

# Nursing Management Of Patient With Catatonic Schizophrenia

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## Abstract:

Key aspects of catatonic schizophrenia and its nursing management are explored in this case report. Catatonic schizophrenia is a subtype of schizophrenia characterised by extreme psychomotor disturbances, including both stuporous and excited states. Comprehensive knowledge of its features and treatment is essential for effective nursing care. This report describes a patient who presented with catatonic symptoms, refusal of oral intake, and severe nutritional compromise. A structured nursing care plan was implemented, focusing on nutritional support, monitoring, safety, and supportive care. The patient showed significant improvement during hospitalisation, including restoration of oral intake, improved hydration status, and a weight gain of 6 kg by the time of discharge. This case highlights the importance of early identification, consistent nursing interventions, and multidisciplinary management in improving outcomes for patients with catatonic schizophrenia.

**Keywords:** Catatonic schizophrenia, stupor, waxy flexibility, benzodiazepines, ECT

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## I. Introduction:

Catatonic schizophrenia is a subtype of schizophrenia characterized by marked psychomotor disturbances, including both stuporous and excited states. Patients may present with symptoms such as mutism, posturing, negativism, rigidity, and refusal to eat or drink, which can lead to serious medical complications. Early recognition and prompt management are essential to prevent morbidity and improve functional outcomes.

Nursing care plays a crucial role in the management of patients with catatonic schizophrenia, particularly in maintaining nutrition, hydration, personal hygiene, and safety. Continuous monitoring, supportive care, and collaboration with the multidisciplinary team are essential components of treatment.

This case report highlights the key clinical features of catatonic schizophrenia and the effectiveness of structured nursing interventions in improving the patient's physical and psychological condition.

## II. Catatonic Schizophrenia:

In ICD-10 (2019), catatonic schizophrenia is coded as F20.2 and is defined by prominent psychomotor disturbances that may alternate between extreme excitement and stupor. The term "catatonic" refers to marked abnormalities in motor behaviour, including severe rigidity, mutism, negativism, and posturing. During a catatonic stupor, patients may appear immobile or "frozen" and can remain in fixed postures for prolonged periods. A characteristic feature is waxy flexibility, in which the patient's limbs remain in positions placed by the examiner, reflecting significant motor dysfunction. These patients often demonstrate reduced responsiveness to external stimuli and limited interaction with the environment. Overall, catatonic schizophrenia encompasses a cluster of catatonic phenomena that require early identification and prompt, multidisciplinary management. (1)

## III. Catatonic Stupor (Schizophrenic Type)

Catatonic stupor presents as extreme inactivity and unresponsiveness. Patients may become completely mute and immobile. Often, catatonia is precipitated by intense fear, distress, or avoidance, distinguishing it from conditions like neuroleptic malignant syndrome (NMS) or serotonin syndrome, which have different etiologies and treatment responses. In catatonic stupor, patients may cling to fixed postures or resist movement despite instructions or stimuli.

### **Key Features of Catatonia:**

- **Catalepsy:** Rigid posturing or trance-like immobility. The person maintains rigid, fixed postures even when moved.
- **Catatonia (waxy flexibility):** Limbs can be positioned by others and will remain in place like wax. The patient resists repositioning, reflecting profound psychomotor rigidity.
- **Mutism:** Very little or no verbal response despite intact speech and hearing ability.
- **Stupor:** Lack of motor activity and responsiveness; the patient appears unconscious-like, unreactive to environmental stimuli.
- **Excitement:** Excessive, purposeless motor activity; patients may be extremely agitated without an external trigger.
- **Negativism:** Either active resistance or opposition to instruction or passive neglect of attempts to be moved.
- **Others:** Posturing (holding rigid poses), mannerisms (odd, exaggerated movements), stereotypy (repeated movements), grimacing, echolalia (meaningless repetition of words), and echopraxia (imitation of another's movements).(2)

### **IV. Prevalence:**

Catatonic features occur in a significant minority of schizophrenia cases. Studies suggest that catatonic symptoms appear in roughly 7–25% of patients with schizophrenia, especially in acute inpatient settings. A recent systematic review and meta-analysis reported a pooled prevalence of about 9–10% for catatonia within schizophrenia spectrum disorders. In India, one national mental health survey found a prevalence of catatonic schizophrenia of around 2.8% of chronic schizophrenia cases, and other studies note rates up to 20% in certain populations. (4)

