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CHAPTER

6

Nursing Management of Patients with Schizophrenia and Other Psychotic Disorders

LEARNING OBJECTIVE

After studying this chapter, the student will be able to gain knowledge regarding the schizophrenia and other psychotic disorders in order to render the nursing care of patient with schizophrenia.

CHAPTER OUTLINE

- Introduction and Meaning
- History
- Prevalence and Incidence
- Etiology
- Diagnosis
- Diagnostic Criteria
- Differential Diagnosis of Schizophrenia
- Three Phases of Schizophrenia
- Positive and Negative Symptoms of Schizophrenia
- Other Psychotic Disorders
- Prognosis of Schizophrenia
- Psychosocial Interventions
- Treatment
- Nursing Interventions
- Geriatric Considerations
- Follow-up, Home Care and Rehabilitation of Patients with Schizophrenia

KEY TERMS

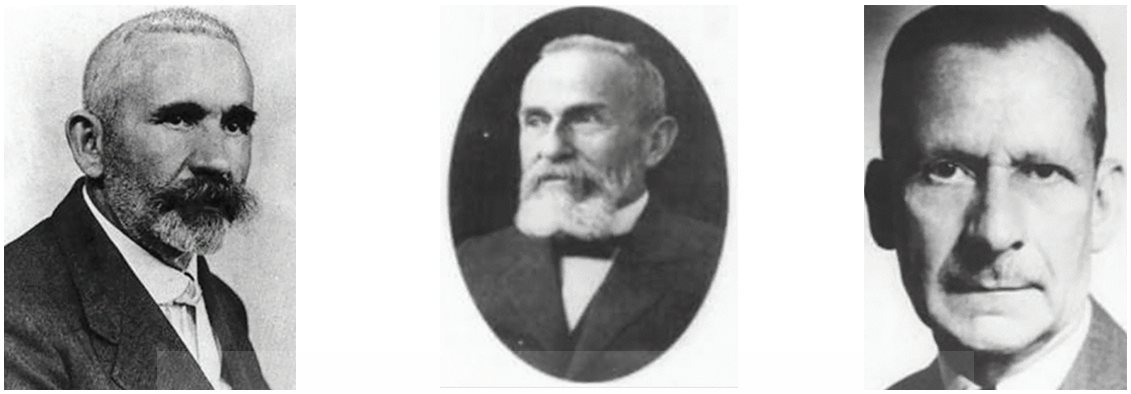
Schizophrenia, DiGeorge syndrome, Expressed emotions, Double bind communication, Hallucination, Delusion, Thought broadcasting, Thought withdrawal, Delusion disorder, Catatonia, Anhedonia, Apathy, Acute and transient psychotic disorder, Brief psychotic disorder, Schizoaffective disorders, Schizophreniform disorder, Schizotypal (Personality) disorder.

INTRODUCTION AND MEANING

The word 'schizophrenia' is derived from the Greek word which means 'split mind". Prefix 'Schizo' means 'Split' and Suffix 'Phrenia' means 'mind'. The term 'split mind' does not denote the split personality or multiple personality disorder, it actually means the split in terms of thought, cognition and emotions. Hence, schizophrenia is a psychotic disorder (disorder in which client believes that he/she will not have a base of reality) characterized by abnormalities in emotion, thinking and cognition.

HISTORY

Eugen Bleuler coined the term 'Schizophrenia' in 1908. Emil Kraepelin classified the psychiatric disorders into Dementia praecox and Manic-depressive illness. The term 'Praecox' means onset in young age (early onset) and the term 'Dementia' denotes gradual decrease in cognitive functions. Kurt Schneider was concerned with improving the method of diagnosis in psychiatry. He contributed to diagnostic procedures and the definition of disorders (Fig. 6.1).



Eugen Bleuler (1857–1939) | Emil Kraepelin (1856–1926) | Kurt Schneider (1887–1967)

Figure 6.1: Pioneers in psychiatry

World schizophrenia day is observed on May 24th every year with an aim to raise public awareness about schizophrenia and to minimize the disgrace associated with the condition.

PREVALENCE AND INCIDENCE

- 1% of total population has life time prevalence rate of schizophrenia and the incidence rate is 0.15–0.25/1,000.
- Usual onset of schizophrenia is adolescence/young adulthood.
- Late-onset schizophrenia is at 45 years of age. Schizophrenia is rarely present before 15 years of age and after 45 years of age.
- Nearly 10% of patients with schizophrenia attempt suicide especially young male adults.
- High rates of schizophrenia are seen in winter season.
- Twin studies of patient with schizophrenia revealed that among twins, monozygotic twins have 47%, dizygotic twins have 12% and nontwin siblings have 8% chance to get schizophrenia as shown in Figure 6.2.

A person is more likely to develop schizophrenia if, someone in his/her family have Schizophrenia. If, the person with Schizophrenia is a parent, brother, or sister, then the chances can go up by 10%. If both the parents are having Schizophrenia, the person can have a 40% chance of getting Schizophrenia. Mostly females around 30 years of age are affected. Mostly males around 20 years of age are affected. Onset of schizophrenia the chances are early in men.

Males and females are equally affected with schizophrenia in general as explained in Table 6.1.

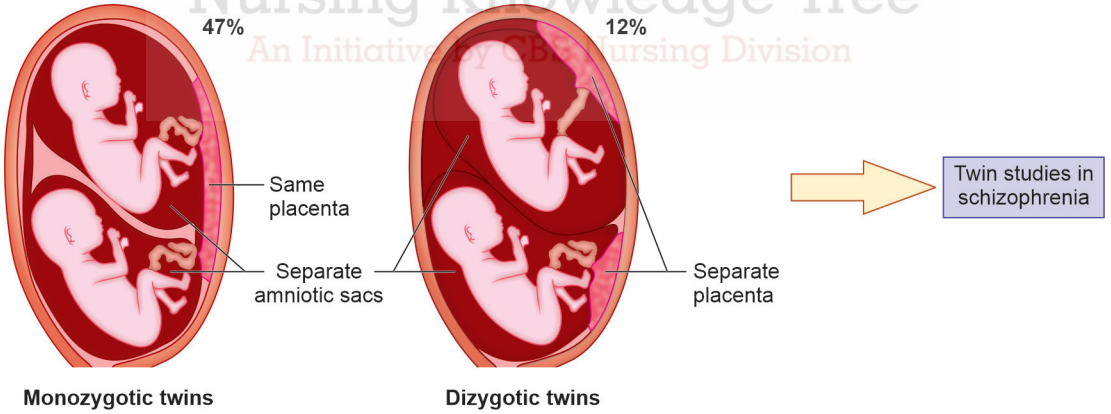
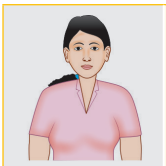
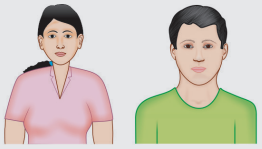


Figure 6.2: Twin studies in schizophrenia

Table 6.1: Gender and schizophrenia

		
Females are affected around 30 years of age	Males are affected around 20 years of age. Onset is early in men	In general, males and females are equally affected with schizophrenia

ETIOLOGY

Factors

The factors responsible for schizophrenia have been discussed here:

- **Neurochemical factors:** Dopamine hypothesis states presence of excess dopaminergic activity, high serotonin level and imbalance in other neurochemicals such as norepinephrine, GABA, glutamate, acetylcholine and nicotine.
- **Genetic factors:** DiGeorge syndrome or Velocardiofacial syndrome or Shprintzen syndrome or Conotruncal anomaly face syndrome or Takao syndrome or Sedlackova syndrome or Cayler cardiofacial syndrome or 22q11.2 deletion syndrome is defined as deletion of 30 to 40 genes in middle of chromosome 22. The symptoms identified on physical examination are wide spaced eyes (hypertelorism), short broad nose, cardiac malformations, umbilical hernia, intestinal blockage and abnormal pelvis, long forehead, oval shaped low set ears, excess nuchal thickness and edematous feet (Fig. 6.3).

