
SCHIZOPHRENIA
STUDY GUIDE
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AGRANULOCYTOSIS (rare)

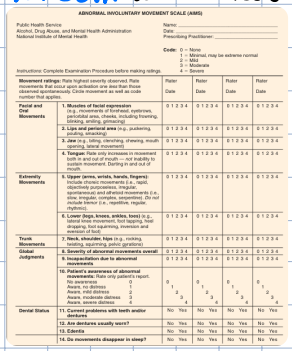
- SYMPTOMS INCLUDE: ↓ neutrophil counts + WBC's
  ↑ severity of infections
  - ↳ fever, sore throat, malaise, body ache, mouth sores
- Associated w/ use of CLOZAPINE (CLORAZIL) ! CALL DOCTOR / BLOOD TEST !

AIMS TEST a brief test for the tracking of TARDIVE DYSKINESIA and other involuntary movements

ABNORMAL
INVOLUNTARY
MOVEMENT
SCALE

EXAMINES MOVEMENTS OF:

- Facial
- Oral
- Extremity
- Trunk



ABNORMAL INVOLUNTARY MOVEMENT SCALE (AIMS)

Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration
National Institute of Mental Health

Name: _____
Date: _____
Presenting Practitioner: _____

Code: 0 = None
1 = Minimal, may be extreme normal
2 = Mild
3 = Moderate
4 = Severe

Instructions: Complete Examination Procedure before making ratings.

		Rater Date	Rater Date	Rater Date	Rater Date
Movement ratings: Rate highest severity observed. Rate only movements judged to be abnormal. Rate only observed spontaneously. Circle movement as well as code number that applies.					
Facial and Oral Movements	**1. Muscles of facial expression** (e.g., movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	2. Lips and perioral area (e.g., pursing, puckering, smacking)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	3. Jaw (e.g., biting, clenching, chewing, mouth opening, lateral movement)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	4. Tongue: Rate only increases in movement both in and out of mouth — not inability to sustain movement. Darting in and out of mouth	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Extremity Movements	**5. Upper (arms, wrists, hands, fingers):** Include chorec movements (i.e., rapid, objectively purposeless, irregular, spontaneous) and athetoid movements (i.e., slow, sinuous, continuous, writhing in type). Do not include tremor (i.e., repetitive, regular, rhythmic)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	6. Lower (legs, knees, ankles, toes) (e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Trunk Movements	**7. Neck, shoulder, hips** (e.g., rocking, twisting, squirming, pelvic gyrations)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Global Judgments	**8. Severity of abnormal movements overall**	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	9. Incapacitation due to abnormal movements	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
	10. Patient's awareness of abnormal movements: Rate only patient's report. No awareness 0 Aware, no distress 1 Aware, mild distress 2 Aware, moderate distress 3 Aware, severe distress 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4
Dental Status	**11. Current problems with teeth and/or dentures**	No Yes	No Yes	No Yes	No Yes
	12. Are dentures usually worn?	No Yes	No Yes	No Yes	No Yes
	13. Edentia	No Yes	No Yes	No Yes	No Yes
	14. Do movements disappear in sleep?	No Yes	No Yes	No Yes	No Yes

AIMS Examination Procedure
Either before or after completing the Examination Procedure, observe the patient unobtrusively, at rest (e.g., in waiting room).

The chair to be used in this examination should be a hard, firm one without arms.

1. Ask patient to remove shoes and socks.
2. Ask patient whether there is anything in his or her mouth (e.g., gum, candy) and, if there is, to remove it.
3. Ask patient about the current condition of his or her teeth. Ask patient if he or she wears dentures. Do teeth or dentures bother the patient now?
4. Ask patient whether he or she notices any movements in mouth, face, hands, or feet. If yes, ask to describe and to what extent they currently bother patient or interfere with his or her activities.
5. Have patient sit in chair with hands on knees, legs slightly apart, and feet flat on floor. Look at entire body movements while in this position.
6. Ask patient to sit with hands hanging unsupported; if male, between legs; if female and wearing a dress, hanging over knees. Observe hands and other body areas.
7. Ask patient to open mouth. Observe tongue at rest within mouth. Do this twice.
8. Ask patient to protrude tongue. Observe abnormal movements. Do this twice.
9. Ask patient to tap thumb, with each finger, as rapidly as possible for 10 to 15 seconds, separately with right hand, then with left hand. Observe each facial and leg movement.
10. Flex and extend patient's left and right arms (one at a time). Note any rigidity.
11. Ask patient to stand up. Observe in profile. Observe all body areas again, hips included.
12. Ask patient to extend both arms outstretched in front with palms down. Observe trunk, legs, and mouth.
13. Have patient walk a few paces, turn, and walk back to chair. Observe hands and gait. Do this twice.

