NRNP/PRAC 6665 & 6675 Comprehensive Focused SOAP Psychiatric Evaluation Template

Learning Objectives

- Identify and understand the challenges of assessing, diagnosing, and formulating a treatment plan for a psychiatric patient with underlying medical conditions.
- State and describe the symptoms of pseudobulbar affect.
- Analyze and differentiate the diagnosis of adjustment disorder and post-traumatic stress disorder (PTSD).
- Apply your knowledge and compare what you would do differently for the treatment plan for the patient in the case study.

Subjective:

CC (chief complaint): "Can I have some Xanax please"

HPI: GH is a 26-year-old Caucasian male who presents to the office with his mother for medication management follow-up for adjustment disorder with anxiety, major depressive disorder (MDD) in partial remission, and pseudobulbar affect (PBA). He has a history of attempted suicide in 2018 by driving his car off a bridge, resulting in a traumatic brain injury and blindness in both eyes. He depends on his parents for care and has significant impairment in social and occupational functioning. His symptoms include restlessness, irritability, inability to concentrate, and insomnia, as reported by GH and confirmed by his mother. He eats excessive calories from junk food out of boredom and a lack of interest in activities. As a result, GH has gained significant weight and become obese since the suicide attempt. During conversations, he frequently has loud outbursts of laughing and making inappropriate jokes when asked questions. He denies delusional thoughts, auditory hallucinations, and suicidal or homicidal ideations.

Substance Current Use: GH does not currently use but has history of alcohol, cannabis, and ampthetamine abuse before suicide attempt.

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Medical History:

- **Current medications and medication trials**: Current medications include Lexapro 10mg QD (anxiety), Topomax 50mg BID (anxiety and to reduce appetite), Neudexta 1 capsule BID (pseudobulbar affect), and Ativan 0.5mg BID PRN (for severe anxiety-mother controls when given). Medication trials: Wellbutrin-increased anxiety and possibly appetite, Abilify-weight gain, Cymbalta-ankle swelling, Trazadone, Hydroxyzine, Amitryptiline, and Nortriptyline-ineffective for sleep
- **Allergies**: No report of food and drug allergies
- **Reproductive Hx**: Single, no children
- **Past psychiatric history**: GH has been going to Benhaven Counseling for medication management and psychotherapy since April 2022.
- **Psychotherapy or previous psychiatric diagnosis:** No previous diagnosis or psychotherapy history are listed.
- **Family psychiatric/substance use:** Unknown, patient was adopted as an infant from Russia.

Psychosocial History: GH lives with both parents and a 28-year-old biologically unrelated brother who is also adopted from Russia. They have always lived in Brecksville, Ohio, a suburb of Cleveland, Ohio. According to his mother, He always complains about his older brother, and they often argue. He graduated high school, has no college, cannot work because of disability, and collects Supplemental Security Income (SSI). GH has been dependent on his parents for care since debilitating traumatic brain injury and blindness five years ago. After his car accident, he had reconstructive facial surgery, extensive rehabilitation, and spent over six months in hospital.

He has no hobbies and is constantly preoccupied with eating fast food. He does not currently have a history or a past of legal issues.

ROS:

- GENERAL: No weight gain, fever, chills, or weakness.
- HEENT: Blind in both eyes, mild deformity and scarring of left eye, Reports no hearing loss, sneezing, congestion, runny nose, or sore throat.
- SKIN: erythema on bilateral ankles
- CARDIOVASCULAR: Reports no chest pain, chest pressure, or chest discomfort. Reports no palpitations or edema.
- RESPIRATORY: Short of breath after walking, No cough, or sputum.
- GASTROINTESTINAL: Reports no nausea, vomiting, or diarrhea. Reports no abdominal pain or blood in stool.
- GENITOURINARY: Report no painful urination, polyuria or iurinary frequency.
- NEUROLOGICAL: Reports no headaches, dizziness, syncope, paralysis, ataxia, numbess, or tingling in the extremeties. No change in bowel or bladder control.
- MUSCULOSKELETAL: Walks with assistance of cane due to blindness, no reports of back pain or stiffness.
- HEMATOLOGIC: No anemia, bleeding, or bruising.
- LYMPHATICS: No enlarged nodes. No history of splenectomy.
- ENDOCRINOLOGIC: No reports of sweating, cold, or heat intolerance. No polyuria or polydipsia. Positive for nocutnal enuresis.

