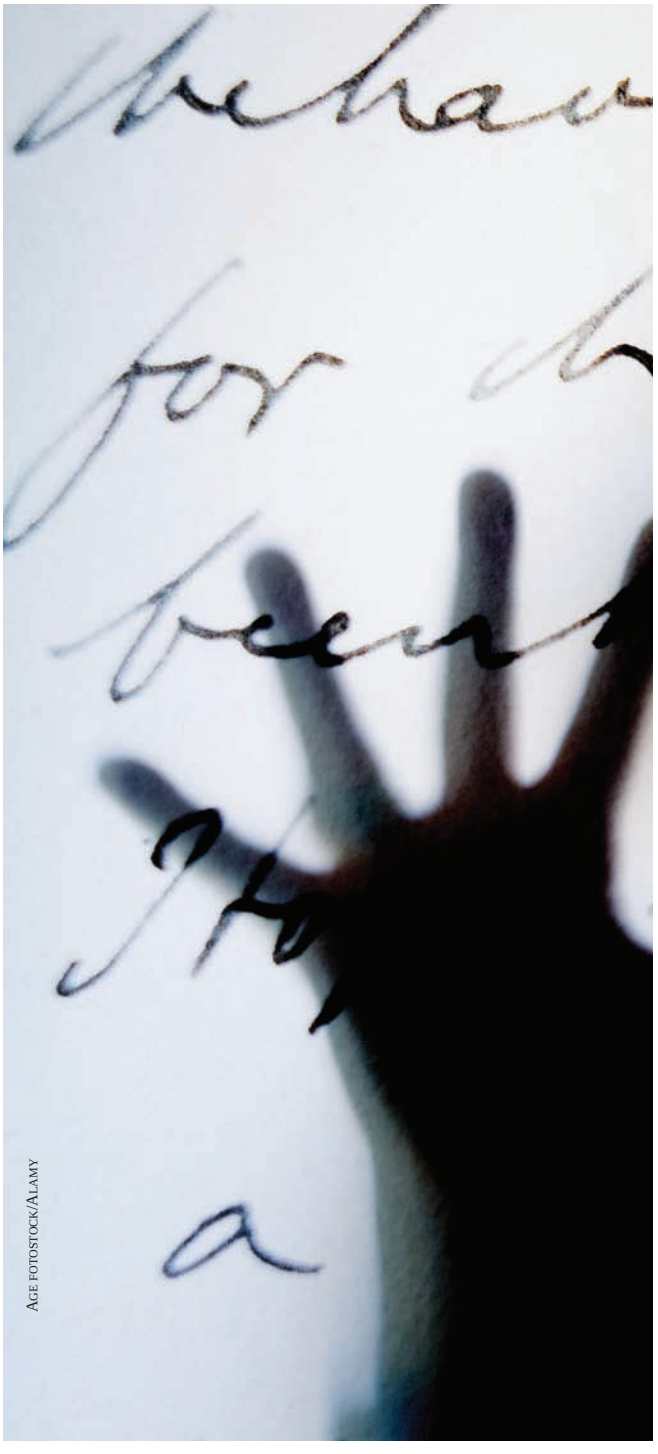
Caring for the patient with acute

You may encounter patients with acute psychosis as a result of schizophrenia in any practice area. Understanding the patient's experience and knowing how to respond are keys to a successful outcome.

By Charles Alan Walker, PhD, RN



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In this article, we discuss how to recognize the event sequence that frequently takes place during a psychotic episode, measures to take when a patient with psychosis experiences anxiety, strategies to help patients with psychosis establish and maintain control of their behavior, how to monitor physical health in the patient with schizophrenia, effective communication techniques when a patient exhibits thought disturbances, and appropriate interventions to use when a patient expresses delusions or has hallucinations.

What's schizophrenia?

Schizophrenic spectrum is a group of psychotic reactions in which the patient experiences loose association of thoughts, dulled or blunted affect, anhedonia, ambivalence, and impaired social relationships. Schizophrenia is characterized by ideas of reference, delusions, and hallucinations (see *Common symptoms of schizophrenia*).

