



Articles

Interpersonal Nurse-Patient Relationship With a Young Schizophrenic Pregnant Woman

Renata Marques de Oliveira^a, Antonia Regina Ferreira Furegato^{*a}

[a] Escola de Enfermagem de Ribeirão Preto (EERP-USP), Ribeirão Preto, Brazil.

Abstract

The objective of this study was to investigate elements of the personal and psychiatric history, as well as the challenges related to motherhood, of a young schizophrenic female, through person-centered therapeutic interaction. The investigation had an exploratory scope, undertaken in a teaching hospital and data were collected during nondirective interaction on the part of the nurse with a young schizophrenic woman who had been treated in the institution for 10 years. Thematic analysis of the content was undertaken, with emphasis on the nuclei of meaning, identification of the themes and definition of the categories. The patient, called L. in this study, was 30 years old, had a two-year-old child and was three months pregnant when data were collected. Her trajectory was characterized by doubts, fears and uncertainties. The episodes of hospitalization, the coexistence with other patients, and the medications promoted insight into the symptoms, and acceptance of the diagnosis. The main challenge was experiencing pregnancy and the puerperium concomitantly with the psychiatric treatment. The interpersonal relationship established evidenced that, the young woman feeling understood and that her needs were attended, overcame several difficulties she had reported and felt fulfilled and integrated into her social environment.

Keywords: schizophrenia, pregnancy, psychiatric nursing, interpersonal relations

Interpersona, 2016, Vol. 10(2), 136–148, doi:10.5964/ijpr.v10i2.207

Received: 2015-12-15. Accepted: 2016-10-25. Published (VoR): 2016-12-23.

*Corresponding author at: Departamento de Enfermagem Psiquiátrica e Ciências Humanas da Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo. Avenida dos Bandeirantes, 3900. CEP 14040-092, Ribeirão Preto/SP. Telefone: (16) 3602-0535. E-mail: furegato@eerp.usp.br



This is an open access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/3.0>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Introduction

Schizophrenia is a chronic mental disorder which affects 24 million people worldwide. It affects men and women from different ethnic groups. It begins, with the highest frequency, in adolescence and the beginning of adult life, with severe symptoms (hallucinations and delusions) which cause the loss of the sense of reality, particularly during acute episodes of the disorder, as well as difficulties in the personal and social relationships of those who suffer it (World Health Organization, 2014).

The beginning of the psychotic symptoms, during youth, brings serious consequences for the person and for her relationships, as these symptoms interfere in the person's studies, their insertion and remaining in work (conquering of financial independence) and in extending social ties. For women, the beginning of schizophrenia, during reproductive age, is even more conflictual, as it calls into question the possibility of raising a family and affirming oneself as a woman (Moura et al., 2012; World Health Organization, 2014).

Difficulty in distinguishing what is real from what is produced by the person's mind can delay the person's ability to recognize the need for professional support, favoring the chronification of the disorder, causing harm to the natural course of the person's life.

According to the World Health Organization, more than half of people with schizophrenia are reluctant to seek specialized help, as they do not recognize their behavior and emotions as symptoms of a disease (World Health Organization, 2014).

The emergence of antipsychotics in the mid-20th century was decisive for people with schizophrenia to be able to experience periods of remission from their symptoms. These drugs are responsible for better biopsychosocial and cognitive functioning and quality of life, increased participation in decisions on their treatment, and reduced need for hospitalization.

Treatment is currently focused on controlling symptoms, as well as on keeping the person in her environment, avoiding hospitalizations and reclusion, and supporting the schizophrenic person in her limitations and daily challenges (World Health Organization, 2014).

The psychiatric nurse is fundamental in the schizophrenic person's process of recovery. When centered on the person's needs, nursing care goes beyond technical and managerial procedures, as it helps the individual to discover the resources which she possesses for confronting adversities, increasing her self-esteem and confidence, finding meaning for her experiences and taking control of her life (Furegato & Scatena, 2009; Gunasekara, Pentland, Rodgers, & Patterson, 2014; Travelbee, 1982).

Changes in the concept of mental illness and the transformations in psychiatric care, through the network of health services, with multidisciplinary teams, indicate the need for nurses to be able to understand the challenges that young schizophrenic people experience. For the interpersonal relationships to favor this process, the nurses' actions must be based in knowledge of the interpersonal skills (Furegato & Scatena, 2009).

