Running Head: CLINICAL PAPER

Clinical Paper

University of Michigan

School of Nursing

Identifying Information

B.M. is a 43 year old white, non-Hispanic female. She is single with no children. Her admitting diagnosis is psychosis NOS, major depressive disorder, and substance dependence.

The patient self-reports that she is in the hospital due to swallowing of blood. She has been tasting blood in her throat since several days before admission but has not reported seeing any blood. She would really like to leave the hospital and return home even though she feels he has cancer. She reports being told that she has cancer from her doctor. Upon further investigation, it has been discovered that the doctor she reports speaking with is her brother's care provider and not her own.

The patient presented to the psychiatric emergency department with complaints of swallowing blood. She had been released from the psychiatric inpatient unit nine days before presentation. While she was filling out paperwork in the emergency department, staff noticed she began to have trouble keeping her eyes open. Her vital signs were taken and were stable and she was easily aroused. Over the next fifteen minutes she became more sedated.

It was suspected that she took a sedating substance. She was given a urine drug screen which was positive for Lidocaine. Her history includes dependence on opiates and benzodiazepines. At the time of admission as well as currently, patient denied suicidal and homicidal impulses. Patient currently denies desire to self-harm or self-mutilate but has a history or pulling out her eyebrows and picking at her skin. During interview patient pulled briefly at her eyelashes for about thirty seconds but there was no evidence that she was pulling any out. She has consistently denied cutting or burning herself. Patient shows no evidence of destruction to property.

Patient reported auditory hallucinations upon admission. She reported hearing voices of family members, especially one of her brothers. They were command hallucinations telling her to do things such as shower. She denied hearing commands to harm herself or others. She also reported that he voices told her they did not know where the blood was coming from. During my interview she denied auditory or visual hallucinations. She continued with the idea that she had cancer and could taste blood. This is likely a delusion since a medical work-up could find nothing that would cause bleeding near her throat or the type of cancers she has been describing.

History and Threads

Patient began outpatient treatment four years ago after the death of her mother with whom she lived and had been providing care to for many years. Beginning after her mother's death she had been receiving frequent outpatient therapy consistently until about two months ago when she began feeling more depressed. She reports a depressed mood, anhedonia, low energy, increased appetite and weight, difficulty falling asleep, and guilt.

She also has a history of substance addiction, specifically opiates and benzodiazepines. Her addiction was discovered by family members after the death of her mother four years ago. At that time, she began participating in the Professionals at Risk program. She currently reports feeling guilty for her history of substance abuse. Her longest period without drug use was nine months. She reports no use since December of last year.

Since May of last year, after her hysterectomy, she has been hearing both male and female voices which tend to be worse when she is more depressed. To fight these voices, she reports picking at her eyebrows and her skin.

Two weeks before the current admission she reported to the UMHS psychiatric emergency department and spent 6 days on the unit. She reported due to visual hallucinations.

Her family history of mental illness includes one brother with substance dependence who is currently in recovery. She also has one maternal uncle with a history of depression. There is no other family history reported.

She currently lives alone in an apartment. Her family lives nearby. She had lived with her parents providing care for them until her mother's death four years ago. She reports no history of developmental delays. She reports that she had a 'good childhood' growing up with two sisters and four brothers. She attended nursing school directly after high school. She reports never dated much but is very close to her family.

She completed nursing school at a Michigan university and worked as a labor and delivery nurse until her mother's death. She enjoyed nursing while she was working. Since her mother's death, she has been on SSI disability unable to work and living off of the money she saved while she was working as a nurse. She does not have financial concerns at this time because she has some money from her mother's death as well as some saving from working as a nurse. She has never been in the military. She does not report ever having any legal difficulties. She has a private source of insurance. She does not report ever being the perpetrator or victim of abuse.

B.M. was raised in a Roman Catholic home and currently identifies as being catholic. She reported during my interview that being catholic influences her life. She attends church sometimes and prays often. She says that religion helps her to know that her parents are in heaven. She does not report being part of a faith community except for her family. Her mother and father were catholic as well and attended mass with her. Some of her siblings are spiritual but many are not catholic anymore.

There are several emotional or spiritual issues to be addressed. First, she has fear about the bleeding in her mouth as well as her cancer. She also has a history of substance addition. She did not mention her mother during my interview but from past interviews it seems likely that she is still experiencing grief due to the loss of her mother.

Medical and Medication History

B.M. has a positive history for hypertension, Meniere's disease, and hysterectomy in 2004 due to endometriosis. She has an allergy to morphine and penicillin. The response to these allergies is unknown.

