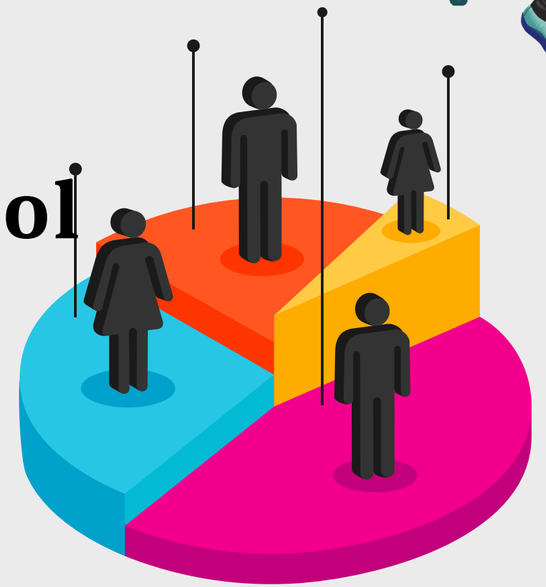
Case study

prepared: Bzhwen araz

Demographic data

Name: B.M
Gender: Female
Age: 42 years
Education level : secondary school
Relgion: Islam
Ethnicity: kurdish
Date of the interview: 5/1/2025



source of Referral

sent from private clinic

Chief Complain and Duration

According to the her sister:
Abnormal thought for about 6 days duration.

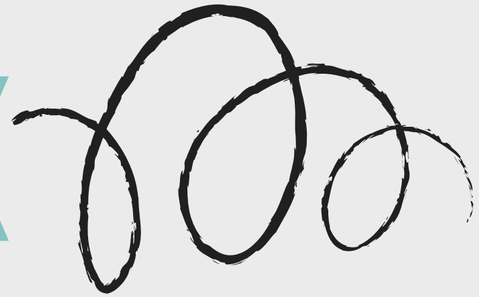
History of present illness

When I wanted to take history from the patient , she would pray and then sit down introduced myself and wanted to ask questions only say her name then she refused to talk to me and pretended to be sleep.
so her sister answered me.

History of present illness

According to her sister . Her condition back to age of eighteen , when she hated students, school and teachers. she was not good in his lessons, she refused to go to school.

History of present illness



After dropping out of school, when her brothers and sisters went to school and he was alone at home with her parents, she had doubts and bad thoughts. She told his family that our neighbor wanted to kill me and she was worried she looked at the doors several times to see if they were closed and repeated this several times. She said he was blind while his eyesight was fine.

History of present illness

she was aggressive with her neighbors and hated them and sometimes beat her mother. she didn't sleep well. her family takes her to the psychiatrist clinic and doctor prescribed medications.

History of present illness

However, she was admitted to hospital at the age of 20 for non-compliance with medication and was admitted again in 2018 at age of 35 for aggressive behavior.

History of present illness

This is the last time since her father died (Their father has been dead for a month) she has been in a very bad condition for the last six days. She has abnormal thinking and talked nonsense .

History of present illness

she has spoken for herself. she said they would put poison in the drink and kill me. She has always thought about his father. She was angry with the people and did not respond their questions . sometimes she became anger without any reason and beat her mother and siblings. She said that she heard noises where there were no any noises . She hasn’t slept for two days , appetite is good.

Past psychiatric hx

- Previous several time visited psychiatrist and she admitted three times to this hospital
- have prescribed drugs for mental illness
- No history of ECT
- No suicidal attempt and idea
- No history of substance abuse.

Medico-Surgical Hx

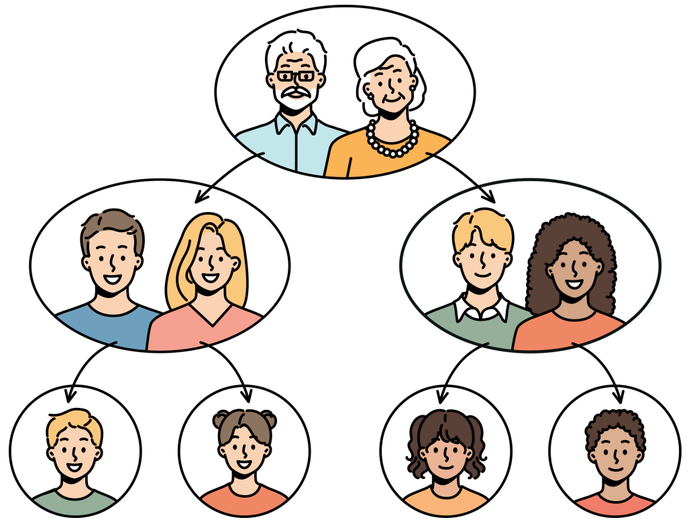
No have any medical surgical history .

No history of blood transfusion and allergies.