Based on these considerations, this study's objective was to investigate elements of the personal and psychiatric history, as well as challenges related to motherhood, of a young schizophrenic woman, through a person-centered therapeutic interaction.

Method

An exploratory study was undertaken with a young schizophrenic woman during her hospitalization in a General Hospital. It is a teaching hospital complex in the interior of the Brazilian state of São Paulo, which serves 62 municipalities, and has 18 beds available for psychiatric hospitalization of acutely-ill patients (percentage of occupation of 78.3%, with a mean length of inpatient treatment of 16 days) and a mental health outpatient center which attends a mean of 682 persons with severe mental disorders per month.

The choice of a single subject was intentional, as part of an academic activity on the "Interpersonal Relationship" postgraduate course. The student had to choose a patient in order to interact professionally with the same, recording the accounts and impressions in order to discuss the therapeutic details of this interaction in an analysis undertaken with the lecturer and other students. A young woman, with a diagnosis of schizophrenia, who had

been treated in the institution for 10 years, was selected. Contact with the patient took place in 2012, during one of her episodes of hospitalization in the psychiatric ward.

The study was approved by the Ethics Committee (EERP/USP 0151/01). After being informed about the study, the woman accepted to participate in it, and signed two copies of the Terms of Free and Informed Consent.

The interview was held by one of the authors, in a consulting room on the ward in question. It lasted for 36 minutes and had, as its principle, non-directive interaction, centered on the report of the patient's experience and on the challenges faced in this journey with schizophrenia. The nurse introduced some questions for better understanding of the report, without changing the focus chosen by the patient. The interview was recorded and transcribed.

After the interaction, the patient's medical records were consulted in order to identify elements of the psychiatric history recorded which might support the present discussion.

The content reported by the patient was subjected to thematic content analysis: 1) skim reading; 2) highlighting of the nuclei of meaning; 3) identification of the themes; and 4) definition of the categories. The discussion was based in the scientific literature on the issue.

Results

The results are presented in two topics: Psychiatric history and Thematic analysis. The patient is referred to as L, in order to ensure her anonymity.

Psychiatric History

L is a 30-year-old woman, of mixed race, married and Roman Catholic. She graduated from high school. She does not currently undertake paid activity (she is a housewife). Her husband is 51 years old, and they have been married for 3 years. They have a two-year-old child and at the time of the study she was three months pregnant.

Her first contact with the hospital complex took place in April 2002, when she attended the Emergency Room complaining of sadness, forgetfulness, hyporexia, tearfulness and suicidal ideation. She was discharged from the emergency unit with the diagnostic hypothesis of depressive episode (F32). Psychological support was indicated and she was referred to the mental health outpatient center.

Her first psychotic episode was recorded in May 2002. A diagnostic hypothesis was made of acute polymorphic psychotic disorder with symptoms of schizophrenia (F23.1). L went to the Emergency Room, presenting auditory hallucinations commanding her to kill herself. She was referred for her first hospitalization in the psychiatric ward of the hospital complex.

In November 2002, she attended the Emergency Room complaining of auditory and visual hallucinations. Her diagnostic hypothesis was altered to non-organic, non-specified psychosis (F29). Throughout the month of November, she returned to the Emergency Room six times for reassessment of her symptoms, and adjustment of the dosage of the medications. As she was being correctly medicated at home, hospitalization was not indicated.

L was diagnosed with paranoid schizophrenia (F20.0) in 2003, during her second episode of hospitalization. She was presenting frequent episodes, agitation and a feeling of death. Over the course of the year, she made various

visits to Emergency Room with auditory and visual hallucinations, suicidal ideation and complaints about the medications' side effects.

Although her referral to the mental health outpatient center had taken place in 2002, her first medical consultation took place in the beginning of 2004. L reported irritability, nervousness, nightmares and feeling angry with family members. It was observed that neither the family nor the patient herself complained about the schizophrenia.

After the first consultation, L attended Emergency Room a further three times, complaining of nightmares, insomnia and hallucinations. She returned home after being treated with drugs.

In mid-2004, she returned to the mental health outpatient center for her second consultation. Indications of progression were recorded in the medical records for the first time, it being observed that the patient appeared to be stable, more active at home and using the medications regularly. The hallucinations had become sporadic.