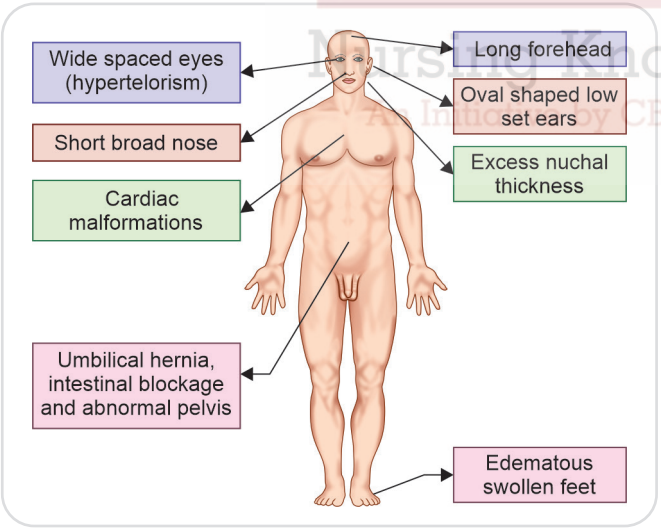


Figure 6.3: Symptoms of DiGeorge syndrome

- **Neuropathological factors:** Enlargement of third and lateral ventricles of cerebrum along with the decreased cerebral volume is seen in patient with schizophrenia. In limbic system, the hippocampus, amygdala and parahippocampal gyrus are in smaller size. In thalamus, loss of neurons in medial dorsal nucleus of thalamus is seen. Anatomical abnormalities in prefrontal cortex, basal ganglia and cerebellum are seen.
- **Neuropeptides:** Imbalance in the neuropeptides such as cholecystokinin, neurotensin, phospholipids, substance P, dynorphin A, neuropeptide Y and peptide YY is risk factor for schizophrenia.
- **Neuroendocrinology:** Imbalance in the hormones such as growth hormone, prolactin, thyroid-releasing hormone and oxytocin.
- **Environmental factors:** Obstetric complications, abnormalities in developmental milestones, prenatal infections, prenatal malnutrition, advanced paternal age, drug abuse, migrated from native place and season of birth in winter or seasonal spring are environmental factors might cause schizophrenia.

Theories and Models

Other theories and models which explain the etiology of schizophrenia have been put forth; some of these are discussed here.

Sociocultural Theory

Downward social drift, i.e., lower social economic background has high chance of developing schizophrenia.

Interpersonal Model

Sullivan explained the interpersonal model, which is highly focused on the mother-child relationship. The internal equilibrium in a body is labeled as self-system. When self-system feels good there will be low level of anxiety, when self-system feels bad it will give rise to high level of anxiety and if self-system feels: it's not me, then it leads to apocalyptic anxiety schizophrenia (Fig. 6.4).

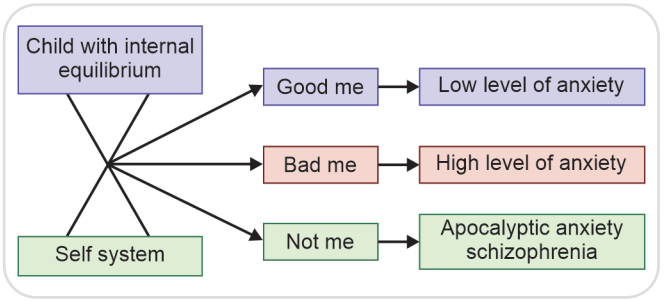


Figure 6.4: Interpersonal model of schizophrenia

Stress-Diathesis Model or Nature-Nurture Model

According to Sandor Rado, genotype (inherited gene) interacts with environment and gives a phenotype namely 'Schizotype'. These are individuals who are unable to cope with the repeated stressors.

Psychoanalytical Theory

In psychoanalytical theory, there is regression to oral stage of psychosexual development, along with use of defense mechanism such as denial, projection, reaction formation and distortion.

Family Theories

- **Double bind communication**: Unable to identify the correct choice (For example, mother says child you can go out to play cricket but your shoes and dress should not get dirty. In this example, mother's nonverbal cues and facial expression denote the child to stay at home).
- **Dysfunctional family:** Hostility between mother and father can lead a child toward schizophrenia.
- **Mother-child relation:** If the mother is overprotective and dominating (try to control the behavior without understanding the feelings—a parenting style).
- **Increased negatively expressed emotion (EE) in family**, i.e., critical comments and emotional over involvement among family members.

NOTE

Dysfunctional family and Mother-child relation explained above are older theories and are currently not accepted.

Dopamine Pathways

Dopamine pathways are a set of projection neurons in the brain that release dopamine responsible for function, execution, motivation, etc. It has four pathways. Dopamine pathways have been summarized in Table 6.2 and Figure 6.5. Physiology of **mesolimbic pathway** is responsible for motivation, emotion, reward and positive symptoms of schizophrenia. Physiology of **mesocortical pathway** is responsible for negative symptoms of schizophrenia, in which dorsolateral prefrontal cortex is responsible for cognition and execution. Ventromedial prefrontal cortex is responsible for emotions and affect. **Nigrostriatal pathway** constitutes 80% of brain dopamine that is responsible for motor activity and shows extrapyramidal symptoms of schizophrenia. **Tuberoinfundibular** pathway increases prolactin level.

Table 6.2: Dopamine pathways

Dopamine pathways	Physiology of each pathway
Mesolimbic	• Motivation • Emotion • Reward • Positive symptoms of schizophrenia
Mesocortical	• Dorsolateral prefrontal cortex—responsible for cognition and execution • Ventromedial prefrontal cortex—responsible for emotions and affect • Responsible for negative symptoms of schizophrenia
Nigrostriatal	• Constitutes 80% of brain dopamine • Responsible for motor activity • Responsible for extrapyramidal symptoms of schizophrenia
Tuberoinfundibular	Hyperprolactinemia

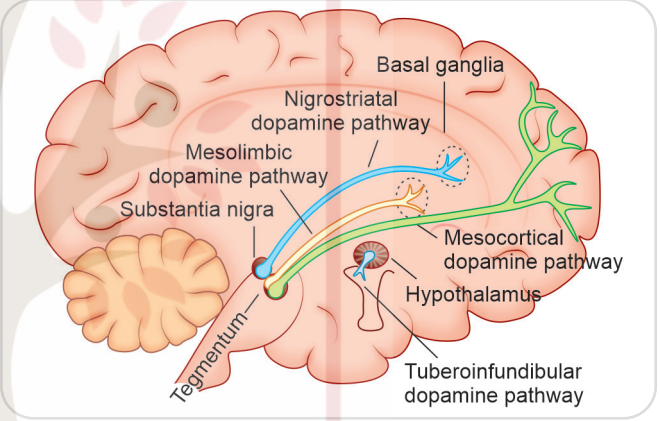


Figure 6.5: Dopamine pathways in brain

A's of Schizophrenia

Bleuler coined the term 'Schizophrenia' in 1908. Four symptoms are considered primary and fundamental symptoms of schizophrenia. Four A's explained by Eugen Bleuler are as follows:

1. **Autistic thinking** and behavior denote excess fantasy thoughts.
2. **Ambivalence** means inability to take decisions due to conflicts existing in mind.
3. **Affect** is inappropriate to the mood.
4. **Associative loosening** (Rapid shifting of one idea to another without any association between those ideas).

Five A's of negative symptoms of schizophrenia are as follows:

1. Anhedonia (Inability to enjoy the pleasure which seems to be pleasurable before).

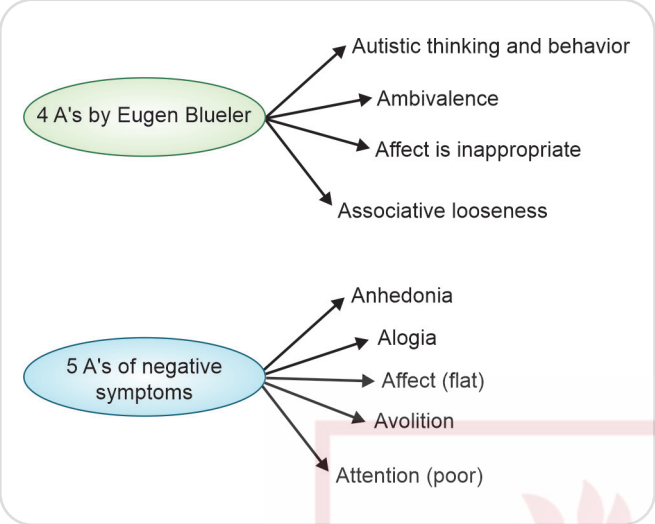


Figure 6.6: A's of schizophrenia

2. Alogia (poverty of speech)
3. Flat affect (lack of emotional expression)
4. Avolition (lack of initiation to perform any action)
5. Poor attention.

Four A's and 5 A's of negative symptoms of schizophrenia have been shown in Figure 6.6.

ICD-11 and DSM-5 Code for Schizophrenia

6A20	ICD-11 code for schizophrenia
295.90	DSM-5 code for schizophrenia

DIAGNOSIS

- **Assessment scales used to identify psychotic symptoms in schizophrenia are as follows:**
  - Brief Psychiatric Rating Scale (BPRS)
  - Scale for Assessment of Negative Symptoms (SANS—Andreasen, 1982)
  - Positive and Negative Syndrome Scale (PANSS—Kay, 1991)
- **Assessment scales used to identify cognitive deficits in schizophrenia are as follows:**
  - Stroop test
  - Trail making test
  - Wisconsin card sorting test
  - Wechsler adult intelligence scale (WAIS)
- **Assessment scales used to identify personality related problems in schizophrenia are as follows:**
  - Rorschach inkblot test
  - Minnesota multiphasic personality inventory (MMPI)
- **CT scan:** Ventricular enlargement and cortical atrophy

NOTE

Ventricular enlargement is also seen in hydrocephalus, Alzheimer's disease and neurodegenerative disorders.

