# UNIT 3 NURSING MANAGEMENT OF A PATIENT WITH SCHIZOPHRENIA

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## 3.0 OBJECTIVES

After studying this unit, you should be able to:

- describe what is schizophrenia;
- enumerate different types of schizophrenia; and
- describe management of patient with schizophrenia.

## 3.1 INTRODUCTION

Schizophrenia is one of the commonest of the serious mental disorders. Because of the heterogenecity of the manifestations, it may be appropriate to speak of the group of schizophrenia rather than each group as a single disease entity. The word Schizophrenia is a combination of two Greek words, Schize, or to "split" and Phren, "mind". According to Bleuler split occurred between the cognitive and emotional aspects of the personality. Symptomatically, schizophrenic reactions are recognizable through odd and bizarre behaviour apparent in aloofness,

suspiciousness, or period of impulsive destructiveness, immature and exaggerated emotionally, and ambivalence, which appears inappropriate to a common observer. The interpersonal perceptions are distorted and, in some serious states, hallucinations and delusions may be present. The patient withdraws into fantasy. Patient has no clear or stable self-concept. S/he has no capacity to assess clearly the realities of the world. The interactions with others are characterized by immature processes of communication and adaptation. Fixated, infantile behaviour is seen in such individuals.

**Onset**: The age of onset is from late childhood to late middle age. Most frequent age of onset is adolescent and early adult life.

## 3.2 SCHIZOPHRENIA

Schizophrenia is one of the major psychotic disorders having primary and secondary symptoms. In this section the discussion will be on symptoms, psychodynamics and nursing management.

### 3.2.1 Definition

In DSM IV TR Schizophrenia is defined as a group of disorders manifested by characteristic disturbance in thinking, mood and behavior. Disturbances that lasts for at least a month of active phase symptoms i.e. two or more of these: delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, negative symptoms.

### 3.2.2 Signs and Symptoms of Schizophrenia

i) **Affect**: Flat or blunted and inappropriate

ii) **Associative looseness**: Associations are thread that ties one thought to another these threads are missing and connections become interrupted. Thinking become haphazard, illogical and confused.

iii) **Ambivalence**: Feeling of love and hatred toward same subject, object at the same time.

iv) **Autism**: Thinking not found to reality.

v) **Neologism**: New words, person makes up which have special meaning for the person.

vi) **Withdrawal**: Used as a defense against uncomfortable levels of anxiety.

vii) **Disturbances in behaviour**: Due to extreme withdrawal from reality a number of alteration in behaviour may appear.

a) Stupor, b) Waxy flexibility, c) Extreme motor agitation, d) Echopraxia, e) Stereotyped behavior, f) Automatic obedience, g) Negativism, h) Deterioration in appearance and manner.

viii) **Disturbance in thinking and perceiving:**

a) associative looseness, b) delusions, c) hallucination, d) concrete thinking, e) depersonalization, f) derealization

ix) **Disturbance in speech pattern**:

a) looseness of association, b) echolalia, c) clang association, d) word salad

x) **Other Symptoms:** General disequilibrium of automatic nervous system; cold hands and feet, blotchy skin and widely dilated pupils loss of weight during acute phase of illness but gain of weight in chronic illness.

### 3.2.3 Psychodynamic

It is believed that schizophrenia behaviour occurs when the ego can no longer withstand the pressure arising from the id and from external reality because of profound distrurbances in the symbiotic mother child relationship, which severely inhabits ego development.

## 3.3 TYPES OF SCHIZOPHRENIA

There are different types of schizophrenia. The most common types are being discussed in the following text.

### 3.3.1 Paranoid Schizophrenia

The onset of this type of Schizophrenia tends to occur later in life, and the features are more stable over a period of time. It is characterized mainly by the presence of delusion of persecution or grandeur. In this type of schizophrenia there is less regression of the mental faculties, emotional responses and behaviour than patients with other types of Schizophrenia.

Patients with paranoid schizophrenia are typically tense, suspicious, grounded, reserved and sometimes hostile or aggressive.

### 3.3.2 Disorganized/Hebephrenic Schizophrenia

A form of schizophrenia that is characterized by a disorganized behaviour, disorganized speech, and flat affect. Involving a disturbance in behaviour, communication, and thought. There is a lack of any consistent theme.

There is prominent disorganized behaviour, disorganized speech and flat affect in these patients. There is no feature of catatonic schizophrenia.