### **V. Risk Factors Of Catatonic Schizophrenia:**

The risk factors for developing catatonic schizophrenia largely overlap with those of schizophrenia in general. Important factors include:

- **Genetics:** A family history of schizophrenia increases risk
- **Viral infection:** Prenatal or early childhood viral infections (e.g., measles, influenza) may predispose to schizophrenia.
- **Fetal malnutrition:** Poor maternal nutrition during pregnancy is associated with higher schizophrenia risk.
- **Early-life stress:** Severe psychosocial stress in early life can contribute to schizophrenia onset.
- **Childhood trauma:** Abuse or trauma in childhood is linked to increased schizophrenia risk.
- **Parental age:** Offspring of older parents have slightly elevated schizophrenia risk.
- **Substance use:** Exposure to psychoactive substances (e.g., cannabis, stimulants) during adolescence can trigger or worsen schizophrenia symptoms. (5)

### **VI. Pathophysiology:**

Dopaminergic dysfunction has been proposed as a contributing factor to catatonia, particularly in relation to immobility and stupor, and early studies focused on the role of dopamine in the development of catatonic symptoms. However, findings from these studies remain inconclusive, and dopamine alone does not fully explain the clinical manifestations of catatonia.

The N-methyl-D-aspartate (NMDA) receptor has been extensively studied in both clinical and animal models. Notably, anti-NMDA receptor encephalitis can present with catatonia-like symptoms, supporting the role of glutamatergic dysfunction in catatonia. Additionally, there have been reports of improvement in catatonic symptoms with the use of NMDA-modulating agents, such as amantadine.

Among neurotransmitters, gamma-aminobutyric acid (GABA) is most consistently associated with catatonia. Neuroimaging studies using positron emission tomography (PET) have demonstrated reduced GABAergic activity in the left sensorimotor cortex in patients with catatonia. The clinical effectiveness of GABAergic agents, particularly benzodiazepines, further supports the central role of GABA dysfunction in the pathophysiology of catatonia. In addition, behavioural and motor symptoms may be related to dysfunction of the ventral prefrontal cortex, which plays a key role in motor regulation and behavioural inhibition. (5)

### **VII. Signs And Symptoms:**

Catatonic schizophrenia is characterised by **prominent psychomotor disturbances**, which may fluctuate between **marked motor inhibition (stupor)** and **excessive motor activity (excitement)**. The clinical presentation includes the following features:

### 1. Motor Symptoms

- **Stupor:** Marked immobility, absence of voluntary movement, and reduced responsiveness to the environment
- **Mutism:** Little or no verbal response despite preserved consciousness
- **Rigidity:** Maintenance of a rigid posture with resistance to passive movement
- **Posturing:** Voluntary assumption and maintenance of inappropriate or bizarre postures for prolonged periods
- **Catalepsy:** Sustained maintenance of imposed postures
- **Waxy flexibility (flexibilitas cerea):** Limbs remain in positions placed by the examiner
- **Negativism:** Resistance to instructions or attempts to move the patient, or doing the opposite of what is requested
- **Automatic obedience:** Exaggerated cooperation with examiner's commands

### 2. Behavioural and Speech Abnormalities

- **Echolalia:** Repetition of words spoken by others
- **Echopraxia:** Imitation of movements or gestures of others
- **Mannerisms and stereotypies:** Repetitive, purposeless movements

### 3. Excitement Phase

- Episodes of **severe psychomotor agitation or excitement**, which may appear purposeless and can sometimes be violent
- Increased risk of exhaustion or injury during excited states

### 4. Associated Psychotic Symptoms

- Delusions – The patient may believe they are being persecuted. Alternatively, they may think they have extraordinary powers and gifts.
- Hallucinations – particularly hearing voices (auditory hallucination), but hallucinations can include visual (seeing things that aren't there) or hallucinations involving any other sensory system.
- Thought disorder – when speaking, the person can jump from one subject to another for no logical reason. The patient's speech might be muddled and impossible to understand.
- Lack of motivation (avolition) – the patient loses their drive. They give up on everyday activities, such as washing and cooking.
- Poor expression of emotions – they may not respond to happy or sad events or may react inappropriately.
- Social withdrawal – when a patient with schizophrenia withdraws socially, it is often because they believe somebody is going to harm them.
- Unaware of illness (also referred to as “poor insight”) – because the hallucinations and delusions seem so real to the patient, many do not believe they are ill.
- Cognitive difficulties – the patient's ability to concentrate, remember things, plan, and organise is affected, and communication becomes more difficult. (8)