Many causative factors have been suggested for this psychiatric disorder, including cortical atrophy, life stress, faulty family interactions, and low socioeconomic status. But prevailing notions about schizophrenia's etiology point to hereditary contributions of various genes, which predispose a person to

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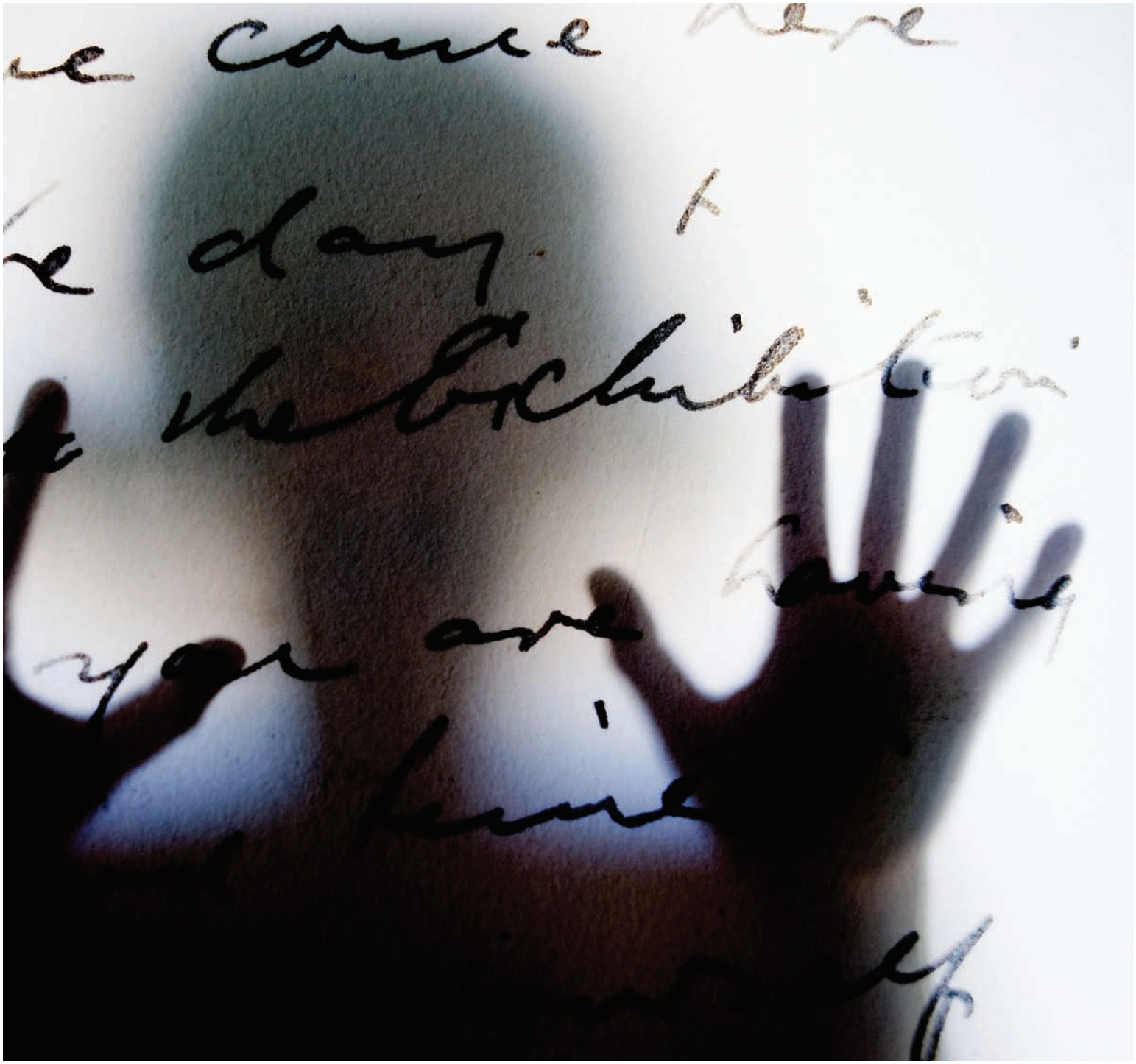
psychosis



an increased number of and sensitivity to dopamine-regulated neurons.