- **SPECT/PET scan** shows increased D_2 receptor density.
- **Diffusion tensor imaging** reveals the abnormalities in white matter fiber tracts.
- **Functional MRI:** If the patient has positive symptoms, changes can be seen in medial prefrontal cortex and hippocampus. If the patient has negative symptoms, changes can be seen in ventrolateral prefrontal cortex and ventral striatum. If the patient has disorganized symptoms, changes can be seen in dorsolateral prefrontal cortex.

DIAGNOSTIC CRITERIA

DSM-5 Diagnostic Criteria for Schizophrenia

- Two or more of following symptoms present for significant portion of time for 1-month period (or less if successfully treated).
  - Delusions
  - Hallucinations
  - Disorganized speech (e.g., frequent derailment or incoherence)
  - Grossly disorganized or catatonic behavior.
  - Negative symptoms (i.e., diminished emotional expression or avolition)
- Significant impairment in the academic, interpersonal, occupational and social impairment.
- Continuous signs persist for at least 6 months (at least 1 month of symptoms in active phase and then may be only negative symptoms in the prodromal or residual phase).
- There should not be major depressive or manic episodes.
- Sign is not due to consumption of any substance.

Specify if it is:

- First episode or multiple episodes either with full or partial remission
- With or without catatonia
- Severity (use of 5-point scale)

ICD-11 Diagnostic Criteria for Schizophrenia

- Schizophrenia is characterized by disturbances in multiple mental modalities, including:
  - Thinking (e.g., delusions, disorganization in the form of thought)
  - Perception (e.g., hallucinations)

- Self-experience (e.g., the experience that one's feelings, impulses, thoughts, or behavior are under the control of an external force)
- Cognition (e.g., impaired attention, verbal memory, and social cognition), volition (e.g., loss of motivation)
- Affect (e.g., blunted emotional expression) and
- Behavior (e.g., behavior that appears bizarre or purposeless, unpredictable or inappropriate emotional responses that interfere with the organization of behavior)

- Psychomotor disturbances, including catatonia, may be present.
- Persistent delusions, persistent hallucinations, thought disorder, and experiences of influence, passivity, or control are considered core symptoms. Symptoms must have persisted for at least 1 month in order for a diagnosis of schizophrenia to be assigned.
- The symptoms are not a manifestation of another health condition (e.g., a brain tumor) and are not due to the effect of a substance or medication on the central nervous system (e.g., corticosteroids), including withdrawal (e.g., alcohol withdrawal).

DIFFERENTIAL DIAGNOSIS OF SCHIZOPHRENIA

- Schizoaffective disorder
- Delusional disorder
- Post-traumatic disorder
- Hypochondriasis
- Mood disorder with psychotic symptoms
- Sleep-related disorder
- Substance-induced psychotic disorder
- Psychotic disorder due to general medical condition (Metabolic disorders, endocrine disorders, anatomic lesions, infectious diseases, vitamin deficiency)
- Schizophreniform disorder or acute transient psychotic disorder or brief psychotic disorder
- Delirium and dementia
- Body dysmorphic disorder
- Schizotypal personality disorder
- Schizoid personality disorder
- Pervasive developmental disorder
- Obsessive-compulsive disorder
- Anxiety disorder
- Misidentification syndrome
- Induced or shared psychotic disorder
- Factitious disorder
- Bipolar affective disorder

THREE PHASES OF SCHIZOPHRENIA

Three phases of schizophrenia are as follows: (1) Prodromal phase, (2) Psychotic phase, and (3) Residual phase. Prodromal phase is a first phase that occurs before psychotic episode. Social withdrawal and irritability occur in prodromal phase. The second phase is psychotic phase. In psychotic phase, altered thought process, disturbances of perception and delusions are seen. The third phase is residual phase which occurs between psychotic episodes in which patient exhibits flat affect (lack of emotional expression), social withdrawal and odd behavior as shown in Figure 6.7.

POSITIVE AND NEGATIVE SYMPTOMS OF SCHIZOPHRENIA

The positive symptoms of schizophrenia are hallucination, delusion, disorganized thoughts and bizarre behavior which are seen in acute phase and also have good response to treatment. The negative symptoms of schizophrenia are apathy, flat or blunt affect, anhedonia, alogia, avolition, asociality and attention deficit as described in Table 6.3.

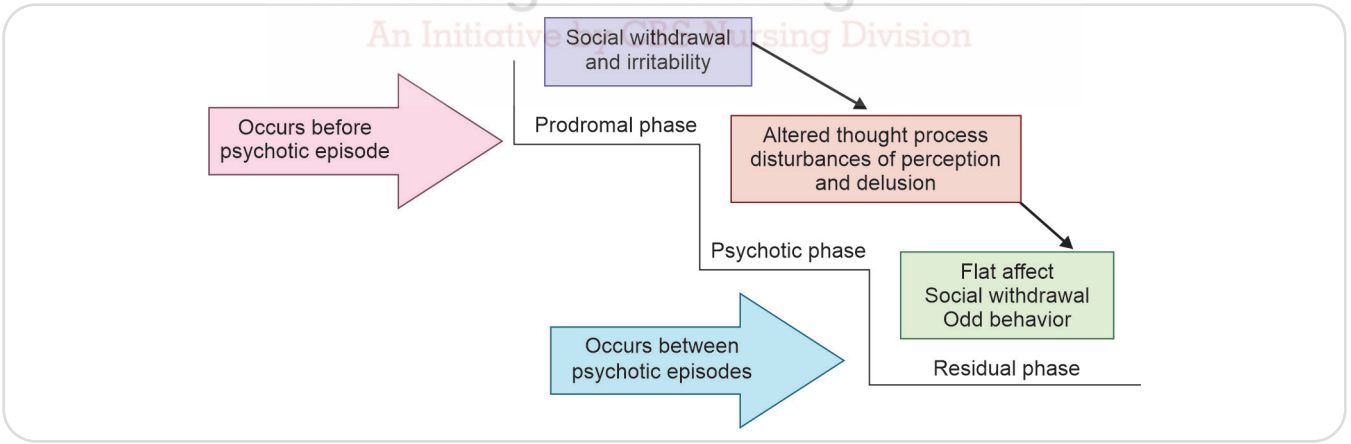


Figure 6.7: Three phases of schizophrenia

Table 6.3: Positive and negative symptoms of schizophrenia

Positive symptoms	Negative symptoms
Hallucination Delusion Disorganized thoughts Bizarre behavior	**Apathy** or **Affective flattening** or **Blunt affect:** Blank facial expression **Anhedonia:** Inability to express pleasure which is pleasurable one previously **Alogia:** Lack of speech output **Avolition:** Lack of initiative to act **Asociality:** Social withdrawal **Attention deficit:** Lack of attention
Seen in acute phase	Seen in chronic phase
Have good response to treatment	Not having good response to treatment when compared with treatment of patient with positive symptoms

Schneider's First-Rank Symptoms: Kurt Schneider, German psychiatrist, enumerated 11 first-rank symptoms of schizophrenia.

- **Three auditory hallucinations:**
  i. Third person voices giving commentary about patient actions
  ii. Third person voices arguing or discussing about patient
  iii. Thought Echo—voices are speaking thoughts a loud
- **Three-thought phenomenon or thought-alienation phenomenon:**
  i. **Thought broadcasting:** Thoughts escaped into outside world and others are experiencing it.
  ii. **Thought withdrawal:** Thoughts have been removed by an external source.
  iii. **Thought insertion:** Thoughts have been inserted by an external source.
- **Three made phenomenon (Client experience emotions, drives and actions influenced by others):**
  i. **'Made' actions:** Actions performed by outside control.
  ii. **'Made' feelings:** Feelings are not own, due to external source.
  iii. **'Made' impulses:** Impulses or drives from an external source.
- **Miscellaneous**
  - **Somatic passivity:** Passive somatic sensation by external source.
  - **Delusional perception:** Illogical meaning attributed toward normal perception.

Symptoms of Schizophrenia

- **Disorders of thought and speech**
  - **Autistic thinking:** Illogical thoughts.
  - **Loosening of association:** Rapid shifting of one idea to other without any association between those ideas.
  - **Thought block:** Interruption in stream of speech before its completion.
  - **Neologism:** Framing new words which do not have any meaning.
  - **Mutism:** Complete absence of speech.
  - **Poverty of ideation:** Speech delivered is adequate but the content of speech is inadequate.
  - **Poverty of speech**: Decreased production of speech.
  - **Echolalia:** Repetition of words by the patient exactly what the examiner says.
  - **Perseveration or verbigeration:** Repetition of words by patient.
  - **Delusions:** False fixed unshakable belief irrespective to their sociocultural values.
- **Disorders of perception**
  - **Auditory hallucinations:** Hearing voices or sounds without external stimuli.
  - **Visual hallucinations:** Visualizing images/shade/something without external stimuli.
- **Disorders of affect**
  - **Blunt affect:** Reduction in intensity of emotional response.
  - **Inappropriate affect:** Mood and affect are not appropriate.
  - **Apathy:** Lack of facial expression.
  - **Anhedonia:** Inability to experience pleasure which seems to be pleasurable before.
- **Disorders of motor behavior**
  - Decreased psychomotor activity or Increased psychomotor activity.
  - **Stereotype behavior:** Repetitive strange behavior.
  - Catatonic features.
- **Miscellaneous**
  - Reduction in social functioning
  - Decreased self-care
  - Perplexity in regard to own identity

