What to know on the Exam

Mania - 7 questions

Assess the clinical picture – behavior on the unit
What are the nursing priorities?
Limit setting-how to handle the pt with mania
Safety and physiologically
How do you manage and prioritize, safety and take care of psych & physio needs

Mania

Several theories: hereditary, possible excess of norepinephrine and dopamine, electrolytes, possible cholinergic or acetylcholine link is also noted with an inadequate amount accounting for mania

Signs and symptoms can be described according to three stages

Stage I – Hypomania
(pt enjoys this phase, not a cause for social or occupational impairment, does not require hospitalization)
Mood: cheerful and expansive, underlying irritability that surfaces rapidly when wishes and desires go unfulfilled, nature is volatile and fluctuating
Cognition and Perception: idea of self being of great worth and ability, thinking flighty, rapid flow of ideas, easily distracted by irrelevant stimulation so that goal-directed activities are difficult
Activity and behavior: increased motor activity, very extroverted and sociable – therefore many acquaintances but not many close friendships, talk and laugh a lot loudly and inappropriately, horny, some anorexic, may phone the President or over spend on credit cards

Signs and symptoms of mania
(listed for children but probably in adults too)
Euphoric/expansive mood: extremely happy, silly, or giddy
Irritable mood: hostility and rage, often over trivial matters
Grandiosity: believes abilities to be better than everyone else's
Decreased need for sleep: may only sleep 4-5 hours per night and wake up feeling rested
Pressured speech: loud, intrusive, and difficult to interrupt
Racing thoughts: rapid change of topics
Distractibility: unable to focus on anything for very long
Increase in goal-directed activity/psychomotor agitation: activities become obsessive, increased psychomotor agitation
Excessive involvement in pleasurable or risky activities: exhibits behavior that has an erotic, pleasure seeking quality about it
Psychosis: may experience hallucinations and delusions
Suicidality: may exhibit suicidal behavior during a depressed or mixed episode or when psychotic

Stage II – Acute Mania
(marked impairment in functioning, requires hospitalization, may get so hyper will die from sleep deprivation)
Mood: euphoria and elation, on continuous "high", but subject to frequent variation, can go to irritable and angry to sad and crying
Cognition and Perception: racing and disjointed thinking, flight of ideas (if severe may be incoherent), pressured speech, distractibility is all-pervasive, hallucinations and delusions (usually of grandeur and paranoia)
Activity and behavior: psychomotor activity is excessive, increased horniness, poor impulse control, may be sexually uninhibited, excessive spending, ability to manipulate others to carry out wishes, skillfully projects responsibility of failure to others, energy is inexhaustible, need for sleep is diminished, hygiene may be neglected, dress may be neglected, flamboyant, or bizarre, excessive use of make-up and jewelry

Stage III – Delirious Mania
(grave for of disorder)
Mood: very labile, despair then quickly to unrestrained merriment and ecstasy, then irritable, or totally indifferent, may have panic anxiety
Cognition and Perception: clouding of consciousness, confusion, disorientation and sometimes stupor, religiosity, delusions of grandeur or persecution, auditory and visual hallucinations, extremely distractible, incoherent
Activity and behavior: frenzied psychomotor activity, agitated purposeless movements, exhaustion, injury to self, or death without intervention

Nursing Diagnosis	Outcomes	Interventions
• Risk for injury r/t hyperactivity	• Pt exhibits no injury	• Reduce stimuli, private room, noise low, remove hazards, stay with pt, provide phys. activities, admin tranquilizers
• Risk for violence – self & others r/t manic excitement, delusions, hallucinations	• Pt has not harmed anyone • Pt exhibits no agitation	• Reduce stimuli, ck q 15 min, remove hazards, physical activity, maintain calm attitude, have enough staff to show strength, admin tranquilizers, restraints
• Imbalance nutrition – less than req r/t refusal to sit still & eat	• Pt eats well balanced diet	• Provide high-protein & calorie snacks for eating on the run (finger food), snacks available at all times, record I & O's, have favorite food, admin vit & minerals, walk or sit w/client while eating
• Disturbed thought process r/t biochem. alt. in brain AEB delusions	• Pt verbalizes accurate interpretation of environment	• Assist client to define and test reality
• Disturbed sensory perception r/t biochem. Alt. in brain AEB hallucinations	• Pt verbalizes hallu. have stopped	• Assist client to define and test reality
• Impaired social interaction r/t egocentric, narcissistic behavior AEB no friends	• Pt accepts resps for behavior • Pt does not manipulate others • Pt interacts appropriately	• Ignore charm or arguments, set limits on violations, positive reinforcement on non-manipulative behavior, help client identify his/her good aspects
• Disturbed sleep pattern r/t excessive hyperactivity	• Pt is able to fall asleep in 30 min • Pt is able to sleep 8 hours	•