AKATHISIA motor inner-driven restlessness (tapping foot incessantly, rocking forward and backward in chair, shifting weight from side to side).

ANHEDONIA (NEGATIVE SYMPTOMS OF SCHIZOPHRENIA)

- inability to experience pleasure in activities that usually produce it.

ANTICHOLINERGIC EFFECT

SYMPTOMS

- Dry mouth
- Urinary Retention / hesitancy
- Constipation
- Blurred vision / Photosensitivity
- Dry eyes
- Sexual Dysfunction

TOXICITY

- Dry mucous membranes
- Reduced / absent peristalsis
- Mydriasis (dilation of pupil w/ont physiological cause
- nonreactive pupils
- hot, dry, red skin.
- hyperpyrexia (temp ↑ 106°F) w/ont diaphoresis
- tachycardia
- agitation
- unstable vital signs
- worsening of psychotic symptoms
- delirium
- urinary retention
- seizure
- repetitive motor movements

* know responsible health teaching

APATHY lack of interest, enthusiasm, or concern

AUDIO HALLUCINATIONS hearing voices or sounds

CIRCADIAN RHYTHMS 24 hour biological rhythm that influences specific regulatory functions such as the sleep/wake cycle, body temperature, and hormonal and neurotransmitter secretions.

CIRCUMSTANTIALITY including unnecessary and often tideous details in one's conversation (describing your breakfast when asked how your day was going).

CLANG ASSOCIATIONS choosing words based on their sound rather than their meaning. (On the track... Big Mac).

CONCRETE THINKING involves literal interpretation

DECANOATE PREPARATION IM injection

DEPERSONALIZATION a feeling that one is somehow different or unreal or has lost its identity

DEREALIZATION false perception that the environment that has changed.

DISORGANIZED SCHIZOPHRENIA disorganized behavior and speech. Includes disturbance in emotional expression.

NANDA:

- DELUSIONS
- HALLUCINATIONS
- DISORGANIZED SPEECH + THOUGHTS

ECHOLALIA pathological repeating of another's words and is often seen in catatonia.

NURSE: Mary, come get your medication

MARY: Come get your medication

EXTRAPYRAMIDAL SYMPTOMS 3 most common are: ACUTE DYSTONIA - acute sustained contraction of muscles (head, neck)

: **AKATHISIA** – psychomotor restlessness evident as pacing or fidgeting, sometimes pronounced and very distressing to patients

: **PSEUDOPARKINSONISM** – medication induced, temporary constellation of symptoms associated w/ Parkinson's disease
- tremor
- reduced accessory movements
- impaired gait
- stiff muscles.

GUSTATORY HALLUCINATIONS experiencing taste

GRANDOISE THINKING believes one is a very powerful or important person.

IDEAS OF REFERENCE interpretations of the verbalizations of actions of others that give special personal meanings to these behaviors.

ILLUSIONS misperceptions or misinterpretations of a real experience

LIABILITY Failure to protect patients creates a liability for the Psych Tech and their employer.

LOOSENESS OF ASSOCIATION speech threads are interrupted or disjointed.

- Don't pretend that you understand "I'm having trouble following what you are saying."
- Look for reccuring topics and themes in the patient's communications, and tie these to events and timelines.
- Summarize or paraphrase patients communications to role-model clearer communication and to give the patient a chance to correct anything you may have misunderstood.
- Reduce stimuli in the vicinity, and speak concisely, clearly, and concretely in sentences rather than paragraphs.

NEGATIVE SYMPTOMS develop slowly, impede one's ability to initiate and maintain conversations and relationships, obtain employment, Make decisions and follow through on plans, Maintain adequate hygiene and grooming

- **AFFECTIVE BLUNTING**: ↓ in expression, range and intensity of affect.
  - **FLAT**: blank facial exp.
  - **BLUNTED**: reduced emo. response
  - **INAPPROPRIATE**: incongruent w/ the actual emo. state or situation (laughs when fearful).
  - **BIZZARE**: odd, illogical, grossly inappropriate, or unfounded (includes grimacing and giggling).
- **ANERGIA**: Lack on energy
- **ANHEDONIA**: Inability to experience pleasure in activities that usually produce it.
- **AVOLITION**: Reduced motivation and spontaneous activity, inability to initiate tasks such as social contracts, grooming, and other ADL's
- **POVERTY OF CONTENT OF SPEECH**: Adequate in amount, speech conveys little info because of vagueness or superficiality.
- **POVERTY OF SPEECH**: Reduced spontaneity and amount of speech, responds in brief or 1 word answers.
- **THOUGHT BLOCKING**: Sudden interruption in the thought process, usually due to internal stimuli (stopping in the middle of a sentence and remain silent
- **COGNITIVE SYMPTOMS**: difficulty with attention, memory, and executive functions (decision making & problem solving).