### 3.3.3 Catatonic Schizophrenia

A form of schizophrenia that is characterized by marked psychomotor activity, a variety of catatonic symptoms. This type of schizophrenia is characterized by phase of stupor or of excitement, but in both phases negativism and automatism are prominent features.

1) **Catatonic Stupor:** The patient in this phase is uncommunicative, with falling of interest, inattention, preoccupation, emotional poverty and dreaminess, mute, stuporous, and with mask like face, staring look and immobile. The patient refuses to dress or to eat, although occasionally if he thinks he is unobserved, he will eat greedily. Saliva, urine and bowel contents are often retained. They display disregard of all cleanliness in the habits of excretion. Gesture, grimacing and grinning are common. Catalepsy, either flexibility or rigidity, is seen.

2) **Catatonic Excitement:** This is characterized by unorganized and aggressive motor activity, which is not accompanied by external stimuli or emotional response. It is usually confined to a limited space and is apparently purposeless and stereotyped. The patient may suddenly attack a bystander or break a window. Patient may destroy clothes and remain nude, s/he may disregard all excretory cleanliness. Attitudinizing mannerisms,

stereotypes and grimaces are frequent. Hostility and feeling of resentment are common. Sleeplessness, delirium, refusal to food, dehydration and exhaustion may be present. Rapid loss of weight could be observed.

### 3.3.4 Undifferentiated (Simple) Schizophrenia

A form of schizophrenia that is characterized by a number of schizophrenic symptoms such as delusion(s), disorganized behaviour, disorganized speech, flat affect, or hallucinations but does not meet the criteria for any other type of schizophrenia.

Shallowness of emotion, indifference and callousness, absence of will or drive may be seen. This patient may become moody, irritable, and indolent. He may have unrealistic goals. They remain uninterested in environment and unimpressed by responsibilities. They withdraw from actual world and their energy is absorbed by subjective life situations.

### 3.3.5 Residual Schizophrenia

A form of schizophrenia that is characterized, by previous diagnoses of schizophrenia, but no longer having any of the prominent psychotic symptoms. There are some remaining symptoms of the disorder however, such as eccentric behaviour, emotional blunting, illogical thinking, or social withdrawal.

**Schizo affective type:** Reoccurring episodes of schizophrenic and affective symptoms, mood may be pronounced elation or depression with bizarre behaviour, which is peculiar to schizophrenia, may be observed.

### 3.3.6 Other Types of Schizophrenia

a) **Pseudoneurotic Type:** A mixture of anxiety, phobic obsessive and hypochondric symptoms.

b) **Schizophrenia in Childhood:** Sick children show impairment of ego functioning. Development of clear body image, sexual identity, and ability to conceive time and space clearly is impaired. As a child grows, the picture of schizophrenia resembles that is seen in adults. However, hallucination and delusions may not occurs below 8 years age. The child may mumble to himself, sleep poorly, maintain odd postures, show diminished or rigid affect, become inaccessible and extremely restless and perhaps sceam and kick. Usually, impairment takes place after several weeks.

c) **Early Infantile Autism:** It results in marked disability in interpersonal relations and the use of severe obsessive compulsive mechanisms. The child usually doesn't talk or respond to people, and has temper tantrums. Parrot-like repetitions of word that are overheard by the child may be present.

**Check Your Progress 1**

1) What are the sign and symptoms of schizophrenia?

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2) List various types of Schizophrenia.

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## 3.4 MANAGEMENT

In this section we will discuss about the medical and nursing management of patient with schizophrenia.

### 3.4.1 Medical Management

i) **Hospitalization**

It is indicated primarily for diagnostic purposes, for stabilization of medication, for patient's safety because of suicidal and homicidal ideation and for grossly disorganized behaviour, including inability to take care of basic needs such as foods, clothing etc. Hospitalization decreases stress and helps them structure their daily activities. Hospital treatment plans should be oriented towards practical issues of self care, quality of life, employment and social relationship.

ii) **Integrated Approach**

Schizophrenia is now officially categorized as a brain disease, not a psychological disorder, and drug treatment is the primary therapy. Studies indicate, however, that an integrated approach is superior in preventing relapses compared to routine care (drugs plus monitoring and access to rehabilitation programmes).

iii) **Family Interventions**

iv) **Early Treatment**

The earlier schizophrenia is detected and treated, the better the outcome. Patients who receive astipsychotic drugs and other treatments during their episodes are hospitalized less frequently during the following five years and may require less time to control the symptoms than those who do not seek help as quickly.

v) **Pharmacotherapy**

Most drugs that treat schizophrenia, effect by blocking receptors of the neurotransmitter dopamine, which is thought to play a major role in psychotic symptoms.