- Multiple somatic complaints
- Suicide if associated with depression
- No disturbances in attention, concentration, memory, cognition and intelligence
- No organic cause
- No prominent mood symptoms (except schizoaffective disorder)

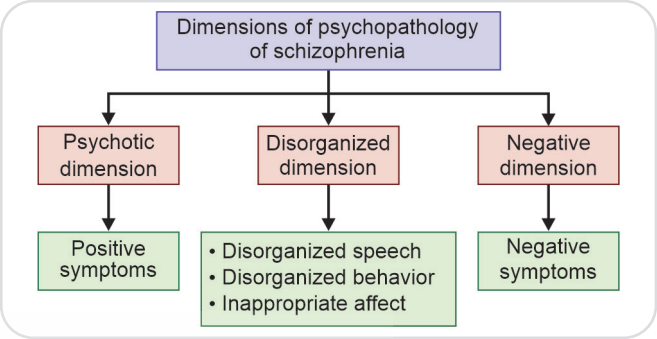
Hallucination

It is defined as misperception without any external stimuli. Common types are auditory, visual, olfactory, tactile and gustatory. Auditory type of hallucination is most common in schizophrenia. Types of auditory hallucination are simple and complex. Simple auditory hallucination is any sound heard whereas complex hallucination is voice heard by the patient. It also referred as second person hallucination and third person hallucination. Hearing voice outside the one's head when the patient is alone clearly identifies auditory hallucination, if not it might be one's own thoughts that refers to pseudo-hallucination.

Dimensions in the Psychopathology of Schizophrenia

The three dimensions in the psychopathology of schizophrenia are: (1) Psychotic dimension, (2) Disorganized dimension, and (3) Negative dimension. Psychotic dimension denotes positive symptoms, disorganized dimension denotes disorganized speech, disorganized behavior and inappropriate affect, and negative dimension denotes negative symptoms as explained in Flowchart 6.1.

Flowchart 6.1: Three dimensions of psychopathology of schizophrenia



OTHER PSYCHOTIC DISORDERS

As per ICD-11 and DSM-5, the classification of other psychotic disorders is given in Table 6.4.

Acute and Transient Psychotic Disorder

The term 'transient' denotes short lasting. Onset of psychotic symptoms is abrupt and acute with positive symptoms such as delusion, hallucination, disorganized thoughts and perplexity or confusion. This symptom is not a manifestation of another health condition or due to influence or withdrawal of any substances.

Duration of the episode: It does not exceed 3 months, and most commonly lasts from a few days to 1 month.

Table 6.4: ICD-11 and DSM-5 classification of other psychotic disorders

ICD-11	DSM-5	Classification of mental disorders
Schizophrenia spectrum and other psychotic disorders		
6A21	—	Schizoaffective disorder
6A22	301.22	Schizotypal (personality) disorder
6A23	—	Acute and transient psychotic disorder
6A24	297.1	Delusional disorder
—	298.8	Brief psychotic disorder
—	295.40	Schizophreniform disorder
—	295.70	Schizoaffective disorder (bipolar type)
—	295.70	Schizoaffective disorder (depressive type)
—	293.81	Psychotic disorder due to another medical condition (with delusions)
—	293.82	Psychotic disorder due to another medical condition (with hallucinations)
6A40	293.89	Catatonia associated with another mental disorder (catatonia specifier)
—	293.89	Catatonic disorder due to another medical condition
6A41	—	Catatonia induced by psychoactive substances, including medications
6A4Z	293.89	Unspecified catatonia
—	298.8	Other specified schizophrenia spectrum and other psychotic disorder
—	298.9	Unspecified schizophrenia spectrum and other psychotic disorder

Epidemiology: It will appear in early adolescence or early adulthood. Onset may occur anytime throughout the life span. Average age of onset is around 30 years of age.

Recovery and prognosis: Recovery is within 3 months and prognosis is usually better than schizophrenia. It does not fulfill the criteria of schizophrenia so it is categorized as acute transient psychotic disorders.

Rating scale: Rating scale used for the assessment was Clinician-rated dimensions of psychotic symptoms severity. It is 5-point Likert scale with 8 domains such as hallucination, delusion, disorganized speech, negative symptoms, mania, depression, impaired cognition and abnormal psychomotor behavior.

Peculiar Clinical Features

- Types of hallucinations and delusions are seen which are found variable in terms of intensity and nature.
- Marked emotional fluctuations from extreme happiness, sadness, irritability and anxiety.

Specification of Subtypes

- First episode or multiple episodes
- Full remission or partial remission
- Currently symptomatic
- Unspecified

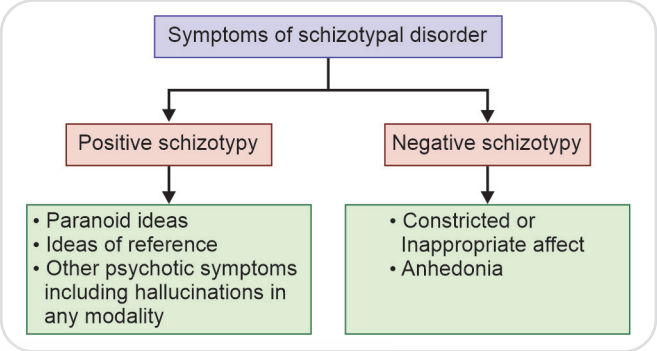
Schizotypal (Personality) Disorder

It is characterized by an enduring pattern (i.e., characteristic of the individual's functioning over several years) of eccentricities in the behavior, appearance and speech, which is accompanied by the unusual beliefs, cognitive distortions, perceptual distortions, often having a reduced capacity for the interpersonal relationships. The symptoms include the paranoid ideas, ideas of reference, or other psychotic symptoms including hallucinations in any modality, may occur (positive schizotypy), and constricted or inappropriate affect, anhedonia (negative schizotypy), but are not of sufficient intensity or duration to meet the diagnostic criteria of schizophrenia, schizoaffective disorder, or delusional disorder. The symptoms might cause the significant personal distress or significant impairment in the personal, family, social, educational, occupational or other vital areas of functioning (Flowchart 6.2).

Delusional Disorder

Delusions are well systematized and non-bizarre type stable and chronic in nature. Patient is not able to differentiate between real and imaginary things. Emotional response and patient's behavior is understood well based on delusions. More often social and occupational life is not affected.

Flowchart 6.2: Symptoms of schizotypal disorder



The peculiar clinical features are as follows:

- ***Duration:*** Persistent delusions at least for 1 month are longer.
- Not prominent hallucinations may be related to the delusional theme (sensation of being infested with the insects might be associated with delusions of infestation).
- No mood disorders, schizophrenia and organic brain disorders.
- Apart from the impact of the delusion, functioning is not markedly impaired and behavior is not bizarre or odd obviously.
- Disturbances is not due to another mental disorder or medical condition or due to substance abuse/withdrawal.
- If there is a manic or major depressive episode, it is brief relative to the duration of delusional period.

Types of delusional disorder on the basis of central theme of delusions have been given in Table 6.5.

Specify if it is:

- First episode or multiple episodes.
- Currently in acute or chronic episode.
- Currently in partial or full remission.
- Continuous presence of symptoms during the course of illness: Present/absent.
- Severity of symptoms: Very severe/moderate/less severe.
- Mixed type: Lack of any one predominant delusional theme.
- Unspecified: Dominant delusional belief not be clearly determined with any specific type.

Brief Psychotic Disorder

Presence of one or more symptoms such as delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior. The duration of an episode of disturbance is at least 1 day but less than 1 month, with the eventual full return

Table 6.5: Delusional disorder on the basis of central theme of delusions

Types of delusional disorder on the basis of central theme	Description	Example
Erotomanic type	Another person is in love with the individual	Patient verbalizes that, 'Actor is having love desire toward me'
Grandiose type	Conviction of having some great or talent or having made some vital discovery	Patient verbalizes that, 'I am the god'
Jealous type	Spouse or lover is not faithful	Patient verbalizes that, 'My wife is having a love with other guy'
Persecutory type	Individual is being cheated, followed, spied on, poisoned or drugged, harassed etc.	Patient verbalizes that, "My friend is having a plan to kill me"
Somatic type	It involves bodily functions or sensations	Patient verbalizes that, 'I feel sound of running water in my stomach'
With bizarre content	Delusions are clearly not understandable and not derived from ordinary life experiences	Individual strongly believes that a stranger has removed one's internal organs and replaced the same with other without any scar in the body

toward the premorbid level of functioning. This disturbance is not well explained by the major depressive or bipolar disorder with psychotic features or other psychotic disorder such as schizophrenia or catatonia, and is not attributable due to the influence of a substance or any other medical condition.

Specify this diagnosis if it is:

- With (brief reactive psychosis) or without stressors
- With postpartum onset (onset is during pregnancy or within 4 weeks' postpartum) or
- With catatonia.

Schizophreniform Disorder

Duration of the episode: This is a mental disorder, diagnosed when symptoms of schizophrenia are at least 1 month but less than 6 months.