NEOLOGISM are made up words that have meaning for the patients but a different or nonexistent meaning to others.

NONCOMPLIANCE a patient does not take medications.

PATIENT: "I dont need to take these medications. I am not sick."

* Due to illness (Schizophrenia), patient dont realize he is really sick.

NEUROLEPTIC MALIGNANT SYNDROME life threatening medical emergency caused by excessive dopamine receptor blockade

- ↓ Consciousness
- ↑ Muscle tone and autonomic dysfunction
  - ↑ body temp. → hyperpyrexia
  - fluctuates from normal to high → labile hypertension
  - fast ♥ rate → tachycardia
  - Rapid breathing → tachypnea
  - sweating → diaphoresis
  - drooling

OLFACTORY HALLUCINATIONS smelling odors

PARANOID SCHIZOPHRENIA irrational fear of others, ranging from mild to profound. May act defensively, harming the other person before that harms the patient; RISK FOR OTHERS.

INTERVENTIONS

- COUNSELING: ↓ client anxiety / ↑ staff effectiveness
- SELF-CARE NEEDS: Poisoned, killed while sleeping
- MILIEU NEEDS: Provide sense of security & safety

PERSEVERATION involuntary repetition of the same thought, phrase, or motor response (brushing teeth, walking).

POORLY ORGANIZED THINKING AKA "DISORGANIZED THINKING": incoherent + illogical thoughts.

POSITIVE SYMPTOMS associated w/ acute onset / alterations in thought, speech, perception, and behavior

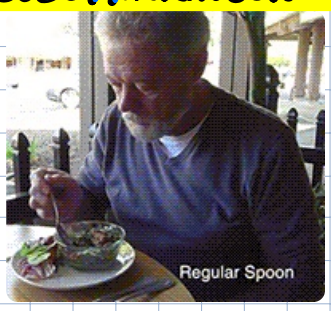
- **DELUSIONS** false beliefs that cannot be corrected by reasoning.
  - Control: "The NSA is spying on us through the fluorescent lights."
  - Ideas of reference: "The birds are singing."
  - Persecution: "FBI is trying to poison me."
  - Grandeur: "I am the President of the U.S."
  - Somatic Delusions: "My arm is disappearing"
  - Erotomanic: "Kim Kardashian want to hook up with me!"
  - Jealous: "My husband came late from work! She met with her mistress!" (Even though all employees came late from work).

POVERTY OF THOUGHT AKA "ALOGIA." ↓ in volume of speech, represented by a lack of spontaneous comments and overly brief responses.

PRODORMAL STAGE OF SCHIZOPHRENIA the onset of symptoms or forewarning symptoms may appear a month to more than a year before the 1st psychotic break or full-blown manifestations of the illness.

- withdrawal
- poor concentration
- misinterpreting
- preoccupation w/ religion

PSEUDOPARKINSONISM medication-induced temporary constellation of symptoms associated w/ Parkinson's disease



* Common w/ 1ST generation antipsychotic drugs.

- Mask like face
- Tremor "Pill-rolling"
- Stiff and stooped posture
- Shuffling Gait
- Drooling

RELAPSE a return or worsening symtoms following a period of remission.

- Family education and therapy improve the quality of life for the patient and reduce relapse rate for many
  - PSYCHOEDUCATIONAL
- PHASE 3: MAINTENANCE: focuses on preventing relapse.
  - Develop a relapse prevention plan.
    - know the early warning signs
      - avoiding others
      - trouble sleeping
      - troubling thoughts
    - Make a list of whom to call, what to do and where to go if signs of relapse appear. Keep it w/ you.
    - Relapse is part of an illness. Not a sign of failure
    - Avoid alcohol/drugs! They can act on the brain and cause a relapse.
- NANDA: Nonadherence to medication regimen related to side effects of therapy, as evidenced by verbalization of nonadherence and persistence of symptoms: failure to take prescribed medications because "They make me tired and I can't have sex." History of recurrent relapse.