The following drug classes are generally used for schizophrenia:

Until recently, the mainstay treatments for schizophrenia have been antipsychotic agents—also called neuroleptic drugs. They include haloperidol (Haldol). Others include chlorpromazine (Thorazine), perphenazine (Trilafon), thioridazine (Mellaril), mesoridazine (Serentil), trifluoperazine (Stelazine), and fluphenazine (Prolixin). These agents have significant side effects, however, particularly extrapyramidal symptoms, which occurs in up to 70% of patients taking these medications.

The atypical, or novel, antipsychotics are proving to be better tolerated than the older antipsychotics and have significantly fewer severe extrapyramidal side effects. They include clozapine (Clozaril) (the first atypical antipsychotic), risperidone (risperdal), olanzapine (Zyprexa), Quetiapine (Seroquel), zotepine (Zoleptil), and ziprasidone (Geodon). There is considerable difference among these agents and comparison studies are needed.

Even newer agents called dopamine system stabilizers are under investigation. These agents ate very selective and block certain dopamine receptors but not others. Such an effect reduces the risk for serve side effects associated with dopamine blockade. They include amisulpride (Solian), aripiprazole, and ilperidone (Zomarill).

Antidepressants and antianxiety agents may also play an important role in treating the patient with schizophrenia, particularly given the role of depression in the high rates of suicide among these patients. You will be reading the details about the drugs in Block 4, Unit 1 of this course.

vi) **Electro-convulsive Therapy(ECT)**

ECT gives the best results in catatonic stupor. It is useful in controlling aggression related to Schizophrenia.

vii) **Psycho-social Therapies**

a) ***Behaviour Therapy:*** Technique used in this are token economies and social skill training to increase social abilities self-sufficiency, practical skills and interpersonal communication.

b) ***Family Therapy:*** To prepare the family to restore the problem quickly when it emerges at home.

c) ***Cognitive Therapy:*** It improves cognitive distortion, reduce distractibility and correct errors in judgment.

d) ***Group Therapy***: It is effective in reducing social isolation, increasing the sense of cohesiveness and improving reality testing for patients with Schizophrenia.

e) ***Individual Psychotherapy:*** In this supportive and insight oriented therapies are more useful.

**Check Your Progress 2**

1) List the modalities of medical management.

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2) Name three antipsychotic drugs, which are commonly used.

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### 3.4.2 Nursing Management

You have already read about types of Schizophrenia in BNSL-108. Here the discussion will be on nursing care plan according to nursing process of a patient with Schizophrenia.

First step in nursing process is assessment.

**Assessment**

Assessment of acutely disturbed patient in an in patient unit takes place on admission. The nurse usually admits the patient to the unit and completes the initial assessment. In includes data collection about the individual, the family and the environment. These will provide base-line data to make comprehensive treatment plan. We may not be able to gather data in one go due to patient's suspiciousness, confusion, disorientation, anxiety, fearfulness, or in ability to communicate. Family members also may not be available. Thus initial assessment process may extent overtime until the patient starts responding or family members are available.

Assessment of patient may be done by asking following questions:

- How does the patient describe the problem s/he is having right how?
- For example response may be: I am so scared I hear voices telling me I'm bad, I try to be good.
- How does the patient describe the circumstances that precipitated the behaviour?
- Does the patient have hallucinations, hypochondrias, depersonalizations etc.?
- Does the patient have thinking disorders e.g. & delusions or autistic communication?
- Describe the patients thoughts and affect whether congruent?
- What are the patient's gestures, posture mannerisms etc.?
- Does the patient abuse drugs or alcohol?

***Family Assessment***

In family assessment you may find out:

- Who are patient's significant others?
- How is the relationship among the family members?
- What is the birth order of patient in the family?
- How is the family communication pattern?
- Describe the role relationships of patient in the family.
- Are there special events or issues in the patient's family that people find difficult to talk about with one another?
- How do family members perceive and deal with independence.
- Has anyone in the patient's family been hospitalized for mental illness?

*Environmental Assessment*

- What is the patient's educational background?
- What is the patient's employment history (type of job, duration of job, job satisfaction, relationships at work)?
- What is the patient and/or family's socioeconomic status.
- How does the patient and/or family's cultural background and beliefs fit with the social system in which they live?
- Does the patient have friends?
- How easy it for him or her to make friends?
- Has the patient ever had a sustained relationship?
- To what extent is the patient involved in the community relationship?
- Does the family have support systems available in the community (family, friends, church, and community organizations)?
- How does the patient spend hid or her leisure time?

