

Week 7: Complex Case Study Presentation

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PRAC 6675: PMHNP Care Across the Lifespan II Practicum

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Subjective Data

Chief Compliant: "I don't know why I am here." "They said something about being molested." The staff at the hospital are jealous of the way I look."

HPI: DC is a 35-year-old AA male admitted for psychiatric stabilization. DC stated that he did not know why he was here and that "they said something about being molested, and staff at the hospital are jealous of my looks." Records indicate that he had become extremely aggressive over the past few months towards staff and other patients at another hospital. DC was reportedly sexually inappropriate towards females and males. The patient exhibited paranoid delusions of being raped by others and plots to harm him. DC reported that someone was using black magic and putting roots on him. He states that the staff is jealous because he is pretty and looks better than Tupac. He reports that two particular male staff are always talking about him and trying to make him gay. He reports hearing the others talking about him, especially the males. He reports I feel suspicious around new people." "When I am around a little kid I've never met, I feel suspicious that I did something to them." "I feel like somebody needs to go to a root doctor or African man to get the black magic off me." He reports that black magic was put on him because he robbed a big-time drug dealer. He believes that spreading salt around him will ward off voodoo. He reports that people are trying to poison him by putting spider eggs in his food. DC starts praying during the interview and asks that I pray with him to get "roots off him. He is constantly looking through the bible and reciting passages.

Past Psychiatric History: DC has been previously diagnosed with paranoid schizophrenia. He has had multiple psychiatric hospitalizations beginning in the early 2000s. Patient reports he has been treated with Haldol, Zyprexa, and Lithium. His records indicate he has also been treated with Ativan, Depakote, Prolixin, and Thorazine.

Substance Current/Use: D. C. denies any present or past illegal substance use. He reports that he started smoking cigarettes when he was 16 and smoked two packs daily. He denies alcohol use.

Family Psychiatric/Substance Use History: Patient reports his mother was diagnosed with Schizophrenia and Bipolar, but the uncle who gave historical data reports no family history of mental illness.

Current Medications: Invega Sustenna 234mg IM every 28 days, Lithium 300mg PO BID, Haldol Dec 150mg IM every 14 days.

Psychosocial History: DC was born and raised in Georgia. He has two younger brothers and an older sister, and he indicated they were all raised by their grandparents. DC's parents, grandparents, and one brother are deceased. He has no children and has never been married. Records indicate he was living with his brother and sister. The patient has a 10th-grade education and tried getting a GED but could not complete it. DC has minimal work history and reports he worked loading trucks at a facility for about three months.

Trauma/Abuse History: DC reports being raped by a neighbor when he was younger and reported being raped by staff during one of his prior hospitalizations. Neither has ever been confirmed.

Medical History: DC has been diagnosed with Ulcerative Colitis and has a history of hemorrhoids. Patient reports abdominal issues resulting from being raped and "turned gay" at the other hospital.

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Allergies: According to records patient has no food, drug, or environmental allergies

Review of Systems:

General: D.C. is a 35-year-old thin-looking male who reports weight loss, fatigue, and decreased appetite, described as problems with eating creamy foods, chocolate, or milk products. Denies fever or chills.

HEENT: Denies visual loss, blurred vision, double vision, or yellow sclerae. Denies hearing loss, sneezing, congestion, runny nose, or sore throat.

Skin: Skin clean and intact. Denies any rashes or itching.

Cardiovascular: No chest pain or discomfort. No palpitations or edema of lower extremities.

Respiratory: No coughing or shortness of breath. No noted sputum production.

Gastrointestinal System: Patient reports diarrhea at times (goes to the bathroom at least 5 or 6 times. Denies nausea or vomiting.

Genitourinary: Denies any burning on urination. No urgency or difficulty urinating. No odor or change in urine color.

Neurological: Denies headaches or dizziness, no numbness or tingling in extremities. Gait is steady.

Musculoskeletal: No muscle or joint pain or weakness is needed.

Hematological: Patient reports fatigue. No bruising noted.

Lymphatics: No enlarged lymph nodes

Endocrinological: No reported sensitivity to temperature changes. No excessive thirst or urination.

Objective Data:

Physical Exam

D.C. is a 35-year-old AA male who is alert and oriented. He reports experiencing fatigue and gastrointestinal issues when eating milk products, creamy foods, cheese, and chocolate. Vital signs: BP 155/86, P 121, R 18, T 98.5, O₂ Saturation 96%, Weight 155.9 lbs., Height 5'2", BMI 28.5.