RESIDUAL SCHIZOPHRENIA Person no longer has active-phase symptoms (+symptoms), only displays mostly − symptoms.

SCHIZOPHRENIFORM person has many of the features of schizophrenia but has had these for a period of **LESS THAN 6 MONTHS** (May / May not develop in Schizophrenia)

SCHIZOPHRENIA NURSING DIAGNOSES

TABLE 12-3 POTENTIAL NURSING DIAGNOSES FOR SCHIZOPHRENIA

SYMPTOM	NURSING DIAGNOSES
Positive Symptoms	
Hears voices that others do not *(auditory hallucinations)*	*Disturbed sensory perception: auditory/visual*
Hears voices telling him or her to hurt self or others *(command hallucinations)*	*Risk for self-directed/other-directed violence*
Delusions	
Shows loose association of ideas *(associative looseness)*	*Impaired verbal communication*
Conversation is derailed by unnecessary and tedious details *(circumstantiality)*	
Negative Symptoms	
Uncommunicative, withdrawn	*Social isolation*
Expresses feelings of rejection or aloneness (lies in bed all day, positions back to door)	*Impaired social interaction* *Risk for loneliness*
Talks about self as "bad" or "no good"	*Chronic low self-esteem*
Feels guilty because of "bad thoughts"; extremely sensitive to real or perceived slights	*Risk for self-directed violence*
Shows lack of energy *(anergia)*	*Ineffective coping*
Shows lack of motivation *(avolition)*, unable to initiate tasks (social contact, grooming, and other aspects of daily living)	*Self-care deficit (bathing/hygiene, dressing/grooming)* *Constipation*
Other	
Families and significant others become confused or overwhelmed, lack knowledge about disorder or treatment, feel powerless in coping with patient	*Compromised family coping* *Caregiver role strain* *Deficient knowledge*
Stops taking medication (because of anosognosia, side effects, drugs costs, mistrust of staff), stops going to therapy, is not supported in treatment by significant others	*Nonadherence*

TACTILE HALLUCINATIONS feeling bodily sensations

TANGIENTIALTY alteration in speech where the person leaves the main topic to talk about less important information (going off on a tangient).

TARDIVE DYSKINESIA involuntary spasmodic muscular contractions that involves the tongue, fingers, toes, neck, trunk, or pelvis

- Grimace, smack lips
- Tongue thrust
- Rocking, hip jerking

*IRREVERSIBLE

THOUGHT BROADCASTING belief that others can hear one's thoughts.

THOUGHT INSERTION thoughts of others are implemented in one's mind.

THOUGHT WITHDRAWAL thoughts can be removed by others

VISUAL HALLUCINATIONS Seeing persons or things

WAXY FLEXIBILITY is a symptom seen in catatonic schizophrenia. It's when a person's arm is placed outward, and remains in that position (abnormal posturing, remains motionless in a stereotyped position).

PRIORITIZE: Physiological needs

NANDA: Self-Care Deficit
- Feeding
- Bathing
- Dressing
- Toileting

WHEN THE VOICES BOTHER

- PATIENT: "The voices say everyone is trying to kill me"

  PSYCH TECH: Implement safety measures.

  : Respond by focusing on the feelings of the patient,
  ↳ "Feeling that way must be very frightening."

NONCOMPLIANT PATIENTS

- a patient is in denial due to his/her illness, making it harder to realized they are ill. (ANOSOGNOSIA)
- side effects of antipsychotic meds can cause patients to not comply.
- Drug costs
- Mistrust of staff
- Not supported by family or loved one.

APPROPRIATE ACTIVITIES AND GROUPS FOR SCHIZOPHRENIA PATIENTS + FAMILIES

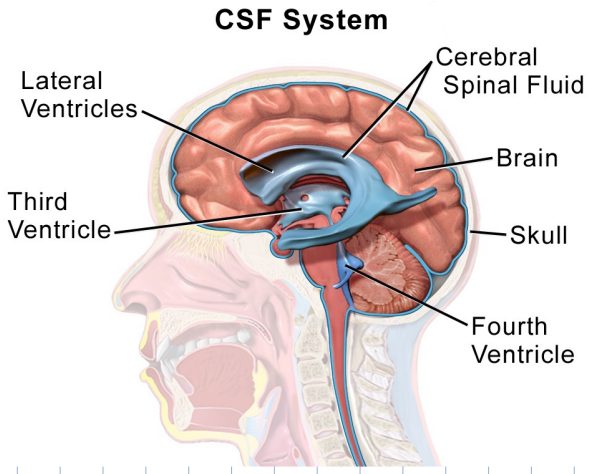
- Walk
- Go to the mall
- Play music / instrument
- Clean the house
- Call a help line or go to a drop in center
- Take a relaxing bath.