After four years of treatment in the mental health outpatient center, and visits to Emergency Room for the adjustment of the medications, when episodes were occurring, during a consultation in the outpatient center, it was evidenced that L had stopped using her medications correctly, alleging that she was concerned with weight gain.

In October 2008, during a consultation in the outpatient center, L spoke of her desire to become pregnant. The physicians advised her regarding the risks, but she showed that she had made up her mind, wanting to have a natural life course, like other women. The planning for pregnancy was begun with the advice and readjustment of her drug therapy. Three months prior to being advised to stop using contraception, the medication Ziprasidone was substituted with Haloperidol.

L became pregnant in 2009. During the pregnancy, during the outpatient consultations, she reported her wish to breast-feed. The professionals advised her regarding the risks and the possibilities. In her fifth month of pregnancy, L presented visual hallucinations triggered by stress. Due to the risk of an episode during childbirth and the puerperium, L was referred to the high risk pregnancy outpatient service.

She gave birth at the end of 2009, without complications. The baby was born weighing 2800 g. L was advised to breast-feed prior to taking medications, and three hours after taking them, and was reminded of the risk posed by the medications for the baby, and of the need to prevent the episodes.

During her trajectory, L was hospitalized 22 times in the psychiatric ward of the same hospital complex, and once in the municipality's psychiatric hospital.

At the time of the study, L was hospitalized in the psychiatric ward. She was 10 weeks pregnant with her second child. She was taking Haloperidol, Biperiden and Folic Acid.

Thematic Analysis

After reading the accounts of the interview, two thematic categories were identified: 1) Progression of the schizophrenia and 2) Challenges posed by the disorder.

Progression of the Schizophrenia

L hid her first psychotic episode for three months, due to fear of being hospitalized. The patient described the progression of the schizophrenia, with emphasis on the reduction of the frequency of the episodes over the years.

I hid it [the first episode] for three months. I didn't really know what it was. In my head, I was going to be hospitalized, never to be released again. [...] As the years went by, the illness [schizophrenia] improved. I took longer to have more episodes. Nowadays, I am much better! (L)

As well as reduction in frequency, there was a change in the characteristic of the episodes, particularly the hallucinations.

The type of episode changed a lot. Before, I saw only a stationary transparent figure; nowadays I see it moving, it talks with me. It is as if it were real. (L)

The psychiatric hospitalizations and the coexistence with other patients were important for the patient to have insight into her symptoms.

During the hospitalizations, I saw that what the people there were doing was what I was doing. I saw people talking on their own [and asked myself]: Why do I have this? [The voices] are talking to me; I don't want to be like this anymore. (L)

The hallucinations always caused the patient discomfort, but she learned to deal with them and to identify when she was about to have another episode.

I begin to become short-tempered, agitated, I develop a dislike for somebody. This happens three days before the episode. [...] [When the episode begins] it is as if I could see a person, but I ignore them. I don't pay attention, because I'm scared of sitting because the person who I can see is sitting next to me. Before, I was not in control of myself. [...] Nowadays, I try to redirect the focus. When I can hear many voices, when I can see many hallucinations, when I have that feeling of being filmed, I try to talk with other people, to do something different in order to distract myself. (L)

The medications were essential for the patient to be able to control the symptoms, understand them, accept them and try to deal with the problem.

The drugs are part of the treatment and when I take them I calm down the hallucinations. Nobody is watching, only I am watching. Today I understand that it is part of the problem, and that there is treatment. There is no cure, but there is treatment, and it becomes much easier. [...] The illness oscillates a lot, I have relapses, but there are always fewer of these once you start undertaking the correct treatment. If you're not taking the medications, there's no way it will work out. (L)

In spite of the difficulties resulting from the illness's symptoms, the patient accepted the diagnosis and overcame the feeling of inferiority in relation to other people.

As time went by, I noticed that everybody has problems. I have schizophrenia, somebody else might have anorexia or another illness. It is different [having schizophrenia], but this doesn't make you different from other people. [...] When – for me – I was different, everybody thought I was different. When I saw that I was the same, everybody thought I was the same. The problem was in me, not the others. [...] Nowadays, I accept myself. (L)

Challenges Posed by the Disorder

One of the first challenges which the patient experienced related to the understanding of the schizophrenia.

