schizophrenia, go to the Companion Web site for this book.

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COMMUNITY RESOURCES

Links to these Web sites can be accessed on the Companion Web site for this book.

American Schizophrenic Association Hotline
800-847-3802
www.schizophrenia.org

ENOSH
P.O. Box 1593
Ramat Hasharon, 47-113
Israel

National Alliance for Research on Schizophrenia and Depression (NARSAD)
60 Cutter Mill Road, Suite 404
Great Neck, NY 11021
516-829-0091
www.mhsource.com

Schizophrenia Association of Ireland
4 Fitzwilliam Place
Dublin 2
Ireland

Schizophrenia Australia Foundation
223 McKean Street
North Fitzroy
3068 Victoria
Australia

Schizophrenia Fellowship
P.O. Box 593
Christchurch
New Zealand

Schizophrenia Society of Canada
75 The Donway West, Suite 814
Don Mills, Ontario M3C 3E9
Canada
1-800-809-HOPE
www.schizophrenia.ca

Voice Hearers Group
http://members.aol.com/wmacdo401/voices/group.htm.

BOOKS FOR CLIENTS AND FAMILIES


KEY CONCEPTS

Introduction
- Schizophrenia is a syndrome characterized by disordered thinking, perceptual disturbances, behavioral abnormalities, affective disruptions, and impaired social competency.
- Schizoaffective disorder is characterized by symptoms common to both schizophrenia and the mood disorders.

Knowledge Base
- The positive symptoms of schizophrenia are added behaviors not normally seen, such as delusions, hallucinations, loose associations, disorganized thinking, suspiciousness, overreactive affect, hyperactivity, and bizarre behavior.
- The negative symptoms of schizophrenia are the absence of normal behaviors, for example, flat affect, minimal
self-care, social withdrawal, low energy level, concrete thinking, lack of insight, attention impairment, lack of motivation, and limited problem solving ability.

- The most common type of hallucination is auditory followed by visual. Tactile, olfactory, and gustatory hallucinations occur in people undergoing withdrawal from or abuse of alcohol and drugs.

- Delusions are false beliefs that cannot be changed by logical reasoning or evidence. It is thought that they represent dysfunctions in the information-processing circuits between the hemispheres.

- Having no apparent relationship between thoughts is referred to as loose association.

- Concrete thinking is a focus on facts and details and an inability to generalize or think abstractly.

- People with schizophrenia frequently have ineffective social skills, which increases their sense of isolation.

- Childhood schizophrenia is a very severe form with a poor prognosis.

- People with late-onset schizophrenia have more delusions and hallucinations but have fewer cognitive disruptions and negative symptoms.

- Individuals who have velocardiofacial syndrome are at higher risk for schizophrenia.

- Clients who smoke may be self-medicating, or smoking may be a risk factor for schizophrenia, or genetic and environmental factors work together to cause both nicotine use and schizophrenia.

- Concomitant disorders include substance abuse, suicide, and depression.

- Neurobiological factors of schizophrenia include genetic defects, abnormal brain development, neurodegeneration, disordered neurotransmission, and abnormal brain structures.

- It is believed that biological vulnerabilities interact with developmental, environmental, and social processes to produce the schizophrenic syndrome.

- Psychiatric rehabilitation emphasizes the development of skills and supports, considers the consumer to be in control, and promotes choices, self-determination, and individual responsibility.

- Group therapy helps prevent the withdrawal and social isolation that may occur for people who are psychiatrically disabled.

- Assertive community treatment (ACT) programs deliver all services when and where the client needs them.

- Alternative therapies include transcranial magnetic stimulation (TMS), omega-3 fatty acids, and aromatherapy.

The Nursing Process

Assessment

Nursing assessment is based on interviews with clients, family members, friends, group home supervisors, or case managers.

Diagnosis

Nursing diagnoses are based on assessment data focusing on how well clients are functioning in daily life, how stable their affect is, how effective their communication is, and how well they are getting along with others.

Outcome Identification

Client goals include client safety, improved communication skills, improved social skills, improved self-esteem, compliance with prescribed medication, effective family functioning, and adaptation to living in the least restrictive setting.

Nursing Interventions

- Opportunities to assist people with schizophrenia occur in a variety of settings, in long-term relationships, or in crisis periods.

- A priority of care is client safety, which includes measures to prevent self-harm, suicide, physical exhaustion, and striking out to protect themselves from perceived danger.

- Consumers may need assistance with self-care, ranging from gentle reminders to more step-by-step directions.

- Helping clients understand the need for medication is an important nursing intervention.

- Reduction of anxiety may be accomplished with relaxation techniques, eliminating caffeine, moderating environmental stimuli, walking, or talking out feelings with another person.

- Look and listen for clues that the person might be hallucinating; identify the needs that may be reflected in the hallucination, stay with the person, and speak in short, simple phrases. If asked, simply point out that you are not experiencing the same stimuli.

- Interventions for people who are experiencing delusions include assessing the content, duration, and frequency of the delusion; correlating it with stressful situations; responding to underlying feelings; and providing distracting activities.

- It is necessary to clarify communication when clients’ thinking is disorganized. You should listen for themes in clients’ conversations.

- Exercises to promote self-esteem include listing positive qualities, keeping a self-esteem journal, making a collage, and focusing on the image we present to others and who we really are.
The goal of psychoeducation is to teach consumers about their illness, the problems they commonly experience, early signs of relapse, and the need for medication. Social skills training is a series of highly structured and organized sessions of practice in basic skills, which can result in improvements in important areas of social adjustment. Parents of young adult children stricken with schizophrenia often feel a sense of responsibility that, at times, can be overwhelming. Family education includes knowledge about the disease, available treatment programs, how to manage on a day-to-day basis, early signs of relapse, and suicide precautions. The family may need help in setting expectations and limits, coping with conflict, and developing appropriate expectations of one another.

**Evaluation**

In evaluating clients’ responses to nursing interventions, you should determine the appropriate intervals for measurement and documentation of the outcomes according to each individual’s status.

**REFERENCES**


