

Schizophrenia with command hallucinations

PART: I

Mr. Smith is a 40-year-old Caucasian male. He admitted because he presented as a clear danger to himself. He found wandering the streets, muttering, and acting confused. He grew up in a rural part of Chicago, dropping out of high school before completion due to attendance problems and challenges learning due to an intelligent incapacity. The onset of his illness occurred when he was 19 years old, at which time he started experiencing auditory command hallucinations and suicidal ideation. Since that, the time he has been hospitalized on multiple occasions. Over the years, Mr. Smith engaged in dangerous behavior while psychiatrically unstable.

He has a lengthy history of torching and assaulting family members in response to command auditory hallucinations; thus, his relationship with his mother and siblings was not good. Despite this, his mother does allow him to live in her home for periods at a time, before kicking him out when he becomes psychotic. Mr. Smith has had a long history of treatment with his local Community Service Board. He has a case manager; however, he has not achieved stability.

Mr. Smith stopped taking his medications reportedly because he could not afford them. He did not report this to his case manager at that time, nor did he contact Emergency Services. He started to experience auditory hallucinations and paranoid that others were laughing at him. Mr. Smith tells that “I don’t want to live anymore”. “People telling me I am a fool; I can’t do anything right.” Occasionally, they hint that something terrible will happen to him if he doesn’t do better. He has also started to think that people are out to get him. He set fire to his mother’s home to get rid of the “demons and voices.”

Subjective data:

“I don’t want to live anymore”.

Patient words “People telling me I am a fool; I can’t do anything right.”

Pt feels “disconnected” from family and world

Objective data:

Mr. Smith’s hair is matted, he has a strong body odor and he is dressed in several layers of heavy clothing even though the weather is warm.

Trauma occurring in life

PART: II

Plan of Care:

1. Nursing Diagnosis: Disturbed thought processes

	Immediate	During Hospitalization	Community
Goal 1.1: Spent time with client	1. Assess what client is thinking	Engage in a trust relationship with staff and care giver	Assess client's background or family members if they are spending time with the client.
	2. Assess physical reaction with talking	Provide client education on thinking	Encourage client to play indoor games with family and spent some time with them
	3. Assess how does patient using coping techniques.	Demonstrate effective problem-solving and coping skills	Assess client's ability to drive or walk and ask him or her to go outside in a park or go to the library read a book
Goal 1.2: Use a firm, calm, relaxed approach	1. Assess what makes client angry	Assess to see if the client feels therapy is beneficial to them	Provide the patient with a list of therapy or group options available to them in their area and make sure they have a way to attend
	2. Assess what this can help form positive coping choices/options.	See if the patient has found any new coping skills that you maybe didn't suggest that she could have picked up in group or from other patients on	Assess the client does have the support they feel they need outside of the unit to promote healthy coping

		the unit.	
	3. Access what are things client's dislike.	Access that does she feel like the coping skills are enough on their own or does she need additional resources provided to her	Evaluate the patients coping abilities outside of the controlled environment of the care facility
Goal 1.3: Arrange for follow up therapy as needed.	1. Identify the traumatic event within 24 to 48 hours.	Participate in a treatment program	Participate in therapy for underlying
	2. Establish an adequate balance of rest, sleep and activity.	Demonstrate decreased physical symptoms within 2 to 3 days	Demonstrate internal control of behavior when confronted with stress
	3. Demonstrate decreased anxiety, fear, guilt, and so forth within 4 to 5 days.	Refrain from harming others or destroying property throughout hospitalization	Maintain an optimal level of functioning level

2. Nursing Diagnosis: Risk for Other- Directed violence

	Immediate	During Hospitalization	Community
Goal 2.1: Refrain from harming others	1 Assess what causes anxiety	Provide client education on to stay away from problem which causes anxiety and unable to control environmental stimuli.	Assess client's background or family members if they are the reason of anxiety