[For] most people, schizophrenia is caused by spirits; I thought the same. I thought I was crazy. (L)

One of the main challenges faced by the patient was her dream to be a mother, in which she was discouraged by the physicians.

I had always wanted to have children, and the doctors told me that I couldn't get pregnant because [the child] might be born with schizophrenia, or with genetic malformations. The doctor even said: 'your child will be born with problems!'. I cried a lot, I was sad, but I didn't lose hope; I wanted to get pregnant and I did. (L)

Although they had advised against the pregnancy, the patient's insistence provoked a change in the physicians' conduct, and they helped her in planning and monitoring the pregnancy. Various challenges and difficulties, such as the need to readjust the medications, had to be faced together.

The pregnancy was planned. At the time, I was taking Ziprasidone, a medication which you can't take when you're pregnant because of the risk of genetic malformations. The doctor took away that medication and put another in its place. She also reduced the dosage. When I got pregnant, she reduced the medication a little more, and everything went well. The pregnancy was considered high risk. (L)

The change in the drug therapy influenced the psychotic symptoms, causing the patient to experience one of the more difficult episodes.

The episode took longer to go away, because during pregnancy you can't be medicated with the correct quantity of the medication that you need. I couldn't be treated with injectable drugs because of the pregnancy. The amount increased by half a tablet [of Haldol], but even so, I continued having the episode. I spent three days hallucinating. It was more difficult. (L)

In spite of her satisfaction at being a mother, the patient recognizes some limitations in the care of her first child.

It is marvelous to be a mother! [In the beginning] I cared for the baby like any other person does. The difference was that at night I couldn't get up to breast-feed, due to the medications, which were strong. When the baby was born, the medication was changed again and they increased the dose. [...] I wasn't able to breast-feed at night, so my husband took care of the baby then. (L)

As well as the limitation for caring for the baby at night-time, the patient had two episodes during the puerperium.

After the baby was born, I had two episodes and was hospitalized once. I began to become short-tempered over nothing. I became short-tempered with my son, without any reason. I never hit him, but I became very short-tempered and irritated. [...] I began to hear voices: the usual one, telling me to kill myself and kill other people... My father, my mother, my son. When it involves your child, you know what I mean? I'm scared of losing control. (L)

The patient accepts the importance of being hospitalized during the episodes due to the risk that her hallucinations represent to her child.

It was difficult [being hospitalized], but I have always understood that it was necessary so as not to put his, and other peoples', lives at risk. Schizophrenia distorts your thinking. (L)

With a two-year-old child, and three months pregnant, the patient was also concerned about how she was to discuss schizophrenia with her children, when they were bigger.

I think about explaining my problem when they are old enough to understand, so that they don't become frightened, because it is difficult. [...] I will tell them [about the schizophrenia] with a professional by my

side, so that they can see that it is not the end of the world. It is a complicated illness, it is a serious illness, I know that it is, but it is not an illness which... If the person understands it, she can live normally. (L)

As well as the challenges related to the pregnancy and bringing up her children, L's roles in her daily routine stop her from going to the service more frequently for multi-professional treatment. Due to this, there is prioritization of the drug therapy, which satisfies the patient and reduces her reliance on the service.

Nowadays, I don't go to the psychologist, because of lack of time and because of transport difficulties. It is once a week, and due to my routine there is no way I can do this. I get seen by a doctor once a month – and when necessary. If I'm not well [an episode], it is once every 15 days. If I'm better, it is once a month. As I get better, the space increases [between consultations], so all I do is collect my prescription. (L)

In spite of all the challenges, the patient has learned to look at life differently.

[Nowadays] I don't consider myself to be even a little bit crazy. It's a mental problem, but it is not madness. For the time being, there isn't a cure – but there is treatment. I can work, I can study, I can have children, I have a normal life. In the beginning, life became very sad, but now my life is much happier, even with the schizophrenia. (L)

Discussion

The young woman in this study was diagnosed with schizophrenia nine years ago. In investigating her history in the hospital complex, it was noted that her trajectory was characterized by doubts, fears and uncertainty. The reports on the progression of her schizophrenia show that being diagnosed with a severe mental disorder is the beginning of a process of changes and challenges.

