

DSM-IV

SCHIZOPHRENIA

295.30 Paranoid type

295.10 Disorganized type

295.20 Catatonic type

295.90 Undifferentiated type

295.60 Residual type

(Refer to *DSM-IV* for other listings.)

Schizophrenia describes psychotic state that at some time is characterized by apathy, avolition, asociality, affective blunting, and alogia. The client has alterations in thoughts, percepts, mood, and behavior. Subjective experiences of disordered thought are manifested in disturbances of concept formation that sometimes lead to misinterpretations of reality, delusions (particularly delusions of influence and ideas of reference), and hallucinations. Mood changes include ambivalence, constriction or inappropriateness of feeling, and loss of empathy with others. Behavior may be withdrawn, regressive, or bizarre (Shader, 1994).

ETIOLOGICAL THEORIES

Psychodynamics

Psychosis is the result of a weak ego. The development of the ego has been inhibited by a symbiotic parent/child relationship. Because the ego is weak, the use of ego defense mechanisms in times of extreme anxiety is maladaptive, and behaviors are often representations of the id segment of the personality.

Biological

Certain genetic factors may be involved in the susceptibility to develop some forms of this psychotic disorder. Individuals are at higher risk for the disorder if there is a familial pattern of involvement (parents, siblings, other relatives). Schizophrenia has been determined to be a sporadic illness (which means genes cannot currently be followed from generation to generation). It is an autosomal dominant trait. However, most scientists agree that what is inherited is a vulnerability or predisposition, which may be due to an enzyme defect or some other biochemical abnormality, a subtle neurological deficit, or some other factor or combination of factors. This predisposition, in combination with environmental factors, results in development of the disease. Some research implies that these disorders may be a birth defect, occurring in the hippocampus region of the brain. The studies show a disordering of the pyramidal cells in the brains of schizophrenics, while the cells in the brains of nonschizophrenic individuals appear to be arranged in an orderly fashion. Ventricular brain ratio (VBR) or disproportionately small brain (or specific areas of the brain) may be inherited and/or congenital. The cause can be a virus, lack of oxygen, birth trauma, severe maternal malnutrition, or cellular damage resulting from an RhD immune response (mother negative/fetus positive).

A biochemical theory suggests the involvement of elevated levels of the neurotransmitter dopamine, which is thought to produce the symptoms of overactivity and fragmentation of associations that are commonly observed in psychoses.

Although overall occurrence is relatively equal between males and females, resources report a predominant male bias with two-thirds of young adults with serious mental illnesses being male. Boys react more strongly than girls to stress and conflicts in the family home, and are more vulnerable to infantile autism. A significantly larger number of males than females exhibit obsessive and suicidal behaviors, fetishism, and schizophrenia. Schizophrenia develops earlier in males, and they respond less well to treatment and have less chance of recovery and return to normal life than females. The incidence in females may have more familial origins. The different brain organization of men and women, and the effect of sex hormones on brain growth are likely to result in subtle differences that define the "scope and range of sex differences in the incidence, clinical presentation, and course of specific psychiatric diseases" (Moir & Jessel, 1991).

Family Dynamics

Family systems theory describes the development of schizophrenia as it evolves out of a dysfunctional family system. Conflict between spouses drives one parent to become attached to the child. This overinvestment in the child redirects the focus of anxiety in the family, and a more stable condition results. A symbiotic relationship develops between parent and child; the child remains totally dependent on the parent into adulthood and is unable to respond to the demands of adult functioning.

Interpersonal theory relates that the psychotic person is the product of a parent/child relationship fraught with intense anxiety. The child receives confusing and conflicting messages from the parent and is unable to establish trust. High levels of anxiety are maintained, and the child's concept of self is one of ambiguity. A retreat into psychosis offers relief from anxiety and security from intimate relatedness. Some research indicates that clients who live with families high in expressed emotion (e.g., hostility, criticism, disappointment, overprotectiveness, and overinvolvement) show more frequent relapses than clients who live with families who are low in expressed emotion.

Current research of genetic and biological influences suggests that these family interactions are more likely to be contributing factors to rather than the cause of the disorder.

CLIENT ASSESSMENT DATA BASE

General

Activity/Rest

Interruption of sleep by hallucinations and delusional thoughts, early awakening, insomnia, and hyperactivity (e.g., pacing)

Hygiene

Poor personal hygiene, unkempt/disheveled appearance

Neurosensory

History of alteration in functioning for at least 6 months, including an active phase of at least 2 weeks in which psychotic symptoms were evident

Family reports of psychological symptoms (primarily in thought and perception) and deterioration from previous level of adaptive functioning

Mental Status:

Thought: Delusions, loose association

Perception: Hallucinations, illusions

Affect: Blunted, flat, inappropriate, incongruous, or silly

Volition: Cannot self-initiate or participate in goal-oriented activity

Capacity to Relate to Environment: Mental/emotional withdrawal and isolation (autism) and/or psychomotor activity ranging from marked reduction to stereotypic, purposeless activity

Speech: Frequently incoherent, echolalia may be noted/alogia (inability to speak) may occur

Delusions:

Disorganized type—Fragmentary delusions or hallucinations (disorganized, unthematized [without theme] content) common; systematized delusions absent

Paranoid type—One or more systematized delusions with prominent persecutory or grandiose content; delusional jealousy may occur

Undifferentiated type—Delusions prominent

Behaviors: Grimaces, mannerisms, hypochondriacal complaints, extreme social withdrawal, and other odd behaviors

Negativism: Resistance to all directions or attempts to move without apparent motive

Rigidity: Rigid posture maintained despite attempts to move client

Excitement: Purposeless motor activity not caused by external stimuli

Posturing: Voluntarily assuming inappropriate or bizarre posture

Emotions: Unfocused anxiety, anger, argumentativeness, and violence

Teaching/Learning

May have had previous acute episodes with impairment ranging from none to severe deterioration requiring institutionalization

Onset of symptoms most commonly occurring between the late teens and mid-30s

Correlations with family history of psychiatric illness; lower socioeconomic groups, higher stressors; premorbid personality described as suspicious, introverted, withdrawn, or eccentric

Disorganized

Neurosensory

Speech disorganized, communication consistently incoherent

Behavior regressive/primitive, incoherent, and grossly disorganized

Psychomotor: Stupor, markedly decreased reactivity to milieu, and/or reduced spontaneity of movement/activity or mutism

Affect: Incoherent, flat, incongruent, silly

Social Interactions

Extreme social impairment/withdrawal; odd mannerisms

Poor premorbid personality

Teaching/Learning

Chronic course with no significant remissions

Catatonic

(Although common several decades ago, incidence has decreased markedly with the advent of antipsychotic medications.)

Activity/Rest

Marked psychomotor retardation or excessive/purposeless motor activity

Exhaustion (extreme agitation)

Food/Fluid

Weight below norms; other signs of malnutrition

Neurosensory

Marked psychomotor disturbance (e.g., stupor, rigidity, mutism or excitement, negativism, waxy flexibility, and/or posturing)

Speech: Echolalia or echopraxia

Safety

Possible violence to self/others (during catatonic stupor or excitement)

Teaching/Learning

Possible hypochondriacal complaints or oddities of behavior

Paranoid

(Absence of symptoms characteristic of disorganized and catatonic types.)