In the active phase of schizophrenia, psychotic symptoms are prominent. The *Diagnostic and Statistical Manual of Mental Disorders, 5th edition*, diagnostic criteria for schizophrenia include two or more of the following:

- delusions
- hallucinations
- disorganized speech
- grossly disorganized behavior
- negative symptoms such as apathy
- level of everyday functioning in work and self-care markedly below expectation
- continuous disturbance of premorbid or acute symptoms lasting 6 months or more
- schizoaffective, depressive, or bipolar disorder with psychotic features ruled out
- the disturbance isn't attributable to the physiologic effects of a substance or another medical condition.

Antipsychotic medications remain the mainstay of treatment for psychotic disorders. Atypical antipsychotics, such as aripiprazole, olanzapine, and ziprasidone, have become the first line of therapy. These medications have a more favorable adverse reaction profile and they address both positive and negative symptoms of schizophrenia. Because schizophrenia is a chronic illness, patients require long-term integrated treatment. For the majority of patients, the most effective treatment is a combination of antipsychotic medication and psychotherapy.

Common symptoms of schizophrenia

Symptom	Definition	Positive or negative symptom
Ambivalence	Indecisiveness about a course of action	Negative
Anhedonia	Lack of pleasure in everyday pursuits	Negative
Apathy	Lack of motivation to accomplish even the most mundane tasks	Negative
Delusion	A firmly fixed belief that can't be corrected by logic	Positive
Grandiose delusion	The belief that one has great power, prestige, or wealth	Positive
Hallucination	A sensory-perceptual experience with no basis in reality; often auditory, but may be visual, tactile, or olfactory	Positive
Ideas of reference	The irrational assumption that, when in the presence of others, one is the object of their discussion or ridicule	Positive
Loose association	Thinking characterized by speech in which focus shifts from one topic to another; if severe, speech may be incoherent	Positive
Thought blocking	The inability to complete a thought or finish a sentence; this experience may be extremely frustrating/bewildering	Negative

Understanding the breakdown

There are four stages of a schizophrenic breakdown. During the first stage, patients experience a kind of euphoria with high energy. They may feel quite good temporarily as if they're on a mission or quest and their life has been given some greater meaning. This phase usually lasts a few days during which the patient doesn't get much sleep, calls friends and family at all hours of the day and night, and may be difficult to live with.

The second stage includes what are termed ideas of reference—everything refers to the patient and there isn't anything that doesn't have special and deep meaning. There's a subtle shift between the euphoric sense of purpose and the patient's belief that everything that's happening has some personal significance. Words spoken on TV are specific messages to the patient, not general advertising. Little glances and conversations between people on the street aren't to each other, but are secret codes to the patient.

The third stage is associated with what's known as the destructuring of perception. Events are either super strong or too weak for the patient to perceive, and there's a breakdown in the sensory processing apparatus. Have you ever seen the world through a kaleidoscope? People and places that were once predictable and familiar become disorienting and unfamiliar; the world is on a tilt. This is what happens to the patient experiencing psychosis.

In the fourth and final stage, patients aren't able to inhibit extraneous or irrelevant stimuli—everything comes flooding in on them. This is no longer a euphoric state, but a very frightening one. At this point in their breakdown, patients often exhibit full-blown delusions and hallucinations. Generally, patients who experience such a break or exacerbation of illness are hospitalized in a community mental health center for a short stay, usually averaging 5 to 7 days. Outpatient treatment is also recommended.

During this hospital stay, psychotropic medications are administered and schizophrenia will usually be brought under control within 2 to 4 weeks. Measures will be taken to reduce the patient's anxiety and care for the patient's physical needs until he or she is well enough to assume these responsibilities. A therapeutic, interpersonal relationship between nurse and patient helps the patient tolerate symptoms when acutely ill. The relationship also serves as a basis for further interaction as the patient gets better.

Reducing anxiety

Reducing the patient's anxiety is one of the most important initial measures you can take. The patient having an acute psychotic episode is intensely frightened. Fear is the prevailing problem in the initial phase of treatment; the more intense the fear, the more intense the psychotic symptoms. You can assume that the more the patient is talking through delusions, the more intense the hallucinations, the more frightened and anxious he or she is.