Prioritize these diagnoses by Maslow's Hierarchy of needs. Another big part of the intervention for manic patients is to educate them about meds --- see lithium below. Also teach about causes and symptoms of mania to pt and family, along with assertiveness and anger management, crisis hotline, support groups, psychotherapy and financial assistance.

Lithium - 4 questions

Toxic levels and their side effects
Patient teaching
N/D-Potential for injury-What is the nurses responsibility in terms of injury?

Lithium – Antimanic Mood Stabilizer –

Used for prevention and treatment of manic episodes of bipolar disorders. Also used for bipolar depression. Unlabeled uses: major depression, neutropenia (abnormally small amt of neutrophils in the blood), cluster or migraine headache prophylaxis, alcohol dependence

How does it work – may enhance reuptake of norepinephrine and serotonin – may take 1-3 weeks to decrease symptoms

Contraindications – hypertension, cardiac or renal disease, dehydration, sodium depletion, brain damage, preg and lact. caution w/ thyroid disorders, diabetes, urinary retention, history of seizures, and elderly

Dose
For acute mania 1800-2400 mg/daily, For maintenance 900-1200 mg/daily
Therapeutic Plasma Range
For acute mania – 1.0-1.5 mEq/L, For maintenance – 0.6-1.2mEq/L

#1 Nursing Diagnosis with any patient on Lithium is Risk for Injury r/t lithium toxicity

Because ?
The therapeutic range is VERY narrow! Therefore, serum lithium levels s/b checked once or twice a week until serum levels are stable, then monthly during maintenance therapy. Blood draws s/b drawn 12 hrs after last dose.
Teach pt & family about follow up blood checks!!!

Because ?
Lithium is chemically similar to sodium in the body. If you loose sodium (*by vomiting, diarrhea, sodium restriction due to diet, dehydration, sweating, fever, diuresis*) the lithium will replace sodium in the blood increasing serum lithium levels causing toxicity.
Teach pt & family about sodium and to avoid excess or strenuous exercise, notify Dr w/ vomiting or diarrhea, eat right!!!

Recognize Lithium Toxicity:
- Mild toxicity – levels 1.5-2.0 mEq/L
  - Blurred vision, ataxia (loss of muscle coordination), tinnitus, persistent nausea & vomiting, severe diarrhea
- Moderate toxicity – levels of 2.0-3.5 mEq/L
  - Excessive dilute urine, increasing tremors, muscular irritability, psychomotor retardation, mental confusion, giddiness
- Severe toxicity – levels above 3.5 mEq/L
  - Impaired consciousness, nystagmus, seizures, coma, oliguria/anuria, arrhythmias, myocardial infarction, cardiovascular collapse

So recognize these! Teach patient to recognize these! Teach family to recognize these! If you see them, if patient says he/she has them, HOLD one med (don't stop abruptly), check lithium levels and notify physician if levels are above 1.5 mEq/L.

MEDS (20 questions)

How do you treat:

- **Anxiety** – antianxiety drugs or anxiolitics (aka minor tranquilizers)

What are the anxiolitics?
Atarax, vistaril
Xanax
Librium
Klonopin
Tranxene
Valium
Ativan
Serax
} benzodiazepines
Miltown
Buspar

What should we remember about theses anxiolitics?
- They're CNS depressants
  - So makes pt drowsy, confused, lethargic
  - Alcohol is CNS depressant too
- Work by GABA potentiating
- They act immediately
  - so may be ordered as PRN meds
- They are very addictive
  - So don't give drug addicts, just be new addiction
- Pt gets dependence, builds tolerance – therefore must be tapered off
  - do not stop abruptly
- Orthostatic hypertension
  - dangle

What should we remember about this anxiolitics?
- Takes 2.5-3.5 half lives or weeks to be effective
  - So not a PRN
- Does not depress CNS
- Must be tapered off this med

How do you treat:

- **Depression** – antidepression drugs or antidrepressants
  - SSRI's, MAOI's, Trycyclics, others

What are things to remember about antidepressants in general (applied to all)?