Neurosensory

Systematized delusions and/or auditory hallucinations of a persecutory or grandiose nature, usually related to a single theme

Safety

Easily agitated, assaultive, and violent (if delusions are acted on)

Impairment in functioning (may be minimal), with gross disorganization of behavior (relatively rare)

Social Interactions

Significant impairment may be noted in social/marital areas

Affective responsiveness may be preserved but often with a stilted, formal quality or extreme intensity in interpersonal interactions

Sexuality

May express doubts about gender identity (e.g., fear of being thought of as, or approached by, a homosexual)

Teaching/Learning

Other family members may have history of paranoid problems

Undifferentiated

(This category is used when illness does not meet the criteria for the other specific types of schizophrenias, illness meets the criteria for more than one, or course of the last episode is unknown.)

Neurosensory

Prominent delusions/hallucinations, incoherence, and grossly disorganized behaviors

*Residual***Neurosensory**

Inappropriate affect

Social Interactions

Social withdrawal, eccentric behavior

Teaching/Learning

History of at least one episode of schizophrenia in which psychotic symptoms were evident, but the current clinical picture presents no psychotic symptoms

DIAGNOSTIC STUDIES

(Usually done to rule out physical illness, which may cause reversible symptoms such as: toxic/deficiency states, infections, neurological disease, endocrine/metabolic disorders.)

CT Scan: May show subtle abnormalities of brain structures in some schizophrenics (e.g., atrophy of temporal lobes); enlarged ventricles with increased ventricle-brain ratio may correlate with degree of symptoms displayed.

Positron Emission Tomography (PET) Scan: Measures the metabolic activity of specific areas of the brain and may reveal low metabolic activity in the frontal lobes, especially in the prefrontal area of the cerebral cortex.

MRI: Provides a three-dimensional image of the brain; may reveal smaller than average frontal lobes, atrophy of left temporal lobe (specifically anterior hippocampus, parahippocampogyrus, and superior temporal gyrus).

Regional Cerebral Blood Flow (RCBF): Maps blood flow and implies the intensity of activity in various brain regions.

Brain Electrical Activity Mapping (BEAM): Shows brain wave responses to various stimuli with delayed and decreased response noted, particularly in left temporal lobe and associated limbic system.

Addiction Severity Index (ASI): Determines problems of addiction (substance abuse), which may be associated with mental illness, and indicates areas of treatment need.

Psychological Testing (e.g., MMPI): Reveals impairment in one or more areas. **Note:** Paranoid type usually shows little or no impairment.

NURSING PRIORITIES

1. Promote appropriate interaction between client and environment.
2. Enhance physiological stability/health maintenance.
3. Provide protection; ensure safety needs.
4. Encourage family/significant other(s) to become involved in activities to promote independent, satisfying lives.

DISCHARGE CRITERIA

1. Physiological well-being maintained with appropriate balance between rest and activity.
2. Demonstrates increasing/highest level of emotional responsiveness possible.
3. Interacts socially without decompensation.
4. Family displays effective coping skills and appropriate use of resources.
5. Plan in place to meet needs after discharge.

NURSING DIAGNOSIS

May Be Related to:

THOUGHT PROCESSES, altered

Disintegration of thinking processes; impaired judgment

Psychological conflicts; disintegrated ego boundaries (confusion with environment)

Sleep disturbance

Possibly Evidenced by:

Ambivalence and concomitant dependence (part of need-fear dilemma interferes with ability to self-initiate fulfilling diversional activities)

Presence of delusional system (may be grandiose, persecutory, of reference, of control, somatic, accusatory); commands, obsessions

Symbolic and concrete associations; blocking ideas of reference

Inaccurate interpretation of environment; cognitive dissonance; impaired ability to make decisions

Simple hyperactivity and constant motor activity (ritualistic acts, stereotyped behavior) to withdrawal and psychomotor retardation

Interrupted sleep patterns

Desired Outcomes/Evaluation Criteria—

Recognize changes in thinking/behavior.

Client Will:

Identify delusions and increase capacity to cope effectively with them by elimination of pathological thinking.

Maintain reality orientation.

Establish interpersonal relationships.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine severity of client’s altered thought processes, noting form (derealistic, autistic, symbolic, loose and/or concrete associations, blocking); content (somatic delusions, delusions of grandeur/persecution, ideas of reference); and flow (flight of ideas, retardation).

Identification of symbolic/primitive nature of thinking/communications promotes understanding of the individual client’s thought processes and enables planning of appropriate interventions.

Establish a therapeutic nurse-client relationship.

Provides an emotionally safe milieu that enables interpersonal interaction and decreases autism.

Use therapeutic communications (e.g., reflection, paraphrasing) to intervene effectively.

Therapeutic communications are clear, concise, open, consistent, and require use of self. This reduces autistic thinking.

Structure communications to reflect consideration of client’s socioeconomic, educational, and cultural history/values.

Lack of consideration of these factors can cause misdiagnosis/inaccurate interpretation (otherwise normal thinking viewed as pathological).

Express desire to understand client's thinking by clarifying what is unclear, focusing on the feeling rather than the content, endeavoring to understand (in spite of the client's unclearness), listening carefully, and regulating the flow of the thinking as needed (Active-listening).

Reinforce congruent thinking. Refuse to argue/agree with disintegrated thoughts. Present reality and demonstrate motivation to understand client (model patience).

Share appropriate thinking and set limits (cognitive therapy) if client tries to respond impulsively to altered thinking.

Assess rest/sleep pattern by observing capacity to fall asleep, quality of sleep. Graph sleep chart as indicated until acceptable pattern is established.

Structure appropriate times for rest and sleep; adjust work/rest activity patterns as needed.

Help client identify/learn techniques that promote rest/sleep (e.g., quiet activities, soothing music, before bedtime, regular hour for going to bed, drinking warm milk).

Assess presence/degree of factors affecting client's capacity for diversional activities.

Client is often unable to organize thoughts (easily distracted, cannot grasp concepts or wholeness but focuses on minutiae), and flow of thoughts is often characterized as racing, wandering, or retarded. Active-listening identifies patterns of client's thoughts and facilitates understanding. Expression of desire to understand conveys caring and increases client's feelings of self-worth.

Provides opportunity for the client to control aggressive behavior. Decreases altered (disintegrated, delusional) thinking as client's thoughts compensate in response to presentation of reality.

Enhances self-esteem and promotes safety for the client and others. Cognitive therapy is directed specifically at thinking patterns that have developed (e.g., illogical associations are made between events that most of us would not believe to be connected). Aim is to modify apparently fixed beliefs, faulty interpretations, and automatic thoughts, and by relating them to "normal experience" to reduce some of the fear attached to them.

Delusions, hallucinations, etc. may interfere with client's sleep pattern. Fears may alter ability to fall asleep. Sleep deprivation can produce behaviors such as withdrawal, confusion, disturbance of perception. Sleep chart identifies abnormal patterns and is useful in evaluating effectiveness of interventions.

Consistency in scheduling reduces fears/insecurities, which may be interfering with sleep. Sleep is enhanced by balancing activity (physical, occupational) with rest/sleep.

Enhances client's ability to optimize rest/sleep, maximizing ability to think clearly.

Presence of hallucinations/delusions; situational factors such as long-term hospitalization (characterized by monotony, sensory deprivation); psychological factors such as decreased volition; physical factors such as immobility contribute to deficits in diversional activity.

Monitor medication regimen, observing for therapeutic effect and side effects (e.g., anticholinergic [dry mouth, etc.], sedation, orthostatic hypotension, photosensitivity, hormonal effects, reduction of seizure threshold, extrapyramidal symptoms, and fatigue/weakness with sore throat or signs of infection [agranulocytosis]).

