Post natal depression case study

Table of Contents

Case Study

Care Plan

Medical Point of view

The Role of the nurse

Building a therapeutic relationship

Respect and Empathy

Communication

Tackling the problem

The Reality Therapy and choice therapy.

Working the therapy with Rachel

Problems met during sessions.

Conclusion

Case Study.

A 21 year old lady presented at Crisis Intervention Team (CIT) stating that she has these thoughts in her mind that she is going to harm her baby. She was experiencing an excessive fear of what she might do to her baby since these thoughts were telling her that she was going to knock the baby’s head against the wall.

She was physically trembling with fear and anxiety. She had reduced her food intake and this had resulted in considerable weight loss. She was not sleeping at night leading to tiredness, lethargy which was hindering Rachel (imaginary name) from performing her daily chores.

The pregnancy was unplanned but her boyfriend Robert (imaginary name) was very supportive during and after the pregnancy. He was very worried about Rachel since she had a complete change in character and from a happy go lucky person she had turned into an introvert always worried and depressed.

Rachel explained that she had always thought that motherhood would be an enjoyable period in life. She had always dreamt of this period but she had never imagined that it would end up to be the worst experience of her life. She was so focused on her baby that she had forgotten how to live. She was all the time concentrating on her childhood, how much she had felt neglected by her mother at that time and her innermost fear was that she will end up behaving like her; that is why she had stopped working, going out and enjoying everyday life. Despite this, she was feeling guilty that she was not giving enough attention to her baby.

CIT offers follow up sessions for 3 to 4 weeks, during which Rachel was asked to identify her problems and prioritise them. By identifying areas where she would like to improve, she would be lessening her suffering and make herself feel better; this was done together with the nurse.

Care Plan

Medical Point of view

Rachel was seen by the CIT psychiatrist who prescribed antidepressants with the aim to try and alleviate Rachel's mood. Glasser (2003) complained that it is a pity that nowadays psychiatrist and medical doctors prescribe psychiatric drugs prior giving counselling sessions first. The role of the nurse regarding her treatment was to educate the patient regarding the importance of concordance and informing Rachel about any side effects that might occur when starting treatment.

The Role of the nurse

The role of the nurse is to help the patient get better by offering the optimum level of care in order to empower her patient and help him/her improve his/her quality of life. Smith, Wolf and Turkel in 2012, explained that for the patient to be cured, s/he needs to be cared for as no curing can occur without caring (p. 137). The nursing care plan should be planned together with the patient in order to identify the patient's needs, plan and set goals to overcome the obstacles. Kelsey (2013) stated that NHS is emphasising on patient participation in the care plan as this will help the nurse to engage more with the patient while the patient will feel more empowered. This concept is firmly believed at CIT, and it was always stressed that all professionals collaborate for optimum care delivery together with patient. The patient also has the right to choose family members and/or friends whom he wished to be involved in his/her care.

Building a therapeutic relationship

In order to formulate a care plan with the patient, a therapeutic relationship must be built for a successful outcome. Caring is based on a relationship and for relationships to be effective both parties must be involved, (Govier, 1992). The fulcrum of nursing care is building a nurse-patient relationship by engaging with the patient and his carers.

Building a therapeutic relationship helps the nurse to gain indispensible information about her/his patient whilst the patient learns how to trust the nurse (Lehman et al., 2004). Although according to nurses trust is vital for building a therapeutic relationship, this can be very difficult to establish with the patient.

Literature states that trust has been a debatable topic in research; it does not concern only on the health care profession but includes also the institutions and other services providing the care, (Laugharne & Priebe, 2006). In Malta there is still a good amount of stigma regarding Mental Health and Mental Hospital thus people are afraid to talk about their mental health problems. The stigma that surrounds the name of the mental health hospital in Malta still carries fear of the unknown and beliefs about mental illness hinder the patients from seeking help. This often results in severe deterioration leading to an involuntary admission (Farrugia, 2006).

The same thing happened with Rachel at the beginning of our sessions when she was still terrified to discuss her innermost thoughts, believing that she would be judged and labelled as mentally ill thus providing grounds for an

admission. Rachel needed to overcome her fears and start to confide in the nurse.

In order to gain her trust, the nurse had to reassure Rachel that no harm will come to her and if she wishes CIT could offer her care in the community reassuring her fears regarding hospitalisation. This could only happen if Rachel agrees to work with the team members and keep to the plan which they had agreed on together. Rachel agreed with the proposal inviting her boyfriend to join the plan, which he accepted. Support and information was provided to both parties and they were satisfied with the plan.

Respect and Empathy

The nurse assured Rachel that both parties should respect each other. Papastavrou et al (2012) explains that to show respect towards a patient one should allow autonomy, show dignity towards the person, care for him/her holistically and ensure privacy and confidentiality. Assuring the patient that since she is seeking help, the team's aim was to provide that help and not to judge her thoughts and actions.

