Indicators Associated with Disorders of Thinking: Schizophrenia

Key Points for Caregivers

1. With schizophrenia, all those who care for verbal clients must try to know the content of any hallucination or delusion their client is experiencing or has experienced. A typical hallucination might involve a deep, loud commanding male voice repeatedly telling a client that he or she is “worthless and must die.” Caregivers are expected to pose a clear question, such as “Are you hearing voices right now?” when clients are talking to themselves.

2. Caregivers of non-verbal clients must try to determine if hallucinations or delusions are occurring. Indicators of hallucinations include

   a. Staring to the side and nodding and making hand motions as though listening to a conversation others do not hear.

   b. Physically attacking an unseen other person.

   c. Staring with an angry or frightened expression at strangers or well-liked companions, in a situation that does not require those emotions.

   d. Covering the eyes or ears as if to protect oneself, when threats are not present.
e. Frowning as though something smelled or tasted foul.

f. Dressing in protective ways such as wrapping on extra scarves or blankets when the weather does not require it.

3. The nature of schizophrenia prevents the client from understanding that the voices or other hallucinations or delusions are not real. The only treatment that is effective in decreasing the thought changes in schizophrenia is antipsychotic medication. Without medication, trying to orient clients to reality can bring on profound anxiety and even aggressive actions. Caregivers must know what psychiatric medications have been prescribed.

4. The major side effects of psychiatric medication are a further challenge to treating schizophrenia. Hallucinations and delusions often include the belief that antipsychotic medication is poison. In response to this belief, psychotic clients frequently pretend to swallow pills, or cheek. Given this unchangeable reluctance to swallowing pills, clients often receive long-acting antipsychotic medications intra-muscularly during monthly clinic visits. However, caregivers must always watch clients swallow their psychiatric medications.

Indicators Associated with Disorders of Thinking: Psychosis

Key Points for Caregivers

1. With psychosis, determine whether clients know that fantasy conversations are not real.
2. Rule out dehydration, particularly in clients who are elderly.
3. Ask whether the client has been having seizures or has a seizure disorder.
4. Note whether a new medication or new medical condition is present.
5. Document any street drug use, as many drugs induce psychotic-like behaviour.

Indicators Associated with Disorders of Thinking: Dementia

Key Points for Caregivers

1. Keep records of changes in behaviour and loss of previous abilities. This is especially important to health care workers diagnosing dementia. Therefore, maintaining clear records of how clients function throughout their adult life is useful. These records can be formal medical charts obtained from physicians, or they can be informal records obtained from family members or clients themselves. Scrapbooks, photo albums, video home movies, and audio recordings will illustrate how clients spoke, moved, and responded when they were well and healthy. Comparing a previous picture, audio, or video with a current cell phone capture of a client can clarify changes that are happening.
2. Record specific examples of physical weakening, particularly in speaking and walking. For example, identify how a client’s gait or how they walk is changing. Keep a record of any falls, stumbles, or times when clients seem...
to lose their balance.

3. **Prepare for and seek medical help immediately if seizures occur.** A seizure in someone previously unaffected, and that is not part of a medical condition, can indicate dementia.

4. **Understand and identify how often confabulation answers are occurring.** Confabulation means *making up answers without intending to lie.* Knowing that clients with dementia are not lying or making things up on purpose can help caregivers understand that this behaviour is part of a psychiatric disorder and not acting-out behaviour.

5. **Understand and identify how often sundowning is occurring.** Sundowning means increased agitation in the evening. Clients may seem to be expressing anger by behaviours such as screaming and yelling, but it is important to understand that this behaviour is likely a response to an intense and constant inner fear that clients are unable to escape.

6. **Create and communicate supports that help memory lapses.** People with dementia are forgetful, get lost, and can have difficulty recognizing friends, family, and staff. Whenever possible, create cues to help with memory loss, such as calendars of events, photo collections, or scrapbooks. Ensure that these cues are consistent and that as many people as possible in the client’s life know about them.

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### Indicators Associated with Disorders of Mood: Vegetative Shift

**Key Points for Caregivers**

Vegetative shift is a term used by mental health professionals to describe problems associated with depressive disorders. A vegetative shift occurs when vegetative signs shift or change. Critical vegetative signs include affect, energy, pleasure, appetite, sleep, and thoughts of suicide. A memory aid for indicators of vegetative shift is “A E P A S S.”