Collaborative

Administer medications as indicated, e.g.:

Antipsychotics:

Phenothiazines, such as chlorpromazine (Thorazine), thioridazine (Mellaril), fluphenazine (Prolixin), perphenazine (Trilafon);
Thioxanthenes, such as chlorprothixene (Taractan), thiothixene (Navane);
Butyrophenones, such as haloperidol (Haldol);
Dibenzoxazepines, such as loxapine (Loxitane);

Atypical antipsychotics:

clozapine (Clozaril);

olanzapine (Zyprexa);

Enables identification of the minimal effective dose to reduce psychotic symptoms with the fewest adverse effects. Prevention of side effects/timely intervention may enhance cooperation with drug regimen. Identification of the onset of serious side effects, such as neuroleptic malignant syndrome, provides for appropriate interventions to avoid permanent damage.

Used to reduce psychotic symptoms. May be given orally or by injection. For long-term maintenance therapy, a depot neuroleptic such as Prolixin may be the drug of choice to maintain medication adherence and prevent relapse in problematic clients. When given at bedtime, the sedative effects of psychotropic medication can enhance quality of sleep and reduce hypotensive side effects.

Useful in treating clients resistant to other medications or in the presence of unacceptable side effects. Clozapine causes no muscular rigidity and is associated with a relatively low rate of akathisia (feeling of restlessness, urgent need for movement). May not be used as first-line therapy because of a lowered seizure threshold or a 1%–2% potential for agranulocytosis, necessitating weekly blood testing for the duration of treatment. **Note:** Combination therapy, e.g., clozapine and a neuroleptic, such as fluphenazine or haloperidol, may be useful for some clients.

Becoming a first-line drug choice as it specifically targets D₄ dopamine receptors, which may be present in unusually high numbers in clients with schizophrenia. Drug seems well tolerated, with many side effects appearing to be dose-related and no known drug interactions that affect plasma level or compromise efficacy.

Risperidone (Risperdal);

Effective therapeutic agent has been associated with few uncomfortable or serious side effects, especially agranulocytosis.

Antiparkinsonism drugs:
Anticholinergics, such as trihexyphenidyl HCl (Artane), benzotropine mesylate (Cogentin), procyclidine HCl (Kemadrin), biperiden HCl (Akineton);

Used to relieve drug-induced extrapyramidal reactions and treat all other forms of parkinsonism. They block action of acetylcholine, thereby reducing excitation of the basal ganglia.

Antihistamines, such as diphenhydramine (Benadryl);

Suppress cholinergic activity and prolong the action of dopamine by inhibiting its reuptake and storage.

Miscellaneous agents, such as amantadine (Symmetrel).

These agents release dopamine from presynaptic nerve endings in basal ganglia.

NURSING DIAGNOSIS

SENSORY/PERCEPTUAL alterations (specify)

May Be Related to:

Panic levels of anxiety

Disturbance in thought, perception, affect, sense of self, volition, relationship to environment

Psychomotor behavior

Possibly Evidenced by:

Illusions, delusions, and hallucinations

Disorientation

Changes in usual response to stimuli

Desired Outcomes/Evaluation Criteria—

Identify self in relationship to environment.

Client Will:

Recognize reality and dismiss internal voices.

Demonstrate improved cognitive, perceptual, affective, and psychomotor abilities.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess the presence/severity of alterations in client's perceptions. Note possible causative/contributing factors (e.g., anxiety, substance abuse, fever, trauma, or other organic illnesses/conditions).

Provides information about client's behavior potentials regarding ADLs, sleep patterns, potential for violence (command hallucinations, homicide, suicide), nonverbal and verbal behaviors (content, form, style, flow).

Spend time with client, listening with regard and providing support for changes client is making.

Continued, consistent support/acceptance will reduce anxiety and fears and enable client to decrease altered perceptions.

Provide a safe environment by not arguing with or ridiculing the client.

Altered perceptions are frightening to the client and indicate loss of control. Because of lack of

Orient to reality by communicating effectively (clear, concise); reinforcing reality of client's altered perceptions; and clarifying time, place, and person.

Set limits on client's impulsive response to altered perceptions. Remain with the client and provide distraction when possible.

Be honest in expressing fears, especially if potential for violence is perceived. (Refer to ND: Violence, risk for, directed at self/others.)

Collaborative

Provide external controls (quiet room, seclusion, restraints); inform client of intent to use touch, as indicated.

insight, client views altered perceptions as reality. Arguing only leads to defensiveness and a regressive struggle with the client.

Client's distortion of reality is a defense against actual reality, which is more frightening. Reality orientation assists client to correctly interpret stimuli within the milieu.

Client who is perceiving the environment incorrectly lacks internal controls to prevent impulsive response to misperceptions. Often client feels more in control if nurse remains in room. Distraction (music, TV, games) may also support client to regain capacity to control response to altered perceptions.

Informing client when behaviors are frightening and providing anticipatory guidance (by verbalizing actions) focuses attention on reality and helps reduce anxiety.

External limits and controls must be provided to protect client and others until client regains control internally and is able to ignore altered perceptions.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria— Client Will:

COMMUNICATION, impaired verbal

Psychological barriers, psychosis

Autistic and delusional thinking

Alterations in perception

Inability to verbalize rationally

Verbal expressions, such as neologisms, echolalia, associative/looseness, paralogic language

Nonverbal expressions, such as echopraxia, stereotypic behaviors (bizarre gesturing, facial expressions, and posturing)

Verbalize or indicate an understanding of communication problems.

Employ strategies to communicate effectively both verbally and nonverbally.

Establish means of communication in which needs can be understood.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Evaluate degree/type of communication impairment.

Degree of impairment of verbal/nonverbal communications (loose associations, neologisms, echolalia, and echopraxia) will affect client's ability to interact with staff and others and to participate in care.

Demonstrate a listening attitude within the nurse-client relationship.

Enables the nurse to listen carefully, observe the client, and anticipate and watch certain patterns of client's communication that may emerge.

Acknowledge client's difficulty in communicating.

Recognition of client's difficulty in expressing ideas and feelings demonstrates empathy, lessening anxiety and enabling client to concentrate on communicating.

Provide a nonthreatening environment/safe forum for client's communications.

Atmosphere in which a person feels free to express self without fear of criticism helps to meet safety needs, increasing trust and providing assurance for tolerance and validation of appropriate negative communications.

Accept use of alternative communications, such as drawing, singing, dancing, mime.

Increases client's feelings of security, provides avenues for expressing needs.

Avoid arguing or agreeing with inaccurate communications; simply offer reality view in nonjudgmental style (communicate your lack of understanding to client).

Arguing is nontherapeutic and may cause the client to become defensive. Agreeing with the client's expression of inaccurate communication reinforces misinterpretation of reality.

Use therapeutic communication skills, such as paraphrasing, reflecting, clarification.

Client's flow of communications (too fast/too slow) may require regulation. These techniques assist with reality orientation, thereby minimizing misinterpretation and facilitating accurate communications.

Be open and honest in therapeutic use of verbal and nonverbal communications.

Client has increased sensitivity to nonverbal messages. Honesty increases sense of trust, a loss of which is at the base of the client's problem. Openness and genuineness in expression of feelings provide a role model for client.

Use a supportive approach to client by communicating desire to understand (ask client to help you do so).

Recognizes that client's past experiences have created distrust, which produces attempt to maintain distance by being vague and unclear in sending messages.

Identify the symbolic, primitive nature of the client's speech/communications.

Note cultural beliefs (e.g., talking to dead relatives) that may be accepted as normal within the client's frame of reference.

Recognition of the symbolism of the client's primitive speech and thinking enables the nurse to better understand the client's feelings. Without this recognition, the actual communications may be vague and disorganized, indicating client's inability to focus and perceive clearly.

