The Battle of a Paranoid Schizophrenic:

A Case Study

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T.S. is a 56 year old Caucasian male diagnosed on Axis I with paranoid schizophrenia and obsessive compulsive disorder. He has an Axis II diagnosis of dependent personality disorder, an Axis III diagnosis of hypertension. His environmental diagnosis (Axis IV) is stated as moderately stressful related to hospitalization and his Axis V diagnosis states that his GAF score is a 40. He has been in the facility where I interacted with him since May of 2007. He is on a forensic unit due to being ruled not guilty by reason of insanity of murdering his uncle in 1983. The patient's internal events surrounding this episode will be discussed further in this text. He has had several psychiatric hospitalizations throughout his life time, even before he was ruled NGRI. The writer's initial meeting with T.S. took place on the afternoon of September 29th, 2010.

The Basic Assessment

At the first meeting, T.S. had just returned to the unit from playing bingo. He is a tall man, and looks to be somewhat overweight. He appeared clean and neatly dressed. He wore a t-shirt tucked into khaki shorts, and socks with tennis- shoes. He was neatly groomed; however, his teeth were in ill repair. His posture appeared normal, but his hands were trembling uncontrollably. He was friendly and willing to speak with me, but he also seemed very agitated. He did not want to go to a private area of the unit to talk, so we stayed out in the open lobby-type area.

T.S. seemed to be alert and oriented X 4 (person, place, time, and situation). He was speech was coherent and he was able to answer questions, but he seemed to be very focused on one topic, his water intoxication. Whenever the conversation drifted to other topics, T.S. always brought it back to the fact that he was not allowed to drink from the water fountain and that it greatly upset him. He did not seem to think that he was drinking too much water, which showed a lack of good judgment. T.S. denied feeling high from his excessive water consumption, but instead stated that his mouth felt dry constantly due to the many medications he was on. He was very irritated that his level of freedom within the facility had been

reduced to a level 1 due to his water consumption. A status of level 1 meant that T.S. was not allowed to go freely about the facility; he had to be escorted by staff. I decided that this issue would be a good one to form a goal around. The researcher asked T.S. if he knew what had to be done to progress to a level 2, but he was unsure.

Progression into the working phase of the relationship was not possible with T.S. during this first interaction due to time restraints and the patient's increasing agitation. As we began discussing progression to a level 2, T.S. became very irritated by another patient who sat down next to him and started to intrude upon our conversation. At this point it became apparent that the conversation could not be recaptured, and the interaction came to an end.

Personal Life and Family

In further interactions, T.S. revealed more about himself. He talked extensively about being a math major in college and stated that he earned his associates degree in math, and that he one day hoped to return to school and get his bachelor's degree in math. He discussed his interest in math on various occasions but indicates a belief that the medications he takes now have decreased his interest in math. This comment may actually be a sign of some depression in the client, as we know that a loss of interest in previously enjoyable activities is related to depression. T.S. mentioned that he was raised a in the Catholic religion, and one of the colleges he attended was a catholic university. He confirms that he still attends mass weekly while being hospitalized.

T.S. also discussed his family situation during our time together. He stated that his parents are both deceased, but that he has a sister and a brother both living. T.S.'s brother lives out of state, but he keeps in contact with T.S. The brother made a trip to visit T.S. a few months prior to my interactions with the client. T.S. states that his brother calls him twice a week and regularly sends care packages containing coffee, candy, clothes and whatever else T.S. asks for. When speaking about his brother, T.S. seemed to illustrate a close relationship with his brother despite the geographical distance between them.

T.S.'s sister lives closer than the brother, but T.S. has not seen or had any other contact with his sister for approximately 12 years. He indicates that he would like to get back in touch with her, but isn't sure how. The possibility of asking T.S.'s brother for her contact information was discussed, and T.S. stated that that was something he was willing to do. T.S. seemed saddened by the fact that he has no relationship with his sister at this time but genuinely acted as if he wished to rekindle this relationship.