She had a urinalysis lab done which detected her prescribed medications as well as Lidocaine. She also had ketones in her urine on admission. Urine should not contain ketones. She also had creatinine level of 1.1 mg/dL, the normal range is .5-1.0 mg/dL. She had an albumin level of 5.2 g/dL, normal is 3.5-4.9 g/dL. Her AST was 42 IU/L, normal is 8-30 IU/L. Her ALT was 77 IU/L, normal is 7-35 IU/L. These levels could indicate possible liver issues although none have been diagnosed. Her blood alcohol was taken when she was admitted and it was 0 mg/dL.

She has a negative history for TB, any STDs, and HIV/AIDS. She has a hepatitis B vaccine. She had one previous surgery which was the hysterectomy in 2004. She had her ears pierced when she was a child. Her last physical, dental, and optical exams are unknown.

Her eating has been diminished since hospitalization. She has reported a loss of appetite since the beginning of January. She is currently eating between ten and fifty percent of her meals. Her weight history is unknown but she reports having a history of poor body image and currently is obese.

Her past medication history was received from the computer as I was unable to obtain specific information from her about them. Some medications she has used are:

- Prozac: Side effects: Anorexia, headache, insomnia, nausea, nervousness
Symptoms of toxicity are nausea, vomiting, dizziness, blurred vision, agitation, altered mental status, hallucinations, mania, and CNS depression.

- Celexa: Side effects: Dry mouth, nausea, somnolence, sweating
Symptoms of toxicity are nausea, vomiting, dizziness, blurred vision, agitation, altered mental status, hallucinations, mania, and CNS depression.

- Seroquel: Side effects: Headache, somnolence, abdominal pain, constipation, dizziness, dry mouth, orthostatic hypotension
Symptoms of toxicity are low blood pressure, rapid heart rate, drowsiness, low serum potassium, arrhythmias, and coma.

- Remeron: Side effects: Somnolence, agranulocytosis, anxiety, weight gain, vertigo, dry mouth, headache
Symptoms of toxicity are CNS depression, confusion, memory loss, seizure, tachycardia, hyper or hypotension, dry mouth, and constipation.

- Paxil: Side effects: asthenia, constipation, dizziness, dry mouth, sexual dysfunction, nausea, somnolence, sweating, tremor

Symptoms of toxicity are nausea, vomiting, dizziness, blurred vision, agitation, altered mental status, hallucinations, mania, and CNS depression.

There was no information in the chart about her compliance with past meds, or blood levels. She did not wish to discuss past medications during her interview. She has refused some of her medications during her hospital stay and requested others that she did not need such as insulin even though she is not diabetic and has healthy blood sugar levels.

The patient has had a history of substance abuse since at least four years ago after her mother's death when it was discovered by her family. She has abused specifically opiates and benzodiazepines. After her family became aware of her addiction, she entered the Professional at Risk program. Her longest period without drug use was nine months. She reports no use since December of last year. She does not report using nicotine or alcohol recently and her blood alcohol level was 0 when she was admitted.

She has one brother who is currently in treatment for a narcotic addiction. He has visited her in the hospital and requests that she attend Narcotics Anonymous meetings with him.

B.M. began using substance when she was 39 years old. She was first able to obtain the substances at her job as a nurse in the hospital. She reports that she used the substances simply because she wanted to use them. She had periods where she did not sue any substances. These were precipitated by concern from family, support from Professionals at Risk, and support from therapy. There were no adverse event recorded in her chart nor did she report any adverse affects from the use of substances. She was unable to list any reasons why she would refrain from using in the future during my interview.

Mental Status Exam

Appearance is unkempt, dressed in pajamas, sitting or lying in bed;

Eye contact is unremarkable while she is speaking but sometimes poor while she is being spoken to AEB she looks away after she is done speaking;

Behavior is somewhat cooperative with minimal crying AEB she answers most questions directly but with short answers and cries when she speaks of her perceived cancer;

Attitude is somewhat cooperative with minimal guarding or disinterest, I was unable to tell, AEB she answers most questions directly but with short answers;

Motor Activity is normal kinetics AEB sitting in bed with only WNL movements during interview;

Mood is self-reported as 'sad' since being in the hospital. She also reports fear about her perceived cancer.

Affect is appropriate to thoughts discussed AEB being sad when talking about her perceived sickness. Intensity seems flat or depressed and somewhat anxious AEB minimal expression in her voice when she speaks about anything beside her cancer and anxiety about her possibly cancer. She was responsive AEB her answers when I asked her questions.

