**Week 7: Schizophrenia and other Psychotic Disorders**

Student Name

College of Nursing-PMHNP, Walden University

NRNP 6635: Psychopathology and Diagnostic Reasoning

Faculty Name

Assignment Due Date

**Subjective:**

**CC** (chief complaint): Felicia brought Patricia in under an emergency after locking herself in a closet and screaming for over an hour. This incident J's Patricia's third presentation to the emergency room in two weeks.

**HPI**: Mrs Patricia Warren is a 42-year-old female brought in under an emergency by her best friend, Felicia, after locking herself in a closet and screaming for over an hour. Although the Emergency Medical Services (EMS) administered a small dose of Ativan to the client after she arrived at the emergency department, this incident is Patricia's third presentation to the emergency room in 2 weeks. In this sense, age had one psychiatric hospitalization last year. The client has never demonstrated self-harm behaviors, has no history of traumatic brain injury (TBI), and refuses to sleep at night. Upon arrival at the emergency department, she refused vitals and labs and was uncooperative. The client's social and family history is a profound consideration when diagnosing the underlying mental disorder (s). For instance, Patricia's parents deceased in the last three years, and her husband is out of town. Further, her father grappled with two previous inpatient psychiatric hospitalizations for paranoia; her mother had a history of bipolar depression, while her paternal grandmother has "shock therapy." Although she denies a history of trauma experience, her friend reports that her parent’s death was extremely difficult for Patricia.

**Past Psychiatric History**:

* **G**eneral Statement: Pt denies a history of traumatic experience, had two previous presentations to the emergency room before this incident and had one psychiatric hospitalization last year.
* **C**aregivers (if applicable): Her best friend, Felicia
* **H**ospitalizations: one psychiatric hospitalization last year and two previous presentations to the emergency department in 2 weeks.
* **M**edication trials: Ativan (small dose) administration in the emergency room, reported allergies to Clozaril
* **P**sychotherapy or **P**revious Psychiatric Diagnosis: not reported

**Substance Current Use and History:** Denies using any drugs and drinks one glass of wine weekly.

**Family Psychiatric/Substance Use History:** Unknown

**Psychosocial History:** Pt lives alone since her husband is out of town, has no children, and has both parents deceased in the last three years. She has a sister who is five years older. Although she denies a history of trauma experience, her parents' death was difficult for her. The patient dropped out of school in 11th grade, was pregnant, and had an abortion**.**

**Medical History:**

* **Current Medications**: no current medications; received a small dose of Ativan in the emergency room
* **Allergies**: **Clozaril**
* **Reproductive Hx**: **no children, was pregnant, and had an abortion**

**ROS**:

* GENERAL: the patient appears to be in good health, with no unexplained weight loss, chills, or fatigue
* HEENT: Eyes: No visual loss, blurred vision, double vision, or yellow sclera. Ears, Nose, Throat: No hearing loss, sneezing, congestion, runny nose, or sore throat.
* SKIN: No itching or rash
* CARDIOVASCULAR: No chest pain, tightness, pressure, or discomfort. No edema or palpitations.
* RESPIRATORY: No sputum, cough, or shortness of breath
* GASTROINTESTINAL: No anorexia, diarrhea, or vomiting. No abdominal pain or blood.
* GENITOURINARY: No incontinence or urgency, no polyuria, denies pain upon urination.
* NEUROLOGICAL: No headache, syncope, ataxia, paralysis, numbness, or tingling in the extremities. No changes in bowel or bladder control. Denies seizures.
* MUSCULOSKELETAL: No muscle, back pain, stiffness, or joint pain. Can ambulate without assistance. Denies pain with movement.
* HEMATOLOGIC: No anemia, bleeding, or stiffness
* LYMPHATICS: No history of splenectomy or presence of enlarged nodes
* ENDOCRINOLOGIC: Denies sweating, cold, or heat intolerance. No polyuria or polydipsia.

**Objective:**

**Physical exam:** if applicable

**General**: No noted distress; the patient is alert and oriented. The client's mood and appearance are consistent with the situation. No unexplained weight loss.