## VIII. Diagnostic Criteria:

### DSM-5:

Catatonia again is a complex combination of psychomotor abnormalities and mood and thought processes. There are at least forty different signs and symptoms that have been associated with catatonia. Three of the twelve symptoms must be present.

Catalepsy (i.e., passive induction of posture held against gravity)

- Waxy flexibility (i.e., slight and even resistance to positioning)
- Stupor (no psychomotor activity; not actively relating to the environment)
- Agitation, not influenced by external stimuli
- Mutism (i.e., no or little verbal response, but this is not applicable if there is established aphasia)
- Negativism (i.e., opposing or not responding to external stimuli)
- Posturing (i.e., spontaneous and active maintenance of a posture against gravity)
- Mannerisms (i.e., odd caricature of normal actions)
- Stereotypies (i.e., repetitive, abnormally frequent, non-goal-directed movements)
- Grimacing

- Echolalia (i.e., mimicking another's speech)
- Echopraxia (i.e., mimicking another's movements)

Walter's paper categorises the symptoms into four major categories:

1. Motor signs (such as immobility)
2. Behavioural signs (negativism)
3. Autonomic instability (tachycardia, hyperthermia)
4. Inability to suppress motor functions (stereotypy, echolalia, echopraxia).

A complete psychiatric history, along with collateral information and a complete neurological examination, is key to diagnosing catatonia in a person with schizophrenia. The onset and duration of symptoms are key to understanding catatonia. (2)

### **IX. Differential Diagnosis:**

- Neuroleptic malignant syndrome
- Serotonin syndrome
- Malignant hyperthermia
- Akinetic mutism
- Epilepsy (nonconvulsive status epilepticus)
- Locked-in syndrome
- Stiff-person syndrome
- Parkinson's disease
- Stroke
- Delirium
- Dementia
- Elective mutism
- Encephalitis (4)

### **X. Treatment:**

Patients with catatonic schizophrenia often require fewer electroconvulsive therapy (ECT) sessions to achieve clinically significant improvement compared to those with non-catatonic schizophrenia. This is because catatonia represents a reversible psychomotor syndrome associated with dysregulation of GABAergic, dopaminergic, and glutamatergic neurotransmission. ECT rapidly restores neurochemical balance and improves motor symptoms such as stupor, rigidity, and mutism, which are core features of catatonia. As these symptoms respond early during treatment, functional recovery is achieved with fewer ECT sessions.

The patient was managed with benzodiazepines as the first-line treatment for catatonia, followed by electroconvulsive therapy (ECT) due to an inadequate clinical response. Antipsychotic medications were introduced cautiously after partial resolution of catatonic symptoms. Medical management was delivered in close coordination with intensive nursing care, which focused on continuous monitoring of motor symptoms, ensuring nutritional support, preventing complications related to immobility, and systematically assessing treatment response using the Bush–Francis Catatonia Rating Scale.(9)

### **XI. Complications:**

Given that acute catatonia can have its origin with medical or neurological illnesses, initial monitoring with vital signs notation and treatment with intravenous fluids and nasogastric tubes are warranted. Complications can include

- Aspiration Pneumonia
- Dehydration
- Embolisms
- Pressure Ulcers
- Malnutrition

These can be life-threatening.

- Anticoagulant therapies can be used to prevent deep vein thrombosis/pulmonary embolism in immobile patients.

- The major measure in preventing complications is a prompt diagnosis and a rapid initiation of adequate treatment of the catatonic state.
- Some patients will require a high level of nursing care, and IV fluids and/or nasogastric tube feeds, to reduce the risk of morbidity and mortality caused by immobility, poor nutrition and dehydration. (4)

## **XII. Conclusion:**

There is a need for research in the field of catatonic schizophrenia in adolescents, as it appears to be a clinically relevant but understudied subgroup. The following case report provides appropriate nursing interventions for a patient on an NG tube and helps improve the patient's prognosis by preventing complications.