ORTHOSTATIC HYPOTENSION Zyprexa w/ a blood pressure medication may cause othostatic hypotension.

USE OF BENZODIAZEPINES can reduce anxiety and agitation and contribute to improvement in positive and negative symptoms

- LORAZEPAM (ATIVAN): helps to reduce akathesia
- ALPAZOLAM (XANAX):
- CLONAZEPAM (CLONOPIN):
- CHLORDIAZEPOXIDE (LIBRIUM):

WHAT IS THE NEUROLOGICAL ORIGIN OF SCHIZOPHRENIA



- Enlarged lateral cerebral ventricles
- 3rd ventricle dilation
- Ventricular asymmetry
- Cortical Atrophy
- Cerebellar Atrophy
- Atrophy of frontal lobe
- Increased size of the sulci (fissures) on the surface of the brain
- Overall brain volume and higher CSF
- Low Blood flow + slow glucose metabolism in the frontal lobes of the cerebral cortex
- Postmortem: reduced gray matter in temporal and frontal lobes.

↳ causes hallucination, delusions, bizzare thoughts, depression.

* **TESTS:** CT scan, MRI, PET.

HOW TO TALK TO SOMEONE WITH SCHIZOPHRENIA

WHEN HALLUCINATING: Call patient by name, speak simply and loudly enough to be understood, present in a non-threatening and supportive manner, maintain eye contact, redirect the patient's focus to your conversation as needed.

"The voices that you're hearing, I can't hear those voices. Tell me what they're saying so I can help you."

"What are the voices telling you to do?"

* Do not challenge what they're hallucinating.
* Ask for permission to do things.
* Convey that you believe the patient is hearing or seeing things

BOX 12-3 HELPING PATIENTS WHO ARE EXPERIENCING HALLUCINATIONS

- Ask the patient directly about the hallucinations. Example: "What are you hearing?"
- Watch the patient for cues that he or she is hallucinating, such as eyes tracking an unheard speaker, muttering, talking to self, appearing distracted, or watching a vacant area of the room.
- Avoid referring to hallucinations as if they are real.
- Do not negate the patient's experience, but offer your own perceptions and convey empathy. Example: "I don't hear the angry voices, but that must be very frightening for you."
- Focus on reality-based, "here-and-now" activities such as conversations or simple projects. Tell the patient, "The voice you hear is part of your illness; it cannot hurt you. Try to listen to me and the others you can see around you."
- Be alert to signs of anxiety in the patient, which may indicate that hallucinations are increasing.
- Encourage the use of competing auditory stimuli such as listening to music through headphones
- Address any underlying emotion, need, or theme that seems to be indicated by the hallucination, such as fear with menacing voices or guilt with accusing voices.

DELUSION:

BOX 12-4 GUIDELINES FOR COMMUNICATION WITH PATIENTS EXPERIENCING DELUSIONS

- To build trust, be open, honest, genuine, and reliable.
- Respond to suspicion in a matter-of-fact, empathic, supportive, and calm manner.
- Ask the patient to describe his beliefs. Example: "Tell me more about someone trying to hurt you."
- Avoid debating the delusional content, but interject doubt where appropriate. Example: "It seems as if it would be hard for a girl that small to hurt you."
- Validate if part of the delusion is real. Example: "Yes, there was a man at the nurse's station, but I did not hear him talk about you."
- Focus on the feelings or theme that underlie or flow from the delusions. Example: "You seem to wish you could be more powerful" or "It must feel frightening to believe others want to hurt you."
- Once trust has been established, acknowledge that, while the belief seems very real to the patient, illnesses can sometimes make things seem true even though they aren't. Introducing this obliquely can make it less confrontational: "I wonder if that might be what is happening here, because what seems true to you does not seem true to others."
- Once the patient has begun to question the delusion and/or understand the concept of delusions, label subsequent delusions to help the patient recognize them as well.
- Do not dwell excessively on the delusion. Instead, refocus onto reality-based topics. If the patient obsesses about delusions, set limits on the amount of time you will talk about them, and explain your reason.
- Observe for events that trigger delusions. If possible, help the patient find ways to avoid such triggers or reduce associated anxiety.
- Promote improved reality testing by guiding the patient to question his beliefs: "I wonder if there might be any other explanation why others might be avoiding you? Instead of hating you, might they simply be busy?"