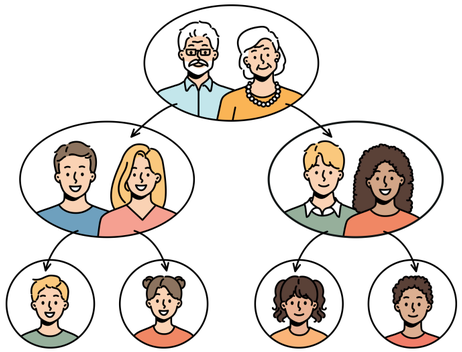
Family history

Her mother is alive, she is 63 years old, she is house wife, illiterate and she hasn’t medical disease (DMS and HTN).

His father is dyeing in (73 years old), has HTN and DM.



Family history

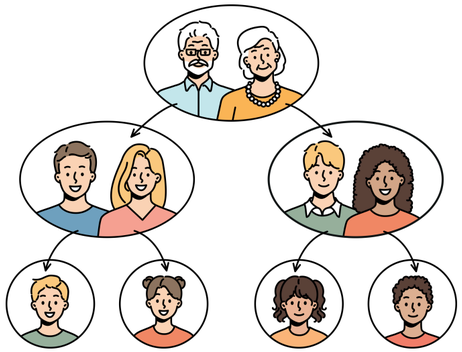


she is the 2nd in her family, she has 3 brothers and 3 sisters.

she has bad socioeconomic family, some of them educated.

her family were cooperative with her condition , most of them try to get better and love her. But she gets angry with them , Sometim she beats his mother.

Family history



Her mother and father have not mental illness.

One of his brothers has mental problem and taking psychiatric medication and have been admitted to a mental hospital once. But now they are in good condition . she doesn't know what his brothers' mental problems are.

Personal Hx.

Perinatal: her older sister said she delivered by NVD and her sister did not know if she had history of jaundice or cyanosis or any other diseases.

childhood:

normal growth milestones. No history of trauma and fear.

Personal Hx.

school :

she started school at age 6 years , she had not relationship with her surrounding and student have not any friend.!

she is bad in her lessons

Personal Hx.

adolescence:

she had abnormal thoughts to people. And sometimes had aggressive behaviors. She was not sociable not talk with people . note love guests come to their home .

Personal Hx.

psychosexual Hx:

she was not married.

Personal Hx.

Forensics hx.

no problem with low.

substance abuse Hx.

no history of any type of substance abuse.

mental state examination

She looked normal her appearance was tidy . Her clothes was good and clean . poor speech pattern and Poor eye contact she close eye ans she did not watching us

mental state examination

Her gait and movement was normal.

mental state examination

Mood affect:

Euthymic

thought disorder:

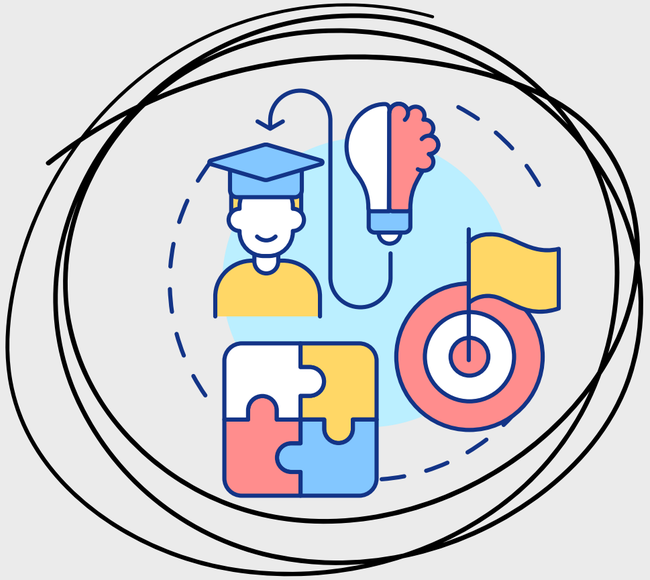
Delusions of persecution , compulsion, hypochondriasis and poverty .

perceptual disorder:

auditory hallucinations.

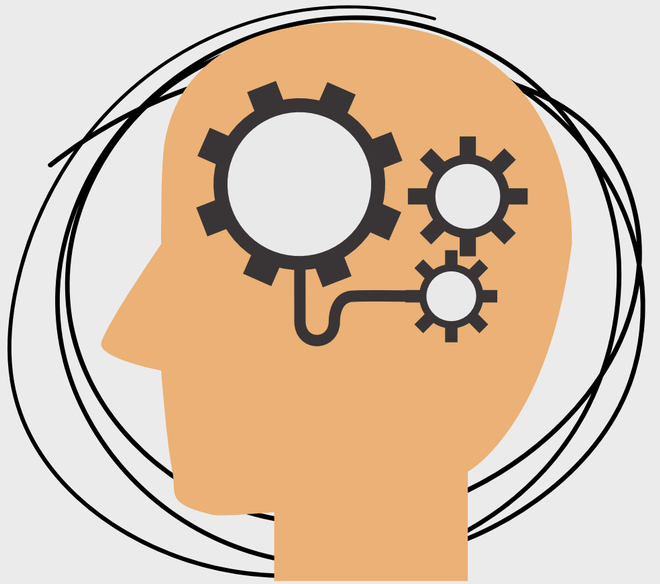
Sensorium and cognition

According to her sister
the patient was oriented to person and place but note to time.
she has poor attention and concentratin.