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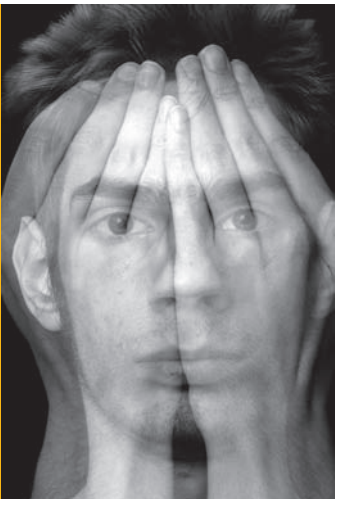


The best approach to a patient whose psychosis appears to be increasing is to reduce his or her anxiety. You can do this by bringing the patient back to your reality. You might say, "I think I'm making you more anxious" or "Talking about this seems to make you more anxious." For example, if a patient says, "I'm Jesus Christ, I'm God"—a grandiose delusion—you shouldn't respond by interpreting that the delusion is a response to the patient's insecurity. Rather, you want to respond to the process: the patient is getting more anxious, which is fueling the psychosis. You might say, "I think right now you're getting more anxious. Why don't we stop this discussion and sit here quietly for a minute" as opposed to "It sounds like what you're saying or feeling is..."

There are times when sitting with the patient silently is the best response. You aren't overstimulating the patient, but you're giving him or her a sense of security—the patient isn't alone and he or she can rely on your reality for a while.

To review, techniques that can help reduce anxiety include sharing your reality, responding to the process rather than interpreting, and staying with the patient quietly.

Helping patients gain control

In addition to reducing anxiety, you'll want to help patients establish and maintain

control of their behavior. If you're working with a newly admitted patient experiencing psychosis, you need some capacity to relate to that individual and these skills must be learned. You must learn to speak to the patient's concern without hemming him or her in and without pressuring too much, yet you have to set firm limits.

The symptoms of psychosis usually wax and wane; that is, if the patient is having auditory hallucinations or ideas of reference, the intensity of those symptoms—and the patient's capacity to distance him- or herself from them, control them, or resist them—probably varies throughout the day and day to day. So a patient who can't help him- or herself at one point during the hospital stay may be able to at another time, particularly if you encourage him or her to do so.

This vacillation in self-control means that extremes are to be avoided. To treat patients with psychosis as if they have no capacity to control themselves is an error. To treat them as if everything is under their control is also an error, but for you to exhort them to manage whatever degree of control they can maintain is quite a reasonable expectation.

You must remember that the patient with psychosis is responding to an internal state of mind over which you have little or no control. In fact, the patient is experiencing things that the observer isn't experiencing.

consider this

Mr. M talked nonstop about fulfilling his messianic mission. He repeatedly emphasized that in the second millennium, he would exalt the 12 tribes of Israel and the saved would number only 2,000. Often, he stopped midsentence and asked, "Do you understand?" To which I replied, "No, I don't understand." Frustrated, Mr. M, said, "Of course, you wouldn't understand. You don't have superior, Godly intelligence." Then he grabbed my legal pad and pencil, and wrote the numerals 2, 12, and 2,000 while continuing to rant. At this point, I said, "What I do understand is that you wrote the numbers 2, 12, and 2,000 on my paper." Mr. M stopped ranting and said, "Yes, I wrote 2, 12, and 2,000 on your paper. Would you like to see my drawings? They're in my room."

Analysis: This patient was talking through his delusion at a rapid pace, anxiously wanting to be understood. When I finally validated something we could both agree on, he ceased his ranting and invited me to see his artwork.

You might say, "We know you may be terribly frightened, but we want you to know that you're safe here. These fears are symptoms of your illness, and we're going to protect you. We aren't going to let you get out of control if that should be a concern to you. And we would like you to warn us if you're concerned about getting out of control." When you make that sort of unilateral statement, the patient is often comforted.

If patients sense, in the midst of their terror, which is often inexpressible, that you understand to some degree what they're experiencing, they're often reassured. If patients fear that they may lose control of their impulses—usually violent impulses—they may be relieved to know that you aren't frightened that they have those concerns, and there are sufficient personnel that if they act out their impulses, you'll assist them to regain control.

Most patients with psychosis, even though they may seem out of touch with reality, have excellent memories for what goes on during an acute episode. They remember what you do for them; what you don't do for them; and whatever you may do *to* them, which they may interpret negatively. Although they may be mute and unresponsive, patients with psychosis remember what's said. Keep this in mind when you work with these patients.