- A patient with bad or vegetative depression with not have energy to carry out suicide, but as these antidepressants start to do their job but have not quite brought the patient to a happy mood, they will have enough of an energy increase to carry out suicide. Therefore, a nursing diagnosis for any patient starting antidepressants is Risk for Suicide.
- All antidepressants cause dry mouth, sedation, nausea, discontinuation syndrome.

Teaching for all antidepressants:

- ✶ Don't drink with antidepressants
- ✶ Don't stop taking meds abruptly
- ✶ Don't stop because your symptoms went away
- ✶ Usually takes 4 weeks for drug to take effect
- ✶ Always carry a card with your drug information on it

Ethnopharmacology exists for **Blacks and Asians**. They will probably get started on a lower than typical dose.

What are SSRI's?
These drugs inhibit the reuptake of excess serotonin in the synaptic cleft. Serotonin is thought to be needed for a happy and well mood. Therefore, the SSRI or selective serotonin reuptake inhibitor leaves more serotonin in the body to do its job.

What are the <u>SSRI's</u>?
Celexa
Prozac, Sarafem
Luvox
Lexapro
Paxil
Zoloft

What teaching goes with SSRI'?

- Serotonin syndrome is a possibility if concurrent w/other serotonin increasing antidepressants
- Taper off these meds or pt may get discontinuation syndrome which presents with flu-like symptoms
- Insomnia is fairly common
  - Also headache, weight loss, sexual dysfunction, GI distress, ^ BP, ^ HR

Symptoms of Serotonin syndrome:
Mental status changes, restlessness, myoclonus, hyperreflexia, tachycardia, labile blood pressure, diaphoresis, shivering, tremors

What are MAOI's?
Monoamine oxidase is an enzyme that destroys or inactivates unused monoamine neurotransmitters in the synaptic cleft. A monoamine is dopamine, epinephrine, norepinephrine, histamine, serotonin, melatonin, and more. Therefore, a MAOI or monoamine oxidase inhibitor stops this enzyme leaving more of these amines available in the brain to do their job.

What are the <u>MAOI's</u>?
Marplan
Nardil
Parnate

What teaching that goes with MAOI's?

- Can't take them with other antidepressants
  - If switch, must be 2-3 wk period between
- Will have a hypertensive crisis with:
  - Foods with tyramine

What has tyramine?
Aged cheese, raisin, wines, smoked or processed meat, caviar, corned beef, liver, soy sauce, brewer's yeast, yogurt, sour cream, beer, coffee, tea, chocolate, bouillon, figs, all alcohol

What are the Tricyclid's?
Elavil, Endep
Asendin
Anafranil
Norparmin
Sinequan
Tofranil
Aventyl, Pamelor
Vivactil
Sumontil

What are Tricyclid's (TCA)?
These are the bad guys. They do many things: inhibit the reuptake of serotonin, and norepinephrine, block alpha$_1$ receptors, Ach receptors, histamine$_1$ receptors

alpha$_1$ function
Smooth muscle contraction, includes vasoconstriction – so you get **orthostatic hypotension**

histamine$_1$ function
Ileum contractions
Modulate circadian cycle
Systemic vasodilation
Bronchoconstriction

Blocking the Ach receptor causes **anticholinergic side effects:**

ACh Side Effects

"Mad as a hatter"	Delirium
"Blind as a bat"	Mydriasis
"Red as a beet"	Flushed
"Dry as a bone"	Dry Skin
"Hot as a hare"	Hyperthermia

Confusion, drowsiness, hallucinations, dry mouth, constipation, palpitations, tachyarrhythmia, urinary retention, dry eyes, blurred vision, falls