Cultural attitudes need to be considered to avoid confusion with pathological condition.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—
Client Will:**

COPING, INDIVIDUAL, ineffective

Personal vulnerability; inadequate support system(s)

Unrealistic perceptions

Inadequate coping methods

Disintegration of thought processes

Impaired judgment, cognition, and perception

Diminished problem-solving/decision-making capacities

Poor self-concept

Chronic anxiety and depression

Inability to perform role expectations

Alteration in social participation

Identify ineffective coping behaviors and consequences.

Demonstrate understanding of and begin to use appropriate, constructive, effective methods for coping.

Display behavior congruent with verbalization of feelings.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine the presence/degree of impairment of client's coping abilities.

Provides information about perceived and actual coping ability, life change units, anxiety level, stresses (internal, external), developmental level of functioning, use of defense mechanisms, and problem-solving ability.

Assist client to identify/discuss thoughts, perceptions, and feelings.

Client is able to view how perceptions/thinking/affect is processed and to strengthen reality orientation and coping skills.

Encourage client to express areas of concern. Support formulation of realistic goals and learning of appropriate problem-solving techniques.

This disorder first manifests itself at an early age, before the client has had an opportunity to learn effective coping skills. In a trusting relationship (a climate of acceptance), the client can begin to learn these skills, without fear of judgment.

Encourage client to identify precipitants that led to ineffective coping, when possible.

Knowledge of stressors that have precipitated deteriorated coping ability enables client to recognize and deal with these factors before problems occur.

Explore how client's perceptions are validated prior to drawing conclusions.

With support, client has the opportunity to learn to validate perceptions before selecting ineffective/inappropriate coping methods (such as acting-out behavior).

Assist client to recognize and develop appropriate/effective coping skills.

Increased/more flexible problem-solving or coping behaviors prevent decompensation (distorted reality, delusional system).

NURSING DIAGNOSIS

SELF ESTEEM, chronic low/ROLE PERFORMANCE, altered/PERSONAL IDENTITY disturbance

May Be Related to:

Disintegrated thought processes (perception, cognition, affect)

Loose/disintegration of ego boundaries

Perceived threats to the self

Disintegration of behavior, affect

Possibly Evidenced by:

Expressions of worthlessness, negative feelings about self

Impaired judgment, cognition, and perception; protective delusional systems; disturbed sense of self (depersonalization and delusions of control)

Role performance deterioration in family, social, and work areas

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Inadequate development of self-esteem and hopefulness

Ambivalence and autism (interfering with acceptance of self and meaning of own existence)

Demonstrate enhanced sense of self by decreasing episodes of depersonalization and delusions.

Verbalize feelings of value/worthwhileness and view self as competent and socially acceptable (by self and others).

Develop appropriate plans for improvement of role performance that promote highest possible level of adaptive functioning.

Demonstrate self-directedness by expressing own needs and desires and making effective decisions.

Participate in activities with others.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess the degree of disturbance in client's self-concept.

Documents own and others' perceptions, client's goals, significant losses/changes. Provides basis for determination of therapy needs and evaluation of progress.

Spend time with client; listen with positive regard and acceptance.

Conveys empathy, acceptance, support, which enhances client's self-esteem. Personal identity is strengthened as client identifies with the nurse and experiences therapeutic caring within the relationship.

Encourage client to verbalize areas of concern/feelings.

Self-esteem is improved by increased insight into feelings. Insight is gained as client verbalizes/identifies feelings (e.g., inadequacy, worthlessness, rejection, loneliness).

Help client identify how negative feelings decrease self-esteem.

Negative feelings can lead to severe anxiety and/or suspiciousness. Increased awareness/perception of factors that cause negative feelings can help client recognize how negative feelings cause deterioration.

Encourage client to recognize positive characteristics related to self.

Discussion of positive aspects of the self-system, such as social skills, work abilities, education, talents, and appearance, can reinforce client's feelings of being a worthwhile/competent person.

Review personal appearance and things client can do to enhance hygiene/grooming. (Refer to ND: Self Care deficit [specify].)

Positive personal appearance enhances body image and self-respect.

Encourage client to participate in appropriate activities/exercise program.

Assess client's capacity to tolerate use of touch.

Provide positive reinforcement for client's abilities/efforts.

Determine current level of role performance and note causative/contributing factors that affect it.

Assist the client to adapt to changing role performance by working with client/significant other(s) to develop strategies for dealing with disturbances in role and enhancing expectations of coping effectively.

Help client set realistic goals for managing life and performing own ADLs.

Assess the current sense of personal identity, considering if client acknowledges sense of self. (Observe how client addresses self (e.g., may refer to self in third person). Also consider if client expresses feelings of unreadiness, merging with people/objects.

Analyze the presence/severity of factors that alter personal identity (e.g., paranoia, blunted affect).

Assess presence/severity of factors that affect client's religious/spiritual orientation. Note presence of religiosity.

Use therapeutic communication skills to support client's verbalization of sense of self and to discover its relationship to meaning of existence.

Facilitate early discharge for client when hospitalization has been required.

Collaborative

Administer appropriate tests (e.g., ask client to draw a stick figure of self, Body Image Aberration, Physical Anhedonia Scale).

Enhances capacity for interpersonal relationships (both 1:1 and in small groups). Activities that use the five senses increase the sense of self. Physical exercise promotes positive sense of well-being.

Careful use of touch can help client reestablish body boundaries (if the experience can be tolerated).

Positive feedback increases self-esteem, provides encouragement, and promotes a sense of self-direction.

Factors such as inadequate knowledge, role conflict, alteration of self/others' perceptions of role, and change in usual patterns of responsibility can affect the client's physical and psychological capacity for effective role performance.

The client's eventual level of performance may be positively influenced by a support system that is responsive and caring.

Client needs to be productive and benefits from being given the responsibility for own life and direction within limits of ability.

Identifies individual needs, appropriate interventions. Inability to identify self poses a major problem that can interfere with person's interactions with others.

Disintegrated ego boundaries can cause a weakened sense of self. Clients often express fears of merging and thereby losing personal identity.

Disintegrated behaviors create such factors as displaced anger toward God, expression of concern with meaning of life/death/values (may be expressed as delusions, hallucinations). These concerns may negatively affect the individual's sense of self-worth. Client may use religious beliefs as a defense against fears.

Therapeutic communications, such as Active-listening, summarizing, reflection, can support client to find own solutions.

Clients can increase their sense of self by early return to own milieu surrounded by personal possessions.

These tests demonstrate client's view, the client's concept of self, and their correlation to many variables.

Refer to resources such as occupational therapist/movement therapy/Outdoor Education Program; others.

Initiate involvement in/refer to religious activities and resources as desired or appropriate. Note over-involvement in religious activity.

Provides activities that promote feelings of self-worth and accomplishment during involvement with partial hospitalization program. Partial hospitalization may facilitate transition from hospital setting to community.

Spiritual resources such as a pattern of prayer, a sense of faith, or membership in an organized religious group may enhance the development of client's coping resources, sense of acceptance/self-worth. Strong attachment to an ideology (religiosity) may be used in an attempt to control feelings of anxiety.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—
Client Will:**

ANXIETY [specify level]/FEAR

Disintegration of thought processes

Perception and affect occurring in response to overwhelming feelings of losing control; threat to self-concept

Change in environment, role functioning, interaction patterns

Extremes in psychomotor activity (occurring with chronicity or severity)

Inappropriate/regressed or absent responses; poor eye contact

Increased perception of danger; focus on self

Decreased problem-solving ability

Fear of perceived loss of control or approval from significant other(s); inappropriate response to such feelings; hurting self or others

Psychomotor disturbances varying from excited motor behavior to immobility

Respond appropriately to feelings of overwhelming anxiety (fears, loss of control, feelings of rejection) by decreasing regressive behaviors (disintegrated thinking/perception affect).