Symptoms: At least one of the following symptoms such as delusions, hallucinations, disorganized speech (e.g., frequent derailment or incoherence), grossly disorganized or catatonic behavior, negative symptoms (i.e., diminished emotional expression or avolition). This symptom is not a manifestation of another health condition or due to influence or withdrawal of any substances.

Specify if it is:

- With good prognostic features: Presence of at least two of the features:
  - Onset of prominent psychotic symptoms within 4 weeks of the first noticeable change in usual behavior or functioning.
  - Confusion or perplexity
  - Good premorbid social and occupational functioning and
  - Absence of blunted or flat affect.
- Without good prognostic features: Two or more of the above features are absent.
- With catatonia
- Specify current severity: Clinician-rated dimensions of psychosis symptom severity scale.

Schizoaffective Disorder

Symptoms: It has both symptoms of schizophrenia and mood disorders which are prominently seen in same episode. (Schizo + Affective = Schizophrenic symptoms + Mood symptoms). Mood symptoms may be mania, depression or mixed mania and depression.

Prognosis: good.

Treatment: Injection lorazepam (IV) and electroconvulsive therapy.

Specify if it is:

- Bipolar type: Manic episode is part of the presentation. Major depressive episodes may also occur.
- Depressive type: Major depressive episode is part of the presentation.
- With or without catatonia.
- First episode or multiple episodes.
- Full remission (a period of time after a previous episode during which no disorder-specific symptoms are present) or partial remission (a time period during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled).

Psychotic Disorder due to Another Mental Disorder

There will be presence of prominent hallucinations or delusions with the clear diagnostic evidence states it is due to the direct pathophysiological consequence of another mental disorder. This disturbance causes clinically significant personal distress and impairment in social, occupational or other vital areas of functioning.

Psychotic Disorder due to Another Medical Condition

There will be presence of prominent hallucinations or delusions with the clear diagnostic evidence states it is due to the direct pathophysiological consequence of another medical condition. The disturbance is not better explained by another mental disorder and does not occur during the course of a delirium. This disturbance causes clinically significant personal distress and impairment in social, occupational or other vital areas of functioning.

Specify if it is:

- With hallucinations
- With delusions.

Catatonia

It is a marked disturbance in the voluntary control of movements which is characterized by extreme slowness or absence of motor activity, purposeless motor activity unrelated to external stimuli, mutism, maintenance of rigid or unusual or bizarre postures, resistance to the instructions or attempts to be moved, or automatic compliance with instructions.

Symptoms: Table 6.6 (3 or more following symptoms should be present as per DSM-5 criteria).

It may be diagnosed in the context of certain mental disorders: Schizophrenia, mood disorders and autism spectrum disorder.

Potential risk of catatonia: Malnutrition, Hyperpyrexia, Exhaustion, self-inflicted injury and harming others

Specify if it is:

- Associated with another mental disorder.
- Due to another medical condition.
- Induced by psychoactive substances, including medications.
- Unspecified (full criteria for the catatonia not met or due to insufficient information to have a specific diagnosis—for example, patient admitted in emergency room situations).

Other Specified Schizophrenia Spectrum and Other Psychotic Disorder

Symptoms of a schizophrenia spectrum and other psychotic disorder which cause significant distress or impairment in social, occupational functioning but do not meet full criteria for any of disorders in the schizophrenia spectrum and other psychotic disorders. When there is presence of specific reason for the presentation such as:

- Persistent auditory hallucinations happen in the absence of other features.
- Delusions with predominant overlapping mood episodes.
- Attenuated psychosis syndrome: Psychotic-like symptoms below a threshold for full psychosis (symptoms are less in severity, transient and presence of insight).

Table 6.6: Symptoms of catatonia

Symptoms of catatonia	Description
Stupor	Absence of psychomotor activity or not actively relating to environment
Catalepsy	Passive induction of a posture held against gravity
Waxy flexibility	Slight, even resistance to positioning by examiner
Mutism	Absence or very little verbal response (exclude if there is known aphasia)
Negativism	Opposition or no response to the instructions or external stimuli
Posturing	Spontaneous and active maintenance of a posture against gravity
Mannerism	Odd, circumstantial caricature of normal actions
Stereotypy	Repetitive abnormally frequent non-goal-directed movements
Echolalia	Mimicking another's speech
Echopraxia	Mimicking another's movements
Grimacing	Fixed facial expression
Agitation	A sense of excitement which is not influenced by external stimuli

- Delusional symptoms present in the individual with delusional disorder.

Unspecified Schizophrenia Spectrum and Other Psychotic Disorder

Symptoms of a schizophrenia spectrum and other psychotic disorder which cause significant distress or impairment in social, occupational functioning but do not meet full criteria for any of disorders in the schizophrenia spectrum and other psychotic disorders. When there is presence of insufficient information to make a more specific diagnosis (for example, in emergency room settings).

PROGNOSIS OF SCHIZOPHRENIA

The prognosis of schizophrenia is given in Table 6.7.

Table 6.7: Prognosis of schizophrenia

Aspects	Good prognosis	Poor prognosis
Onset	Acute/abrupt	Insidious
Age of onset	Late	Early
Duration	<6 months	>2 years
Episode	First episode	Previous history of schizophrenia
Gender	Female	Male
Stressor	Absent	Present
Depression	Absent	Present
Symptoms	Positive symptoms	Negative symptoms
Social support	Good	Poor
Types	Acute catatonia (Paranoid has intermediate prognosis)	Disorganized, undifferentiated and simple
Relapse of symptoms	Absent	Present
Drug adherence	Present	Absent
Nature of treatment	Outpatient basis/ community based	Inpatient/ hospitalization
CT scan	Normal	Enlargement of ventricles
Premorbid functioning	Good	Poor

PSYCHOSOCIAL INTERVENTIONS

Psychosocial interventions for schizophrenia have been given in Table 6.8.

Table 6.8: Psychosocial interventions for schizophrenia

Psychosocial interventions for schizophrenia	Description
Psychoeducation	• Regarding the nature and course of schizophrenia • Treatment of schizophrenia
Social skills training	• Patient with negative symptoms of schizophrenia will have lack of social skills • Social skills such as maintaining eye to eye contact, shaking hands with others, making ward rounds, social interaction with others are said to be implied
Cognitive training/Cognitive remediation	Cognitive deficits such as lack in attention/ concentration/memory should be targeted and appropriate training should be provided to improve it
Supportive employment or Vocational rehabilitation	Promotion of vocational guidance and placement in a right job helps the client to cope up with the situation well
Token economy	• Acts as a positive reinforcement in case of desired positive behavior • One token will be issued for one desirable positive behavior • If a number of tokens have been collected by a patient, then a particular gift can be provided to motivate the client
Family interventions	Steps taken to avoid 'Expressed Emotions' in family (i.e., to avoid critical comments, hostile behavior and high emotional involvement)
Psychosocial weight management	• Research data states that tablet Olanzapine might cause increase in weight up to 5 kg within 1 week • Even other antipsychotics might increase the weight • So, balanced high fiber diet has to be maintained
Interventions to enhance drug compliance	• Important cause of relapse of symptoms is drug nonadherence • So, education in regard to drug compliance is needed

Antipsychotics: Discussed in Chapter 5.

TREATMENT

Psychotherapy for Schizophrenia

Individual psychotherapy, group psychotherapy, supportive psychotherapy and cognitive behavior therapy are the first line of treatment which should be started in the patient's suffering from schizophrenia.

Treatment-Resistant Schizophrenia

Clozapine is a drug of choice for the treatment of resistant schizophrenia. If it fails, it can be treated with amisulpride, risperidone, aripiprazole, lamotrigine, topiramate, benzodiazepines, depot preparations and antidepressants (for negative symptoms) (Fig. 6.8).

Repetitive Transcranial Magnetic Stimulation

In this noninvasive technique, changing magnetic field is used to cause electric current to the brain (specific area) through electromagnetic induction. It is a brain stimulation technique and is mainly used to treat depression when applied in prefrontal cortex. However, research evidence suggests auditory hallucination reduces when applied in temporoparietal cortex.

Assertive Community Treatment and Intensive Psychiatric Rehabilitation

Assertive community treatment is defined as group of psychiatric health team workers joins together to render the care to mentally ill patients in a community setup and they do regular follow-ups to promote the holistic mental well-being of patients.

Intensive psychiatric rehabilitation is defined as the structured measures taken for the promotion of mental health of the person (he/she) before the onset of mental illness.