- **ASSOCIATIVE LOOSENESS:** Reduce stimuli in the vicinity, and speak concisely, clearly, and concretely in sentences rather than paragraphs.
- Don't judge!
- Focus on what the person is feeling
- Remain calm
- Allow time for them to respond

SAFETY FOR SCHIZOPHRENIC CLIENTS

- **PHASE 1:** overall goal is patient safety and stabilization
- **HALLUCINATING:** 1 to 1 supervision
- **COMORBID DEPRESSION:** must be identified and treated to reduce the potential for suicide, substance abuse, nonadherence, and relapse

SAMPLE NURSING DIAGNOSIS FOR SCHIZOPHRENIA

- Impaired thought processes *related to* possible hereditary factors *as evidenced by* the individual experiencing auditory and visual hallucinations and a family history of schizophrenia
- Impaired verbal communication *related to* disordered thought processes *as evidenced by* rapid speech and tangential thinking
- Risk for violence, self directed, *related to* suicidal ideation *as evidenced by* the individual stating I want to kill myself and several past suicide attempts
- Risk for other directed violence *related to* poor impulse control *as evidenced by* the individuals hitting or scratching others without provocation
- Disturbed sensory perception (visual and auditory) *related to* biochemical imbalance *as evidenced by* auditory and visual hallucinations and the individual reporting I see dead people

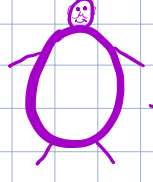
MEDICATIONS

- MED: THORAZINE (CHLORPROMAZINE) 1ST GEN
  - BEST USE: Psychotic episode due to hallucination or delusion
  - SIDE EFFECTS: Cornea Deposit

- MED: HALDOL (HALOPERIDOL) 1ST GEN
  - BEST USE: Target positive symptoms of Schizophrenia (less anticholinergic)
  - SIDE EFFECTS: Sedation and muscle stiffness.
    Acute dystonic reaction (painful contractions of face, tongue, neck, and back. ↑ chances of EPS

- MED: RISPERDAL (RISPERIDONE) 2nd GEN
  - BEST USE: less sedative for elderly
  - SIDE EFFECTS: Neuroleptic Malignant Syndrome
    Gynecomastia ~Rise-Pair-adon
    - Severe muscle stiffness
    - Diff. swallowing/drool
    - Hyperpyrexia

- MED: ZYPREXA (OLANZIPINE) 2nd GEN
  - BEST USE: Schizophrenia
  - SIDE EFFECTS: Weight gain, hyperglycemia, orthostatic hypotension, akathisia, dizziness, tremor.



- MED: CLOZARIL (CLOZAPINE) 2nd GEN
  - BEST USE: Schizophrenia (never 1ST line of treatment
  - SIDE EFFECTS: May produce agranulocytosis!

"Watch CLOZ-ley for Agranulocytosis

- MED: ABILIFY (ARIPIPRAZOLE) THIRD GEN ANTIPSYCHOTIC

  BEST USE: Schizophrenic patient who is overweight and hypertensive

  SIDE EFFECTS: tardive dyskinesia, NMS, tremors, muscle spasms.

- MED: GEODON (ZIPRASIDONE) 2nd GEN

  BEST USE: Schizophrenia w/ acute agitation, Bipolar I disorder

  SIDE EFFECTS: May prolong the QT interval (don't give w/ ♥ disease, orthostatic hypotension, hyperglycemia, EPS.

- MED: BUSPAR (BUSPIRONE)

  BEST USE: anxiety

  SIDE EFFECTS: Chest pain, ringing

- MED: NARDIL (PHENELZINE)

  BEST USE: Depression

  SIDE EFFECTS: Orthostatic hypotension, asthenia, hyperreflexia

- MED: DESYREL (TRAZODONE)

  BEST USE: Antidepressant, cocain withrawal, alcohol withdrawal

  SIDE EFFECTS:

- MED: ARTANE (TRIHEXYPHENIDYL)

  BEST USE:

  SIDE EFFECTS: Dry mouth, fever, tachycardia.

- MED: BENADRYL (DIPHENHYDRAMINE)

  BEST USE: Treat DYSTONIA (head rotated to one side in a stiffly fixed position, lower jaw thrust forward and drooling.