Objective:

Vital signs: No vital signs performed with this visit. Should have BMI assessed and monitored.

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Diagnostic results: No diagnostic test results.

Assessment:

Mental Status Examination: The patient is a 26-year-old Caucasian male who looks disheveled, is tall, obese, wearing a ballcap, and has scarring and mild deformity of the left eye. His gait is unsteady, and he walks with the assistance of a cane and direction from his mother. His behavior is oppositional, and he often answers questions with sarcasm. He has sporadic loud outbursts, laughing and making inappropriate jokes during conversations. His affect is labile, and his mood is anxious. He does not make eye contact due to his blindness, and his language is sometimes inappropriate (swearing). His speech is tangential and loud, with uncontrolled outbursts. He denies delusional thoughts and auditory hallucinations. His attention requires redirection, and his remote memory is fair. His thought process is illogical, and his intelligence is average. His judgment and insight are poor. His thought content is obsessive, and he is constantly referring to eating. He is orientated to person, place, time, and situation. He denies suicidal and homicidal ideations.

Diagnostic Impression:

Diagnosis one: Adjustment Disorder with Anxiety

The primary diagnosis that GH is being treated for at this time is adjustment disorder with anxiety. The stressor of adjusting to the challenges of becoming blind and having a traumatic brain injury has caused emotional and behavioral symptoms as described in the DSM5-TR under diagnostic criteria A (American Psychiatric Association, 2022). He also has impairment in social and occupational functioning and the capability to care for himself as listed under criteria B (APA, 2022). For criteria C, his symptoms do not fully meet the criteria of another mental disorder or are an exacerbation of another mental condition (APA, 2022). The

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symptoms are not caused nor represent normal bereavement as described for diagnostic criteria D. However, according to diagnostic criteria E, the symptoms do not last longer than six months, but GH has had the diagnosis for over a year. So maybe a more appropriate diagnosis should be adjustment disorder unspecified with anxiety or post-traumatic stress disorder (PTSD). According to one article, the main difference between adjustment disorder and PTSD is the level of stress intensity of the event, and adjustment disorder is usually caused by life stressors; divorce, disability, illness, relocation or financial problems (Zelviene & Kazlauskas, 2018). One study concluded that patients who had symptoms from a traumatic event lasting longer than three months were 2.67 more likely to develop PTSD, MDD, and GAD (O'Donnell et al., 2019). His predominant mood is anxious, which is why anxiety is specified in his diagnosis.

Diagnosis two: Major Neurocognitive Disorder (NCD) due to TBI

GH meets the differential diagnosis in the DSM5-TR for having NCD according to the diagnostic criteria:

- A significant cognitive decline in several cognitive domains.
- The deficits interfere with independence in everyday activities.
- Cognitive deficits are not in the context of delirium.
- Another mental disorder does not better explain cognitive deficits (APA, 2022).

Another defining feature is a known history of TBI following his car accident, with neurocognitive deficits immediately occurring after the injury. GH also presents with PBA affect, a condition with mood incongruent, short involuntary episodes of emotional crying or laughing common in patients with TBI (Kerkere et al., 2022). His episodes consist of loud, sporadic, inappropriate jokes with laughter.