The patient reported that the first psychotic symptoms were hidden for three months, as she was scared of being hospitalized. The Emergency Room was the first place where she sought help, evidencing how important it is for the professionals of this service to be trained to embrace the person with a mental disorder – as the earlier the treatment is begun, the better are the chances of remission of the symptoms. One Swedish study with persons with psychotic disorders ($n = 243$) revealed that the subjects who were in remission regarding their symptoms presented better performance in daily activities, and better social and occupational functioning (Helldin, Kane, Karilampi, Norlander, & Archer, 2007).

If the professionals of the Emergency Room had not embraced the patient appropriately, the illness's course might have moved in a different direction, with negative consequences for the progression of the schizophrenia. In spite of recognizing the importance of the Emergency Room, at times of exacerbation of symptoms, particularly in those municipalities where there is no Psychosocial Care Center (CAPSIII), open 24 hours, it is important to admit that this type of care is not enough. Treatment by specialized professionals, aligned with the principles of psychosocial rehabilitation, is important for the schizophrenic person to be treated therapeutically, in the control of the illness's symptoms as well as in the patient's social insertion (World Health Organization, 2014).

One Mexican study monitored 119 people with schizophrenia over a six-month period: 68 subjects participated in a group for developing social skills, as well as continuing to receive the drug therapy – and 51 subjects received drug treatment alone. At the end of six months, it was observed that the people with schizophrenia who participated

in the group had better remission of their symptoms and social functioning than those treated with medications alone (Valencia, Fresan, Juárez, Escamilla, & Saracco, 2013).

Besides the technical and managerial procedures, the psychiatric nurse can contribute to the recovery of the person with a mental disorder through the interpersonal relationship. Through the use of person-centered interpersonal techniques, the nurse values the subject and her experiences, providing her with an opportunity to listen to herself, reflect on her actions and identify the internal resources which she has for facing adversities. Being recognized and valued by the professional increases hope and optimism and contributes to the discovery of her identity and of meaning for the episode of suffering (Furegato & Scatena, 2009; Rogers, 2009; Travelbee, 1982).

One Australian study showed that psychiatric patients wished to be recognized as people and not as a set of signs and symptoms. They value the proximity of the nurse and the establishment of dialogue and trust (Gunasekara et al., 2014).

At the beginning of the disorder, one of the greatest difficulties for the patient L was dealing with the delusions and the hallucinations. This type of difficulty was also recognized in a study undertaken with 13 young schizophrenic Americans (18-35 years old). These reported fear of losing control of their actions in the face of the disorder's productive symptoms, defining their minds as a "dangerous world" (Buckland, Schepp, & Crusoe, 2013).

As the years passed, the frequency of the episodes reduced and the patient understood that the delusions and hallucinations were not real. The psychiatric hospitalizations, the coexistence with other patients, the correct use of medications and care focused on her needs were decisive for the patient to have insights into her symptoms, accept the diagnosis and become an active participant in this process.

A study undertaken in Israel with 68 people with schizophrenia in their first episode and 51 chronic schizophrenic persons assessed the insight into the disorder at three points: upon admission to hospital, upon discharge, and six months after returning home. It was observed that the two groups of patients had considerable increase in the level of insight in the period between admission and discharge from hospital, showing that the education, socialization and adherence to drug therapy, during psychiatric hospitalization, are important resources for the knowledge and acceptance of the illness (Koren, Viksman, Giuliano, & Seidman, 2013).

Ten years after the beginning of the first psychotic symptoms, the patient L seeks, in an aware manner, to redirect the focus of the delusions and hallucinations, during the episodes, involving herself in activities which capture her attention. This resource is recognized by a group of American researchers who developed a model so that psychiatric nurses could address those patients who presented auditory hallucinations. Based on the assessment of the hallucinatory experience, the nurse is guided to elaborate – together with the patient – a care plan such that the patient will be able to deal with the auditory hallucinations in her day-to-day. Some strategies recommended for the self-control of hallucinations are: ignore the voices; converse with other people; listen to music; watch television; control the anxiety; keep oneself busy by helping other people; take medications correctly, and avoid the use of alcohol and other drugs (Buccheri, Trygstad, Buffum, Birmingham, & Dowling, 2013).