After collecting the information on above questions, we shall formulate the nursing diagnosis.

**Nursing Diagnosis**

1) Withdrawn behaviour related to:
   - Disordered thought processes
   - Feeling of fear of suspicion
   - Delusion and hallucination
   - Misperceptions of environment or other persons
2) Low self-esteem related to:
   - Inadequate interpersonal relationship
   - Lack of successful coping strategies
   - Delusions or hallucinations
3) Disorientation related to:
   - Disordered thought processes
   - Hallucinations or delusions
   - Misperceptions of environment
4) Potential for injury to self and others related to:
   - Disordered thought processes
   - Delusions or hallucinations
   - Feelings of worthlessness and threatened

5) Hallucination or delusion related to:
   - Disturbed thought process
   - Disturbed perception
6) Potential for disturbed homeostasis related to:
   - Effect of medication
   - Inadequate food or fluid intake
   - Sleep pattern disturbance
7) Bizarre behaviour, anxiety, agitation, and aggression related to:
   - Feelings to fear and suspicion
   - Lack of control over self and/or environment
   - Disturbed thought processes

**Planning**

Its second step in nursing care plan to formulate goals which we want to achieve, which can be short term or long term goals:

***Short Term Goals***

The patient will:

- Maintain an adequate balance of rest, sleep and activity.
- Maintain an adequate balance of nutrition, hydration, and elimination.
- Free of injury
- Participate in the therapeutic milieu
- Communicate effectively with others
- Establish contract with reality
- Express feelings in an acceptable manner
- Report increased feeling of self worth
- Identify strengths and assets

***Long Term Goals***

The patient will:

- Utilize strengths and assets
- Demonstrate increased self esteem
- Reach or maintain his or her optimal level of functioning
- Cope effectively with the illness
- Comply with prescribed regimen, such as medications.

Third step of nursing process is intervention, which is given in Table 3.1.

**Table 3.1**

| Nursing Diagnosis | Nursing Intervention | Rationale |
|---|---|---|
| Withdrawn behaviour related to:<br>— Disorder of thought process<br>— Misperception of environment or other persons<br>— Inadequate interpersonal relationships | Spend time with the patient even when he or she is unable to respond verbally.<br>— Limit the patient's environment to enhance his or her feeling of security.<br>— Begin with one to one interaction then progress to small groups as tolerated.<br>— Support the patient's success, fulfilled work, projects, interactions with staff members and other clients.<br>— Avoid trying to convince the patient verbally of his or her own worth.<br>— Help the patient improve his or her grooming; assist when necessary in bathing, doing laundry, and so forth. | — Non verbal caring can be conveyed to the patient even when verbal caring is not understood.<br>— Unknown boundaries as limits can foster insecurity in the client.<br>— Limited contact is better<br>— Sincere and genuine praise that the client has earned can improve self esteem.<br>— The patient will recognize unfounded praise or flattery and can feel worse. The patient must demonstrate a positive behaviour before you can genuinely record it.<br>— Good physical grooming can foster feelings of well-being and self esteem. |
| Hallucination and Delusion related to charge in thought processes. | — Provide protective supervision for the patient but avoid hovering over the patient.<br>— Remain aware of cues indicating that the patient is hallucinating.<br>— Be aware of all surrounding stimuli, including sounds from other rooms.<br>— Try to decrease stimuli or move the patient to another area.<br>— Avoid conveying to the patient the belief that hallucinations are real. Do not converse with the voices as it otherwise will reinforce the patient's belief in the hallucination as reality.<br>— Communication with the patient verbally in direct concrete, specific terms. Avoid gesturing, abstract ideas, and indirect accusations.<br>— Avoid placing the patient in situation where choices need to be made. Do not ask "would you like to talk or be alone for while"? Rather, suggest that the patient talks with you. | — The safety of the patient and others is a priority. Allowing the patient to have some distance may help diminish agitation.<br>— The patient may act on what he or she hears.<br>— Many seemingly normal stimuli will trigger an intensity of hallucinations.<br>— Decrease stimuli, provide fear opportunities for misperceptions. The patient has diminished ability to deal with stimuli.<br>— You must be honest with the patient, letting him or her know the hallucination are not real.<br>— The patient's ability to deal in abstractions are diminished. The patient may not correctly interpret your guesses. |