Cognition and Mood

T.S. demonstrates an ability to understand abstract thinking when the term "social butterfly" was used. His chart has no history of substance abuse listed, and T.S. confirms this. He stated that he has tried beer before, but that he did not like the taste. He has an interest in sports and stated that he regularly watches football and basketball on television as well as music videos. He indicates that he often socializes with other patients on the unit, especially when he leaves the unit to play Bingo. T.S. also discussed his 13-year career in construction and became animated when describing the different types of equipment he used on the job.

Throughout several conversations T.S. has had quite a labile mood. He became angered on several occasions, and often became excited and raised his voice. These occasions all occurred when discussing T.S.'s inability to move forward to a level 2 and also when discussing his preoccupation with drinking excessive amounts of water. It is apparent that these topics cause T.S. much stress. The fact was addressed that if T.S. could stop going to the water fountain and drinking excessive amounts of water, most of his anxiety could be eliminated. The writer suggested that if T.S. could just drink what he was given at meals and with medications, he would not be harming himself and would therefore be able to progress to a level 2. Despite T.S.'s anxiety and lability of mood, he did demonstrate good insight into his diagnosis. He knows that he has paranoid type schizophrenia and obsessive compulsive disorder, and acknowledges that he murdered his uncle in 1983 because of his illness. He states that he hears no voices now, but that when the murder occurred he heard numerous voices telling him that his uncle was involved

in the Mafia and that he was going to hurt T.S.'s family. He stated "but I was sick then, and I was doing all kinds of weird things." T.S. says that since he has been on his medications he has been doing very well and has no longer had hallucinations or psychotic episodes.

T.S. generally seemed to have the mental outlook of a child approximately 10-12 years of age. At 56 years of age, T.S. should be in Erikson's developmental conflict stage of generativity vs. stagnation. T.S.'s actual conflict stage seems to be closer to that of a school-aged child which is industry vs. inferiority. He is preoccupied with what he needs to do to get to the next level within the facility, but he does not seem to take to heart why he should do specific things. He focuses on just the actions. He often refers to "getting in trouble" for various things, and this leads the writer to believe that T.S. feels inferior to adults his own age.

Medications

T.S. is on numerous medications for his psychiatric illnesses as well as for medical problems. The following table identifies T.S.'s medications, doses and frequency, as well as the desired effect of these medications.

Medication	**Dose, Route, and Frequency**	**Desired Therapeutic Effect and Classification**
Docusate Sodium	240 mg capsule po tid	Stool softener, Prevention of constipation
Toprol XL	50 mg tab (1) po every morning	Beta-blocker, management of hypertension
Toprol XL	100 mg (two 50 mg tabs)po hs	Beta-blocker, management of hypertension
Thera M plus	1 tab po every morning	Vitamin, prevention of vitamin deficiency
Catapres 3 patch	0.3 mg td every week	Transdermal patch. Adrenergic, management of hypertension
Lisinopril	40 mg (two 20 mg tabs) po bid	Ace-inhibitor, management of hypertension
Cozaar	50 mg tab (1) po bid	Angiotensin II receptor antagonist, management of hypertension

Aspirin	81 mg tab (1) po every morning	Salicylate, prevention of myocardial infarction and anti-platelet effects
Cardiazem CD	360 mg (two 180 mg capsules) po every morning	Calcium-channel blocker, management of hypertension
Risperdone	4 mg tab (1) po hs	Antipsychotic (benzisoxazole), Treatment of schizophrenia
Risperidone	1 mg tab (1) po every morning	Antipsychotic (benzisoxazole), Treatment of schizophrenia
Clomipramine	200 mg (four 50 mg capsules) po hs	Tricyclic antidepressant, treatment of depression and obsessive-compulsive disorder.
Ativan	1 mg tab (1) po bid	Benzodiazepine, Treatment of anxiety and acute psychosis
Lorazepam	2 mg tab (1) po prn	Benzodiazepine, Treatment of anxiety, panic, and acute psychosis
Haloperidol	5 mg tab (1) po q6h prn	Butyrophenone, Treatment of acute psychotic episodes related to schizophrenia, management of aggression and agitation