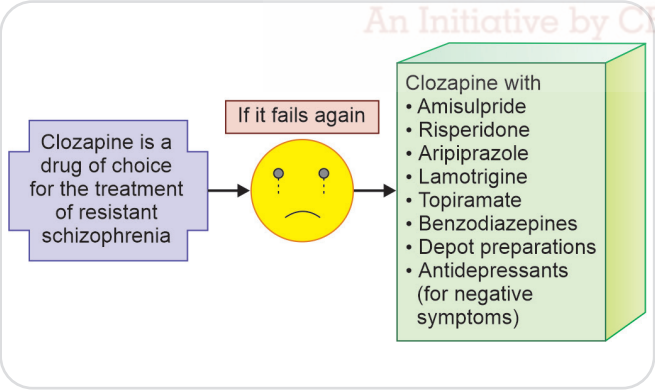


Figure 6.8: Medications for the treatment-resistant schizophrenia

NURSING INTERVENTIONS

- **Disturbed thought process related to neurochemical factors as evidenced by delusion of persecution**

Nursing interventions	Rationale
Assess the intensity, content, frequency and duration of delusion	To obtain baseline data about delusion
Assess the environmental triggering factors	To reduce the environmental triggering factors
Communicate with client calmly and gently	Since the client is having suspiciousness therefore, he/she might have fear of everything
Avoid arguing about delusion	Argument about delusion might put the delusion stronger
Monitor the client carefully	Clients with delusions might harm to self and others
Encourage the client to ventilate the distressing thoughts	To reduce the stress
Encourage the client for group activities	To promote self-esteem
Educate the client and caregivers regarding the importance of psychotropic drugs	To enhance the drug adherence and to prevent the relapse of symptoms
Do's • Assign the same staff for taking care of the patient • Be truthful to the client • Be assertive with patient **Don'ts** • Touch the client unnecessarily • Laughing, murmuring or whispering in front of client	To promote trust

- **Disturbed sensory perception related to genetic or biochemical factors as evidenced by hallucinatory behavior**

Nursing interventions	Rationale
Assess the intensity, content, frequency, duration and type of hallucination	To obtain baseline data about hallucination
Ask the client, 'What the voices saying to you?'	To explore whether the commanding voices will cause any harm to the patient or not
Avoid arguing about hallucination	Argument about hallucination might put the hallucination stronger

Contd...

Nursing interventions	Rationale
Identify the triggering factors	To reduce the severity of hallucination
Interrupt the hallucination by diverting or calling the patient	It helps to divert the patient from hallucination
Encourage the client to say 'stop' or 'go away' or whistle slowly to dismiss the hallucination	It helps to deal the hallucination effectively

- **Social isolation related to negative symptoms of schizophrenia as evidenced by social withdrawal**

Nursing interventions	Rationale
Convey the acceptance attitude to the patient	To promote the feeling of self-worth
Involve the client for group activities	To enhance social skills
Promote positive reinforcement if the client performs voluntary interaction to others	To motivate the client to perform task
Provide social skills trainings such as maintaining eye contact while interacting, shaking hands, talking in polite way, providing a leadership role, etc.	To improve social skills

- **Self-care deficit related to cognitive impairment or lack of trust or anxiety as evidenced by inability to do the tasks such as bathing, grooming, eating, toileting and sleeping**

Nursing interventions	Rationale
Assess the patient ability to perform the self-care activities	To obtain baseline data
Assist the client to perform self-care activities	To promote the comfort and safety
Encourage the patient to perform the task independently	Helps to promote the behavior by motivation
Demonstrate the activities need to be performed in simple steps	Helps to guide the client how to perform the task step by step
Allow enough time to perform the self-care activities	Patient might take more time due to shorter attention span
Withdraw the assistance gradually and supervise the patient's self-care activities	It promotes the sense of independence

- **Ineffective health maintenance related to poor dietary intake or lack of trust or suspiciousness that food is poisonous as evidenced by significant loss of weight**

Nursing interventions	Rationale
Assess the nutritional status of the patient	To obtain the baseline data
Monitor the food intake regularly	It provides a pathway of continuous assessment
If client is suspicious about the food is poisonous, ask the client himself/herself to get the food from shop	It helps to decrease the suspiciousness
Educate the client regarding the nutritious diet	It helps to improve the health status
Provide the menu plan to the patient	Guide the client to eat the food at proper time
Provide food that the client likes	Motivate the client to eat

- **Risk of violence related to command hallucination as evidenced by destruction of nearby objects**

Nursing interventions	Rationale
Observe the client carefully and frequently	To obtain baseline data
Remove the sharp and dangerous objects from the client's room	To ensure the client's safety
Provide scheduled daily activities to patient	To make the client being committed with daily activities
Provide physical restraints to the client. Check the distal pulse rate and color of skin every 15 minutes once	Restraints prevent harm to oneself and also to others. Monitoring pulse and skin color will ensure the proper blood circulation
Encourage the client to ventilate the distressing thoughts	To reduce the aggression
Administer relaxation therapy	To reduce the stress
Redirect the violent behavior into physical outlet. For example, involve the patient in outdoor sports	To redirect the violence into fruitful activity

- **Impaired verbal communication related to unrealistic thoughts as evidenced by flight of ideas**

Nursing interventions	Rationale
Use therapeutic techniques of communication, e.g., clarification—can you clarify it still better	Helps to have clear communication between nurse and patient
Assign the staff nurse consistently with the patient who feels reluctant to talk with other staff nurse	Promote empathy and verbalize the feeling to the nurse after gaining trust

Contd...

Nursing interventions	Rationale
Talk in a simple language	It will help the client to understand properly
Motivate the client to talk to other patients	It will help the patient to improve the communication skills

- **Ineffective family coping related to conflicts among family members, impaired communication among family members and more concern on illness**

Nursing interventions	Rationale
Assess the communication pattern, conflicts and importance of patient among family members	To have a baseline data
Give psychoeducation to the family members regarding the treatment process and prognosis	It will help to reduce the problems among family members
Educate the family members that the conflicts occurring in your family will affect prognosis of the patient	Helps to promote the unity among them
Facilitate the proper communication among family members	Useful to prevent the issues among family members

GERIATRIC CONSIDERATIONS

Late-onset schizophrenia (onset after 45 years of age) characterized by paranoid ideations along with varying degrees of impairment can be observed in older patients. Psychosis in elderly may be comorbid with depression or dementia. Antipsychotics and psychotherapy will be helpful for elders to reduce the psychotic symptoms.

FOLLOW-UP, HOME CARE AND REHABILITATION OF PATIENTS WITH SCHIZOPHRENIA

Follow-up of Patients with Schizophrenia

Regular follow-up by the psychiatric nurse is found vital to prevent the relapse of psychotic symptoms. Follow-up can be done either by home visits or through telephone to provide the necessary guidance and counseling to the patient and family members. Proper documentation of follow-up helps the nurse to promote the quality nursing care.

Home Care of Patients with Schizophrenia

Taking care of patients in home settings will promote the mental health in far better way. Family members have to understand that negatively expressed emotions might provoke the psychotic symptoms so necessary psychoeducation has to be given to the family members. Patient has to be motivated for the right behavior and family members should not express the negative emotions about patient.

Rehabilitation of Patient with Schizophrenia

The term 'Rehabilitation' denotes restoring the health status of mentally ill individuals as early as possible. Nurses can refer to the self-help group or rehabilitative centers in order to promote mental health of patient and to prevent the relapse of psychotic symptoms. The rehabilitative services are as follows:

- Day hospitals
- Half-way homes
- Long-term homes
- Occupational therapy
- Social skills training
- Monetary management skills
- Recreational therapy
- Cognitive training

EXTRA EDGE

ICD-10 Classification of Schizophrenia

- F20.0: Paranoid schizophrenia
- F20.1: Hebephrenic schizophrenia
- F20.2: Catatonic schizophrenia
- F20.3: Undifferentiated schizophrenia
- F20.4: Post-schizophrenic depression
- F20.5: Residual schizophrenia
- F20.6: Simple schizophrenia
- F20.8: Other types of schizophrenia
- F20.9: Schizophrenia, unspecified

EXTRA EDGE

Types of Schizophrenia

Paranoid Schizophrenia

It is most common type of schizophrenia. Onset is late and has good prognosis. Personality is said to be preserved, i.e., client is able to perform activities of daily living (ADLs) and has good social interaction. Hallucination, delusion and thought disorders are peculiarly seen. Examples of hallucinatory themes are commenting, arguing, threatening, body sensations/movements. Examples of thought disorders are irrelevant, incoherent and neologisms in speech. Prognosis is good in case of earlier treatment. Minimal deterioration of personality is seen.

Examples of delusional themes are persecution, grandiose, jealousy and reference.

- Delusion of persecution means patient having strong suspiciousness of being cheated, poisoned, spied on, harassed, etc.

Contd...

- Delusion of reference denotes that the irrelevant or innocent events happen in the surroundings refer to oneself. For example, patient believes that others are talking about him/her.
- Delusion of jealousy means unfaithfulness with individual's sexual partner.
- Delusion of grandiosity means irrational ideas in regard to talent, power or knowledge.

Hebephrenic or Disorganized Schizophrenia
Behavior is aimless and not goal directed in hebephrenic schizophrenia. Hallucinations and delusions are not prominent. Inappropriate and incongruent affects are seen. Speech is incoherent. Early and insidious onset is associated with poor premorbid personality.

Catatonic Schizophrenia
Motor symptoms are present predominantly. Types of catatonic schizophrenia are stuporous, excited and periodic are explained in Flowchart 6.3. Prognosis is good. Treatment includes injection lorazepam (IV) and electroconvulsive therapy.

