

Psychiatric nursing case history example

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**ASSIGN
BUSTER**

Discuss theories of etiology for Axis I and Axis II diagnosis: Bipolar Disorder (in Psychosis): The etiology for Bipolar disorder is based on the stress-diathesis model. This model shows the relationship between biological risks (genetic predisposition) and environmental stressors. It is postulated that those who are biologically at risk may develop the psychosis secondary to a stressor. Bipolar Disorder is often seen with people who have mood disorders, schizophrenia, delirium, dementia, or substance abuse. They may experience hallucinations, delusions, or disorganized speech or behavior.

Substance abuse and a family history of the disorder are both risk factors. Bipolar Disorder (in Depression): The etiology for Bipolar disorder related to depression revolves around incomplete synthesis and increased metabolism of neurotransmitters. Environmental stressors and behavior that is learned can affect these neurotransmitters and an influence on depression. Patient needs to be given education involving smoking cessation and alcohol buse. Patient also needs to be given medication education so that adherence may be attainable.

6. HPI: (History of Present Illness: What behaviors/ symptoms led to this hospitalization, what symptoms are still being experienced? How do these symptoms compare with those found in the literature?) My patient was found publically intoxicated while walking on the sidewalk near her home. The police said she stated that she was “ depressed” and wanted to end her life. From the paperwork, they stated that they found what appeared to be a suicide note in her pocket.

Upon talking with the patient, she told me that she was walking down the street intoxicated and does not discount the policeman's story, but she does not believe she was actually suicidal. She denied having a note with her and does not believe she would "write such a thing".

Some of the symptoms seen in her story correlate with what I have seen in literature for Bipolar Disorder related to depression. The patient will have a depressed mood for the majority of the day with instances of anhedonia. She states that she has sleep disturbances (insomnia) and is often restless.

Patient stated that she has had suicidal ideations that recur somewhat frequently but she does not know if they are "real" or not. All of these above symptoms relate directly to the symptoms often seen with bipolar disorder.

7. Mental Status Exam (General, Orientation, Memory, Insight/Judgement, Thought processes [formal, content, perceptual]; description should be concise) Appearance: 59 year old white female admitted on 10/5 with an average height and weight with good body hygiene. Patient had no visible tattoos, scars, or other markers. She could ambulate on her own and move all extremities.

Behavior: Patient was calm and cooperative.

She displayed good eye contact throughout questioning and did not show abnormal extra movements or nervous fidgeting. Speech: Speech volume was appropriate but patient was hyper verbal and appeared pressured. No disturbances in speech such as slurring were noted. Responses were irrelevant. Facial symmetry present while speaking.

Mood: Patient described herself as depressed. Affect: Patient was labile, but appropriate. She quickly changed her demeanor based on what subject we were speaking of. Formal Thought Disorders: Thoughts were often irrelevant and unrelated.

No occurrences of word salad noted.

Answers were given spontaneously and without delay. Content Thought Disorders: Patient's content was reality based with no delusions. No obsessions present. Perceptual Thought Disorder: Patient denied presently having hallucinations or illusions. None noted by observation.

Cognition: Patient was alert and oriented x4 and able to recall the past with ease. Patient's attention span was appropriate and could communicate effectively when on topic. She had adequate insight about why she was admitted and the background of her disorder. 8. Lethality:

Suicidality: (Past or present suicidal ideation, intent or attempts? Self-mutilation?): Denies feeling suicidal at this time, but prior to admission, patient had threatened to kill herself when law enforcement found her.

Patient states this is not the first time she has felt suicidal. Past history of intent in February 2010, but no past history of attempts, or self-mutilation.

Violence: Past or previous attempts to hurt others? : Patient denies ever wanting to hurt others. No history noted. 9.

Psychiatric history: (Onset and course of illness, previous diagnosis, include any previous diagnosis)

Patient states she was diagnosed with Bipolar Disorder in June of 2009. She says that after a period of severe depression that was accelerated by ETOH abuse, she went to a psychiatric counselor and was then referred. Patient states that her pattern of depression is fairly constant but often not severe. She says that most of the time it keeps her from getting out of the house to do simple tasks or go out with her husband. From these responses, I believe anhedonia is present.

Patient also reports sleep disturbances and feelings of restlessness. 10.

Family history: (psychiatric history or substance abuse): No psychiatric history noted within the family. Father has history of ETOH abuse.] 11.

Substances of Abuse: • Tobacco Use: Yes Stage of change: None. 1 pack per day • Alcohol Use: Yes Frequency: Daily Amount: 5-6 drinks per day Age of first use: 16 y/o Last Use: 10/5/11 (date of admission) Stage of change: None. History of physical symptoms of withdrawal (describe): Patient states she has had feelings of lethargy secondary to alcohol use. Patient denies withdrawal presently or in the past.

Legal Problems Secondary to use: Cited for public intoxication on 10/5/11. No previous legal problems.

Physical Problems secondary to alcohol use: -Cirrhosis of the liver. Kidney disease. Social Problems secondary to alcohol use: -Social isolation. Drinks primarily at home. Other drug use: Patient denies 12. Abuse History (physical, emotional, sexual): Patient denies 13.

Family's reaction to and understanding of patient illness: Patient states that her husband has been supportive throughout her psychiatric stays. She says that he understands that her depression fluctuates.

She has told her husband that she “ can not control my thoughts” (in reference to suicide). Patient states that husband understands her bipolar disorder to be an issue of dealing with depression and not knowing how to cope. Patient's parents are deceased.

No other family is involved in her life. 14. Medical Conditions: Patient has HTN, liver cirrhosis, and kidney disease. 15. Patient understanding of condition and self-management ability: (Coping skills, support system): Patient understands to “ get help” when she feels overwhelmed and uncertain about being able to control herself.

She mentioned coping skills that she has been working on such as “ compartmentalizing” (not letting the problems of the day “ build on each other” making it unbearable). She has stated awareness that a lack of coping mechanisms exacerbates her depressive episodes. 16. Cultural Considerations: No cultural considerations. (But religious considerations: Patient Is Protestant).

16. Lab/ Diagnostics studies: (include those tests that have to do with the Axis I-III diagnosis. For example: submit information on an alcohol blood level procedure that was performed on an alcoholic patient.

Indicate any abnormal levels and its significance for your patient and any critical nursing implications.) Lab Values upon admission: Ethyl Alcohol: 280 mg/dL. High.

Implications: patient safety, patient education. Monitor for withdrawal symptoms. BUN: 48 mg/dL: High. Impaired Kidney Function. Dietary restrictions, drug therapy, control of blood pressure.