## **XIII. Case Report**

A 23-year-old female, with a family history of BPAD in mother and seizure disorder in sister, got admitted for the second time in the Acute Care Room. In 2018, she was diagnosed with acute psychosis and was treated with Tab. Quetiapine and Tab. Lorazepam, subsequently leading to full recovery. In November 2024, owing to personal reasons, Tab. Quetiapine was tapered and stopped by the parents. Since then, she has not taken medications for the next 5 months, and the sudden illness of her grandmother has triggered the present onset.

She presented with catatonic symptoms, including mutism, staring, posturing, rigidity, ambivalence, immobility, and muttering to herself. She expressed suspicious ideas that her food was mixed with poison and that someone intended to harm her. She reported an unknown fear, which contributed to her refusal to eat. Additionally, she exhibited excessive salivation and stiffness of the limbs.

She also demonstrated social withdrawal, decreased appetite and oral intake, reduced speech and activity, preoccupation, poor self-care, crying spells, and episodes of urinary and bowel incontinence. These symptoms had been present for one month, with a marked increase in severity over the past week.

She was restarted on Tab. Quetiapine and Inj.FFD, following which she developed severe dystonia. Hence was referred to emergency services. She was advised NG feeds and Tab. Bromocriptine 2.5mg QID for the same. On physical examination, her pupils were reactive, reflexes normal, drooling was present and bilateral limb rigidity was noted. Mental status examination revealed poor eye contact, stary gaze, bradykinesia, perplexed affect, apathetic, psychomotor retardation and diminished reactive movements.

During her hospital stay, she was treated with bromocriptine 2.5 mg tablets four times daily, trihexyphenidyl 2 mg tablets once daily, lorazepam 1 mg tablets three times daily, and quetiapine 50 mg tablets in the morning and 100 mg tablets at night. She received nasogastric feeds of 200 ml every two hours. With dose adjustments of Trihexyphenidyl and quetiapine, she showed gradual improvement, including better response to verbal commands, sustained eye contact, and reduced limb rigidity.

Electroconvulsive therapy (ECT) was planned. Subsequently, she developed bilateral pitting pedal oedema with reduced urine output. In view of dehydration, the nasogastric tube was reinserted, leading to gradual resolution of oedema and normalisation of urine output. She underwent eight sessions of ECT, after which the nasogastric tube was removed, and she was able to tolerate oral solid feeds. No post-ECT complications were observed. At discharge, she was ambulatory without assistance, and her speech had improved significantly.

### **Nursing care of a patient with catatonic schizophrenia (10)**

Nursing diagnoses were prioritised based on physiological needs, safety, and functional abilities, following Maslow's hierarchy and acute psychiatric nursing principles, with nutritional imbalance and immobility identified as the highest priorities.

#### **1. Assessment:**

**Subjective data:** Mother verbalised that the patient is not eating and has lost weight.

**Objective data:** Refusal of oral intake, Poor skin turgor, 38kgs of weight, easily distracted during conversations, on nasogastric (NG) tube feeding, and diagnosed with catatonic stupor

**Nursing Diagnosis:** Imbalanced nutrition less than body requirements related to refusal of oral intake secondary to catatonic stupor as evidenced by weight loss, poor skin turgor, and need for NG tube feeding.

**Expected outcome:** Patient would not exhibit signs and symptoms of malnutrition and would show weight gain and improved hydration.

#### **Nursing Interventions:**

- Nutritional status was assessed daily, including weight, skin turgor, and laboratory values if available.
- Intake and output were monitored and recorded accurately.

- NG tube feeding was administered as prescribed, and tolerance was monitored.
- The NG tube was checked for patency and correct positioning before each feed.
- High-calorie, high-protein, and nutritious fluids were provided as ordered.
- Prescribed vitamins and mineral supplements were administered.
- Oral intake was encouraged when the patient was alert and cooperative.
- Small, frequent, and preferred foods were offered when possible.
- The nurse sat with the patient during meals to provide support and encouragement.
- Adequate hydration (6–8 glasses per day unless contraindicated) was maintained.