In review, to help patients establish and maintain control, you should speak to patients' concerns, set firm limits, encourage patients to control themselves as much as they're able, and ensure them of their safety.

Monitoring physical health

Monitoring the physical health of patients with psychosis is also necessary. You must make sure that patients are having their daily needs met—eating, toileting, and resting sufficiently. Patients may ignore some of these functions during a psychotic episode. Be alert to signs of physical illness, such as lassitude or lethargy. Not all of the patient's physical symptoms may be manifestations of the psychiatric problem.

You should actively intervene when the patient is behaving in ways detrimental to his or her health. Although an intervention principle is to allow the patient to control as much of his or her life as possible, there are instances when a psychiatric disorder can seriously interfere with the patient's well-being. An instance might be when a patient is unable to voluntarily decide to rest for the sake of his or her own health. Because of the patient's ambivalence, he or she might walk into the room in preparation for taking a nap, then walk back out, walk in, and walk back out.

You have the difficult challenge of deciding at which point you need to take responsibility for the patient's well-being, with the ultimate goal of gradually transferring that control back to the patient as he or she achieves some level of readiness. In this instance, it would be appropriate for you to take the patient gently, but firmly by the arm and walk with him or her to the room. After you're there, you would assist the patient to sit on the bed and then lie down. You might say, "Now you'll rest. I'll stay with you while you rest or I'll check back with you to make sure you're resting. But now you'll rest."

To review, monitoring the patient's physical health includes meeting basic needs, attending to urgent health concerns, recognizing signs of illness, and preparing for the patient's indecision related to matters affecting his or her physical well-being.

Communicating effectively

The ability to communicate effectively is important when caring for patients who are experiencing an acute psychotic episode. It's impossible to provide a nurse with a script of therapeutic words, phrases, or sentences; instead, it's preferable for you to use your own personal style to operationalize a number of therapeutic principles (see *Five therapeutic principles*). If you're extroverted and sociable, then use it to greatest effect without overstimulating the patient. If you're introverted and soft-spoken, then use silence to allow the patient to reveal his or her feelings.

Consider these strategies to communicate effectively (see *Suggestions for communication*).

- ***Listen for themes.*** When interviewing a patient with psychosis, it's often difficult to understand his or her story. If the patient is talking but is difficult to follow, you can listen for themes. Try to understand the most important theme in the patient's conversation. For example, the patient might be repetitively speaking about "decapitated babies, bloody knives, zombies, and empty graves." Rather than asking questions about these things, it's better to simply ask the patient, "Are you feeling frightened?" Often, a patient who's rambling will respond that he or she is feeling frightened.
- ***Speak simply and concretely.*** One of the most important things to keep in mind when caring for a patient with psychosis is to speak simply and concretely so that the patient is able to follow. A long paragraph with many abstract ideas will be difficult for the patient to understand and respond to because it's too much stimulation. Accompany simple language with simple gestures. Rather than orienting the patient to his or her room using complex instructions about the call bell, TV remote device, or bed controls, you might say simply, "Come and sit" while gesturing with an open hand and an inviting facial expression.
- ***Anticipate the patient's experience.*** Sensitive communication is particularly helpful when a patient experiences thought blocking (the patient has

Five therapeutic principles

- Show acceptance without value judgment.
- Observe the patient's verbal and nonverbal cues.
- Focus on the patient's feelings.
- Be honest and direct.
- Actively listen.

Suggestions for communication

- Listen for themes.
- Speak simply and concretely.
- Anticipate the patient's experience.
- Ask if the patient is hallucinating; if so, ask if he or she is hearing voices and what they're saying.
- Avoid disagreeing with delusions or asking detailed questions about them.
- Notice the patient's nonverbal cues; look for incongruence with what he or she says.
- Stay with the patient who's having auditory imperative or command hallucinations.

many thoughts but can't choose one to say), expresses a delusion, or appears to be having hallucinations. When a patient is having tremendous difficulty with thought blocking, letting him or her know that you understand what's happening is often a relief. The patient who can't complete a sentence is very embarrassed and feels that something strange is happening to him or her that no one can understand. So it's immensely helpful for the patient to know that you can anticipate what he or she is experiencing, even if just a little bit.