Speech is slightly delayed AEB she takes a few moments to respond when I ask her questions.

Thought processes seem organized with limited insight AEB her sentences were clear but she was unable to verbalize that she was in the hospital due to MDD or psychosis.

Content of her thoughts was delusional AEB she kept coming back to the idea that she had blood in her throat although the medical exam showed no bleeding. She also continued to insist that her doctor had called her to tell her that she had cancer when he had not. These were the main topics. She denied suicidal impulses, homicidal impulses, and hallucinations.

Perception is hallucinations AEB by taste of blood in her mouth while medical team has ruled out bleeding. She does not currently report auditory hallucinations.

Cognition includes the patient was oriented to person, and place AEB she stated her name and that we were at the U of M hospital in Ann Arbor, she was off by one day with the date. She had attention AEB ability to spell ‘world’ backward. Her concentration was evident in her ability to focus AEB she answered all of my questions.

Short term memory was intact AEB she remembered what she ate for breakfast and that she did not blow dry her hair after her recent shower.

Long term memory intact AEB she reported where she went to nursing school more than twenty years ago and where she grew up with her family.

Abstraction intact AEB patient states that ‘people who live in glass houses shouldn’t throw stones’ means that everyone makes mistakes so we shouldn’t judge people.

Insight is poor AEB she insists that she is in the hospital due to throat bleeding and her cancer and does not want to be in the psychiatric unit. She does not appear to understand the need for treatment.

Information and intelligence includes an education level of a bachelor’s degree, with vocabulary consistent with this level of education AEB the words that she used during the interview. Her vocabulary was broad in range AEB her use of a variety of words in answering my questions. Patient was able to name my pen and repeat a sentence.

High Risk Factors

This patient is at a risk for self-injury or mutilation as evidenced by her history of self-harm, this self-harm included picking at her eyebrows and skin. Her history of mood lability, psychosis and history of substance abuse also contribute to this self-harm risk. Except in ways that the above may affect her, the patient is not at high risk for suicide, incarceration, abuse or violence as evidenced by her history.

DSM Diagnosis and Clinical Problems

Axis 1: Major Depressive Disorder, Psychosis NOS, Substance dependence
Axis 2: Deferred
Axis 3: HTN, Meniere's disease, and hysterectomy in 2004 due to endometriosis
Axis 4: Moderate
Axis 5: 25 in the medical record

The main problem B.M. has had with her primary support group has been the death of her mother four years prior. She had lived with her mother and taken care of her for many years. Related to her social environment, B.M. has the stressor of living alone. Occupationally, she was a nurse until four years ago when her mother died; she is currently on SSI disability with no occupation. Her economic situation is slightly stressful due to lack of a job therefore current income but she is managing with money saved from nursing as well as from her mother. She has no healthcare access, legal, educational, or housing issues.

The GAF score listed in the medication record is 25. This was upon admission. I would give her a current GAF score of about 35. She continues to have delusions that affect her behavior considerably. On the other hand, she denied suicidal and homicidal impulses. Additionally, she did not have a gross impairment in personal hygiene of communication. I did not give her a higher score because she continues to have delusions which impair her functioning.

One correlation between axis IV and axis V is that she had delusions which affect all of her functioning including her psychosocial relationships and environment. Even though she was functioning relatively well while we interacted, her preoccupation with her delusions dramatically affects her actions and lifestyle.

Psychodynamic Formulation

Some biological considerations for B.M. are her family's history of depression and substance dependence. She has no visible limitations created by an illness, temperament, or by mental retardation.

Her environment includes living alone without a job. This could contribute to major depressive disorder as she may not have a sense of purpose and relies on government assistance and her past savings for support.

Additionally, she has a brother whom she is close to that has substance dependence. This may make her feel like her own substance dependence is acceptable. It may also give her a connection to him. Another factor is that she lived with and took care of her parents by herself with no help from her siblings. Many of the auditory hallucinations that she hears are from her family members and sometimes she hears them telling her derogatory comments about herself.

Also, her history indicates that she finds value caring for others (as evidenced by her nursing career choice and her care for both her mother and father). After the loss of her mother and her job, she may have felt like she had less purpose. Now, she feels unable to even care for herself as she feels that she has cancer but nothing is being done for it. She displays poor coping skills when she experiences stressful events for example the death of her mother (which precipitated her increase in substance abuse) or her hospitalization.