Simple Schizophrenia
Simple schizophrenia shows prominent negative symptoms of schizophrenia such as amotivation, apathy, social withdrawal, flat or blunt affect and poverty of speech. Positive symptoms are absent. Social functioning gets reduced. Onset is early and insidious. Course is progressive. Prognosis is worst.

Residual Schizophrenia
Progression is from early stage (hallucination and delusions are predominant) to late stage (hallucination and delusions are minimal). Negative symptoms are present.

Undifferentiated Schizophrenia
Schizophrenia not conforming any subtypes will come under the category of undifferentiated schizophrenia.

Postschizophrenic Depression
Depressive episode develops after the resolution of schizophrenic symptoms in post-schizophrenic depression. Patient might be at high suicidal risk.

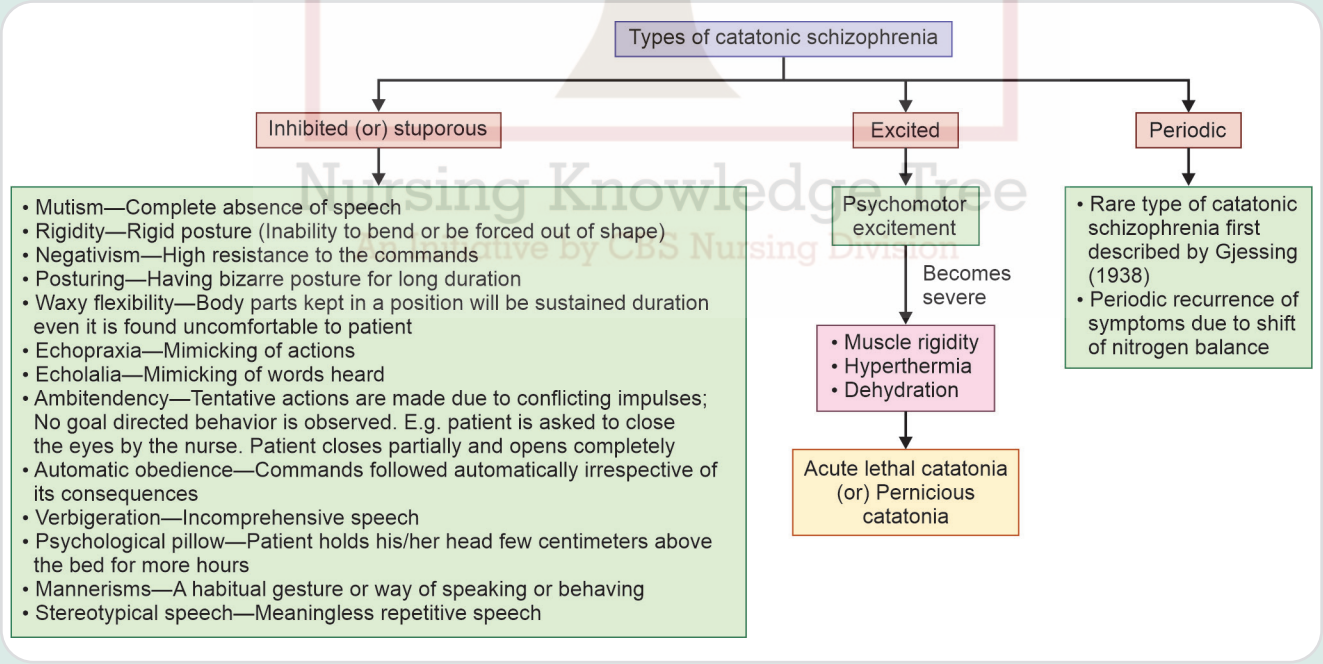
Schizophreniform Disorder
Features of schizophrenia are present, but when the duration is less than 6 months then it is labeled as schizophreniform disorder.

Pseudoneurotic Schizophrenia
Hoch and Polatin explained this type. Prominent neurotic symptoms are present in initial phase. Classical triad of pseudoneurotic schizophrenia includes pan-anxiety, pan-neurosis and pan-sexuality as explained in Figure 6.9. Pan-anxiety denotes free floating anxiety which will not subside easily. Pan-neurosis includes the predominant neurotic symptoms. Pan-sexuality denotes that patient with pseudoneurotic schizophrenia is preoccupied with sexual desires.

Pfropf Schizophrenia
It occurs with the presence of mental retardation. Behavior disturbance is more prominent than thought disorder. It differs from schizophrenia due to unsystematized delusions and poverty of ideation.

Van Gogh Syndrome
Self-mutilation or self-injurious behavior is seen in this type of schizophrenia. Van Gogh was a famous painter, he cuts his ear in state of acute illness and hence this term is named after him.

Flowchart 6.3: Types of catatonic schizophrenia



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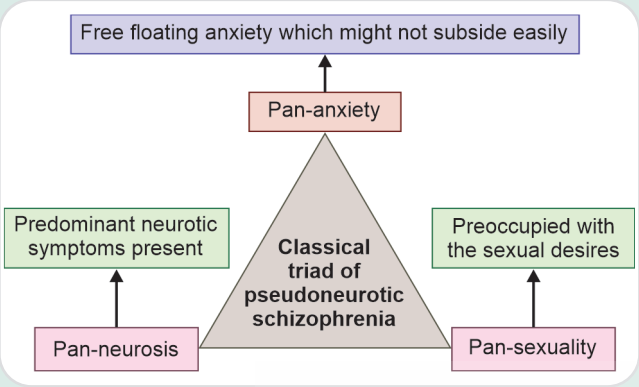

Figure 6.9: Classical triad of pseudoneurotic schizophrenia

Late Paraphrenia

Sir Martin Roth explained this type. Onset is too late. It is common in unmarried or widow women. Delusion of persecution with bizarre/fantasy is present. Visual, auditory, olfactory, gustatory and tactile hallucinations are seen.

Oneiroid Schizophrenia

Mayer-Gross explained this type. Onset is acute and usually the episode is brief. Term 'Oneiroid' means 'dream' so client remains in dream like state. Symptoms are such as clouding of consciousness, perceptual disturbances and disorientation.

Type I and Type II Schizophrenia

TJ Crow is classified schizophrenia as type I and type II. Symptoms, course of illness, cognitive deficit, condition of ventricles, response to medications and prognosis of type I and type II are explained in Table 6.9.

Bouffée Délirante

It is a French term for 'short-lived psychosis'. It is mainly characterized by hallucination, delusion, confused state, amnesia after attack and polymorphous symptoms. Remission takes place within 3 months even without any treatment. It occurs mainly due to consequences of urbanization and westernization.

According to ICD-10, required duration to diagnose schizophrenia is given in Table 6.10.

Table 6.9: Type I and type II schizophrenia

Aspects	Type I schizophrenia	Type II schizophrenia
Symptoms	Positive symptoms	Negative symptoms
Course of illness	Acute	Chronic
Cognitive deficit	Absent	Sometimes present
Ventricles	Normal	Dilated
Response to drugs	Good	Poor
Prognosis	Better	Poor

Table 6.10: Required duration to diagnose schizophrenia as per ICD-10

Types of schizophrenia	Duration
Paranoid schizophrenia	1 month
Hebephrenic or Disorganized schizophrenia	1 month
Catatonic schizophrenia	½ month or 2 weeks
Simple schizophrenia	12 months

Induced Delusional Disorder or Shared Psychotic Disorder

An uncommon delusional disorder in which the delusions have been shared between two individuals due to the emotional bonding is termed folie à deux. If those persons got separated then the dependent individual might be free of the delusions. So, the individual with true delusions has to be treated properly (Fig. 6.10).

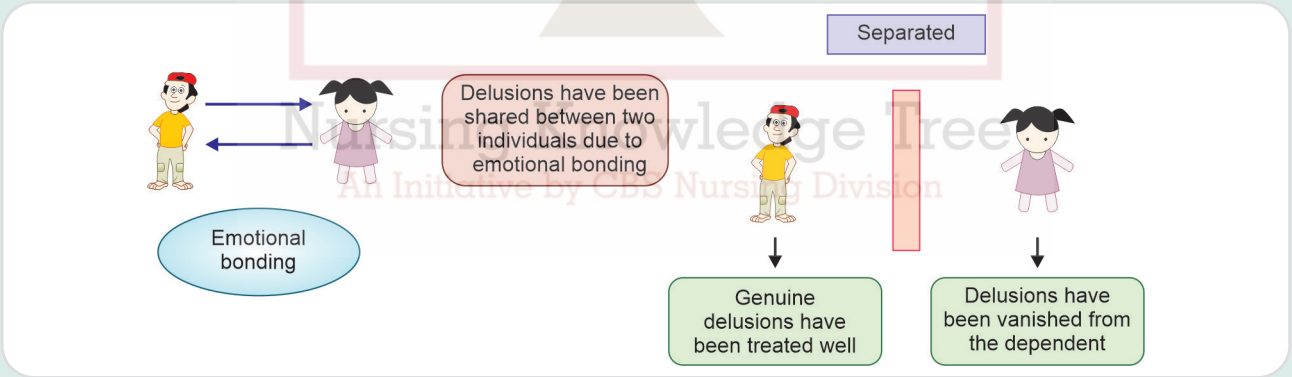

Figure 6.10: Concept map to understand induced delusional disorder

SUMMARY

- Schizophrenia is a psychotic disorder (disorder in which the client believes that he/she not have a basis of reality) characterized by abnormalities in emotion, thinking and cognition.
- 6A20 is ICD-11 code and 295.90 is DSM-5 code for schizophrenia.