VCU

Asendin has high risk for EPS

Patients only get one week's worth of these prescribed at one time because they are so dangerous and good to use for suicide

Other side effect from TCA's:
Sedation
Weight gain
Cardiac arrhythmias

What are the "other's"?
Zyban, Wellbutrin
Ludiomil
Remeron
Desyrel
Serzone
Effexor
Cymbalta

These all work in different ways

- **Ludiomil (maprotiline)** and **Remeron (mirtazapine)** have anticholinergic side effects
- They all have **sedative effects** exception Zyban,Wellbutrin (bupropion)
- **Desyrel (trazodone)** can give you priapism – prolonged or inappropriate erection (hold meds and contact physician immediately)
- **Serzone (nefazodone)** may cause life-threatening liver failure (report jaundice, anorexia, GI complaints, or malaise immediately). FDA has put a black box warning on this drug for that reason.
- **Remeron (mirtazapine)** causes patient to gain weight

How do you treat:

- **Mood Disorder** – mood stabilizing drugs or antipsychotic mood stabilizers

What are they?
There are 4 different kinds of mood stabilizing drugs:

Antimanic:
Lithium

Antipsychotic:
Zyprexa
Abilify
Thorazine
Seroquel
Risperdal
Geodon

Calcium Channel Blocker:
Calan, Isoptin
(Verapamil)

Anticonvulsant:
Klonopin
Tegretol
Depakene, Depakote
Lamictal
Neurontin
Topamax

What to remember about mood stabilizing drugs?

- **Lithium** is the oldest and most often used mood stabilizer. Is often used with other mood stabilizing drugs
- **Lamictal** (lomotrigene) causes an increased risk of Stevens Johnson Syndrome
- **Depakene, Depadote (valproic acid)** causes and increased risk of prolonged bleeding time
- Antipsychotic drugs used for mood stabilization have the **'anticholinergic'** and **'EPS'** side effects
-

What is Stevens Johnson Syndrome?

- Another kind of SJS is Toxic Epidermal Necrolysis (TEN)
- It is a severe adverse reaction to drugs which is a rash on the mucous membranes
- Starts out with
  - Flu symptom
  - Blisters in mouth, eyes, ears, nose
  - Burning during urination
- Stop the meds immediate at first signs of blister
- Literature as links to NSAIDS and carbamazepine (tegretol)

How do you treat:

- **Schizophrenia** – antipsychotic drugs

What are the antipsychotic drugs (aka neuroleptic)?
Three types according to Ms. Nelson

1st generation – targeted the positive symptoms
Phenothiazines – chemical class:
Thorazine (chlorpromazine)
Prolixin (fluphenazine)
Trilafon (perphenazine)
Compazine (prochlorperazine)
Mellaril (thioridanzine)
Stelazine (trifluoperazine)

2nd generation – targeted the negative symptoms –
Thioxanthene – chemical class:
Navane (thiothixene)
Butyrophenone – chemical class:
Haldol (haloperidol)

Atypical – targeted both positive and negative symptoms – Various chemical classes:
Risperdal (risperidone)
Loxitane (loxapine)
Moban (molindone)
Clozaril (clozapine)
Orap (pimozide)
Zyprexa (olanzapine)
Seroquel (quetiapine)
Geodon (ziprasidone)
Abilify (aripiprozole)

What do we need to remember in general with antipsychotic drugs (applies to all)?

- Most work by blocking dopamine receptors with some muscarinic and adrenergic blocking also.
- Even with just 8% of the dopamine receptors blocked, **Extrapyramidal symptoms (EPS)** occur AND this is the major reason for noncompliance for antipsychotics drugs.
- With the muscarinic blocking, **Anticholinergic symptoms occur**.
- With long-term use, **Tardive dykinesia** is a risk (can be irreversible)
- There is a risk of **Neuroleptic malignant syndrome (NMS)**.
- **Orthostatic hypertension** occurs but will usually go away after 3-4 weeks
- Hormonal effect occur including: **retrograde ejaculation** (ejaculation into the bladder), **gynecomastia** (large and lactating breast on men), **amenorrhea** (no menstrual period for women)
- ECG changes or **arrhythmia** car occur (including prolonged QT interval)
- **Agranulocytosis** can occur
- If a diabetic takes antipsychotic drugs their risk of **hyperglycemia** is increased
- These drugs lower the **threshold for seizures** – so watch pt w/ seizure history closely.
- **Skin rash, GI upset, sedation, photosensitivity**