Needs Assessment

T.S. has many problems to deal with due to his mental illnesses, but this writer had chosen to focus on three main issues. T.S.'s anxiety is very important to address, because it puts him and others at risk for being unsafe. Because T.S. is so anxious and labile of mood, he is also a risk for other-directed violence. And T.S.'s schizophrenia and obsessive-compulsive disorder have led him to become obsessed with water and to partake in excessive consumption of it. Through conversations and observations the writer was able to address these problems in the form of nursing diagnoses. The nursing diagnoses, goals, interventions, and rationales are illustrated in the following charts.

Priority Nursing Diagnosis	Short & Long Term Goals	Interventions	Rationales
Anxiety related to powerlessness as evidenced by patient's exclamation of "I can't stand this!", psychomotor agitation, and the patient's consistently being assigned as a close observation patient and/or a one-to-one observation.	STG: Patient will be able to keep his anxiety from going above a rating of 5 for one week LTG: Patient will learn to decrease his anxiety to a level 3 or below on a 1-10 scale within a 3-month time span.	1. Advise the patient to limit caffeine intake to 100mg (about one cup of coffee) per day. 2. Teach the patient breathing control by instructing the patient to place a hand on his belly to ensure that he is breathing from his belly, and teach the patient to take 10 slow, deep breaths when he becomes anxious. 3. Medicate the patient with an anti-anxiety medication as prescribed. 4. Help the patient to identify cues that worsen his anxiety. 5. Assess the patient's sleep pattern 6. Assist the patient to implement a regular exercise routine (Thirty minutes three times a week of moderate activity such as walking).	1. Caffeine promotes anxiety by increasing a person's heart rate (Boyd, 2008). 2. Often people in anxious states breathe rapidly and hyperventilate, which contributes to greater feelings of anxiety (Boyd, 2003). 3. Medications such as Ativan and Lorazepam have a quick therapeutic onset and are helpful in treating intensely distressed patients (Boyd, 2008). 4. This intervention will help the patient learn to self-monitor his anxiety. One study found that patients with panic disorder, anxiety levels were increased the day following an unpredictable panic attack, but that anxiety levels were reduced or stabilized in the day following a predictable panic attack (Fonteyen, Vervliet, Hermans, Baeyens, & Vansteenwegen, 2009). This study suggests that anxiety may be reduced by making threatening or anxiety-producing events (i.e., social and/or environmental disturbances) predictable. 5. Sleep disturbances are common when patients experience anxiety, and lack of a restful night of sleep can greatly contribute to a patient's anxiety, initiating a vicious circle of worry. Things that can help an anxious person get a restful night of sleep include medications (sleep aids), dietary modification, and a relaxing environment. Encourage the patient to avoid alcohol, eat the last meal of the day early in the evening, avoid drinking fluids after 8:00 p.m., and to participate in relaxing activities before bedtime, such as taking a warm bath/shower or

			reading. These activities all help to promote a relaxing state in which a person may be able to get a full night of sleep (Boyd, 2008). 6. Some studies show that acute physical activity may have an anxiolytic effect. There are many ways in which exercise is thought to reduce anxiety, including biologically (with the release of norepinephrine), cognitively (as a form of self-mastery), and as a form of distraction from anxious thoughts (Strohle, 2008).