  Akathisia (Psychomotor restlessness

  SIDE EFFECTS: Sedation, dry mouth, dizziness, insomnia

ACUTE DYSTONIA
(4 hours)
"Muscle"

AKATHISIA
(4 days)
"Rustle"

AKINESIA
(4 weeks)
"Hustle"

TARDIVE DYSKINESIA
"Chewing Tar-dive

HYPERPROLACTINEMIA
(DUE TO RISPERIDONE)
"Rise-Pair-idone of breast

NEUROLEPTIC MALIGNANT SYNDROME

- Confusion
- Agitation
- Hyperthermia (>105°F)
- Muscle Rigidity
- Seizures

+ Recent antipsychotic use = NMS

MED: Dantrolene

Dan Never Miss a Step

"PO before Depot"

BOOK NOTES

SCHIZOPHRENIA: Brain Disorder that affects a person's

- Thinking
- Language
- Emotional
- Social Behavior
- ability to perceive reality accurately

OTHER PSYCHOTIC DISORDERS

- **SCHIZOTYPAL PERSONALITY DISORDER** social and interpersonal deficits, cognitive or perceptual distortions, eccentric behavior.
  - Ideas of reference
  - Magical thinking
  - Unusual perceptual experiences
  - Odd thinking and speech
  - Paranoid Ideation (Suspicious of others)
  - Inappropriate or constricted affect
  - Behavior or appearance that is odd, eccentric, peculiar
  - Lack of close friends
  - Excessive social anxiety that doesn't diminish w/ familiarity

- **DELUSIONAL DISORDER** experience nonbizzare delusions
  - being followed
  - have an infection

- **BRIEF PSYCHOTIC DISORDER** acute onset of psychosis OR grossly disorganized OR catatonic behavior in response to extreme stress. LASTS < 1 MONTH
  - delusions

- hallucinations
- disorganized speech.

- **SUBSTANCE-INDUCED PSYCHOTIC DISORDER** induced by drugs, alcohol, medications or toxins

- **PSYCHOSIS OR CATATONIA ASSOCIATED W/ ANOTHER MEDICAL CONDITION** caused by medical condition such as:
  - delirium
  - neurological conditions
  - metabolic conditions
  - hepatic disease
  - renal disease

- **SCHIZOPHRENIFORM DISORDER** a person has many of the features of schizophrenia but has had these for a period of < 6 MONTHS.

- **SCHIZOAFFECTIVE DISORDER** when an episode of MAJOR DEPRESSION, MANIA, or MIXED occurs in the presence of symptoms schizophrenia

- **PSYCHOTIC OR CATATONIC DISORDER NOT OTHERWISE SPECIFIED** involves psychotic features such as impaired reality testing or bizzare behavior but dont meet the criteria. Persons exhibiting

EPIDEMIOLOGY

- 1% of adults have Schizophrenia (doesnt matter the race, culture, social status)
- Usually presents during late teens and early 20s.

- Early onset ⟶ occurs more often in males
- Late onset ⟶ occurs more often in females.

COMORBIDITY occurs in ____% of persons w/ schizophrenia

- SUBSTANCE ABUSE DISORDER: 50%
- NICOTINE DEPENDENCE: 70-90%
- ANXIETY, DEPRESSION, SUICIDE: 10%
- PHYSICAL HEALTH ILLNESS: 6-24%
- POLYDIPSIA: 20%

ETIOLOGY

- Schizophrenia occurs when multiple inherited gene abnormalities combine w/ nongenetic factors, altering the structures of the brain, affecting the brain's neurotransmitter systems, and/or injuring the brain directly (DIATHESIS-STRESS MODEL OF SCHIZOPHRENIA).

BIOLOGICAL FACTORS

- TWINS

NEUROBIOLOGICAL FACTORS

- DOPAMINE THEORY
-
-

Schizophrenia Medications

called: antipsychotics, neuroleptics, or major tranquilizers

- medications are #1 treatment for schizophrenia spectrum Dis
  - ↳ all medications have side effects
    - ↳ side effects are #1 reason patients stop taking meds

People w/ mental illness die, on average, 2 decades earlier
Heart disease & diabetes #1 cause of death

1st generation antipsychotics

aka: standard, traditional, or "typical" antipsychotics
Thorazine (chlorpromazine) > main 2
Haldol (haloperidol)
no longer first line of defense
Targets ONLY positive systems
- These medications can cause serious side effects (Parkinsons) & selection is often made on basis of these major side effects

Thorazine - most sedating but fewer EPS symptom
given IM, anticholergenic effect

Haldol - least sedating, super high EPS!
often used in large doses to reduce assaultive beh

Mellaril - not recommended as a 1st line
antipsychotic b/c it can cause
severe ECG, ↑sedation, ↓EPS,
anticholergenic effects