Clients have to decide whether they want altered thoughts or altered body control

Extrapyramidal symptoms (EPS) include:
Pseudoparkinsonism
Akinesia
Akathasia
Dystonia
Oculogyrics crisis

EPS's are fixed with the ABC'S
Artane (anticholinergic)
Benadryl (antihistamine)
Cogentin (anticholinergic)
Symmetrel (dopaminergic agonist)

Tardive dyskinesia (or dystonia) includes:
Face (tics, blinking, grimacing)
Tongue (chewing, protrusion, tremor, writhing)
Lips (smacking, pursing puckering)
Limbs (toe-tapping, pill rolling, writhing)
Respiratory (irregular breathing, grunting)

Important to know about *TD's:*
Don't panic with mild symptoms and stop drug because patient's chance of committing suicide is great.

TD's are potentially irreversible. They can be acutely suppressed with an increased dose (Ms. Nelson). Drug should be stopped immediately at first signs to stop chance of permanence (book).

Neuroleptic malignant syndrome (NMS) symptoms include:
Parkinsonian muscle rigidity
Hyperpyrexia (107oF)
Autonomic dysfunctions
- Tachycardia, Tachypnea, labile BP, diaphoresis, HTN, altered consciousness, urinary increase

Elevated WBC (white blood count) CPK (creatine kinase) LFT (liver function test)

NMS can be fatal. Stop drug immediately. Counteract with Dantrium or Parlodel.

Agranulocytosis is potentially fatal blood disease where the WBC count false extremely low levels:
- ✶ WBC – below 3,000 mm3 (normal is 4,100-10,800 mm3)
- ✶ Granulocytes – below 1,500 mm3

It is reversible if caught early.
Symptoms:
- ✶ Sore throat
- ✶ Fever
- ✶ Malaise

Stop meds immediately. If not, pt may have to have chemotherapy and be on neutropenic diet.

What are the things we need to know about specific antipsychotics?

Clozaril (clozapine)
- × It makes you drool (hypersalivation) which is embarrassing and a risk for aspiration.
- × There is a significant risk for Agranulocytosis with this drug and pt should get blood draws weekly for the first 6 months and then monthly after that (can get expensive)
- × 5% of these patients will experience seizures
- × It has a *very high* occurrence of anticholinergic symptoms and sedation, and a *high* occurrence of HTN and seizures.
- × These things make Clozaril a last line drug – try everything else first.

Geodon (ziprasidone)
- × Particularly prone to give patients arrhythmias

Risperdal (risperidone)
Although this drug is atypical and is listed as having low side effect, Ms. Nelson says:
"Risperdal is Haldol in drag and at 2-4 mg it comes out of the closet."
Haldol has a high occurrence of EPS and Risperdal's normal dosage is 1-6 mg per day.

Depression/suicide-5 questions

Suicide Assessment
Who is at higher risk? Age group
Who will follow through? Age group
How do you monitor them?

Suicide Assessment

- According to our notes in depression:
  - Ask "Do you have ideas of suicide?"
  - Get a safety contract for them promising that they will tell you before they do anything to harm themselves
  - Other information you would want to assess so that Maslow's hierarchy of needs could be handled would be
    - Have you gained or lost any weight recently?
    - How have you been sleeping lately?
- According to the Suicide section of the power points:
  - Assess their demographics because all of these increase risk
    - Age →
      - 3rd leading cause of death for 15-24
      - 5th leading cause of death for 25-44
      - 8th leading cause of death for 45-64
    - Gender – men more than women
    - Ethnicity – highest whites, then in order Native American, African American, Hispanic Americans, Asian Americans
    - Marital status – single more likely by 50%
    - Socioeconomic status – highest and lowest class more than middle
    - Occupation – health care professionals and executives more
    - Method – presents of fire arms more than overdose
    - Religion – with affiliation, risk is lowered
    - Family history of suicide – with history more
  - Assess for presenting signs or diagnosis of psychiatric disorders – more likely
  - Assess for suicide ideations:
    - Seriousness of intent
    - Plan – do they have a specific plan
    - Means – how will they do it and do they have access to that means
    - Behavioral clues – have they been giving away possessions, writing suicide notes, putting financial affairs in order, sudden lift is mood
    - Verbal clues – "I want to die", "I'm going to kill myself", "This is the last time you'll see me", "I won't be around much longer", "I don't have anything worth living for"
  - Interpersonal support system – do they have one
  - Analysis of the suicide crisis
    - Precipitating stressors – divorce, recent loss of loved person or anything else
    - Relevant history – have they tried suicide before
    - Life-stage issues – grief overload
  - Family history – relatives that had depression or other
  - Coping strategies – has pt handled previous crisis's, how is this one different