The auditory hallucinations are produced by the schizophrenic person as an attempt to mask situations and/or conditions which cause her suffering. Their contents are closely linked to the person's own needs: a person who feels alone may develop hallucinations for overcoming the feeling of solitude (company). Through this interactive

process, the nurse helps to control the schizophrenic person's hallucinations – the relationship with real people reduces the psychic suffering and the need to distort reality (Travelbee, 1982).

The process of recovery from chronic mental disorders is defined as the search for one's own identity and meaning for life. One important indicator of the progression of this process is when the schizophrenic person comes to take responsibility for somebody's life, ceasing to focus only on the disorder and its symptoms (Andresen, Caputi, & Oades, 2013). This stage was identified in the reports of the patient, when she spoke about her intention to start a family.

The relationship of trust and respect, established based on the nurse-patient interpersonal relationship, encouraged the young woman in this study to describe one of the biggest conflicts in her life: her dream to become a mother, in spite of the schizophrenia. According to one important pioneer of the nurse-patient interpersonal relationship, three stances characterize individuals' mental health/recovery process: 1) loving oneself and other people; 2) facing reality and 3) finding a reason/purpose to live. The schizophrenic person in this study found, in her dream of being a mother, a purpose for her life (Travelbee, 1982).

Although the desire to be a mother is an expectation which is characteristic of that age, it became a challenge from the point at which the professionals did not support L's decision. They were aware of the risk of the disorder being inherited.

One cohort study, held in Denmark, monitored 2,486,646 subjects born between 1955 and 1993, from their 15th birthdays onward. The monitoring was finalized when one of the following events occurred: schizophrenia diagnosed (case-patients), death or change of country. The patients who had not met any of these criteria by mid-2009 were considered the "controls". The incidence of schizophrenia among the subjects who had one parent with a diagnosis of schizophrenia was 23.47 per 10,000 inhabitants; while the incidence among the children of parents with no psychiatric history was 2.81. The diagnosis of schizophrenia in both parents increased the risk of developing the disorder by 20 times (Sørensen et al., 2014).

Studies undertaken in a Psychosocial Care Center (CAPS, in Portuguese) in the Brazilian state of Ceará, evidenced that knowledge of the risk of inheritance is a factor which discourages some people with mental disorders from wishing to become pregnant. This perception is also present in the accounts of the professionals who know of the possible consequences of pregnancy among people with mental disorders (Guedes, Moura, & Almeida, 2009; Moura et al., 2012).

Besides the risk of heredity, difficulties and complications are recognized, both during the pregnancy of women with mental disorders and following the birth of the child: the teratogenic effect of the psychotropics for the fetus and for the infant; a greater risk of episodes during the pregnancy and the puerperium, due to modification or interruption of the drug therapy; limitations for care of the child (motherhood as overload); recurrent hospitalizations, compromising care of the child and the mother-child bond; and hindering of the development of the child's abilities to deal with adversity and stressful situations (Acera Pozzi, Yee, Brown, Driscoll, & Rajan, 2014; Guedes et al., 2009; Moura et al., 2012).

The young woman in this study had one episode during the pregnancy with her first child, two in the puerperium, and one during the current pregnancy; two of these culminated in hospitalizations. The difficulty which people with mental disorders have in adapting to changes (physical, psychological or environmental) is a risk factor for

triggering the episodes. One American study with a person with a mental disorder showed that these psychiatric symptoms were exacerbated during pregnancy when considerable changes began to be perceived in her body, such as the beginning of fetal movements and the growth of the abdomen (Acera Pozzi et al., 2014).

The episodes during pregnancy and puerperium put the physical and mental integrity of the mother and child at risk. The young woman in this study described that, at some points, the content of the auditory hallucinations was directed towards her child. One study with 82 women with severe mental disorders, hospitalized on a psychiatric ward in India, in the postpartum period, identified that 38% presented suicidal ideation and 18% had attempted to take their own lives. Approximately one third of these women had ideas regarding hurting their children or of committing infanticide. Evidence was found of association between suicidal ideation and thoughts about injuring the child (Babu, Subbakrishna, & Chandra, 2008).

