# NRNP 6650: Psychiatric Mental Health Nurse Practitioner Role I: Child and Adolescent

## Case Study: I am Feeling Like I'm Going Crazy

IDENTIFICATION: The patient is a 15-year-old male of Native American descent who resides at home with his mother and 6-year-old brother.

He is seen for the psychiatric evaluation on an inpatient crisis unit. Collateral information was obtained from the patient's mother.

CHIEF COMPLAINT: "I am feeling like I'm going crazy"

HISTORY OF CHIEF COMPLAINT: Patient reports that he intentionally cut his leg at school yesterday before gym class. He realized that he would not be able to participate in class because he could not control the bleeding of the cuts. He went to the nurse and she referred him to the ER for admission. The ER provider admitted him to the acute psychiatric unit as he was at risk of harming himself due to suicidal ideation. He reports that he harmed himself by cutting as he was feeling abandoned by his boyfriend. He states that he is not emotionally supportive. He reports that self-injurious behavior began 10 months ago, and he uses a disposable razor to cut his upper arm or forearm. He reports problems with sleep onset. He reports low self-esteem and low energy level. He endorsed a history of two prior suicide attempts by taking a palm-full of acetaminophen; the most recent attempt was 2 months ago. He did not report his attempt denies serious adverse effects. His last suicidal ideation due to pressure of getting good grades and low self-esteem. He used to participate in the school band but stopped attending rehearsals about 2 months ago because he was no longer interested.

Patient's mother expressed frustration and difficulty understanding why the patient treats her disrespectfully when she gives the patient everything the patient wants, such as clothing and money to go out with friends. The patient's mother acknowledged that she works a lot and is infrequently at home, but stated that when she tries to spend time with the patient and express interest in his life, the patient shuts her out or states that he does not have time to spend with her because she needs to finish his homework. Patient's mother additionally expresses confusion about why the patient behaves so differently than she did at that age, reporting that he was expected to be respectful and comply with her mother's requests.

PAST PSYCHIATRIC HISTORY: No prior psychotherapy or trials of psychiatric medication.

MEDICAL HISTORY: Multiple wounds noted on patient's right upper arm, which appear to be healing. No known allergies. No acute or chronic medication conditions. Review of systems is negative. Patient appears to be average height and weight. He denies any recent changes in weight.

HISTORY OF DRUG OR ALCOHOL ABUSE: No alcohol use. States that he tried marijuana once 3 months ago. Denies use of any other illicit substances.

FAMILY HISTORY: Patient's parents were both born in the US. The patient was born in the United States. Patient reports that her parents got divorced when she was 5 years old. His father currently lives in Los Angeles and he has minimal contact with him.  Family history of mental illness denied.

Personal History

Perinatal: No known perinatal complications.

Childhood/Adolescence: The patient attends the local private high school where he used to get good grades in her classes, mostly As and Bs; however, he states her grades have declined recently and she is in danger of failing several classes. He reports recent loss of close friends due to interpersonal conflict. He identifies as pansexual and is currently dating a male peer. They have been dating for the past 2 months. He states that she would like to have sex with him, but he is not ready yet.

TRAUMA/ABUSE HISTORY: Patient denies trauma or abuse history.

Mental Status Examination

Appearance: Good grooming and hygiene. Cooperative.

Behavior and psychomotor activity: no increased or decreased psychomotor agitation. Sits quietly in chair.

Consciousness: Alert.

Orientation: To person, place, time.

Memory: Not formally assessed but appears to be intact based on patient's ability to relate details from the past.

Concentration and attention: Not formally assessed, but no indication of abnormalities.

Visuospatial ability: Not formally assessed.

Abstract thought: Intact.

Intellectual functioning: Appears to be above average.

Speech and language: Quiet volume, regular rate and rhythm.

Perceptions: No evidence of perceptual disturbance. Patient denies auditory and visual hallucinations.

Thought processes: Coherent and goal directed.

Thought content: Distressed about peer relationships.

Suicidality or homicidality:

Denies current suicidal or homicidal ideation; however, reports suicidal thoughts yesterday on the way to the hospital.

Mood: "Depressed"

Affect: Constricted.

Impulse control: Limited as evidenced by impulsive self-injurious behavior.

Judgment/Insight/Reliability: Poor/Poor/Fair