Ms. Nelson:
- White men over the age of 80 have the highest occurrence of suicide

Ms. Nelson: Men more than women because they choose a more lethal means

How do you monitor?

- Check every 15 minutes.
- With pt starting on antidepressants, look for increased energy, but not mood – likely for suicide
- Remove items that pt might use to harm themselves
  - Razors, sharps, cords (phone, extension, equipment, curtain), belts, matches, cigarettes, window locks, break-proof glass and windows, plastic flatware

Schizophrenia – 15 questions

Describe the clinical picture

The 4 A'a of Schizophrenia

1. Affect
    a. Flat
    b. Blunt
    c. Inappropriate
    d. Incongruent
2. Associative Looseness
    a. Jumbled illogical thinking
    b. Blocking
    c. Echolalia
    d. Word salad
    e. Clang associations
    f. Concrete thinking
3. Ambivalent
    a. Conflicting thoughts
    b. Simultaneously for and against, like and dislike
4. Autism
    a. Delusions
    b. Hallucinations
    c. Illusions

Classic Symptoms of Schizophrenia

- Ideas of Reference
    - Misconstruing trivial events or remarks and giving them personal significance
- Persecution
    - Think they are being singled out for harm
- Grandeur
    - Think they are a powerful, important or famous person
- Somatic
    - The body is changing ("I have worms crawling all over me")
- Jealousy
    - One's spouse is unfaithful

Know negative and positive symptoms

Positive Symptoms:

- Hallucinations
    - Auditory
    - Visual
    - Olfactory
    - Gustatory
    - Tactile
- Delusions
    - Persecution
    - Grandeur
    - Reference
    - Control or influence
    - Somatic
- Disorganized thinking or speech
    - Loose associations
    - Incoherence
    - Clang associations
    - Word salad
    - Neologisms
    - Concrete thinking
    - Echolalia
    - Tangentiality
    - Circumstantiality
- Disorganized Behavior
    - Disheveled appearance
    - Inappropriate sexual behavior
    - Restless, agitated behavior
    - Waxy flexiblity

Negative Symptoms

- Affective Flattening
    - Unchanging facial expression
    - Poor eye contact
    - Reduced body language
    - Inappropriate affect
    - Diminished emotional expression
- Alogia (Poverty of Speech)
    - Brief, empty responses
    - Decreased fluency of speech
    - Decreased content of speech
- Avolition/Apathy
    - Inability to initiate goal-directed activity
    - Little or no interest in work or social activities
    - Impaired grooming/hygiene
- Anhedonia
    - Absence of pleasure in social activities
    - Diminished intimacy/sexual interest
- Social isolation

Remember, Ms. Nelson said that 1st generation psychotropic drugs took away positive symptoms, 2nd generation took away negative symptoms and atypical took away both.

Nursing care for client with paranoid schizophrenia, catatonic schizo-monitor nursing care involved.

Communications to a Hallucinating Client

- Ask directly about hallucinations
- Watch for cues that client is hallucinating
- Avoid reacting to hallucinations as if they are real
- Do not negate the client's experience
  - Book says to say "That's hard to believe"
- Offer you own perception
- Focus on reality-based diversions
- Be alert to client anxiety

Communications to delusional client

- Be open, honest, reliable
- Be matter-of-fact calm
- Ask to describe
- Avoid arguing but interject doubt
- Focus on feelings the delusion generates
- Once delusion is described, don't dwell on it
- Observe events that trigger delusion
- Validate any true part of delusion

With a catatonic client, you should speak to them, describe what you're doing just like they could hear you or like you would speak to any other patient.