**HEENT**: Eyes: No visual loss, blurred vision, double vision, or yellow sclera. Ears, Nose, **Throat**: No hearing loss, sneezing, congestion, runny nose, or sore throat

**Cardiovascular**: Normal rate, regular rhythm. No murmur, rub or gallop

**Pulmonary**: No wheezes, rales, or bronchi. Symmetrical chest and clear breathing sound across all fields.

**Skin**: No rashes, lesions, or wounds.

**Abdomen**: Soft, non-tender, and nondisintend. No masses.

**Diagnostic results**:

A Brief Clinical Assessment Scale for Schizophrenia (BCASS)-a 14-item scale for identifying common symptoms of schizophrenia (Yildiz et al., 2021). Lab tests for underlying schizophrenia include complete blood count with neutrophil count (CBC+Be), low-density lipoprotein cholesterol, gamma-glutamyltransferase (GGT), and thyroid stimulating hormone (TSH) (Eskelinen et al., 2020).

**Assessment:**

**Mental Status Examination:**

A mental status examination is profound in assessing how people exhibit observable symptoms consistent with different mental disorders. A mental exam can reveal the speech, mood, affect, thought consent, cognition, judgement, and appearance of people grappling with mental health disorders (Vos & Dass, 2022). These aspects formed the basis of Patricia's mental exam.

The patient appeared well-groomed and dressed appropriately. She was oriented, alert, and maintained eye contact throughout the interview. However, she demonstrated pressured speech with regular rhythm and tone. She denies suicidal or self-harm thoughts. Patricia's thought process was logical and cognitively organized, but she showed unduly suspicion of the examiner and some "socially awkward" behavior. The patient had a flat affect (little range of expressed emotion). Finally, she expressed some odd beliefs about the examiner, justifying delusions.

**Differential Diagnoses:**

**Schizophrenia**

Schizophrenia is a degenerative condition and a spectrum of disorders with clinical manifestations of various symptoms, including delusions and hallucinations. According to Cleveland Clinic (2022), risk factors for schizophrenia are genetic, environmental, developmental, and recreational. In this sense, a family history of schizophrenia, extreme stress, autoimmune diseases, gestational diabetes, preeclampsia, and recreational drug use can increase the individual vulnerability to Schizophrenia (Cleveland Clinic, 2022). The DSM-5 criteria for diagnosing schizophrenia requires the presence of at least two of five main symptoms, including hallucinations, delusions, incoherent speech, unusual movements, and negative symptoms. These symptoms should persist for at least one to six months. Finally, these symptoms should contribute to social or occupational dysfunction.

**Schizoaffective Disorder**

Schizoaffective disorder is a mysterious mental illness that shares symptoms of schizophrenia and mood disorder. Brannon (2021) argues that this condition has a clinical manifestation of distorted thinking, hallucinations, delusions, and depression/mania. Since the coupling of schizophrenia and mood disorder symptoms renders schizoaffective diagnosis complex, the DSM-5 criteria require the persistence of delusions or hallucinations for two or more weeks, the disturbance that is not attributed to the effects of substances like drugs, and an interrupted period of illness that must include depressed mood and significant symptoms of schizophrenia.

**Anxiety Disorder**

Generalized anxiety disorder (GAD) is a common mental condition that manifests through multiple symptoms, including fear, worry, restlessness, sleep disturbances, irritability, and concentration difficulties. According to Munir & Takov (2022), the DSM-5 criteria for diagnosing GAD include the following considerations: excessive anxiety and worry (apprehensive expectation) for at least six months, sleep disturbances, fatigue, restlessness, irritability, and lack of concentration for the last six months. These symptoms should result in significant distress and social and occupational wellness impairment. Anxiety should not emanate from any physical cause.

**Reflections:**

Mrs Patricia's case scenario presents the need to conduct a comprehensive physical and mental status examination to reveal the presence of schizophrenia or other psychotic disorders with similar clinical manifestations. The patient's psychosocial history, exposure to traumatic events, and self-reported symptoms can provide clues for the underlying mental condition (s). However, mental status examinations and subsequent lab tests can give specific information for differential diagnosis. For example, schizophrenia, schizoaffective disorder, and generalized anxiety disorder (GAD) demonstrate divergent spectrums and share some symptoms, rendering their diagnoses complex. As a result, it is crucial to identify diagnostic criteria consistent with the patient's demonstration of observable symptoms and mental status examination results.

Similarly, clinicians should understand the complexities of schizophrenia and other psychotic disorders. For example, patients grappling with these illnesses can be uncooperative and demonstrate disorganized thoughts, irritability, suspicion, and hallucinations. Amidst these challenges, healthcare professionals have an ethical obligation to ensure and safeguard patient autonomy, justice, beneficence, and privacy. According to Bipeta (2019), healthcare professionals must obtain consent from patients before embarking on examinations and diagnoses. Also, it is ethical to involve patients and family members in the decision-making process to improve care plans and increase people's involvement in disease management interventions.

**References**

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