Contd...

- Dopamine pathways are mesolimbic, mesocortical, tuberoinfundibular and nigrostriatal.
- 4 A's of schizophrenia by Bleuler are autistic thinking, ambivalence, affect is inappropriate and associative looseness.
- Positive symptoms of schizophrenia are hallucination, delusion, disorganized thoughts and bizarre behavior.
- Negative symptoms of schizophrenia are anhedonia, alogia, affect (flat), avolition and attention (poor).
- Kurt Schneider's first-rank symptoms of schizophrenia are three auditory hallucinations, three thought phenomenon or thought alienation phenomenon, three made phenomenon, somatic passivity and delusional perception.
- Other psychotic disorders are delusional disorder, acute and transient psychotic disorder, schizotypal (personality) disorder, brief psychotic disorder, schizoaffective disorder (bipolar or depressive type), schizophreniform disorder, psychotic disorder due to another medical condition (with delusions or hallucinations), catatonia associated with another mental disorder, catatonia induced by psychoactive substances, including medications, unspecified catatonia, other specified schizophrenia spectrum and other psychotic disorder and unspecified schizophrenia spectrum and other psychotic disorder.
- The rehabilitative services are day hospitals, half-way homes, long-term homes, occupational therapy, social skills training, monetary management skills, recreational therapy and cognitive training.

ASSESS YOURSELF

Long Answer Questions

1. Explain the types, etiology, psychopathology, diagnosis, clinical manifestations and management of patients with schizophrenia.
2. Explain the types, etiology, psychopathology, diagnosis, clinical manifestations and management of patients with catatonia.

Short Answer Questions

1. Define schizophrenia.
2. Define catatonia.

Short Notes

Write short notes on:

1. First-rank symptoms of schizophrenia
2. Delusional disorder
3. Nursing interventions of patient with schizophrenia
4. Etiology of schizophrenia
5. Clinical features of schizophrenia
6. Psychosocial interventions of schizophrenia
7. ICD-11 classification of schizophrenia
8. ICD-11 and DSM-5 diagnostic criteria of schizophrenia

Multiple Choice Questions

1. Who first coined the term 'schizophrenia'?
a. Eugen Bleuler b. Emil Kraepelin
c. Sigmund Freud d. None of the above

2. Which dopamine pathway constitutes 80% of brain dopamine?
a. Mesolimbic b. Mesocortical
c. Nigrostriatal d. Tuberoinfundibular

3. Which dopamine pathway might cause hyperprolactinemia?
a. Mesolimbic b. Mesocortical
c. Nigrostriatal d. Tuberoinfundibular

4. ICD-11 code for schizophrenia is _____.
a. 6A20 b. 5A20
c. 5A21 d. None of these

5. Most common type of hallucination in psychiatric disorders is _____.
a. Visual b. Auditory
c. Tactile d. Olfactory

6. Schizophrenia occurs due to _____ in dopamine level.
a. Increased
b. Decreased
c. Neither increase nor decrease
d. Fluctuate

7. Which of the following are positive symptoms of schizophrenia; except:
a. Hallucination b. Delusion
c. Anhedonia d. Disorganized thoughts

8. Drug of choice for treatment-resistant schizophrenia is:
a. Haloperidol b. Risperidone
c. Clozapine d. Olanzapine

9. Thought has been removed by an external source means:
a. Thought insertion b. Thought withdrawal
c. Thought broadcasting d. None of these

10. Peculiar symptom identified in mental status examination among patients with schizophrenia is:
a. Delusion b. Delirium
c. Sundowning syndrome d. Cogwheel rigidness

Answer Key

1. a	**2.** c	**3.** d	**4.** a	**5.** b
6. a	**7.** c	**8.** c	**9.** b	**10.** a

Textbook of

Mental Health/Psychiatric Nursing

for BSc Nursing Students

Learning Objectives in the beginning of every Chapter help readers understand the purpose of the chapter.

LEARNING OBJECTIVES

After studying this chapter, the student will be able to understand the basic concepts of psychiatric nursing.

Chapter Outline gives a glimpse of the content covered in the chapter.

CHAPTER OUTLINE

- Perspectives of Mental Health and Mental Health Nursing
- Mental Health Team or Multidisciplinary Team
- Nature/Philosophy of Psychiatric Nursing

Key Terms are added in each chapter to help understand difficult scientific terms in easy language.

KEY TERMS

Mental health nursing, Mental health, Mental health policy, Mental health team, Normal behavior, Abnormal behavior, Evolution of mental health services, Functions of psychiatric nurse.

Numerous **Tables and Figures** have been used in the chapters to facilitate learning in a quick way.

Table 3.14: Drug levels in blood

Name of the drug	Blood therapeutic value
Lithium	0.6–1.8 mEq/L
Carbamazepine	6–12 mg/mL
Sodium valproate	50–100 mg/mL

Figure 3.7: Assessment of triceps reflex

Evolving conceptual details for application in clinical situations are depicted in **Clinical Implication** boxes.

CLINICAL IMPLICATION

Frontal Lobe Syndrome

Damage to the dorsolateral (upper and outer) areas of the frontal lobes may cause symptoms such as lack of drive and spontaneity. Damage to the anterior aspects of frontal lobes might lead the changes in mood or affect, which in turn exhibits the impulsive and inappropriate behavior in patients.

Clinical correlations from nursing point of view have been covered under **Nursing Implication** or **Nursing Responsibility** boxes.

NURSING IMPLICATION

Implications for Nursing Practice

- Understanding the psychosexual stages of childhood provides a framework for understanding behaviors observed in adult patients.
- Effective parenting can be promoted by teaching parents about the child's needs during each psychosexual stage.

Extra Edge boxes provide highly useful additional information to enhance the knowledge of the students.

EXTRA EDGE

Types of Schizophrenia

Paranoid Schizophrenia

It is most common type of schizophrenia. Onset is late and has good prognosis. Personality is said to be preserved, i.e., client is able to perform activities of daily living (ADLs) and has good social interaction. Hallucination, delusion and thought disorders are peculiarly seen. Examples of hallucinatory themes are commenting, arguing, threatening, body sensations/movements. Examples of thought disorders are irrelevant, incoherent and neologisms in speech.

Important takeaway points of respective chapters have been highlighted under **Summary** boxes.

SUMMARY

- Antipsychotics are medications to treat psychotic disorder and psychosis related to other psychiatric and medical disorders.
- The other names of antipsychotics are D_2 receptor blockers, major tranquilizers, neuroleptic agents, ataractics and anti-schizophrenic drugs.

At the end of chapters, **Assess Yourself** section is given which contains frequently asked questions in exams and multiple choice questions to help students attain mastery over the subject.

ASSESS YOURSELF

Long Answer Questions

1. Explain the scope of psychiatric nursing practice.

Short Answer Questions

1. Name the members of a mental health care team.

Short Notes

Write short notes on:

1. Functions of psychiatric nurse

Multiple Choice Questions

1. **Misperception of taste is _____ hallucination.**
   a. Auditory b. Visual
   c. Functional d. Gustatory

Case Study demonstrates example(s) of specific clinical scenarios covered in separate section from clinical and applied aspects.

CASE 2 PATIENT WITH DEPRESSIVE DISORDER

Mr K, 63-year-old male, unmarried, he is a carpenter, completed Higher Secondary Certificate (HSC). Mr K has a pervasive low mood, poor appetite, decreased sleep, fearfulness, lack of interest in activities, decreased self-care and social withdrawal.

Giving extra edge to book from the practical point of view **OSCE** station and **Viva Voce** covered in a separation section.

Objective Structured Clinical Evaluation (OSCE)

STATION 1–ANXIOUS PERSONALITY DISORDER

Instructions to the Examinee

Ms X aged 28 years came with complaint of avoiding social gathering and family functions. Her mind is preoccupied with being criticized or rejected and she also shows extreme anxiety, nervousness and low self-esteem.

Participant number: _____ **Date:** _____

Viva Voce

1. **Define mental illness.**
   Mental illness is a maladjustment in living which produces disharmony in life.

P Prakash *PhD (N), MBA (HM)* is presently working as an Assistant Professor in Department of Nursing at Prince Sattam Bin Abdulaziz University, Kingdom of Saudi Arabia (KSA), and Adjunct Teaching Faculty cum Post-Doctorate Research Fellow in Nursing at Lincoln University College, Malaysia. He has 11 years of experience in Nursing as a Teaching faculty, ward in-charge (Psychiatric Unit), and Nursing Officer (Liver Transplantation Unit). The author received the prestigious Florence Nightingale Award for Best Nurse in Philanthropy in 2016 by Doctors United Charitable Trust (DUCT). He has presented scientific papers at national and international levels.

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