**Evaluation:**

The patient demonstrated significant improvement in nutritional status, evidenced by a 6-kg weight gain, improved skin turgor, good tolerance to NG feeding, and gradual restoration of oral intake before discharge.

**2. Assessment:**

**Subjective data:** She verbalised that she just wanted to sit in one place.

**Objective data:** She was observed sitting in one place for a long time without any movement.

**Nursing Diagnosis:** Impaired physical mobility related to possible biochemical changes in the brain and inability to synthesise information.

**Expected outcome:** The patient mobilised independently.

The patient remained free from injury and complications related to immobility.

**Intervention:**

- The patient's ability to perform activities of daily living was assessed to determine the level of assistance required, and the need for assistive devices was evaluated.
- Skin integrity was assessed regularly, and the patient was observed for signs of thrombophlebitis such as redness, swelling, and pain.
- Passive and active-assisted range-of-motion exercises were performed to prevent stiffness and improve circulation.
- Ambulation was promoted and facilitated as tolerated to prevent complications related to immobility and to enhance functional mobility.
- The patient was encouraged and motivated to gradually increase activity levels within her tolerance limits.

**Evaluation:**

The patient showed improvement in mobility. She gradually participated in assisted ambulation. No signs of skin breakdown or thrombophlebitis were observed. The patient remained free from injury and other complications related to immobility. The expected outcomes were fully achieved.

**3. Assessment:**

**Subjective data:** The mother verbalised that her daughter was not speaking to anybody.

**Objective data:** Diagnosed with catatonic schizophrenia; mutism was present.

**Nursing Diagnosis:** Impaired verbal communication related to panic anxiety, disordered, unrealistic thinking, evidenced by mutism, poor eye contact.

**Expected outcome:**

The patient would be able to communicate appropriately and comprehensibly by the time of discharge.

**Intervention:**

- Efforts were made to understand the patient's non-verbal and incomprehensible communication patterns.
- Clarification was sought by verbalising the implied meanings to validate the patient's responses.
- Consistent staff assignments were maintained to promote trust and a sense of security.
- The technique of verbalising the implied was used with the mute patient to facilitate communication.
- The patient's needs were anticipated and met until effective communication patterns gradually returned.
- A calm and supportive environment was maintained to reduce anxiety and promote communication.
- The patient was encouraged to use alternative methods of communication, such as gestures or writing, when possible.

**Evaluation:**

The patient showed gradual improvement in communication. She began to respond to simple verbal cues and instructions. Eye contact improved during interactions with staff. The patient started using non-verbal methods such as gestures to express her needs. Gradual restoration of verbal communication was observed before discharge. The expected outcome was partially achieved.

**4. Assessment:**

**Subjective data:** The mother verbalised that her daughter was not turning or cooperating while changing position every two hours.

**Objective data:** Presence of bedsores, akinesia, and inability to change position independently.

**Nursing Diagnosis:** Impaired skin integrity related to altered circulation secondary to pressure ulcers.

**Expected outcome:** The patient's pressure ulcer would decrease in size and would be free from wound infection.

**Intervention:**

- The pressure ulcer was assessed regularly for size, colour, drainage, and odour to monitor healing.
- Appropriate wound and tissue care were provided as required, and sterile dressing techniques were followed to prevent infection.
- The patient's healing status was monitored closely, and exposure of the affected area to contaminants was minimised.
- Prescribed antibiotics were administered as ordered.
- The patient was repositioned every two hours to relieve pressure and prevent further skin breakdown.
- Supportive devices such as pillows and pressure-relieving surfaces were used to reduce pressure on affected areas.

**Evaluation:**

The pressure ulcer showed a gradual size reduction. No signs of wound infection were observed. Skin integrity improved with regular repositioning and wound care. The patient remained free from further skin breakdown. The expected outcome was fully achieved.

**5. Assessment:**

**Subjective data:** The mother verbalized that the patient is unable to take a bath independently.

**Objective data:** The patient is on prolonged bed rest and is in a stuporous state.

**Nursing Diagnosis:** Self-care deficit (feeding, bathing, toileting) related to decreased level of consciousness (stupor), as evidenced by inability to perform activities of daily living independently.