In the event that any client's anxiety level reaches a point where it is thought that he/she might become dangerous, clear the room of everyone else but the nurse and large techs that indicates a show of strength. Then you try to calm them by "talking down" with the "one to one", then give medications as ordered, then the mechanical restraints, if necessary.

Pt with altered perception-what is the right thing to say.

- "I understand that it is very scary (or upsetting) for you, but I don't see it." per Ms. Nelson. In words be empathetic but don't treat it as if real.
- The books says to say "that's hard to believe".

Know thought process-

- **Associative Looseness:** Thinking is characterized by speech in which ideas shift from one unrelated subject to another. With associative looseness, the individual is unaware that the topics are unconnected. When the condition is severe, speech may be incoherent.
- **Neologisms:** The psychotic person invents new words, or neologisms, that are meaningless to others but have symbolic meaning to the psychotic person.
- **Clang associations**: Choice of words is governed by sounds. Clang associations often take the form of rhyming.
- **Word salad**: A group of words that are put together randomly, without any logical connection.
- **Concrete Thinking**: Concreteness, or literal interpretations of the environment, represents a regression to an earlier level of cognitive development. Abstract thinking is very difficult.
- **Circumstantiality**: The individual is delayed in reaching the point because of unnecessary & tedious details. The point or goal is usually met but only w/ numerous interruptions by the interviewer to keep the person on track of the topic being discussed.
- **Tangentiality:** Tangentiality differs from circumstantiality in that the person never really gets to the point of the communication. Unrelated topics are introduced, & the original discussion is lost.
- **Mutism**: The individual's inability or refusal to speak.
- **Perseveration:** The individual who exhibits perseveration persistently repeats the same word or idea in response to different questions.

Types of delusions

- **Delusions:** false personal beliefs, inconsistent w/ the person's intelligence or cultural background. The individual continues to have the belief in spite of obvious proof that it is false or irrational. Delusions are subdivided according to their content.
- **Delusions of Persecution**: The individual feels threatened & believes that others intend to harm or persecution toward him or her in some way**.**
- **Delusions of Grandeur:** The individual has a exaggerated feeling of importance, power, knowledge, or identity.
- **Delusions of Reference**: All events within the environment are referred by t he psychotic person to himself.
- **Somatic Delusion:** The individual has a false idea about the functioning of his or her body.
- **Nihilistic Delusion:** The individual has a false idea that the self, a part of the self, others, or the world is nonexistent.
- **Religiosity:** An excessive demonstration of or obsession w/ religious ideas or behavior. The individual w/ schizophrenia may use religious ideas in an attempt to provide rational meaning & structure to his or her behavior.
- **Magical thinking:** The individual believes that his or her thoughts or behaviors have control over specific situations or people. Magical thinking is common in children.
- **Paranoia:** Individuals w/ paranoia have extreme suspiciousness of others & of their actions or perceived intentions.

Ideas of reference

- Less rigid than "delusions of reference". An example of an idea of reference is irrationally thinking that one is being talked about or laughed at by other people.

Extrapyramidal Symptoms defined:

- **Dystonia -** involuntary muscular movements (spasms) of the face, arms, legs, and neck.
- **Akathisia**
  - Objective: Restlessness; an urgent need for movements, fidgeting (normally in the chest or thighs, can't be still.
  - Subjective: Also a restlessness that is inside and can't be seen
  - These patient's commit suicide more often because it gets very severe, it usually goes undiagnosed, or it's misdiagnosed and the patient is given more meds.
- **Akinesia** Muscular weakness or a loss or partial loss of muscle movement, flaccid.
- **Pseudo-parkinsonism** tremor, shuffling gait, tremor, rigidity, flat affect, absence of arm swing, very slow movement. Most often occurs in women, elderly, and dehydrated individual.
- **Oculogyric crisis** An attack of involuntary deviation and fixation of the eyeballs, usually ion the upward position, lasting several minutes to hours. Get Cogentin, stay with the patient until it takes effect