Priority Nursing Diagnosis	**Short & Long Term Goals**	**Interventions**	**Rationales**
Risk for other-directed violence related to episodes of impulsivity as evidenced by a raised voice and anxious behavior	STG: Patient will not become violent while conversing with the writer. LTG: The patient will not physically harm another human being during his stay at the psychiatric hospital.	1. Offer patient a choice as to time and place of conversation. 2. Reducing the environmental stimuli by keeping the conversation with the patient in a room that is quiet, neutral temperature, and that is free of fluorescent lighting 3. Commend the patient's strengths during the conversation. 4. Pt. will attend an anger-control therapy group at least once per week throughout his psychiatric hospitalization. 5. Observe for signs that the	1. Offering choices gives the patient a sense of control even if he really doesn't have much control over his situation (Boyd, 2008). 2. Too much environmental stimuli can make it hard for a person's brain to process everything, which can in turn lead to aggressive behavior (Boyd, 2008). 3. Highlighting the ability of the patient to assume responsibility and make good choices can help damper aggressive behavior (Boyd, 2008). 4. When schizophrenic patients at one inpatient psychiatric facility participated in an anger-control group, they learned to manage their perception of their anger, and trained in self-instruction, relaxation, social skills and problem solving (Chan, Lu, Tseng, & Chou, 2003). The results of this trial group showed that anger

		patient may become violent at every contact with patient. 6. Staff members must work to have an empathic attitude and involve themselves in patients' social and supportive activities.	expression (i.e. violent episodes) in schizophrenic patients was decreased and anger control was increased after 10-week participation in the group. (Chan et al., 2003). 5. Psychotic symptoms, excitement, and akathesia are known to be associated with violent behavior (Raja, Azzoni, & Lubich, 1996). 6. This behavior leads to a therapeutic environment that can reduce hostility and agitation, therefore reducing the risk for violent behavior (Raja et al., 1996).

Priority Nursing Diagnosis	**Short & Long Term Goals**	**Interventions**	**Rationales**
Fluid volume excess related to polydipsia as evidenced by the patient's compulsion to drink excessive amounts of water, the patient's low sodium level (129), and the patient's one-day 9 lb water weight gain.	STG: Patient will keep his weight gain under 5 pounds a day for 5 days in a row. LTG: Patient will not become ill or injured from excess water consumption throughout his stay in the psychiatric facility.	1. Limit access to fluids during the day to 1700 ml each day. 2. Give patient access to sugarless candies, gum, and fruit. 3. The patient's weight should be taken at regular times throughout the day. 4. Regularly monitor the client's serum sodium levels (levels should be drawn daily until patient can continuously meet the short term goal for this diagnosis.) 5. Monitor the client for behavioral changes every hour. 6. Discuss medication changes	1. By limiting fluid intake the pt. will avoid becoming profoundly water intoxicated (Boyd, 2008). 2. These items help reduce feelings of thirst (Boyd, 2008). 3. Large weight changes can be caused by excessive water consumption, and by having a regular schedule of weighing times it increases the accuracy of each measurement (Boyd, 2008). 4. When water intoxication occurs, sodium levels can rapidly drop below the normal range of 135-145 mEq/L to the 120's or below, which can cause electrolyte imbalances and can be fatal (Boyd, 2008). 5. Often people with water intoxication seem "driven to drink" and will find unique ways to access water (Boyd, 2008). Watching for this type of behavior can decrease the risk that the

		with the patient's physician.	patient will become profoundly intoxicated. 6. One study found that chronic treatment with dopamine-depleting medications (i.e. haloperidol) increase the drive to drink by affecting the release of vasopressin (Hirayama et. al, 2001).

An Opportunistic Experience

The relationship that was built during the few weeks the writer was able to visit T.S. was very eye-opening. It was an opportunity to look into the physical, emotional, and social stressors that affect the well being of all people, but also those that are specific to a paranoid schizophrenic. Human beings are in a continuous struggle to move to the next level of security and/or awareness, and unfortunately, people struggling with mental illness may never have a full sense of security or self-awareness. The diagnoses and interventions this text discussed focused on problems specific to T.S., but they could possibly be adjusted and implemented to better the quality of life for other people with mental illness. Nurses have an obligation to provide high quality care for their patients, and when the patient is a person with mental illness, the care may become even more complicated. However, if a nurse remembers to look at each patient's unique situation and approaches the client with a nonjudgmental attitude, the care he or she provides can not only be high quality, it can be an effective problem-solving tool.

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