Communicate anxious feelings openly in an acceptable manner.

Orient to reality as evidenced by interpreting milieu correctly.

Verbalize no perceived danger in interactions with others.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Note the level of the client's anxiety, considering severity, unfulfilled needs, misperceptions, present use of defense mechanisms, and coping skills.

The weakened ego of schizophrenia causes a decreased capacity to distinguish reality and a diminished capacity to problem-solve. This can and coping skills result in a heightened sense of helplessness and anxiety.

Assess the degree and reality of the fears currently perceived by the client.

The client's experience of fear may contribute to decreased coping capacity and increased anxiety/fear.

Establish trust through a patient, supportive, caring, and accepting relationship.

Trust, which is difficult for schizophrenic clients, is the basis of a therapeutic nurse-client relationship. The mutuality of the 1:1 experience enables clients to work through their fears and to identify appropriate methods for problem-solving by role-modeling within the relationship.

Encourage the client to verbalize fears.

Verbalization of frightening perceptions (fears) reduces withdrawal and/or potential for violence (projection of aggressive impulses).

Assist client to identify/communicate sources of anxiety and areas of concern.

Anxiety can arise from misperceived threats to self, unfulfilled needs, and perceived losses (of control/approval). Disintegration of thinking, perception, and affect may be reduced as client verbalizes frightening feelings.

Monitor for drug effectiveness/side effects.

Prevention of medication side effects can reduce frightening physiological experiences that can escalate anxiety.

Demonstrate/encourage use of effective, constructive strategies for coping with anxiety (e.g., relaxation and thought-stopping techniques, meditation, and physical exercise). Use role-modeling, positive reinforcement.

Maladaptive coping needs to be examined with emphasis on ineffectiveness of outcomes. Reduces secondary gain and enables client to learn more adaptive/effective decision-making, problem-solving, coping skills. (Refer to NDs: Communication, impaired verbal; Sensory/Perceptual alterations.)

Remain with the client and clarify reality.

Assists the client to achieve effective coping. The presence of a trusted individual can help client feel protected from external dangers and maintain contact with reality.

Involve client in planning treatment.

Participation in treatment increases client's sense of control and provides opportunity to practice problem-solving skills.

NURSING DIAGNOSIS**May Be Related to:****Possibly Evidenced by:****Desired Outcomes/Evaluation Criteria—****Client Will:****SOCIAL ISOLATION**

Disturbed thought processes that result in mistrust of others/delusional thinking

Environmental deprivation, institutionalization (as a result of long-term hospitalization)

Difficulty in establishing relationships with others; social withdrawal/isolation of self

Expressions of feelings of rejection

Dealing with problems using anger/hostility and violence

Verbalize willingness to be involved with others.

Participate in activities/programs with others.

Develop 1:1 trust-based relationship.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Assess presence/degree of isolation by listening to client's comments about loneliness.

Mistrust can lead to difficulty in establishing relationships, and client may have withdrawn from close contacts with others.

Spend time with client. Make brief, short interactions that communicate interest, concern, and caring.

Establishes a trusting relationship. Consistent, brief, honest contact with the nurse can help the client begin to reestablish trusting interactions with others.

Plan appropriate times for activities (by limiting withdrawal, varying daily routine only as tolerated).

Consistency in 1:1 relationship and sameness of milieu are required initially to enable client to decrease withdrawn behavior. Motivation is stimulated by the humanistic sharing of a 1:1 experience.

Assist client to participate in diversional activities and limited/planned interaction situations with others in group meeting/unit party, etc.

With toleration of 1:1 relationship and strengthened ego boundaries, client will be able to increase socialization and enter small-group situations. Brief encounters can help the client to become more comfortable around others and provide an opportunity to try out new social skills.

Identify support systems available to the client (e.g., family, friends, coworkers).

Support is an important part of the client's rehabilitation, providing a network to assist in social recovery.

Assess family relationships, communication patterns, knowledge of client condition.

Problems within family (poor social/relationship skills, high expressed emotion) may interfere with client's progress and indicate need for family therapy.

Note client's sense of self-worth and belief about individual identity/role within milieu and setting.

When client feels good about self and own value, family interactions with others are enhanced. (Refer to NDs: Self Esteem, chronic low/Role Performance, altered/Personal Identity disturbance.)

NURSING DIAGNOSIS

PHYSICAL MOBILITY, risk for impaired**Risk Factors May Include:**

Disintegration of thought and behavior

Perceptual impairment; sensory overload/deprivation

Psychomotor retardation; diminished muscle strength; impaired coordination and limited range of motion/total immobility

Psychomotor activity (occurring with chronicity or severity) varying from excited motor behavior to immobility

Possibly Evidenced by:

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

Desired Outcomes/Evaluation Criteria—

Maintain optimal mobility and muscle strength.

Client Will:

Demonstrate awareness of the environment (psychomotor behavior) and capacity to regulate psychomotor activity.

Engage in physical activities.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Determine the level of impairment (rate from complete independence to dependence with social withdrawal) in relation to preillness capacity, considering age, meaning (motivation, desire, tolerance), onset, duration, coordination, range of motion, muscle strength, and control. Measure capacity for activity by observing endurance (attention span, psychomotor response, appropriateness of participation).

Encourage client to identify need for/plan resumption of activities/exercise.

Determine current activity level appropriate for client by assessing attention span, capacity to tolerate others in milieu.

Provides information to determine the amount of nursing assistance required and client potentials. Note the presence/severity of factors that affect the client's level of mobility, such as psychotic functioning, control needs, sensory overload/deprivation. These factors need to be considered in planning nursing care, as they can affect client's ability to perform activities.

As psychotic functioning decreases, the capacity to relate to milieu/others and to self-initiate increases. Involving client in scheduling activities provides client with sense of independence (control over environment).

Presence of psychotic features can cause mental/emotional withdrawal or agitation.

Structure appropriate times for exercise/activity (turning/moving unaffected body parts); monitor environmental stimuli such as radio, TV, visitors.

Schedule adequate periods of rest/sleep. Monitor client's response and set limits as needed.

Movement reduces physiological deterioration. Environmental stimulation can be used to maintain/promote sensory-perceptual capacity.

Establishing a regular sleep pattern helps client become rested, reducing fatigue, and may improve ability to think. When client is able to think more clearly, participation in treatment program may be enhanced.

NURSING DIAGNOSIS**Risk Factors May Include:****[Possible Indicators:]****Desired Outcomes/Evaluation Criteria—
Client Will:****VIOLENCE, risk for directed at self/others**

Disintegrated thought processes stemming from ambivalence and autistic thinking, hallucinations, delusions

Lack of development of trust and appropriate interpersonal relationships

Disintegrated behaviors

Perception of environmental and other stimuli/
cues as threatening

Physical aggression to self; irrational, threatening, or assaultive behavior

Religiosity

Demonstrate self-control, as evidenced by relaxed posture, nonviolent behavior.

Resolve conflicts and/or cope with anxiety without the use of threats or assaultive behavior (to self or others).

Participate in care and meet own needs in an assertive manner.