One major treatment goal for B.M. is to focus on medication compliance to reduce the symptoms of her MDD and her psychosis. It is possible that her psychosis and MDD are exacerbating one another so lessening the symptoms of one could lessen the symptoms of the other. In addition to medications, it would likely be helpful to the patient to attend groups; nursing should encourage her to attend even when she initial does not want to attend. Since she has been living alone with a small support group, these group help increase her sense of belonging.

Additionally, it would be good for her to have support for her recovery from substance use. It is important to assess which type of support would be best for her which is difficult for me to do with the information that that I have. Once an appropriate type of treatment is found, it will be necessary to evaluate its effectiveness to make sure it is the best option and also to encourage and evaluate her compliance.

In my opinion, B.M.'s prognosis is better than some because she has sought treatment currently and in the past. Her prognosis depends a great deal on her support system, which she states is her family, and how supportive they are or she perceives them to be (often supporting family members who are mentally ill can be draining to the family and they can become 'burned out'). Her medication compliance will also affect her prognosis. While in the hospital she has been compliant with some medications but not with all of them. It will be more difficult for her to remain compliant in the community than it has been in the hospital with a nurse bringing all of her medications at the appropriate time. Her substance use will also affect her medication compliance and overall prognosis.

Nursing Care Plan

- Disturbed thought processes related to inaccurate interpretations of environment as evidenced by inappropriate, non-reality based thinking about blood in her throat, her cancer, and the possible death of her relatives.

One long term goal for B.M. is to remain free from actual or potential self-harm. The method is to assess the potential for self harm at the current time. The outcome and measure is to have a decrease in the causes of potential self-harm and no actual self-harm. The target date for this is two months. One intervention for this is to identify and remove potentially dangerous items in the environment. Patients should be in interviewed in a private area while maintaining staff safety. Staff should sit closest to the door (Ackley& Ladwig 2004). Additionally the nurse should stay with B.M. is she is agitated and likely to be injured. A quiet environment with the presence of another person can calm an agitated client. One-on-one time with staff is the first step in successful de-escalation (Ackley& Ladwig 2004).

One short term goal is for B.M. to understand the actions of her medications. Method is to assess the number of medications that she currently understand the purpose for. Outcome and measure is to have an increased number of medications that she understand the purpose for as evidenced by her verbalization during medications passes and by the fifth day to know all medications. The target date for this is five days. One intervention for this goal is to observe B.M.'s readiness to learn. Astute assessment is necessary to determine readiness to learn. Learning best occurs when the learners are motivated and attend to the important aspects of what is to be learned (Ackley& Ladwig 2004). Use easy to understand language when giving B.M. information and encourage her to ask questions. An estimated 90 million Americans cannot understand the complex language of health care delivery (Ackley& Ladwig 2004). Develop a therapeutic alliance with B.M. to increase trust. Approaching the patient in a non-judgmental manner, acknowledging her experience, and not questioning her reality help develop a therapeutic alliance (Ackley& Ladwig 2004).

Another short term goal is that B.M. remains oriented to person, place, and time. The method for this is to assess her baseline status by asking her the appropriate questions. The outcome and measure is to have an increase in the frequency of times oriented until she remains consistently oriented. The target date for this is five days. Some interventions for this goal are to orient B.M. and call her by name; introduce self on each contact; frequently mention time, date, and place; and prominently display a clock and calendar that are easy to read. These steps help reinforce reality and provide cues that encourage orientation (Ackley& Ladwig 2004). Also, limiting the use of sedatives and drugs affecting the nervous system might be beneficial to B.M.'s level of orientation. Sedation increases the risk of falls and confusion. Cognitive impairment can result in communication difficulties (Ackley& Ladwig 2004).

- Anxiety related to unconscious conflict with reality as evidenced by expressed concern about cancer and family member's safety and rumination about throat bleeding.

A long term goal of B.M.'s is to demonstrate return of two basic problem solving skills. Method is to ask patient about ways that she has handled anxiety in the past and and assess for current usage. Measurement is patient self-report or nurse observation of usage of two different problem solving skills. Target date for this is discharge date. One

intervention is to explore coping skills previously used by client to relieve anxiety; reinforce these skills and explore other outlets. Methods of coping that have been helpful in the past are likely to be helpful again and listening to clients while helping them to sort through fears and expectations encourages them to take charge of their lives (Ackley& Ladwig 2004). Another intervention is to encourage the patient to use positive self-talk and give examples. Cognitive therapies focus on changing behaviors and feelings by changing thoughts. Replacing negative self-talk with positive helps to reduce anxiety (Ackley& Ladwig 2004).