For the nurse to be able to understand the patient better she has to put him/herself in the patient's shoes and this skill is called Empathy. Empathy was found helpful to humanize the care delivered to the patient (Barker, 2003). When the nurse shows that his/her intentions are genuine and is trying to understand the situation by offering help and keeping agreements, the patient will start to trust her/him.

Communication

Establishing trust, showing respect and empathy to the patient, needs good communication skills; Taylor, Lillis, Lemone, Lynn, and Smeltzer (1989), claimed that a therapeutic relationship can never be built if there is no good communication skills. It is imperative for the nurse to learn to listen attentively to verbal communication but also to learn to read the non-verbal communication that the patient is sending. Through the non-verbals, the nurse can extract information which the patient wishes to hide such as fear and anxiety through her body language (Stuart, 2009). Glasser (2003), emphasised on the importance to allow time for patient to narrate their problem, in order to be able to assess the patient in depth.

Tackling the problem

- She does not like her life at the moment.
- She misses work and school (she was learning art, her hobby is drawing)
- She hates the thought of becoming like her mother
- She hates the thoughts that are obscuring her mind preventing her from enjoying life.

The nurse went through the list of problems written by the patient and together with Rachel she tried to group them into categories. Keeping in mind that CIT service is provided over a limited amount of time, it is of utmost importance that the team tackle the urgent problems which have prevented the patient from functioning normally and reaching a Crisis. For secondary problems, Rachel will be referred to another team who can offer longer term care.

The first two problems discussed were the fact that she is absent from work and not attending art school at the moment. This fact is making her feel useless and lonely. She is not doing these things because she thinks that if she starts to do things that she used to enjoy, she will neglect her child. This will make her worst fear that she will become like her mother come true. This made it easier for the nurse to narrow the amount of problems because in agreement with Rachel they decided to group all the three problems under one heading: fear of becoming like mum. Rachel admitted that if she could be sure that she would be nothing like her mother she would feel less stressed.

The second problem was her bizarre thoughts which were persecuting her. During the first meeting they discussed at length the issue of harming her child and what chance there was that she would actually harm him. She took so much care of her child since his birth three months ago that it was highly unlikely that she would ever harm him. In reality she was caring fulltime for the child, taking care of him 24 hours a day and never leaving his side. Rachel’s boyfriend assured the nurse that she never left her child unattended. He explained that they were living with her mother who took care of the house chores and gave them moral support whilst Rachel took care of her child.

After discussing all this with Rachel it was concluded that what she was feeling was unhappy, she lost her joy of living. It was important for Rachel to try to control her thoughts and worries and to try learning to sort them out. First she needs to work out if the worries are founded or not and when that answer is found she needs to choose whether to ignore or believe them. The

nurse opted to work with Rachel on the steps of Reality/ Reality Theory by Glasser to help her overcome these fears.

The Reality Therapy/Choice therapy.

William Glasser developed Reality therapy way back in the sixties and it was based on identity theory, (Zastrow, 2010). The last two decades Glasser noted that his therapy focused more on human behaviour, how can it be altered and improved leading him to change the name of Reality Therapy to Choice Therapy, (Wubbolding, 2013). The choice theory explains how the life of the individual is determined by the choices he made. Every individual has his perceptions about his/her reality of life and according to Glasser the individual behaviour is in constant attempt to narrow between what we want and what we have (Zastrow, 2010 pg 491). The aim of the therapy is to help and teach individual to satisfy the internal motivation and or basic psychological needs.

The Choice therapy focuses on the basic needs of the individual. Glasser (1996) explained that the therapy emphasised the four basic psychological needs which included belonging, power, freedom and survival (Jong-un, 2007). Belonging refers to family and friends. People; with whom a person can socialise, enjoy him/herself with, as well as feel loved. Power refers to the individual achievements in life such as achieving dreams and feeling worthwhile. Having your own space, acting independently, being autonomous and deciding for yourself covers the need of freedom. Whereas, survival needs are covered by nourishment, intimate relationships and shelter. Sunich (2007) in his article argued that Glasser wrote about five basic needs and the ones mentioned above and adding fun.

Contrary to traditional theories, the Reality Therapy promotes the idea to focus on the ‘ here and now’ and reduce concentrating on the past. The therapy is based on the patient’s willingness to change, make choices, take responsibility and sustain commitment. Its aim is to assess and identify the unmet needs of the patient exploring what behaviours they are displaying that either assist or interfere with them meeting their needs (Sunich, 2007 pg. 3).