	2. Assess physical reactions to anxiety	Provide client education on anxiety also plays a role in somatoform disorders, which are characterized by physical symptoms such as pain, nausea, weakness, or dizziness that have no apparent physical cause.	Assess client if he/she have any other medical problem and get help with medical doctor
	3. Assess how the patient uses coping techniques to cope with anxiety	Provide client education on some coping strategies to reduce anxiety	Assess client's ability to drive or walk and ask him or her to go outside in a park or go to the library read a book
Goal 2.2: Be free of psychotic behavior	1. Assess client what causes to do suicide	Be free of injury throughout hospitalization	Encourage client to join some group meetings or go somewhere outside and spend time with friends to avoid suicidal thinking.
	2. Assess physical reaction when patient thinks about suicide	Educate client and family about risk-taking behavior and how to avoid it	Teach about behavioral signs to family and how to seek treatment in early stage
	3. Assess what client like to talk on	Clarify the meaning of the client's communication	Encourage client to talk with family members and spend time with them.
Goal 2.3: Demonstrate internal	1. Find out what the patients current	Assess if the patient has used any of the	Return to optimal level of functioning

control of behavior	<p>1. What are the patient's coping skills are.</p>	<p>suggested coping skills sense admission and see if the patient feels like they have helped at all</p>	
	<p>2. What are things patient enjoys this can help form positive coping choices/options</p>	<p>Does the patient feel like the coping skills are enough on their own or does the patient need additional resources provided to the patient</p>	<p>Manage health condition</p>
	<p>3. what are things patient dislikes.</p>	<p>See if the patient has found any new coping skills that you maybe didn't suggest that she could have picked up in group or from other patients on the unit.</p>	<p>Seek medical treatment as needed</p>

APA References:

Bekhet, A. K., Zauszniewski, J.A, & Matel-Anderson, D.M. (2018, May). *Evidence for Psychiatric and Mental Health Nursing Interventions*. Retrieved April 09, 2020, from <https://ojin.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Vol-23-2018/No2-May-2018/Evidence-Psychiatric-Mental-Health-Interventions.html>

Lecomte, T., Corbière, M., Simard, S., & Leclerc, C. (2014, November 6). *Merging evidence-based psychosocial interventions in schizophrenia*. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4287699/>

PART III

NCLEX Questions with Rationale:

Question #1: A client diagnosed with schizophrenia is experiencing anhedonia. Which nursing diagnosis addresses concerns regarding this client's problem?

a) Impaired verbal communication.

b) Risk for suicide.

c) Disturbed sensory perception.

d) Disturbed thought processes.

Rationale: "People with schizophrenia are more likely to commit suicide if they are young, male, white, and never married." (Bhandari, 2016).

Reference:

Bhandari, S. (2020, January 16). *Schizophrenia and Suicide: Risk Factors and Suicide Prevention*. Retrieved from <https://www.webmd.com/schizophrenia/schizophrenia-and-suicide>

Question #2:

A client with schizophrenia is referred for psychosocial rehabilitation. Which of the following are typical of this type of program? Select all that apply.

a) Analyzing family issues and past problems

b) Developing social skills and supports

c) Learning how to live independently in a community

d) Learning job skills for employment

e) Treating family members affected by the illness

f) Participating in in-depth psychoanalytical counselling

Rational: People with schizophrenia often have problems relating to or socializing with others. Support groups provide a welcoming environment for people who deal with mental illness to get together and share their experiences.

Reference:

Brichford, B., Rauf, D., Dolan, M., Upham, B., & Landau, M. (n.d.). *Social Deficits and Schizophrenia - Schizophrenia Center*. Retrieved from <https://www.everydayhealth.com/schizophrenia/schizophrenia-tips.aspx>

Question #3:

A 19-year-old-client diagnosed with paranoid schizophrenia experiences command hallucinations to harm others. The client's parents ask a nurse, "Where do the voices come from?" Which is the appropriate nursing reply?

- A. **"Your child has a chemical imbalance of the brain which leads to altered thoughts."**
- B. "Your child's hallucinations are caused by medication interactions."
- C. "Your child has too little serotonin in the brain causing delusions and hallucinations."
- D. "Your child's abnormal hormonal changes have precipitated auditory hallucinations."

Rational: It's often said that mental health conditions, such as depression and anxiety, are caused by a chemical imbalance in the brain.

Reference:

Cafasso, J. (2019, December 04). *Chemical Imbalance in the Brain*. Retrieved from <https://www.healthline.com/health/chemical-imbalance-in-the-brain>