| Nursing Diagnosis | Nursing Intervention | Rationale |
|---|---|---|
| | — Encourage the patient's contact with real people, interactions and activities. | — The patient's ability to make decision is impaired. Also if given a choice the patient may choose to be alone (and hallucinate) rather than deal with reality (talking to you).<br>— It helps to keep patient in real environments. |
| Disorientation related to:<br>— Disordered thought processes<br>— Hallucinations and delusions<br>— Misperceptions of environment | — Spend time with the patient.<br>— Reorient the patient to person, place and time as indicated (call the patient by name, tell the patient where he or she is) | — Your physical presence is reality.<br>— Repeated presentations of reality is concrete reinforcement for patient. |
| Inability to distinguish self from environment related to:<br>— Disordered thought processes<br>— Delusions or hallucinations<br>— Potential for injury to self and others relation<br>— Delusions and hallucinations<br>— Feeling of being threatened<br>— Misperception or others behaviour. | — Help the patient establish what is real and unreal. Validate the patient's real perceptions and correct the patient's misperceptions in a matter-of-fact manner.<br>— Stay with the patient if she or he is frightened.<br>— Be simple, direct and concise when speaking to the patient.<br>— Provide safe environment for the patient.<br>— Remove the patient from the group if his or her behaviour becomes too bizarre, disturbing, and dangerous to others.<br>— Explain to other patients that they have not done anything to warrant the patient's verbal or physical threats, rather, the threats are the result of illness. | — The unreality of psychosis is not reinforced; reality is reinforced.<br>— Your physical presence and touch can provide reassurance from the real world.<br>— The patient is unable to process complex ideas effectively.<br>— It helps to feel secure.<br>— The benefit of involving the patient with the group is outweighed by the groups need for safety and protection.<br>— Other patient may interpret verbal and physical threats as personal and may feel that they are doing something to warrant or bring about threats. |

| Nursing Diagnosis | Nursing Intervention | Rationale |
|---|---|---|
| Potential for disturbed homeostasis:<br>— Inadequate food and fluid intake<br>— Sleep pattern disturbance | — Be alert to the patient's physical needs.<br>— Observe the patient's patterns of food and fluid intake; you may need to monitor and record intake, output, and daily weight. | — Physical needs must be met to enhance the patient's ability to meet emotional needs.<br>— The patient may be unaware of or may ignore his or her own physical needs. |
| Bizarre behaviour, anxiety, agitation or aggression related to:<br>— Feeling of fear and suspicion<br>— Delusion or hallucination<br>— Lack or control of self<br>— Disordered thought processes. | — Monitor the patient's elimination pattern. You may need to administer medications to the patient to establish regularity.<br>— Self limits on the patient behaviour when he or she is unable to do so. Do not set limit to punish the patients.<br>— Decrease the excessive stimuli in the environment. The patient may not respond favourably to activities or activity in large groups.<br>— Be aware of the patient's varying need for them. | — Constipation frequently occurs with the use of major tranquilizers.<br>— Limits are established by others when the patient is unable to use internal controls effectively.<br>— The patient is unable to deal with excess stimuli. The environment should be not be threatening to the patient.<br>— Chemical control can help the patient gain control over his or her own behaviour. |
| Regressive behaviour related to:<br>— Inadequate coping strategies<br>— Inability to relate to others<br>— Feelings of worthlessness | — Assess the patient's present level of functioning and help him from there.<br>— Help the patient to improve regressed behaviour to adult behaviour. Help the patient to identify unmet needs or feelings that causes regressive behaviour. Encourage the patient to express these feelings to help alleviate anxiety.<br>— At first do not offer choices to the patient e.g. would you like to have food instead of that, say, its time to eat, pick up your spoon.<br>— Set realistic goals. Set daily goals and expectations. | — It is important to begin where the patient is now not where he or she should be<br>— As the patient starts expressing and dealing with feelings more effectively, regressive behaviour will decrease.<br>— Patient's ability to make decisions is impaired. Patient may not be able to make decision.<br>— Patient is unable to deal with complex activities. Daily goals he can deal easily. |

### Evaluation

It is the fourth step in nursing process. Evaluation of patient's progress and nursing intervention is based on the attainment of relief of sign and symptoms of patient. Observation and documentation of the patient's initial behaviour and subsequent behavioural change provides a concrete yard stick by which to measure this process. When you are evaluating the schizophrenic patient, changes that would indicate movement toward higher levels of wellness include.