In spite of the serious risks, does it fall to the health professionals to decide whether the person with mental disorders may not become pregnant? It is an obligation of the professionals to provide guidance regarding the risks to the mother and to the baby, while, however, respecting the patient's choices. To force the female patient to use contraceptive methods is to harm her autonomy. The study undertaken in the Psychosocial Care Center in the Ceará ($n = 255$) revealed that 15% of women underwent sterilization due to having been pressured by physicians or family members. The professionals' authoritarian behavior may drive people with mental disorders and their family members away from the care. The most sensitive option is to move in the direction indicated by the subject who is suffering, respecting her choices, although providing guidance when necessary, ensuring the safety of the mother and of the child (Acera Pozzi et al., 2014; Guedes et al., 2009).

The person-centered interpersonal relationship is contrary to paternalistic and authoritarian attitudes. Some attitudes which the patients value in the nurses and other professionals of the team are respect, calmness, patience, trust, compassion, concern, sensitivity, empathy and humor, sincerity, understanding, honesty, dialogue, and attentive listening and looking (Benjamin, 2011; Gunasekara et al., 2014).

Brazil's Women's Integral Health Program (*Política Nacional de Atenção Integral à Saúde da Mulher*) (PAISM) proposes that women with mental disorders should be included in the actions of care, including those directed towards guidance regarding conception. Attention to family planning is one of nurses' incumbencies, with the establishing of trust being fundamental if the woman with mental disorders, and her family members, are to be open to receiving information regarding the complications, risks and possibilities of a pregnancy during the course of the mental disorder. Based on the guidance and clarification, in family planning, the option to conceive may be a more aware decision (Ministério da Saúde, 2011; Moura et al., 2012).

Caring for young people with schizophrenia is a hard task for the professionals, as they need to balance the expectations and possibilities of youth (promoted by the new means of treatment and encouragement for the reinsertion of the individual in society) and the limitations and challenges resulting from the disorder. To raise questions about the challenges, and to help the person with a mental disorder to confront these, in the most aware manner, is vital for the patient and strengthens the nurse-patient therapeutic relationship (Buckland et al., 2013).

Human relationships always involve impact and change. "The change which we wish to help to promote is basically that which the interviewee is capable of building" (Benjamin, 2011). In this regard, the nurse-patient interpersonal relationship helped the young woman in this study to overcome her difficulties and to perceive how much

she felt fulfilled having been understood, in spite of the schizophrenia. The attentive listening to her needs shows the importance of the multi-professional team providing space for the subject to relate and reflect on her experiences.

This study brings important contributions to nursing, as it allows nurses to view the patient with schizophrenia from a new perspective. The stereotype of the person with a mental disorder confined in a lunatic asylum has given way to a young woman who presents expectations, dreams and hopes which are appropriate to this phase of her life. Together with the new expectations and possibilities, new challenges also arise. The treatment by specialized professionals, aligned with the principles of psychosocial rehabilitation, was important in order to provide therapeutic treatment in the control of the symptoms, as well as in L's social insertion. In this interaction, the nurse had a proactive attitude, helping the young woman with schizophrenia to place herself in society, taking healthier decisions.

Conclusions

The episodes of pregnancy of this young schizophrenic woman were characterized by doubts, fears and insecurity. The psychiatric hospitalizations, with attendance by the multi-professional team, the coexistence with other patients and the correct use of medications promoted insight into her condition, the acceptance of the diagnosis, overcoming of the feeling of inferiority and the appropriate confrontation of her difficulties.

The main challenge faced by the young woman was the expectation of being a mother and the experience of the period of pregnancy and of the puerperium with interference in her drug therapy, further episodes, limitations for care of her child and auditory hallucinations directed towards the child.

The interpersonal relationship is a therapeutic tool which the nurse can use in caring for people with schizophrenia. Through the interpersonal techniques, the subject is encouraged to reflect on her context, experiencing her illness in the healthiest way possible.

Limitations of the study: 1) a single subject was studied, which does not allow generalizations.

Funding

The authors have no funding to report.

Competing Interests

The authors have declared that no competing interests exist.

Acknowledgments

The authors have no support to report.