Working the therapy with Rachel

The nurse explained how choice therapy works and Rachel agreed that she would like to give it a try. The nurse explained that reality therapy is best summarized as WDEP which means: wanting, doing, evaluation and planning, (Cameron, 2013)

In Rachel’s situation, it is important to focus on what she reallyWants; she wished to get rid of her thoughts and fear. It was explained to her that she needs to start to learn to identify unrealistic thoughts and learn to control them. After the problem was ascertained the next step taken was to ask Rachel what she wasDoing to try and get what she wished for. Rachel tried to explain what she had been doing butEvaluating the situation together Rachel admitted that the method she had chosen was not working. After that Rachel and the nurse agreed to try and formulate a new Plan which will help Rachel gain her joy in life back,(Cameron, 2013) .

In the first session Rachel described herself as: “ blocked in a black tunnel”, she was afraid to talk about her thoughts because the nurse might think that she was “ going crazy”. but could feel that with the right support there is

hope for her illness. The nurse had to explain to Rachel that she should stop labelling herself as depressed and concentrate on how she was feeling at that moment. Rachel admitted she was feeling unhappy, and this was caused because the patient had stopped doing the things, she liked to do so that she would be able to concentrate on her son 24 hours a day 7 days a week. Although she knew that she was still fearful of the thought that she might harm the baby. The nurse explained that feeling unhappy for a reason is not being " crazy"; the important thing is doing something about it to improve the situation (Glasser, 2003).

The thought that she might harm the baby was explored at length. Rachel admitted that she never did anything to harm her baby, she loved him unconditionally, and she took care of his Adls. She never misses his appointment at the baby clinic where they confirm that the baby is very healthy and this was confirmed by Robert. The nurse documented everything they said on a page divided into two columns, labelled good care and neglect After Rachel finished, the nurse handed her the paper and explained to her what she had done. All the things Rachel had stated were listed under the good care column and the neglect column remained empty. Then the nurse asked Rachel " Seeing this paper how much are the chances that you are neglecting your son?" Rachel stared amazed at the paper as she answered " none", thus this makes your thought unfounded. The nurse explained to Rachel needs to learn to do this exercise each time she has a thought so that she can identify if the thought is realistic or just an imaginary one.

So they planned Rachel's homework until her next session which focused mainly on identifying the thought and reasoning it out. After the first session

she confessed that she felt better; the fear that she was going crazy subsided, she felt that she was not alone any more in her dark tunnel and hope was instilled.

Sessions went by and Rachel started to learn how to control her thoughts better but choosing to ignore them. She was better but not good enough yet. Rachel had to start to stay away from her son a couple of hours so she has time for herself. It was the biggest step for her and as she described it as the most painful but with the help of Robert and their extended families she started to work a couple of hours a week. This made a drastic change in Rachel's mood and she started to feel happy again. She started to make friends and felt that she belonged in society again and not isolated anymore.

" Happiness or mental health is enjoying the life you are choosing to live, getting along well with the people near and dear to you, doing something with your life you believe is worthwhile, and not doing anything to deprive anyone else of the same chance for happiness you have" (Glasser, 2003 pg 7).

Problems met during sessions.

Seeing the story in writing might look as if it had been easy to empower Rachel enough to achieve goal. It included four weeks of intensive counselling with two planned sessions a week and several phone calls from Rachel asking for support and reassurance. This could be done by praising Rachel for her decisions and actions.

There were times that the patient had to be confronted about her decision for example " you are thinking and assuming that your mum will not be

capable to look after your baby. Did she show any signs of mistreating him or being unloving towards the baby? Are these just your thoughts tormenting you or there are facts which might lead you to think that she is incapable of looking after him?” There are many authors who criticise this method because of the above: they argue that it is a harshly confronted therapeutic approach towards the patient. Wubbolding and Brickell (2000), did not deny it but emphasised the fact that reality therapy is a gently confronted approach. Glasser (2002), explained clearly the consequences of seven deadly habits, which may arise during reality therapy session. These habits are criticising, blaming, complaining, nagging, threatening punishing and bribing or rewarding to control, but they cannot be allowed in any relationship because they will simply destroy it (Sommers-Flanagan & Sommers-Flanagan, 2012).

There was one episode at the beginning when Rachel entered the office unannounced shaking and sobbing. She was so desperate at that moment that she could not even talk. The nurse waited for Rachel to calm down but each time she did and the nurse asked her to talk Rachel ended up sobbing again. After more than half an hour, in a soft but stern voice the nurse had to tell Rachel that she had to speak up if she wanted help. The statement might have sounded insensible and blunt but it was all about the reality of the situation; Rachel understood that and reached for a paper and with great difficulty wrote what was troubling her. Sommers-Flanagan & Sommers-Flanagan (2012) agreed with other above authors who believe that Reality therapy at times is too directive and might become almost offensive and unethical towards the patient.

Conclusion

Rachel started to look forward to her therapy session; she worked hard on her problems, kept with the plan and gradually she reached her goal. Basic knowledge about the therapy helped the nurse conduct the sessions but also made her aware of the need for more intensive training (Sommers-Flanagan & Sommers-Flanagan, 2012).