- Increased reality orientation indicates a decreases in anxiety.
- Increased clarity of communication implies more functional communication pattern.
- Willingness to share thoughts and feelings indicates increased trust and willingness to risk self-disclosure.
- Initiation of communication by the client indicates increased interpersonal comfort and tolerance for closeness relationships.
- Initiation of activities with others indicates more openness to relatedness.
- Increased decision making and self direction indicates improved self esteemed and self confidence.
- Increased attentions to grooming and personal hygiene conveys improved self esteem.

## 3.5 PROGNOSIS

Several studies have shown that 10-20 percent of patients can be described as having good outcome. More than 50 percent of patients have poor outcome.

Reported recovery rate range from 10 to 60 percent and 20 to 30 percent of all Schizophrenia patients are able to lead somewhat normal lives. The factors responsible for good prognosis are: if there is late onset, obvious precipitating factors, acute onset, good premorbid social, sexual and work histories, marries family history and good support system.

## 3.6 LET US SUM UP

Now you are thoroughly acquinted with Schizophrenia. You have also learnt its definition, sign and symptoms, psychodynamic, types and management both medical and nursing. The understanding of this mental disorder will help you to give better care to patient suffering from Schizophrenia.

## 3.7 KEY WORDS

**Catelapsy** : A state in which an immobile position is constantly maintained.

**Delusion of grandiosity** : An exaggerated concept of one's own importance power, knowledge of identity.

**Depersonalization** : This is a state in which interest and affect are withdrawn from the conscious, family, material with which they were connected, and are attached to the content of the unconscious.

**Hallucinations** : Sensory perceptions without external stimuli.

## 3.8 ANSWERS TO CHECK YOUR PROGRESS

**Check Your Progress 1**

1) The following are the sign and symptoms of Schizophrenia

   i) **Affect:** Flat or blunted and inappropriate.

   ii) **Associative looseness:** Associations are thread that ties one thought to another these thread are missing and connections become interrupted. Thinking become haphazard illogical and confused.

   iii) **Ambivalence**

   iv) **Autism:** Thinking not found to reality

   v) **Neologism:** New words, person makes up which have special meaning for the person.

   vi) **Withdrawal:** Used as a defense against uncomfortable levels of anxiety.

   vii) **Disturbances in behaviour:** Due to extreme withdrawal from reality a number of alternation in behaviour may appear.

   a) Stupor b) Waxy flexibility c) Extreme motor agitation,
   d) Echopraxia, e) Stereotyped behaviour, f) Automatic obedience,
   g) Negativism, h) Deterioration in appearance and manner.

   viii) **Disturbance in thinking and Perceiving:** a) associative looseness b) delusions c) hallucination d) concrete thinking e) depersonalization f) derealization

   ix) **Disturbance in speech pattern:** a) looseness of association b) echolalia c) clang association d) word salad

   x) **Others Symptoms**

   General disequilibrium of automatic nervous system; cold blius hand and feet, blotchy skin and widely dilated pupils.

   Loss of weight during acute phases of illness but gain of weight in chronic illness.

2) Following are the different types of Schizophrenia:

   i) Paranoid Schizophrenia

   ii) Catatonic Schizophrenia

   iii) Undifferentiated (Simple) Schizophrenia

   iv) Disorganised /Hebephrenic Schizophrenia

   v) Residual Schizophrenia

vi) Other types of Schizophrenia:

a) Psuedoneurotic type

b) Schizophrenia in Childhood

c) Early Infantile autism

**Check Your Progress 2**

1) Modalities of medical management of schizophrenia are:

i) Hospitalization

ii) Intragrated approach

iii) Family interventions

iv) Early treatment

v) Pharmacotherapy

vi) Electro-convulsive therapy

vii) Psychosocial therapies

a) Behaviour therapy

b) Family therapy

c) Group therapy

d) Cognitive therapy

e) Individual psychotherapy

f) Supportive psychotherapy

g) Insight oriented psychotherapy

2) Commonly used three antipsychotic drugs are:

— Haloperidol

— Risperidone

— Clozapine

## 3.9 FURTHER READINGS

Kapoor, Bimla, *Text Book of Psychiatric Nursing,* Vol. I and Vol. II, Kumar Publishing House, Pitampura, Delhi.

Stuart, G.W. and Laraia, M.T. (2001), *Principles and Practice of Psychiatric Nursing,* 7th edition, Mosby, Inc, St.Louis, Missouri.