**Expected outcome:** The patient will demonstrate improvement in self-care abilities by performing activities of daily living with minimal assistance and showing interest in participating in self-care activities.

**Intervention:**

- Assessed the patient's ability to perform self-care activities to identify limitations and remaining strengths.
- Helped with feeding, bathing, and toileting as required, while encouraging maximum possible independence.
- Monitored skin integrity regularly to prevent pressure sores and maintain hygiene.
- Established a structured daily routine to promote consistency and gradual participation in self-care activities.
- Offered positive reinforcement and verbal praise whenever the patient attempted or completed self-care tasks to enhance motivation and engagement.

**Evaluation:**

The patient showed improvement in participation in self-care activities. She gradually demonstrated interest in personal hygiene and feeding. The patient was able to perform selected self-care activities with minimal assistance. Skin integrity was maintained without the development of pressure sores. Overall, there was a partial to significant improvement in self-care abilities while hospitalization.

**6. Assessment:**

**Subjective data:** The mother verbalized that the patient is not making any effort to eat or drink and has suspicious ideas that people are mixing poison in her food.

**Objective data:** Ryle's tube was removed and reinserted due to very low oral fluid intake.

**Nursing Diagnosis:** Impaired health maintenance related to extreme suspiciousness and inability to trust others, as evidenced by poor dietary intake, inadequate food and fluid consumption, and disturbed sleep.

**Expected outcome:** The patient will maintain adequate nutrition, hydration, and elimination.

**Intervention:**

- Assessed the patient regularly for signs of malnutrition and dehydration.
- Monitored food and fluid intake closely.
- Maintained nasogastric feeding as indicated to ensure adequate nutrition and hydration.
- Administered prescribed sedatives to reduce anxiety and improve rest.
- Implemented measures to promote adequate sleep and prevent daytime fatigue.
- Provided emotional support and reassurance to reduce suspicious thoughts related to food intake.

**Evaluation:**

The patient showed improvement in nutritional and hydration status. Food and fluid intake gradually increased. Nasogastric feeds were tolerated well without complications. Sleep pattern improved with reduced anxiety and suspiciousness. Overall, the patient demonstrated improvement in health maintenance during hospitalisation.

**7. Assessment:**

**Subjective Data:**

**Objective data:** The patient exhibited wandering behaviour and restlessness.

**Nursing diagnosis:** Risk for injury related to wandering behaviour, poor judgment, and restlessness.

**Expected outcome:** The patient will remain safe and free from injury during hospitalization.

**Intervention:**

- Maintained close supervision to ensure patient safety.
- Provided a clutter-free environment to reduce the risk of falls.
- Implemented safety measures, including a secure ward setting.
- Observed the patient closely for wandering behaviour and restlessness.
- Initiated prompt interventions whenever signs of agitation or wandering were noted to prevent injury.

**Evaluation:**

The patient remained safe and free from injury throughout hospitalization. Episodes of wandering and restlessness were managed effectively. The patient responded to supervision and environmental safety measures. No falls or accidental injuries were reported during the hospital stay.

**8. Assessment:**

**Subjective Data:**

**Objective data:**

**Nursing diagnosis:** Disturbed sensory perception related to disorientation, lack of adequate support, and psychosocial stressors.

**Expected outcome:** The patient will stop talking to himself and demonstrate the ability to maintain a conversation without experiencing hallucinations.

**Intervention:**

- Used clear and direct verbal communication by all healthcare team members instead of relying on nonverbal gestures.
- Encouraged the patient to describe his hallucinatory experiences without judgmental comments.
- Taught techniques to interrupt hallucinations, such as listening to music, plugging the ears, and engaging in drawing or craft activities.
- Applied therapeutic communication techniques, including **presenting reality** (stating that only the patient's and nurse's voices were heard).
- Acknowledged and accepted the patient's feelings underlying the hallucinations.
- Administered prescribed antipsychotic medications and educated the patient about their role in reducing psychotic symptoms.

**Evaluation:**

By the time of discharge, the patient verbalized that he was no longer experiencing hallucinations. The patient was able to engage in conversations without responding to internal stimuli. Violent outbursts had completely subsided at the time of discharge.

**9. Assessment:**

**Subjective data:** The patient verbalized that others are trying to harm or poison her and expressed fear of being persecuted.