ACTIONS/INTERVENTIONS**Independent**

Assess the presence/degree of client's potential for violence (toward self or others) on a 1–10 scale. Determine suicidal/homicidal intent, indications of loss of control over behavior (actual or perceived), hostile verbal/nonverbal behaviors, risk factors, and prior/present coping skills.

Provide safe, quiet environment; tell client "you are safe."

Be careful in offering a pat on the shoulder/hug, etc.

RATIONALE

Information essential for planning nursing care and documents degree of intent (may be no. 1 nursing priority if score is high). Prior history of violent behavior increases risk for violence, as would factors such as command hallucinations.

Keeping environmental stimuli to a minimum and providing reassurance will help prevent agitation.

Touch may be misinterpreted as an aggressive gesture.

Encourage verbalizations of feelings and promote acceptable verbal outlet(s) for expression, e.g., yelling in room, pounding pillows.

Assist client to identify situations that trigger anxiety/aggressive behaviors.

Explore implications and consequences of handling these situations with aggression.

Help client define alternatives to aggressive behaviors. Initially engage in solitary physical activities, instead of group. Monitor competitive activities; use with caution.

Set limits, stating in a clear, specific, firm manner what is acceptable/unacceptable. Use demands only when situation requires.

Be alert to signs of impending violent behavior: increase in psychomotor activity; intensity of affect; verbalization of delusional thinking, especially threatening expressions; frightening hallucinations.

Accept verbal hostility without retaliation or defense. Be aware of own response to client behavior (e.g., anger/fear).

Isolate promptly in nonpunitive manner, using adequate help if violent behavior occurs. Hold client. Tell client to STOP behavior.

Collaborative

Place in seclusion, and/or apply restraints as indicated, documenting reasons for action.

Administer medications as indicated. (Refer to ND: Thought Processes, altered.)

Ventilation of feelings may reduce need for inappropriate physical action.

Promotes understanding of relationship between severe anxiety and situations that result in destructive feelings leading to aggressive actions.

Helps client realize the possibility and importance of thinking through a situation before acting.

Enables client to learn to handle situations in a socially acceptable manner. Appropriate outlets will allow for release of hostility. Anxiety and fear may escalate during activities in which the client perceives self in competition with others and can trigger violent behavior.

Being clear and remaining calm increase chance that client will cooperate, lessening potential for violence. Having few but important limits enhances chances of having them observed.

Promotes timely interventions as therapeutic techniques are more effective before behavior becomes violent.

Behavior is not usually directed at nurse personally, and responding defensively will tend to exacerbate situations. Looking at meaning behind the words will be more productive. Awareness of own response allows nurse to express/deal with those feelings.

Removal to quiet environment reduces stimulation, can help calm client. Usually the individual is being self-critical and afraid of own hostility and does not need external criticism. Sufficient help will prevent injury to client/staff. Often holding client and/or saying "Stop" is enough to help client regain control.

May be needed for short-term control until client regains control over self.

Used to reduce psychotic symptoms, decrease delusional thinking, and assist client to regain control of self.

NURSING DIAGNOSIS

May Be Related to:

SELF CARE deficit (specify)

Perceptual and cognitive impairment

Immobility resulting from social withdrawal, isolation, and decreased psychomotor activity

Possibly Evidenced by:

Autonomic nervous system side effects of psychotropic medications

Inability/difficulty feeding self, keeping body clean, dressing appropriately, and/or toileting self

Bladder stasis/paralysis; urinary calculi formation

Decreased bowel activity with constipation, fecal impaction, and/or paralytic ileus

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Perform self-care and ADLs at highest level of adaptive functioning possible.

Recognize cues/maintain elimination patterns, preventing complications.

Identify/use resources available for assistance.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine current vs. preillness level of self-care (specify levels 0–4) for feeding, bathing/hygiene, dressing/grooming, toileting.

Identifies potentials and determines degree of nursing care to be provided.

Assess presence/severity of factors that affect client’s capacity for self-care (e.g., disintegrative perceptual/cognitive abilities, mobility status).

Impairment in these areas can alter client’s ability/readiness for self-care.

Discuss personal appearance/grooming and encourage dressing in bright colors, attractive clothes. Give positive feedback for efforts.

Appearance affects how the client sees self. A run-down, disheveled appearance conveys a sense of low self-worth, whereas an attractive, well-put-together appearance conveys a positive sense of self to the client as well as to others.

Determine client’s regular elimination patterns and compare with current pattern. Monitor oral intake. Note contributing factors (e.g., anxiety, decreased attention span, disorientation, reduced psychomotor activity, as well as use of psychotropic medications).

Identifies appropriate interventions, as patterns of elimination are individually influenced by physiological (including amount of intake), cultural, and psychological factors. These factors can affect toileting (e.g., client does not pay attention to cues; dehydration from inadequate intake results in lessened urinary output and contributes to constipation; anticholinergic effect of medication may result in urinary retention).

Encourage/provide diet high in fiber and at least 2 liters of fluid each day. Encourage/structure appropriate times for intake. (Refer to ND: Nutrition, altered, less/more than body requirements.)

A diet high in fiber and residue promotes bulk formation and at least 2 liters of fluid daily regulates stool consistency (facilitating bowel elimination) and renal function. Scheduling of intake provides for an accurate record and helps to ensure that adequate amounts are ingested.

Monitor mental status, vital signs, weight, skin turgor; presence of medication interactions/side effects.

Observe/record urinary output as appropriate. Note changes in color, odor, clarity. Encourage client to observe/report changes.

Provide regular intervals for toileting.

Increase daily activity level as client progresses.

Collaborative

Plan with client for effective use of community resources, such as nutritional programs, sheltered workshops, group/transitional/apartment homes, home care services.

Administer laxatives/stool softeners, as indicated.

Careful monitoring and early recognition of symptoms can prevent complications of inadequate fluid intake (e.g., orthostatic hypotension, reduced circulating volume which directly affects cerebral perfusion/mentation, increased risk of tissue breakdown).

Bladder paralysis/retention can occur from psychotropic medications, increasing risk of infection. **Note:** Polyuria is a frequent side effect of psychotropics.

A schedule prevents accidents that can occur due to polyuria from psychotropic medication or decreased attentiveness to cues and psychomotor activity.

Adequate exercise increases muscle tone; consistency in daily routine stimulates bowel elimination.

Assists client to develop an effective plan for hygienic/self-care needs and promotes maximum level of independence.

Used cautiously for brief period or as needed to enhance bowel function. **Note:** Overuse can promote dependency.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria—

Client Will:

NUTRITION: altered, less/more than body requirements

Imbalance between energy needs and intake

Disintegration of thought and perception

Inability/refusal to eat

Delusions or hallucinations related to food intake

Reported dysfunctional eating patterns (e.g., eating in response to internal cues other than hunger; increased appetite [side effect of some psychotropic medications])

Weight loss/gain

Sore, inflamed buccal cavity

Maintain adequate/appropriate nutritional intake.

Demonstrate progressive weight gain/loss toward agreed-upon goal.

Identify behaviors/lifestyle changes to maintain appropriate weight.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess presence/severity of factors that create altered nutritional intake.
inability/refusal to eat.

Factors such as psychotic thinking or excessive activity to prevent frightening thoughts may cause

Review dietary intake via 24-hour recall/diary noting eating pattern and activity level.

Provides accurate information for assessment of client's nutritional status and needs. Alterations in dietary intake (decreased/increased calories, salt, fats, sugars) can aid in correcting faulty eating patterns. Lack of knowledge of appropriate dietary needs, perception of food, and activity/exercise (immobility) results in improper caloric intake.

Encourage client to regulate caloric intake with activity/exercise program.
can enhance mental functioning.