A short term goal related to anxiety is B.M. will verbalize symptoms of anxiety. The method is to ask the patient when she experiences anxiety as well as what she is experiencing during those periods. The measurement includes a scale from 1-4 rating this behavior as 'never demonstrates' to 'consistently demonstrates.' Target date for this is a rating of 4 or 'often demonstrates' within 4 days. One intervention for this is to assess the patient's level of anxiety and physical reaction to be able to remind patient to verbalize anxiety. Anxiety symptoms are often correlated with physical complaints and depression (Ackley& Ladwig 2004). Another intervention is to approach the patient's anxiety in a non-judgmental fashion. The inability of others to perceive the patient's anxiety does not make it any less distressing for the client (Ackley& Ladwig 2004).

Another short term goal is B.M. will verbalize precipitants of anxiety. The method is to ask her about some of the causes of her anxiety. The measurement includes a scale from 1-5 with 1 being 'never verbalizes' and 5 being 'consistently verbalizes.' Target date for this is a level of 4 or 'often verbalizes' within 4 days. One intervention is to approach the patient's anxiety in a non-judgmental fashion in order to encourage them to verbalize precipitants. The inability of others to perceive the patient's anxiety does not make it any less distressing for the client (Ackley& Ladwig 2004). Explain all activities and procedures to patient; do this in advance when possible and validate patient's understanding. With preadmission client education, experience less anxiety and have greater coping skills because they know what to expect (Ackley& Ladwig 2004).

I was not able to assess any of the goals, short term or long term, because I was only in clinical for one morning. After looking at the patient records, I would speculate that she did not meet the goals because her condition continued to deteriorate. Her psychosis and delusions were worsening and her psychiatrist was beginning to suspect bipolar disorder. She wanted to leave the hospital but her care team did not think that was appropriate so the court was contacted and she became an involuntary patient. Under the current system, she was unable to stay at UMHS as an involuntary patient and was thus transferred to another institution. I have no information about her progress after that time.

Learning Accrued

I feel like it was really helpful to me to be able to look at a patient in a more in-depth manner than we are able to in clinical. I appreciated being able to look at her history and see how so many of the factors in her life came together. It is interesting to see the

different backgrounds of people with mental illness and look at similarities and differences. I would have liked to talk to B.M. more about her middle age before her parents died because I think that I would have discovered some interesting things about her and the history of her illness.

Often in class we learn about the biological factors that play a role in mental illness. There are theories about the environmental factors that contribute to the development or persistence of mental illness but they seem very theoretical when we are learning them. Since a lot of this paper focused on the environmental factors, it was interesting to see how those factors contribute on a more personal level. It was interesting to really focus on the environmental and psychosocial without knowing many of the biological factors since we had not yet learned about Major Depressive Disorder when I wrote the paper. Then when we learned about the biological factors in class, it all came together.

This paper helped me to gain a more in-depth understanding of psychiatric nursing by allowing me the opportunity that many psychiatric nurses have of getting to know the patient on a deeper level.

References

Ackley, B., & Ladwig G. (2004). Nursing diagnosis handbook: A guide to planning care (7th ed.). St. Louis: Mosby.

Blom, M.,. (2007 November) Work and marital status in relation to depressive symptoms and social support among women with coronary artery disease. J Womens Health.;16(9):1305-16.

British Psychological Society Division of Clinical Psychology. (2006 March) Understanding mental illness - Recent advances in understanding mental illness and psychotic experiences. London

Dean, A., Kolody, B., Matt, G., & Wood, P. (1992) The influence of living alone on depression in elderly persons. Journal of Aging and Health, Vol. 4, No. 1, 3-18

Delahanty , J., (2001) Differences in rates of depression in schizophrenia by race. Schizophrenia Bulletin, Vol. 27, No. 1,

Duckworth, K., (2006 September) Major depressive disorder. Retrieved on February 18, 2008 from www.nami.org

Gottlieb, S., Khatta, M. (2002) The influence of age, gender, and race on the prevalence of depression in heart failure patients. Journal of the American College of Cardiology 43:1542-1549

Larson, B., McCullough, M. (1999 April) Religion and depression: a review of the literature. Twin Research and Human Genetics 2(2): 126-136

Murphy, J. (1991 March) Depression and anxiety in relation to social status. A prospective epidemiologic study. General Psychiatry 48(3)

World Health Organization. (2004) Prevalence, severity, and unmet need for treatment of mental disorders in the world health organization. Journal of the American Medical Association 291:2581-2590.