**Objective Data:** She had Suspicious behavior toward staff and family members, Refusal to eat or take medications due to fear of poisoning, social withdrawal and guarded interaction, increased anxiety and restlessness.

#### **Nursing Diagnosis**

Disturbed thought processes related to delusional thinking, as evidenced by persecutory beliefs, suspiciousness, and refusal of food or medication.

#### **Expected outcome:**

The patient will demonstrate reduced suspiciousness; the patient will accept food and medications as prescribed and interact with staff without fear or hostility and verbalise decreased intensity of persecutory thoughts.

#### **Interventions:**

- Established a trusting and consistent nurse–patient relationship.
- Used calm, clear, and non-threatening communication.
- Avoided arguing or directly challenging the delusional beliefs.
- Presented reality gently and consistently when delusional thoughts were expressed.
- Encouraged the patient to express feelings and fears.
- Ensured that food and medications were given in the patient’s presence to reduce suspicion.
- Maintained a structured and predictable environment to reduce anxiety.
- Involved family members in care when appropriate to enhance trust.
- Administered prescribed antipsychotic medications and monitored for effectiveness and side effects.
- Provided psychoeducation about the illness and the importance of treatment once the patient’s condition stabilised.

#### **Evaluation:**

The patient showed a reduction in suspiciousness and anxiety. She began accepting food and medications with less resistance. Interaction with staff improved without fear or hostility. The intensity and frequency of persecutory thoughts decreased. Overall, the patient demonstrated improvement in thought processes during hospitalisation.

### **XIV. Conclusion**

Catatonic schizophrenia is a severe but treatable manifestation of schizophrenia spectrum illness. It often heralds significant impairment and medical risk, requiring early detection and aggressive management. Primary treatments include high-dose benzodiazepines and ECT, which remain cornerstones of therapy. Multidisciplinary care – involving psychiatrists, nurses, and therapists – is critical. Nurses play a pivotal role in monitoring, safety, and implementing the treatment plan, which ultimately improves patient recovery and quality of life.

### **References**

- [1]. World Health Organization. The ICD-10 Classification Of Mental And Behavioural Disorders: Clinical Descriptions And Diagnostic Guidelines. Geneva: WHO; 1992.
- [2]. American Psychiatric Association. Diagnostic And Statistical Manual Of Mental Disorders. 5th Ed., Text Revision (DSM-5-TR). Washington, DC: APA; 2022.
- [3]. Bush G, Fink M, Petrides G, Dowling F, Francis A. Catatonia I: Rating Scale And Standardized Examination. *Acta Psychiatr Scand.* 1996;93(2):129-136.
- [4]. Solmi F, Pigato G, Roiter B, Guaglianone A, Martini L, Fornaro M, Et Al. Prevalence Of Catatonia And Its Moderators In Clinical Samples: A Meta-Analysis. *Schizophr Bull.* 2018;44(5):1133-1150.
- [5]. Northoff G. What Catatonia Can Tell Us About “Top-Down Modulation”: A Neuropsychiatric Hypothesis. *Behav Brain Sci.* 2002;25(5):555-604.
- [6]. Ramdurg S, Kumar S, Kulkarni S, Shankar Reddy K, Et Al. Catatonia: Etiopathological Diagnoses And Treatment Response In A Tertiary Care Setting. *Indian J Psychiatry.* 2012;54(3):244-248.
- [7]. Thirthalli J, Et Al. Clinical Relevance Of Chronic Catatonic Schizophrenia In Children And Adolescents. *World J Biol Psychiatry.* 2009;10(4-3):772-777.
- [8]. Tandon R, Nasrallah HA, Keshavan MS. Schizophrenia, “Just The Facts” 4. Clinical Features And Conceptualization. *Schizophr Res.* 2008;102(1-3):1-23.
- [9]. Jakhar D, Bhatia MS. Catatonic Schizophrenia. In: Statpearls [Internet]. Treasure Island (FL): Statpearls Publishing; 2023.
- [10]. Townsend MC, Morgan KI. *Psychiatric Mental Health Nursing: Concepts Of Care In Evidence-Based Practice.* 10th Ed. Philadelphia: F.A. Davis; 2021.