Stelazine, Prolixin, Navane ↑EPS ↓sedation

decanoate - long acting, IM (2 track)
(lasting) expensive

2nd Generation Atypical Antipsychotics

- diminishes both positive & neg. symptoms
- has fewer or no EPS
- diminished tardive dyskinesia
- may improve neurocognitive defects associated w/ schizophrenia
- Tend to make you gain weight

*Metabolic syndrome: caused by atypical meds
- extra weight around middle of body (apple shaped)
- insulin resistance, body cannot use insulin effectively → can lead to diabetes

- drugs of choice for schizo -

Abilify: less weight gain, & less increase in glucose & cholesterol.
- give to client w/ obesity / heart disease
Black Box warning for Suicide
used for Schizo, Bipolar I, & major depressive dis.
- abilify keeps you skinny & fly, heart healthy for bae

Geodon may prolong QT interval affecting heart rate
NOT FOR: client w/ cardiac disease, elderly w/ dementia or lactating moms
Bully Geodude is bad for heart, dementia, & milk

low weight gain

Zyprexa 2.5-20mg: for schizo, acute / mixed episodes of bipolar & bipolar Rx maintenance
- orally / injected
- weight gain, high cholesterol & ↑ Blood sugar

- Zyprexa makes you fat & sugar sexy

Zyprexa Zydis: for schizo & Bipolar disorders
Whatch w/ high blood pressure meds; may cause orthostatic hypotension
- anticholinergic & benzodiazepine use may increase side effects (newer drug)

Risperdal 4-16mg: schizo & mania, appoved for schizophrenia & irritability in autistic children, high dosage = ~~[illegible]~~ ↑EPS
Risperdal Consta - long acting injection (2weeks)
less ~~weight gain than others~~ too

clozaril: associated w/ agranulocytosis & lowered seizure threshold (3000mm & 1500mm)

Review of Med Side effects

EPS: dystonia, akathesia, Pseudoparkinsonism

anticholinergenic side effects: dry mouth, blurred vision, constipation, urinary retention: can be fatal be careful
educate patien to report side effects

Orthostatic hypotension advise:

lowered seizure threshold: clozaril

agranulocytosis: S&S: fever, sore throat, malaise
observe for infection

Seroquel: schizo, Bipolar, depression
↓ doses for insomnia (Seroquel sounds like nyquil)
↑EPS

early signs of relapse: social withdrawal, trouble sleeping, increase in bizarre/magical thinking

Hallucinating: darting eyes, muttering, watching empty area of room

nandas

- risk for other-directed violence
- risk for self-directed violence
- disturbed thought process
- disturbed sensory perception
- impaired verbal communication
- Ineffective coping
- chronic low self esteem, risk for loneliness, social isolation, impaired parenting, role strain?
- comprimised family coping
- disabled family coping
- Imbalanced nutrition: less than body req.
- activity intolerance
- constipation / incontinence
- impaired physical mobility
- self-care deficit

(Clozaril will be used to reduce nasea/vomit.

MED: CLOZARIL (CLOZAPINE) 2nd GEN
BEST USE: Schizophrenia (never 1st line of treatment
SIDE EFFECTS: May produce agranulocytosis!
"Watch CLOZley for Agranulocytosis

Tardive dyskenesia: protuding & rolling tongue, smacking lip facial distortion.

(rash) steven Jonson Syndrome: sheet like skin, sores on mucous membrane, may be caused by meds.

Toxic Epidermal necrolysis
samish as ↑

Potentially Fatal) neuroleptic malignant Syndrome (NMS): reduced consciousness, increased muscle tone, fever, drooling

Polydipsia: fatal water intoxication

family psychoeducation is essential

low potency = ↑sedation, high ACH, low EPS
High potency = ↓sedation, ↓ ACh, high EPS

2-3 weeks for antipsycotics to take effect

disease course (3 phases)

- Phase 1: Acute Phase
  - onset of florid symptoms (hallucin., delusions, apathy)
  - withdrawal w/ loss of functional ability
  - individuals require increase care / hospitalization

acute phase goals: crisis intervention, safety & stabalization
- discharge planning → identify after care needs

phase 2: stabilization phase
- acute symptoms diminish in severity
- moving towards previous level of functioning
- day hosp., residential crisis ctr., or supervised home

Stabilization phase goals: manage medication & disease education,
- teach relapse prevention skills

Phase 3: maintenance phase
- Florid symptoms in remission, (milder symptoms may linger
- individuals can live w/in community

maintenace phase goals: client participation / cooperation
- appropriate setting for client success
- external structure
- support group by-in

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