Diagnostic results:

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DC has ulcerative colitis and has been treated with steroids, and he also reports multiple bouts of diarrhea. To rule out medical conditions or substances that may explain symptomology and assess baseline functioning before initiating any pharmacological interventions, a CBC, CMP, thyroid function test, liver function test, FBS, urinalysis, urine drug screen, and EKG would be done. We would also request a gastroenterology consult. The urine drug screen was negative; no other laboratory findings required additional interventions. Given the DC's existing medical condition, these assessments of bodily functions are essential parameters to help guide and monitor treatment options.

Assessment:

Mental Status Examination

DC is a 35-year-old alert, oddly dressed African American male who appears younger than his stated age. He has a hood over his head, a mask on his face, and dark sunglasses. He refuses to pull down his mask, uncover his head, or remove his glasses. He states that his face is pretty and does not need to be seen. He is ambulatory without assistance. Has poor grooming and hygiene. He is oriented to person, place, and time. DC is cooperative with the interview. He has a constricted affect and reports that his "mood is not too good, and they are jealous of me." His speech is repetitive and perseverative. His thoughts are disorganized, and he has paranoid and persecutory delusions. He reports that others are listening to his conversation, and certain staff are plotting to turn him gay. He also reports that black magic has been used on him, and he needs to see a root doctor or African healer. He reports that voodoo is everywhere, especially among men, and that women must be protected. He lacks insight into his mental and physical illness and has impaired judgment, as exhibited by his medication non-adherence. He denies having a psychological or physical illness; instead, he is a victim of black magic and turned gay. DC started reciting scriptures from the bible and praying during the interview. He asked that I pray for him so the demons would leave him alone.

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Diagnostic Impression:

Primary Diagnosis: Schizophrenia

DC's clinical presentation and reported history are most suggestive of Schizophrenia. The patient was delusional and paranoid and responded to auditory and visual hallucinations. He exhibited disorganized thinking. He reported that black magic is being used on him, and he is not mentally ill. He reports that staff are trying to turn him gay and are jealous of him because he has a pretty face. DC's symptoms have impacted his functioning in interpersonal relationships, work, and self-care. DC has not been gainfully employed; he reports that he had difficulty getting along with his family and has had several hospitalizations for psychiatric stabilization over several years. The DSM-5 criteria for diagnosis of Schizophrenia includes the presence of cognitive, behavioral, and emotional dysfunction. The individual must have delusions, hallucinations, disorganized speech, and disorganized behavior or decreased emotional expression for over a month (American Psychiatric Association, 2022). The symptoms must cause significant functional impairment, persist for at least six months, and schizoaffective, depressive, or bipolar disorder with psychotic features have been ruled out.

Additionally, the symptoms must not be caused by substances or other medical conditions (American Psychiatric Association, 2022). According to the patient report and collateral information, DC has exhibited active symptoms intermittently and has not used any substances for years. Urine drug screen for negative.

Schizophreniform Disorder

Schizophreniform disorder is diagnostically similar to schizophrenia except for duration of symptom presentation. In schizophreniform disorder, patients experience delusions, hallucinations, disorganization, and negative symptoms for a period of less than six months, unlike individuals diagnosed with schizophrenia whose symptomology persists for longer than six months. Additionally, individuals with schizophreniform disorder are not required to meet the impairment in daily functioning

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criteria of schizophrenia (American Psychiatric Association, 2022). The duration of DC's psychotic symptoms and degree of functional impairment leads to the rule out of Schizophreniform disorder.

Schizoaffective Disorder

To be diagnosed with schizoaffective disorder, an individual must meet criterion A of schizophrenia and experience a major depressive or manic episode simultaneously. The manic or depressive episode must be present for most of the active phase of the illness (American Psychiatric Association, 2022). A period of at least two weeks of active delusions or hallucinations where the individual is neither manic nor depressed must be present. DC did not report nor was there any history of manic or depressive episodes occurring at the same time as his psychotic symptoms. His clinical presentation did suggest mania or depression; therefore, schizoaffective disorder was ruled out.

Schizotypal Personality Disorder

A schizotypal personality disorder is characterized by social and interpersonal impairments leading to a lack of close relationships. The individual with a schizotypal personality disorder also suffers cognitive and perceptual distortions. Ideas of reference, superstitious beliefs, odd behaviors, and inappropriate or constricted affect are present (American Psychiatric Association, 2022). Individuals with schizotypal personality disorder may be paranoid or suspicious. Although DC exhibited symptoms seen in those with schizotypal personality disorder, it could not be confirmed that personality dysfunctions were present before the onset of psychotic symptoms, and he experienced persistently severe psychotic symptoms that are not typically prevalent in schizotypal personality disorder. DC's presentation was more suggestive of Schizophrenia.

