

Week 4: Complex Case Study Presentation

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PRAC 6675: PMHNP Care Across the Lifespan II

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Subjective:

Chief Complaint: "My family thinks I'm getting worse again. My coworkers are trying to kill me, but I know what I saw. I am not going back to work."

HPI:

VC is a 34-year-old male Army veteran who presents as a new patient accompanied by family members for worsening psychosis, paranoia, and manic symptoms. The patient has a psychiatric history significant for Bipolar I Disorder with psychotic features, Post-Traumatic Stress Disorder (PTSD), and Attention-Deficit/Hyperactivity Disorder (ADHD). Family reports a recent exacerbation of psychotic symptoms over the past week, particularly following regular use of prescribed Adderall. Over the weekend, the patient became increasingly paranoid and developed persecutory delusions, believing his coworkers were planning to kill him and his parents. He also reported believing that local law enforcement was involved in the conspiracy and therefore refused to contact the police for assistance.

According to family members, the patient missed work on Monday due to worsening psychiatric symptoms and exhibited increased agitation, decreased sleep, racing thoughts, and grandiosity consistent with a hypomanic to manic episode. Family members expressed concerns regarding medication adherence, suspecting that the patient may be taking Adderall consistently while inconsistently taking Lamictal and Olanzapine. The patient acknowledged that stimulant medication makes him feel energized and productive and initially resisted recommendations to discontinue Adderall, stating, "It's the only thing that works for me" and "I feel better when I take it." After extensive psychoeducation regarding stimulant-induced psychosis and mood destabilization in Bipolar Disorder, the patient agreed to discontinue Adderall and trial a non-stimulant alternative.

Substance Current Use:

- Denies alcohol use.
- Smokes approximately half a pack of cigarettes daily.
- Reports ongoing marijuana use daily

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- Denies other illicit substance use.

Psychiatric History: Post Traumatic Stress Disorder (PTSD), Bipolar I Disorder with psychotic features, Attention Deficit Hyperactivity Disorder (ADHD), Cannabis Use Disorder, Alcohol Use Disorder, and Substance Use Disorder (Cocaine).

Medical History: History of L5-S1 discectomy, Pancreatitis.

Current Medications:

- Adderall 15 mg PO BID (discontinued).
- Lamotrigine (Lamictal) 100 mg PO BID.
- Olanzapine 10 mg PO daily.
- Guanfacine ER (Intuniv) 2 mg PO daily (newly prescribed).

Allergies: No known drug allergies reported.

Reproductive Hx: 34-year-old male, currently divorced. No reproductive concerns reported.

Review Of Systems (ROS)

GENERAL: Reports decreased sleep, increased energy, racing thoughts, irritability, and worsening paranoia. Denies fever, chills, or recent illness.

HEENT: Denies visual changes, hearing loss, headaches, or dizziness.

SKIN: Denies rashes, lesions, or skin abnormalities.

CARDIOVASCULAR: Denies any chest pain or palpitations. Recent EKG demonstrates a prolonged QT interval and sinus tachycardia with a heart rate greater than 108 bpm.

RESPIRATORY: Denies cough, wheezing, or shortness of breath.

GASTROINTESTINAL: Denies nausea, vomiting, diarrhea, constipation, or abdominal pain.

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GENITOURINARY: Denies urinary symptoms.

NEUROLOGICAL: Denies seizures, loss of consciousness, weakness, or numbness.

MUSCULOSKELETAL: History of L5-S1 discectomy. No current musculoskeletal complaints, denies any current back pain

HEMATOLOGIC: Denies bleeding disorders or easy bruising.

LYMPHATICS: Denies lymphadenopathy.

ENDOCRINOLOGIC: Denies heat intolerance, cold intolerance, or endocrine disorders.

Objective Data:

Patient presents accompanied by family members. Appears mildly disheveled with increased psychomotor activity. Speech is pressured at times. Thought content notable for persecutory delusions involving coworkers and law enforcement. Insight is significantly impaired regarding current psychotic symptoms. Family collateral information supports worsening paranoia and mood instability associated with stimulant use (Gallagher et al., 2022). Patient initially resistant to medication changes but became more agreeable following psychoeducation.

Diagnostic Results:

- EKG reviewed from the previous week: Sinus tachycardia (HR >100 bpm) and prolonged QT interval.
- No acute laboratory abnormalities reported.
- Family reports significant recent psychotic and manic symptoms.