Diagnosis three: PTSD

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Another diagnosis to consider in the case study is PTSD. GH has experienced a traumatic event that has left him disabled and has caused prolonged psychological distress. A review of the pathology and treatment of TBI and PTSD indicates both diagnoses commonly coexist and share similar symptoms of cognition impairment, irritability, sleep disturbances, and anxiety (Monsour et al., 2022). His symptoms have lasted longer than one month, as described under the diagnostic criteria for PTSD. During the short medication review follow-up appointments experienced with GH, his symptoms do not fully align with the criteria for PTSD in the DSM5-TR. Therefore, the diagnosis would not be accurate at this time.

Case Formulation and Treatment Plan:

GH has been a patient with Benhaven Counseling for over a year and receives pharmacological management and weekly psychotherapy sessions. He is currently treated for symptoms associated with adjustment disorder with anxiety, MDD in partial remission, and pseudobulbar affect. The main objectives in the treatment for GH are to decrease symptoms of anxiety and insomnia, better control of PBA, and weight control.

Continue pharmacological management with PMHNP and routine medication follow-up reviews

- Lexapro 10mg QD (anxiety)
- Topomax 50mg BID (anxiety and to reduce appetite)
- Neudexta 1 capsule BID (pseudobulbar affect)
- Ativan 0.5mg BID PRN (for severe anxiety and sleep-mother controls when given)

Continue weekly psychotherapy sessions with a licensed therapist.

- CBT weekly sessions to help decrease symptoms of anxiety and depression by teaching coping skills, overcoming problematic thoughts, and processing traumatic memories.

The treatment plan also includes psychoeducation provided by both the therapist and PMHNP.

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- Continue to explain the diagnoses, causes, symptoms, and treatment.
- Continue to encourage the mother to participate and be involved in the treatment plan.
- Explain techniques for good sleep hygiene.
- Teach and encourage healthy eating habits, exercise (for weight control), and promote social activities.

Nonpharmacologic treatments and Alternative Therapies

- Respite Care provides temporary relief for caregivers to help them maintain their role as primary caregivers (Min et al., 2020).
- Music therapy-reduce anxiety
- Massage-reduce anxiety
- Pet therapy service dog to provide guidance, safety, confidence, and companionship

Discuss with the mother and GH the treatment plan and answer questions or concerns that they may have. Provide supportive and active listening. Verify verbal understanding of the need for psychotherapy and pharmacological treatment. Ensure they are agreeable with the treatment plan and have consent from GH and the mother.

Make an appointment for a follow-up in four weeks with PMHNP.

Reflection Notes

In reflection of the case study, GH has several factors that complicate his diagnosis, assessment, and treatment plan. His attempted suicide resulted in a TBI, blindness, and becoming dependent on his parents for care. He also deals with the complications of pseudobulbar affect, insomnia, obesity, anxiety, and depression. GH can be a challenge to assess because of his TBI and PBA, and his mother is often relied upon for information regarding his symptoms and

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effectiveness of treatment. I believe his primary diagnosis needs to be reevaluated and possibly changed to PTSD according to the duration of his symptoms as described in the DSM5-TR.

One major problem that GH struggles with is insomnia. He has tried multiple medications that have not helped. However, there is one medication on the market that GH may benefit from called Heltioz (Tasimelteon), but his insurance company rejects it. The drug is a safe and efficacious treatment option for blind patients who suffer from a non-24-hour sleep–wake disorder (N24SWD) (Yuhas, 2022). Although Heltioz is approved by the Food and Drug Administration (FDA) for treating N24SWD, it is only available as a brand name, making the drug very expensive and why his insurance will not cover it. Insurance rejection of medications is a primary example of an ethical dilemma in the pharmacological management of patients with medical and psychiatric disorders.

Discussion Questions

- Do you have any other ideas that may be helpful in the treatment plan for the patient presented in the case study?
- Have you had a similar experience in treating a patient with underlying disabilities as described in the scenario presented?
- The patient attempted to commit suicide when he was only 20 years old, and resulted in devastating disabilities. As psychiatric nurse practitioners, how can we get involved in preventing suicide in young adults and adolescents, the leading cause of death among young people in the United States (US Department of Health and Human Services, 2023)?

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