A balance between activity and caloric intake maintains weight loss/gain, improves nutritional status, and

Structure consistent times for eating and limit use of food for other than nutritional needs.

Positively reinforces client's appropriate eating behaviors. Limits behaviors (rituals, acting out) that allow client to withdraw/refuse meals or overeat. Secondary gains that may occur can be reduced by setting appropriate expectations.

Provide small, frequent feedings as indicated.

May enhance intake when psychotic thought/behavior interferes with eating.

Encourage client to choose own foods, when possible.

Individual is more likely to eat chosen food than what has been arbitrarily given to him or her, especially when paranoid thoughts of poisoning are present.

Assess presence/severity of factors that affect client's oral mucous membranes. Identify strategies to relieve to minimize irritation, such as rinsing with water, chewing sugarless gum/candy or glycerin-based cough drops, drinking lemonade, and mouth care before and after meals.

Altered nutrition can cause dehydration, edema, oral lesions, or altered salivation, which can adversely affect/restrict intake. With relief of dry mouth, client's anxiety is reduced and nutritional intake enhanced.

Collaborative

Arrange consultation with dietitian/nutritional team, as indicated.

May be necessary to establish/meet individual dietary needs.

NURSING DIAGNOSIS**FAMILY PROCESSES, altered/FAMILY COPING, ineffective: disabling****May Be Related to:**

Ambivalent family system/relationships; change of roles
Difficulty family members have in coping effectively with client's maladaptive behaviors

Possibly Evidenced by:

Deterioration in family functioning; ineffective family decision-making process
Failure to adapt to change/deal with crisis in a constructive manner and meet needs of its members
Difficulty in relating to each other for mutual growth/development; failure to send/receive clear messages.
Extreme distortion regarding client's health problem, including extreme denial about its existence/severity or prolonged overconcern
Client's expressions of despair at family's lack of reaction/involvement; neglectful relationships with client

**Desired Outcomes/Evaluation Criteria—
Family Will:**

Express feelings appropriately, honestly, and openly.
Demonstrate improvement in communications (clear), problem-solving, behavior control, and affective spheres of family functioning.
Verbalize realistic perception of roles within limits of individual situation.
Encourage and allow member who is ill to handle situation in own way.

ACTIONS/INTERVENTIONS**RATIONALE****Independent**

Determine current and preillness level of family functioning. Note factors such as problem-solving skills, level of this interpersonal relationships, outside support systems, roles, boundaries, rules, and communications.

Provides information about client and family to assist in developing plan of care and choosing interventions. These factors affect the family's capacity for returning to precrisis level of adaptive functioning as well as set the tone/expectations for a favorable prognosis. **Note:** Some family members may demonstrate psychopathologies that may make their influence detrimental to the client.

Determine whether family is high in expressed emotion (e.g., criticism, disappointment, hostility, solicitude, extreme worry, overprotectiveness, or emotional over-involvement).

Provide opportunity for family members to discuss feelings, impact of disorder on family, and individual concerns.

Assess readiness of family members/significant other(s) to participate in client's treatment.

Provide honest information about the nature and seriousness of the disorder and enlist cooperation of family members to help client to remain in the community.

Promote family involvement with nurses/others to plan care and activities.

Help client/family/SO(s) to identify maladaptive behaviors and consequences. Support efforts for change.

Establish/encourage ongoing open communication within the family.

The emotional climate of the client's family has been shown to significantly affect the client's recovery. Relapse is associated with the expression of certain feelings in specific ways rather than emotional openness itself. Relapse occurs significantly more often in families with a high degree of expressed emotion (EE), especially criticism and hostility. **Note:** Some studies suggest EE may be more a response to the client's bizarre behavior, rather than a family trait, and may lessen as the condition persists and the family becomes used to the symptoms.

Feelings of guilt, shame, isolation; loss of hopes/expectations regarding client; and concerns for personal and client safety have an impact on family's ability to manage crisis and support client. Chronic nature of condition, with a wide range of socially, emotionally, and intellectually disabling symptoms that come and go unpredictably, can exhaust family physically, emotionally, and financially. The disproportionate allocation of resources can create deep feelings of resentment and family conflict as time and energy are focused on the client to the possible exclusion of the needs of other family members, and monetary expenses may restrict the family members' ability to take vacations, go to college, or even consider retirement.

Family theorists believe that the "identified patient" also represents disintegrated/enmeshed schizophrenogenic family system. Aftercare of client must include family/SO(s) to raise level of interpersonal functioning.

The family that already has maladaptive coping skills may have difficulty dealing with diagnosis and implications of a long-term illness. Client's behavior may be difficult and embarrassing for some families who have problematic coping skills or have a high profile in the community.

Involvement with others provides a role model for individuals to learn new behaviors/ways of handling stress, and problem-solving.

Client's success in treatment depends on effective change of whole systems rather than treatment of client's behaviors as a separate entity.

Promotes healthy interaction, allows for timely problem-solving, and maintains effective relationships.

Help family identify potential for growth of family system and individual members. Role-model positive behaviors during this process.

Assess readiness of the family/SO(s) to reintegrate client into system, such as family's ability to use assistance or to cope with crisis appropriately by adaptation or change.

Collaborative

Promote family involvement in behavioral management programs. Discuss negative aspects of blame and ways to avoid its use.

Encourage family to participate in family education, therapy, community support groups.

Promote involvement with mental health treatment team (e.g., mental health center, family physician/psychiatrist, psychiatric/public health nurse, social/vocational services, occupational/physical therapist), and respite care, when necessary.

Provide client/family/SO(s) with assistance to deal with current life situation (e.g., therapy [family/couples/1:1]; aftercare services including day-care centers, night hospitals, halfway houses, sheltered workshops, rehabilitation services).

Family that has previously functioned well has skills to build on and can learn new ways of dealing with changed family structure and challenges of marginally functioning family member. The nurse can provide an example for learning new skills.

Ability to tolerate and assist with management of client behavior affects client's reentry into the family system.

Helps family members to realize that, although they can have a positive or negative influence on the course of the illness, they are doing the best they can in a difficult situation, and communication/problem-solving skills can be learned to reduce stress. Blaming themselves or the client is counterproductive, and it is more important to talk about individual responsibility.

Multiple stressors, labile nature of disorder, lack of definitive treatment options, or lack of resolution of condition increases likelihood of family conflict, disorganization, and even dissolution. Providing the family with information about the disorder; showing them how to help the client, without neglecting family members' needs; and better ways to communicate with one another and with the client; as well as training family to identify and solve problems as they arise—enhances family's coping abilities and may lessen the client's risk of relapse.

When bizarre behavior is difficult for family to manage, assistance/support may enhance coping abilities, improve the situation, and provide opportunity for individual growth, thereby strengthening the family unit. Having the opportunity to take time away from the situation enhances the family's ability to manage the client's long-term illness.

Aftercare may include efforts to enlarge social spheres and increase client's/family's level of functioning, enhancing ability to manage long-term illness and enabling the client to remain in the community.

NURSING DIAGNOSIS**HEALTH MAINTENANCE altered/HOME MAINTENANCE MANAGEMENT, impaired****May Be Related to:**

Impaired perception, cognition, communication skills, and individual coping skills

Inadequate developmental task accomplishment; lack of knowledge

Inability or lack of cooperation

Lower socioeconomic group with limited resources

Impaired or diminished family functioning

Possibly Evidenced by:

Mistrust, lack of autonomy, and disturbed capacity for relationship formation

Impairment of personal support system (e.g., family conflict/disorganization)

Decreased capacity to identify and mobilize adequate support systems and maintain a safe, growth-promoting immediate environment

**Desired Outcomes/Evaluation Criteria—
Client Will:**

Maintain optimal health and family functioning through improved communications and coping skills.