Assessment

Mental Status Examination:

VC is a 34-year-old male who appears to be of stated age and is casually dressed. Hygiene is fair. He is alert and oriented to person, place, time, and situation. Behavior is

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cooperative but intermittently guarded. Eye contact is variable. Speech is pressured with an increased rate but normal volume. Mood is described as "fine," though affect appears expansive, anxious, and mildly irritable. Thought processes are circumstantial with occasional tangentiality. Thought content is notable for persecutory delusions involving coworkers and law enforcement. No current auditory or visual hallucinations are reported, although psychotic thought content is present. Insight is poor as the patient minimizes the relationship between stimulant use and symptom exacerbation. Judgment is impaired. Attention and concentration are mildly impaired. Memory is grossly intact. He denies suicidal ideation, homicidal ideation, intent, or plan.

Diagnostic Impression

Primary Diagnosis: F15.959 Stimulant-Induced Psychotic Disorder (Amphetamine-Induced Psychosis)

The primary diagnosis for VC is Stimulant-Induced Psychotic Disorder, as there is a clear temporal relationship between the use of Adderall and the onset or worsening of psychotic symptoms. The patient and family report that psychotic symptoms, including paranoia, persecutory delusions, suspiciousness, and manic behaviors, become significantly more pronounced while taking Adderall (Bouthillier et al., 2026). Specifically, the patient developed fixed delusional beliefs that his coworkers were planning to kill him and his parents and that law enforcement was involved in a conspiracy against him. These symptoms resulted in functional impairment, including missing work and increasing conflict with family members (Jangra et al., 2024).

Several factors support stimulant-induced psychosis as the primary diagnosis according to the DSM-5 TR. First, the patient's psychotic symptoms appear to worsen during periods of stimulant use and improve when stimulants are withheld. Second, the patient demonstrates limited adherence to his prescribed mood stabilizer (Lamotrigine) and antipsychotic medication (Olanzapine) while consistently taking Adderall, further increasing the risk of stimulant-induced psychiatric decompensation (Jangra et al., 2024). Third, amphetamine-based medications are well documented to precipitate psychosis, paranoia, mania, and behavioral dysregulation, particularly in individuals with pre-existing mood disorders such as Bipolar I Disorder. The

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patient's insistence that Adderall is "the only thing that works" despite significant adverse psychiatric consequences further supports the role of stimulant use in perpetuating his symptoms.

The clinical presentation is consistent with amphetamine-induced psychosis, characterized by persecutory delusions, impaired reality testing, paranoia, agitation, mood elevation, decreased need for sleep, and functional decline. Additionally, the recent EKG findings of sinus tachycardia and prolonged QT interval raise concerns regarding the physiologic effects of stimulant therapy and support the decision to discontinue Adderall immediately. Given the severity of psychotic symptoms, the presence of poor insight, and the potential risk for further deterioration, close monitoring and consideration of psychiatric hospitalization are warranted if symptoms do not improve following stimulant discontinuation (Janjra et al., 2024).

Differential Diagnosis #1: F31.2 Bipolar I Disorder, Current Episode Manic, Severe With Psychotic Features

Bipolar I Disorder remains a significant differential diagnosis and likely represents an underlying chronic psychiatric condition. The patient has a documented history of Bipolar Disorder and currently exhibits symptoms consistent with mania, including decreased need for sleep, increased energy, pressured speech, racing thoughts, irritability, poor judgment, and psychotic features. However, the timing and severity of the current episode strongly suggest that stimulant use is the precipitating factor responsible for triggering and exacerbating the manic and psychotic symptoms (Tondo et al., 2022). Therefore, Bipolar I Disorder is considered a secondary diagnosis contributing to vulnerability rather than the primary cause of the current presentation. The patient's history indicates that periods of stability are more likely when stimulants are avoided and mood-stabilizing medications are consistently taken (Tondo et al., 2022).

Differential Diagnosis #2: F43.10 Post-Traumatic Stress Disorder (PTSD)

VC has a history of military service and PTSD, which may contribute to chronic hypervigilance, mistrust of others, anxiety, sleep disturbances, and heightened threat perception. PTSD symptoms may partially explain his suspiciousness and tendency to perceive danger in his environment. However, PTSD alone does not adequately explain the severity of his persecutory

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delusions, manic symptoms, impaired reality testing, or psychotic thought content. While PTSD remains an important comorbid condition requiring ongoing treatment, it does not account for the acute psychiatric deterioration observed during periods of stimulant use.