If the patient is experiencing delusions, one of the key principles of effective communication is letting him or her know when you don't understand. Communication can proceed most effectively if you're clear on what has been understood and what hasn't. It's important that you don't disagree with the patient's delusion; don't attempt to rationalize or argue with him or her. What you can say is, "I don't share that fear, but I understand that's the way you see things now." In that way, you provide some consensual validation of the patient's reality without taking a punitive or disrespectful attitude toward his or her experience.

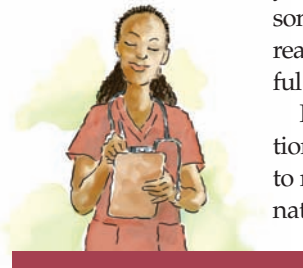
If the patient is experiencing hallucinations, to intervene constructively you need to remember, first and foremost, that hallucinations, although not real for you, are experienced as very real for the patient. In most cases, hallucinations are threatening and ominous. It's useful for you to reassure the patient who's hallucinating. Any areas in which you have some control over protecting the patient should be pointed out. You might say, "I won't let anyone hurt you. I will protect you. I will stay with you." You can share your perception of reality by saying, "I don't see, smell, or hear what you're experiencing, but I can see how it's upsetting you."

It's critical for you to realize that whenever a patient is experiencing perceptual distortions, other sensory input can be equally distorted and become equally frightening. Avoid touching patients who are actively hallucinating without telling them that you're going to touch them. Patients who are hallucinating may interpret sensory input in a way other than you intended.

For patients experiencing auditory hallucinations, some of the time it's blatant enough that they'll respond to the voices. Often, you can pick this up through subtle behavior. You see the patient moving his or her head or lips as if responding to something in the environment. You should then ask, "Are you hearing voices?" If the answer is yes, then say, "What are the voices telling you?"

It's important to know the content of auditory hallucinations: there's a difference between voices making benign statements and voices telling the patient to harm him- or herself or someone else (command hallucinations). When a patient hears auditory imperative or command hallucinations, stay with the patient and constantly observe him or her.

In review, to communicate effectively, you should use your own style, listen for themes, speak simply and concretely, indicate when you don't understand, avoid disagreeing with delusions, share your perception of reality, and remain with the patient having auditory command hallucinations.



consider this

Ms. R stood in a corner of the day room waiting her turn for morning snacks, which included peanut butter and sliced apples. When she finally approached, I asked her pleasantly if she would like a piece of apple. She responded with a deep and furious growl, "I don't want an apple unless there's a snake wrapped around it." Instead of trying to interpret Ms. R's imagery, I simply said, "I'm not going to harm you with this apple slice. Apples are good for us…see," and I bit into the apple slice. Ms. R reluctantly took two apple slices and some peanut butter.

Analysis: Rather than rush to interpret Ms. R's response as an allusion to the Genesis narrative about Eve, the serpent, forbidden fruit, original sin, and guilt, I responded to the process. Ms. R was fearful and I spoke to her fear.

Epilogue: Eight days later, as she was preparing for discharge, Ms. R sat next to me and said, "I'm sorry for the way I spoke to you that day you offered me the apple. I know I scared many of the other patients, including my roommate. I was scared, too. I saw the snake as vividly as I see you now."

Awareness and sensitivity needed

Care of the patient with acute psychosis requires your awareness of the

sensory-perceptual problems he or she is experiencing and being able to apply that awareness to specific situations. Care also requires you to be sensitive to the patient's feelings and preserve as much of his or her dignity as possible. Doing so will positively influence patients' progress during the rehabilitative phase of their illness. ■

on the web

- **American Psychiatric Association:** http://www.psychiatry.org/schizophrenia
- **Cleveland Clinic:** http://www.clevelandclinicmeded.com/medicalpubs/diseasemanagement/psychiatry-psychology/schizophrenia-acute-psychosis
- **Mayo Clinic:** http://www.mayoclinic.org/diseases-conditions/schizophrenia/basics/definition/con-20021077
- **National Alliance on Mental Illness:** http://www.nami.org/Learn-More/Mental-Health-Conditions/Schizophrenia
- **National Institute of Mental Health:** http://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml
- **World Health Organization:** http://www.who.int/mental_health/management/schizophrenia/en

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The author and planners have disclosed no potential conflicts of interest, financial or otherwise.

DOI-10.1097/01.NME.0000462645.52688.23

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