Return home and maintain optimal wellness with minimal complications.

Identify and use resources effectively.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Compare present and preillness level of home/health maintenance. Consider deficits in communication, knowledge, decision-making, developmental tasks, and support systems and their effect on client's basic health practices.

Assist client/family to identify appropriate healthcare needs/practices (e.g., dental, physician/clinic, regular hygiene practices, as well as some social contacts).

Involve client/SO(s) in the development of a long-term plan for optimal home health management, encouraging identification/use of resources.

Dysfunction in family (diminished problem-solving, poor financial management/inadequate resources, and ineffective support system; emotional impoverishment) and lack of motivation to participate in treatment can impair functioning.

Poor organizational capacity for ADLs and socialization as well as personal involvement can lead to neglect of these areas and provides opportunity for nurse to assess capacity for/compliance with home/health management needs.

Involvement increases the potential for cooperation with the plan.

Collaborative

Provide referrals to community resources (e.g., medical/dental clinics, transportation assistance, sheltered living center, legal services).

Ineffective coping requires support/teaching, which often necessitates referrals. Legal assistance may be required to provide conservatorships and client advocacy.

NURSING DIAGNOSIS

May Be Related to:

Possibly Evidenced by:

Desired Outcomes/Evaluation Criteria— Client Will:

SEXUAL dysfunction

Ego boundary disintegration; inability to distinguish between self and environment

Weakened sexual identification; gender identity confusion, which interferes with normal sexual orientation formation

Development of delusions around the primitive sexual orientation

Lack of drive and energy, normal social inhibitions, and passivity

Uninhibited sexual behavior; involvement in multiple sexual liaisons

Preoccupation with sex or gender identity

Inability to find sexual partner

Endocrine changes associated with antipsychotic drugs (e.g., ejaculatory inhibitions, impotence in men/amenorrhea in women, decreased libido)

Strengthen ego boundaries to enable identification and acceptance of sexual orientation.

Verbalize understanding of, identify, and report changes in body functions (if they occur) while taking antipsychotic medications.

Demonstrate behavioral restraint in public.

Identify and use individually effective birth control method.

Practice safer sex.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Have client describe own perceptions of sexuality/sexual functioning.

When concerns and perceptions are shared, it provides an opportunity to understand the client's point of view, identify individual needs, and clarify misconceptions.

Determine presence/degree of factors that alter sexuality/sexual functioning.

Ego boundary disintegration can cause regressive behavior (withdrawal, preoccupation with self), which interferes with the formation of attachments and creates gender identity confusion. Antipsychotic medications can cause endocrine changes (amenorrhea, lactation in women; and impotence, ejaculatory inhibition, gynecomastia in men).

Provide information regarding medications, their effects and regulation, and counseling/teaching about problem-solving (expressing feelings of loss and seeking alternate solutions).

Lack of sufficient knowledge may be a contributing factor to the dysfunction.

Encourage client to identify/report any alterations in sexuality/sexual functioning.

Timely intervention may prevent future disintegration of ego boundaries and further side effects of medications.

Counsel client about birth control, genetic implications of having children.

Severely ill clients have difficulty with relationships and do not make good partners or parents. Although higher-functioning clients may find marriage supportive, they need to be aware that each child has a 12%–15% chance of developing schizophrenia. Premarital expert eugenic counseling is extremely important.

Identify "safer sex" practices and discuss risk of contracting sexually transmitted diseases (STDs).

The lack of social inhibitions (multiple partners, unprotected sex) places these clients at risk for the possibility of contracting a sexually transmitted disease, and a poor level of functioning may result in neglect of treatment.

NURSING DIAGNOSIS

KNOWLEDGE deficit [LEARNING NEED] regarding condition, prognosis, and treatment needs/THERAPEUTIC REGIMEN: Individual, ineffective management of

May Be Related to:

Cognitive limitation (altered thought process/psychosis)

Misinterpretation/inaccurate information; unfamiliarity with information resources

Chronic nature of the disorder

Possibly Evidenced by:

Ambivalence and dependency strivings

Inappropriate or exaggerated behaviors; need-fear dilemma and withdrawal (can lead to abrupt termination of therapy, medication)

Inaccurate follow-through of instructions; appearance of side effects of psychotropic medications

Recidivism

**Desired Outcomes/Evaluation Criteria—
Client/SO(s) Will:**

Verbalize understanding of disorder and treatment.

Participate in learning process/treatment regimen.

Assume responsibility for own learning within individual abilities.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine the current level of knowledge about the disorder and its management.

Identifies areas of need and misperceptions. Communication skills such as validation of perceptions can assist in assessment of accuracy of client's/SO(s) knowledge base and readiness to learn.

Assess the presence/severity of factors that affect client's cognitive framework for decision-making about disorder and management, noting lack of recall, and ignorance of resources and their use.

Factors such as disintegrated thinking, cognitive deficits, ambivalence, denial, and dependency needs can limit learning/block use of knowledge for management of disorder.

Instruct client/family about disorder, its signs and symptoms, management (medication, ADLs, vocational rehabilitation, socialization needs).

Provides information and can promote independent behaviors within client's ability.

Identify/review side effects of medications client is taking (e.g., sedation, postural hypotension, photosensitivity, hormonal effects, agranulocytosis, and extrapyramidal symptoms [tremors, akinesia/akathisia, dystonia, oculogyric crisis, and tardive dyskinesia]).

The anticholinergic effects of psychotropics (and antiparkinsonian drugs that may be given concomitantly to decrease the incidence of extrapyramidal effects of neuroleptics) alter autonomic nervous system functioning and may cause dry mouth (xerostomia), oral lesions, or hemorrhagic gingivitis. Most side effects occur within the first few weeks of treatment and subside with time. However, signs indicative of adverse reactions such as agranulocytosis (sore throat, fever, malaise), extrapyramidal symptoms, and tardive dyskinesia need immediate attention.

Encourage measures such as frequent mouth care, chewing sugarless gum or sucking on hard (sugarless) candy, and drinking lemonade.

Reduces oral cavity discomfort associated with effects of medication. **Note:** Omit gum/hard candy for aged client when danger of choking is present (e.g., phenothiazines alter the swallowing reflex).

Emphasize importance of immediate medical attention for onset of high fever and severe muscle stiffness and discontinuation of the medication until able to consult with healthcare provider.

Have individuals verbalize/paraphrase knowledge gained.

Assist the client to develop strategies for continuing treatment. Make contract with client to provide for actions to take when problems arise.

Discuss importance of, and establish schedule for, follow-up/postdischarge care.

Identify appropriate therapies and community support systems to meet individual needs.

Severe muscle stiffness and high fever are the hallmarks of neuroleptic malignant syndrome, which can usually be effectively treated before it becomes life threatening if it is detected early.

Evaluates comprehension of information regarding disorder's characteristics and management needs and may reduce recidivism.

Understanding that feeling better is no indication for discontinuing medication, that no addiction can develop with continued treatment, and that providing for self-administration often enhances cooperation with therapeutic regimen.

Monitoring of client's behavior (e.g., medication usage, socialization, vocation, exercise, and diet) helps to determine appropriateness of therapy, problem-solve identified needs, reduce risk of recidivism.

Promotes trusting relationships and encourages further cooperation with treatment plan. Adequate management plans and organizing social supports for the family enable these clients to remain in the community.