Differential Diagnosis #3:

F90.2 Attention-Deficit/Hyperactivity Disorder, Combined Presentation

The patient has a longstanding diagnosis of ADHD and reports significant benefit from stimulant medications in terms of concentration, productivity, and focus. However, ADHD symptoms such as distractibility, impulsivity, and inattention do not explain the presence of psychosis, paranoia, grandiosity, or manic behaviors. Furthermore, the treatment of ADHD with stimulant medications appears to have contributed to psychiatric destabilization. Consequently, while ADHD remains an active diagnosis requiring treatment, it is not the primary cause of the current clinical presentation. A transition to non-stimulant treatment with Guanfacine ER is clinically appropriate given the patient's vulnerability to stimulant-induced psychosis and mood destabilization.

Reflections

If I were able to conduct this encounter again, I would further explore medication adherence patterns, obtain additional collateral information regarding the timeline of stimulant use and symptom escalation, and perform a more detailed assessment of psychotic symptoms, including possible hallucinations. Given the severity of paranoia and impaired insight, assessment of access to weapons and safety planning would be prioritized (Gallagher et al., 2022).

Legal and ethical considerations include balancing patient autonomy with concerns regarding potential deterioration and the need for involuntary psychiatric evaluation should symptoms worsen. Health promotion should focus on smoking cessation, marijuana cessation, medication adherence, sleep hygiene, and routine medical follow-up. Early intervention is

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critical to reduce the risk of hospitalization, occupational impairment, and worsening psychosis (Gallagher et al., 2022).

Case Formulation and Treatment Plan

VC is a 34-year-old Army veteran with Bipolar I Disorder with psychotic features, PTSD, and ADHD who presents with worsening stimulant-associated psychosis and manic symptoms. Current symptoms appear exacerbated by ongoing Adderall use in the setting of Bipolar Disorder and questionable adherence to mood stabilizing and antipsychotic medications. Family collateral information raises significant concern regarding medication compliance and progressive psychiatric decompensation (Gallagher et al., 2022).

Treatment Plan & Medication Management

- Discontinue Adderall immediately.
- Initiate Guanfacine ER 2 mg PO daily for ADHD symptoms.
- Continue Lamotrigine 100 mg PO BID.
- Continue Olanzapine 10 mg PO daily.
- Monitor adherence closely.

Psychotherapy:

Individual psychotherapy will be utilized to address VC's mood instability, psychotic symptoms, emotional dysregulation, and trauma-related symptoms. Dialectical Behavior Therapy (DBT) interventions will be incorporated to help VC develop skills in emotional regulation, distress tolerance, mindfulness, and interpersonal effectiveness. These skills are particularly important given his history of bipolar disorder, impulsivity, poor judgment during manic episodes, and difficulty managing intense emotions (Goldstein et al., 2024). DBT can assist him in recognizing early warning signs of mood destabilization, improving coping strategies, and reducing behaviors that may place him at risk during periods of mania or psychosis. (Tondo et al., 2022).

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Additionally, VC is already enrolled in trauma-focused therapy, which should continue once his psychotic symptoms have stabilized. Trauma-focused therapy will help him process traumatic military experiences, reduce PTSD symptoms such as hypervigilance and intrusive memories, challenge trauma-related cognitive distortions, and develop healthier coping mechanisms. Combining DBT with trauma-focused treatment will provide a comprehensive approach that addresses both his emotional dysregulation and unresolved trauma while supporting long-term psychiatric stability and improved overall functioning (Goldstein et al., 2024).

Safety Planning

- Monitor closely for worsening psychosis or mania.
- Recommend inpatient psychiatric admission if psychotic symptoms persist beyond Wednesday or worsen (Wei et al., 2022).
- Emergency evaluation if the patient becomes a danger to self or others.

Long-Term Management

- Plan to consider transitioning to a long-acting injectable antipsychotic due to medication adherence concerns.
- Potential options include Invega Sustenna or Haloperidol Decanoate (Wei et al., 2022).
- Repeat EKG monitoring due to prolonged QT interval and psychotropic medication use.

Follow-Up

- Follow-up within 1 week.
- Reassess psychosis, mood stability, medication adherence, sleep, occupational functioning, and safety concerns.
- Family education included calling 911 and taking the patient to the closest Emergency room if the patient become a danger to himself or others.

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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: _____

A handwritten signature in blue ink, appearing to read "Chedhya", is written over a horizontal line.

Date: 6/17/2026