References

- Acera Pozzi, R., Yee, L. M., Brown, K., Driscoll, K. E., & Rajan, P. V. (2014). Pregnancy in the severely mentally ill patient as an opportunity for global coordination of care. *American Journal of Obstetrics and Gynecology*, *210*, 32-37.
doi:[10.1016/j.ajog.2013.07.029](https://doi.org/10.1016/j.ajog.2013.07.029)

- Andresen, R., Caputi, P., & Oades, L. (2013). Development of a short measure of psychological recovery in serious mental illness: The STORI-30. *Australasian Psychiatry*, 21, 267-270. doi:10.1177/1039856213476352
- Babu, G. N., Subbakrishna, D. K., & Chandra, P. S. (2008). Prevalence and correlates of suicidality among Indian women with post-partum psychosis in an inpatient setting. *The Australian and New Zealand Journal of Psychiatry*, 42, 976-980. doi:10.1080/00048670802415384
- Benjamin, A. (2011). *A entrevista de ajuda* (13th ed.). São Paulo, Brazil: Martins Fontes.
- Buccheri, R. K., Trygstad, L. N., Buffum, M. D., Birmingham, P., & Dowling, G. A. (2013). Self-management of unpleasant auditory hallucinations: A tested practice model. *Journal of Psychosocial Nursing and Mental Health Services*, 51, 26-34. doi:10.3928/02793695-20130731-02
- Buckland, H. T., Schepp, K. G., & Crusoe, K. (2013). Defining happiness for young adults with schizophrenia: A building block for recovery. *Archives of Psychiatric Nursing*, 27, 235-240. doi:10.1016/j.apnu.2013.07.002
- Furegato, A. R. F., & Scatena, M. C. M. (2009). Bases do relacionamento interpessoal em enfermagem. In M. M. J. Leite (Ed.), *PROENF – Programa de atualização em enfermagem Saúde do Adulto* (pp. 45-72). Porto Alegre, Brazil: Artmed.
- Guedes, T. G., Moura, E. R. F., & Almeida, P. C. (2009). Particularities of family planning in women with mental disorders. *Revista Latino-Americana de Enfermagem*, 17, 639-644. doi:10.1590/S0104-11692009000500007
- Gunasekara, I., Pentland, T., Rodgers, T., & Patterson, S. (2014). What makes an excellent mental health nurse? A pragmatic inquiry initiated and conducted by people with lived experience of service use. *International Journal of Mental Health Nursing*, 23, 101-109. doi:10.1111/inm.12027
- Helldin, L., Kane, J. M., Karilampi, U., Norlander, T., & Archer, T. (2007). Remission in prognosis of functional outcome: A new dimension in the treatment of patients with psychotic disorders. *Schizophrenia Research*, 93, 160-168. doi:10.1016/j.schres.2007.01.014
- Koren, D., Viksman, P., Giuliano, A. J., & Seidman, L. J. (2013). The nature and evolution of insight in schizophrenia: A multi-informant longitudinal study of first-episode versus chronic patients. *Schizophrenia Research*, 151, 245-251. doi:10.1016/j.schres.2013.10.013
- Ministério da Saúde. (2011) *Política Nacional de Atenção Integral à Saúde da Mulher: Princípios e diretrizes*. Retrieved from http://bvsms.saude.gov.br/bvs/publicacoes/politica_nac_atencao_mulher.pdf
- Moura, E. R. F., Guedes, T. G., Freire, A. S., Bessa, A. T., Braga, V. A., & Silva, R. M. (2012). The family planning of women with mental disorders: What CAPS professional have to say. *Revista da Escola de Enfermagem da USP*, 46, 935-943. doi:10.1590/S0080-62342012000400022
- Rogers, C. L. (2009). *Tornar-se pessoa* (6th ed.). São Paulo, Brazil: Martins Fontes.
- Sørensen, H. J., Nielsen, P. R., Pedersen, C. B., Benros, M. E., Nordentoft, M., & Mortensen, P. B. (2014). Population impact of familial and environmental risk factors for schizophrenia: A nationwide study. *Schizophrenia Research*, 153, 214-219. doi:10.1016/j.schres.2014.01.008
- Travelbee, J. (1982). *Intervención en enfermería psiquiátrica: El proceso de la relación de persona a persona*. Washington, DC, USA: OPAS/OMS.

Valencia, M., Fresan, A., Juárez, F., Escamilla, R., & Saracco, R. (2013). The beneficial effects of combining pharmacological and psychosocial treatment on remission and functional outcome in outpatients with schizophrenia. *Journal of Psychiatric Research*, 47, 1886-1892. doi:10.1016/j.jpsychires.2013.09.006

World Health Organization. (2014). *Schizophrenia*. Retrieved from http://www.who.int/mental_health/management/schizophrenia/en/