Sensorium and cognition

She has poor short term memory, long term memory is good .
her intelligence was poor.
she was poor adjustment and self confidence and poor judgment.



she has no insight.

Risk assessment

He generally had no dangerous behavior, only sometimes he was angry with his brothers and sisters and his mother, and sometimes she beat her

Formulation

Demographic data;
B.M. 40 years old female , not married, Kurdish, Muslim, from Rania,
presented with abnormal thought for 6 days duration .

Formulation

DXX:

schizophrenia.

Formulation

Etiology;

predisposing factors:

Genetic history

low socioeconomic status

non sociable personality

precipitating factors:

her father died.

Formulation

Carbamazepine tab.	400 mg
olanzapine tab.	10 mg

Formulation

Prognosis

bad prognosis factor

because of genetic and poor socioeconomic status.

Nursing

Nursing Diagnosis and nursing interventions

Nursing diagnosis	Nursing intervention
Disturbed Thought Processes related to altered sensory perception (hallucinations) and delusional thinking.	• Be friendly and Create a structured and predictable environment to reduce confusion and anxiety. A calm setting helps minimize distractions and increases the patient's ability to focus. • Establish trust and Use clear, simple, and direct language to facilitate understanding. Avoid complex sentences or abstract concepts. • Help the patient organize their thoughts by allowing time for them to express themselves. • Provide comfort and reassurance, as patients with disturbed thought processes can often feel anxious, fearful, or overwhelmed. • Show empathy and listen actively, allowing them to express themselves without judgment. Be calm and respectful.

Nursing diagnosis	Nursing intervention
Aggressive behavior related to her condition and environmental triggers.	1. promote therapeutic relationships with the patient this is provide feeling of safety and respect to the patient. 2. Assessing the patent aggregation such as determine specific phrases, food and situation which triggers her condition. 3. speaking calm and quite with the patient avoid raising voice and speaking quickly and clearly. 4. maintain suitable environment and avoid the patient any trigger like any food or event , music and word which trigger the patient . 5. encourage the patient coping strategies like positive distraction and relaxation technique. 6. during aggression maintain patient and others safety .show empathy and listen to the patient. Use soft void tone. Showing understanding her condition and help her .

Nursing diagnosis	Nursing intervention
Sleep disturbance related to psychotic symptoms and medication side effects.	1 assess sleep routine, sleep history, sleep environmen what the patient do before sleeping including eating an drinking. 2. provide regular sleep routine, regulate the patient sl awake routine. Ask the patient to wake up and go to be regular time . 3. provide quite sleep environment with comfort dark a temperature. Reduce nose and uncomfortable light. 4. the patient to avoid drinking caffeine, nicotine, snack hours before sleeping . 5. If appropriate teach the patient relaxation technique help falling asleep including deep breathing, muscle relaxation.

Nursing diagnosis	Nursing intervention
Poor speech patterns related to though disturbances	1. Assessing the patient speech patterns and communication skills . 2. reduce interruption and distractions to help focus and concentration.. 3. allow space during talking and be patient when the patient are blocked helped the patient by comparative with her. 4. speak slowly and gif the patient fully explanation 5. provide sense of trust, love and safety because the patient may fear and don’t love you to give explanation .

Nursing diagnosis	Nursing intervention
Impaired Social Interaction related to impaired communication and withdrawal.	Assess for any factors that may inhibit social interaction Show active listening and offer genuine support, ensuring the patient feels heard and understood. being consistent, empathetic, and non-judgmental. Trust is crucial for patients Initially, guide the patient to engage in low-stress, structured social settings (such as group therapy or supported social activities). These controlled environments can help ease anxiety and encourage positive interactions. Gradually increase social interaction opportunities, helping the patient feel more comfortable interacting with peers and staff.

Nursing diagnosis	Nursing intervention
obsession (check and recheck) related to the condition and delusional thinking	Assessment and Monitor frequency and intensity of the behavior Identify triggers for the obsessive behavior, such as specific thoughts or situations that lead the patient to check or recheck things. Create a predictable environment with clear routines, which can reduce anxiety and help reduce engage in obsessive checking. By cooperative with family set achievable goals for gradually reducing the frequency of checking behaviors. Start with manageable targets for example Check the door only once. encourage the o modify the patient’s thinking patterns by reframing obsessive thoughts and reducing the need to act on them.

Nursing diagnosis	Nursing intervention
Deficit knowledge regarding to disease progresses and treatment	1 Assess patient and family level of knowledge and information about the disease process and treatment . 2 identify the disease to the patient´s family and copying strategies to deal with the condition. 3 encourage the family to colse moniter their patient and respect him 4 inform the patient and fmily about importnce of medication and compliance of medication

Thank you