Case Formulation and Treatment Plan

D.C. is a 35-year-old African American male who presents for admission for psychiatric stabilization. The patient presents with auditory and visual hallucinations, paranoid and persecutory delusions, and disorganized thinking. The patient has suffered significant functional impairment

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according to history and self-report. The patient has been treated with Haldol, Zyprexa, Lithium, Seroquel, Abilify, Risperdal, Depakote, Prolixin, and Thorazine. The patient did not provide information on the medications' efficacy or side effects. Although the collateral informant stated no history of mental illness, the patient reported that his mother was diagnosed with Schizophrenia and Bipolar.

The recommended care plan for DC would include antipsychotic medication for stabilization and a method for psychosocial interventions that include social skills training, CBT, and family intervention. The first line of treatment for Schizophrenia is antipsychotic medications which have been shown to improve symptoms and behaviors. Clinical practice guidelines indicate that psychological monotherapy poses an uncertain risk of psychiatric stabilization and is, therefore, advises a combination of psychotherapy and pharmacotherapy (Barnes et al., 2020). DC's previous history and treatment record indicated multiple medication trials with less than optimal response and non-compliance. Although Clozapine is considered to be more effective than other antipsychotics for treatment-resistant schizophrenia, patients must adhere to weekly WBC monitoring, which for some patients is a deterrent to use due to delusional beliefs and refusal of laboratory requirements (Siafis et al., 2023). DC constantly reported that others were out to harm him and that staff was using black magic on him, and he often refused medications; therefore, Clozaril was not an option for him. Due to his established pattern of non-adherence, the severity of psychosis, and past medication trials, Haldol Dec 100mg every 14 days, Invega Sustenna 234mg every 28 days, and Lithium 300mg po BID. Using a combination of antipsychotic medications for treating patients who have a poor response to treatment is not a part of most treatment guidelines. Still, it is acceptable when patient history and clinical judgment determine that the benefit of symptom remission outweighs the risk of possible adverse effects. Careful and diligent monitoring of symptom improvement and adverse effects is essential (Kamei, 2022). The clinical decision to use polypharmacy is to promote treatment response, avoid high doses of single antipsychotics, and elevate related symptoms of anxiety, impulsivity or aggression, and cognitive

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dysfunction. DC was previously treated with Haldol, Lithium, and Invega with no reported severe adverse effects; therefore Haldol Dec and Invega Sustenna were recommended. Although Lithium is a mood stabilizer and is used in combination with other antipsychotic medications to promote mood stability and treat aggression, it also suppresses the production of proinflammatory cytokines and exhibits anti-inflammatory activity on dendritic cells in the presence of pathogens (Leu et al., 2017). Because of its anti-inflammatory properties, Lithium could help with DC's GI discomfort. Another pharmacological treatment option could be using Seroquel combined with Invega Sustenna and Depakote, as the patient reportedly had some response from previous treatment with these agents.

Individuals with schizophrenia require comprehensive, evidence-based care. That care includes routine nursing care, family intervention, and cognitive behavioral therapy (CBT). CBT-p, or cognitive behavioral therapy for psychosis, is used to reduce the distress associated with the symptoms of psychosis and improve functioning (Sivec et al., 2017). CBT, family therapy, and social skills training is recommended. Alternative therapy for DC is positive psychotherapy of psychosis which focuses on building and accepting one's identity, developing opportunities and talents, and understanding life experiences and emotions. DC could benefit from psychical health and wellness classes to understand his medical condition and the importance of treatment. DC will be provided with education on medication side effects, illness progression, adherence benefits, monitoring of medical issues, and community resources. While hospitalized, DC is monitored for symptom improvement and medication tolerability and evaluated weekly or as needed. Aftercare recommendations would include follow-up with a primary care physician to manage ulcerative colitis and an outpatient mental health center for mental health medication management and other community resources, including the Assertive Community Treatment (ACT) team.

Reflections:

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DC is a very complex and challenging case. Although the patient presented with well-defined symptoms of Schizophrenia, he also presented with challenges of treatment choices considering his history of poor response to medications and continued active psychosis. During another encounter with the patient, I attempted to ascertain additional information regarding treatment response or concerns with prior medicines. Still, the individual was not receptive and stated he did not want to discuss that but would rather pray. Interviewing patients with such complex symptomology and treatment course allows me to continue building my diagnostic confidence and critical thinking skills.

Discussion Questions:

1. What are the challenges of treatment-resistant schizophrenia?
2. What are the risks and benefits of polypharmacy?
3. What are the best psychosocial interventions for paranoid schizophrenics?

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PRECEPTOR VERIFICATION:

I confirm the patient used for this assignment is a patient that was seen and managed by the student at their Meditrek approved clinical site during this quarter course of learning.

Preceptor signature: Jenna Melan PMHNP

Date: 2/11/23