**Use the “A E P A S S” (Affect, Energy, Pleasure, Appetite, Sleep, Suicide) memory aid to document a shift in vegetative signs.**

- **“A” – an Affect of sadness and poor concentration.** Identify sad facial, postural, and emotional responses that last for weeks at a time and that do not seem to fit the context. Sadness in clients may or may not be a response to something that has happened. Clients may show their depression through crying, becoming withdrawn and non-responsive, or becoming agitated and verbally and physically aggressive.

- **“E” – Energy loss and fatigue.** Write down the number of times clients are refusing to leave their beds, take care of activities of daily living such as bathing and dressing, and attend work or leisure activities. Include times when either constipation or incontinence occurs in relation to lacking the energy to go to the bathroom. Include the number of hours clients spend sitting or lying down for long periods of time just watching TV or doing nothing.

- **“P” – Pleasure or interest.** Notice whether clients are no longer taking pleasure in activities they once enjoyed. Notice also when clients with a bipolar disorder are cycling into a manic or hyperactive state, when they may carry out pleasurable activities impulsively. In particular, monitor reckless behaviour in spending money and sexual activity.

- **“A” – Appetite changes.** Appetite can increase or decrease in depressive disorders. Carefully record client weight and identify any gains or losses. Tantrums at meals, and stealing or hoarding food for constant nibbling, can reflect a need to soothe the emotional distress of depression. In contrast, refusing to take time to eat can reflect the
hyperactivity associated with a manic state.

- **“S” – Sleep disturbances.** Keep a record of the number of hours clients sleep each night, including the time they go to bed, the number of times they get up in the night, and the time they wake up. Difficulty falling asleep can be an indicator of anxiety. Waking up early can be an indicator of depression. Sleeping in late can be a response to dysthymia, where people feel sad in the morning but then feel better as the day progresses. Remaining in bed and sleeping or dozing for long periods of time during both night and day can be a way of withdrawing that is often associated with depression. In contrast, going to bed late, getting up frequently in the night, and getting out of bed early can indicate a pattern of hyperactivity associated with a manic state.

- **“S” – Suicidal thinking.** Ask verbal clients if they have thought about taking their own life, if they have a plan to do so, and what (if anything) stops them. Assess if clients seem to speak often about death when such discussions are out of context. Probe whether the thinking behind self-harming behaviour is related to an intent to commit suicide. **Important:** Remove any objects that could be used for self-harm.

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**Indicators Associated with Disorders of Mood: Anxiety, Post-traumatic Stress Disorder (PTSD)**

**Key Points for Caregivers**

1. Monitor sleeping and **identify whether nightmares are occurring.** When possible, identify what the nightmares are about.
2. **Record situations when clients seem fearful,** particularly when there does not seem to be anything or anyone around who could hurt them. Notice if clients avoid certain situations or individuals by verbal and non-verbal resistance and behaviours.
3. Provide records of known traumatic events to caregivers and family members. Exchange information about these events to **distinguish whether they are new traumas or flashbacks.**

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**Indicators Associated with Disorders of Mood: Anxiety, Obsessive-compulsive Disorder (OCD)**

**Key Points for Caregivers**

1. **Delay rather than interrupt ritualistic behaviours.** Expect that clients may respond with aggression when redirected away from their repetitive behaviours. When caregivers view the behaviours through the eyes of clients, caregivers can acknowledge a client's belief that these behaviours are the only possible relief from unbearable anxiety.

2. **Prepare for and seek medical help immediately if seizures occur,** particularly if clients have or have the potential for seizure disorders and are taking the antidepressant medication clomipramine (also called Anafranil).

3. **Make comfort measures available when ritualistic behaviours result in physical symptoms.** For example,
hand lotion for excessive hand washing, and padding or helmets for head banging.

Indicators Associated with Disorders of Behaviour: Borderline Personality Disorder

Key Points for Caregivers

1. Gather as much information as possible about clients’ patterns of over-reacting and behaviour that is harmful to self or others. Identify if the patterns began occurring at a young age and whether any elements of the behaviour have changed and improved over time and with support.

2. With borderline personality disorder, consistent communication among caregivers is critically important. Divisions among caregivers can occur if clients split or view individuals around them only as all good or all bad.