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Psychopathology and Diagnostic Reasoning

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01/25/2023

Subjective:

CC (chief complaint): "Referred by the VA for psychiatric services."

HPI: S.R is a 75-year-old white male presents for initial psychiatric evaluation. Patient is a veteran who was previously seen and serviced by the VA. He served the army for 35 years. He has 3 deployments during his active-duty time. He has history of PTSD, anxiety, and stress. He states currently taking trazodone 50mg PO, QHS, Lexapro 20mg PO, QAM. He states having trauma from his service in the army. He reports having flashbacks and nightmares at night. He states nightmares are related to his deployments. Patient did not want to disclose the traumatic event. He states wife had to wake him up from nightmares. He has bad night sweats at night. Patient rates his depression 7/10 on a 0-10 scale with 10 being the worst. He states depression is high for most of the day. He reports sleeping 4-5 hours of sleep. He has trouble falling asleep and states waking up too early. He reports having vivid nightmares of his time in the army. Patient reports feelings of hopelessness and worthlessness. Patient reports feeling guilt. Patient reports energy is low. He reports feeling very tired during the day. Patient reports concentration is poor. Patient voices appetite is low. He reports losing 30 lb in 4 months. Patient denies any psychomotor changes. Patient reports praying to God to take him. He states having passive thoughts. He voices having irritable mood. He states being easily trigger by little things. He reports mood swings are constant. He reports being easily distracted. He reports impulsive behaviors as wanting to get on fights with random individuals. He reports having issues with his anger. Denies Grandiosity ideas. He reports flight of ideas. He reports activity level is fair. He has normal rate/rhythm/tone. He denies any current a/v hallucinations. He reports delusional thoughts. He states feeling as if people are looking at him. He reports thoughts are more related to his survival instincts. He states not liking to bottle his emotions and wants to express feelings. He has trouble expressing his emotions. He rates his anxiety 9/10 on a 0-10 scale with 10 being the worst. He reports feeling anxious when he gets at home. He reports anxiety gets worse when he is bored not doing anything.

Substance Use History: Patient denies any substance abuse. He reports being sober for many years. He reports last drink was 40 years ago. He reports history of taking hydrocodone for 2 months prescribed by a Doctor J.O from William Beaumont. He stated it was prescribed due to a work injury. He it has 2 months since his last dose. He states no longer taking any hydrocodone. Denies any histories of withdrawal complications from tremors, Delirium Tremens, or seizures.

Current Medications: Trazodone 50mg PO, QHS started on 03/2023

Lexapro 20mg PO, QAM for depression started 03/2023.

He denies using any OTC or homeopathic products.

Allergies: No known drug allergies. No known food allergies. No latex allergies.

Reproductive Hx: Patient did not disclose any reproductive hx.

ROS:

GENERAL: No weight loss, fever, chills, weakness, or fatigue.

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

SKIN: No rash or itching.

CARDIOVASCULAR: No chest pain, chest pressure, or chest discomfort. No palpitations or edema.

RESPIRATORY: No shortness of breath, cough, or sputum.

GASTROINTESTINAL: No anorexia, nausea, vomiting, or diarrhea. No abdominal pain or blood.

GENITOURINARY: Burning on urination, urgency, hesitancy, odor, odd color

NEUROLOGICAL: No headache, dizziness, syncope, paralysis, ataxia, numbness, or tingling in the extremities. No change in bowel or bladder control.

MUSCULOSKELETAL: No muscle, back pain, joint 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.

Objective:

Diagnostic results: TSH with reflex T4 to rule out any thyroid that may be affecting patient health as Graves; disease (Khouzam et al, 1991).

Assessment:

Mental Status Examination: He is a 75-year-old White American male who looks his stated age. He is cooperative with examiner and appropriate to situation. He is neatly groomed and clean, dressed appropriately. There is no evidence of any abnormal motor activity. His speech is clear, coherent, soft in tone and low in volume. His thought process is goal directed and logical. There is no evidence of looseness of association or flight of ideas. His mood is sad, and his affect is flat. He was distracted during assessment. He denies any auditory or visual hallucinations. There is no evidence of any delusional thinking. He denies any current suicidal or homicidal ideation. Cognitively, he is alert and oriented x 4. His recent and remote memory is intact. His concentration is fair. His insight is fair.

Diagnostic Impression: Examining the patient's symptoms and conduct. Post-traumatic stress disorder, major depressive disorder without psychotic features, and bipolar 2 disorder are all possibilities based on S.R symptoms. Therefore, these are the three alternative diagnoses for him.

Post-traumatic stress disorder: S.R is a Veteran who directly experiences traumatic events during his deployments (Smith et al., 2008). He states having nightmares related to his deployments. He states constantly being hypervigilant of other people and feels he will get attacked. Patients tend not to be in places with big crowds. The patient believes people can't be trusted. He reported feelings of guilt. The patient reports having irritable behavior and having angry outbursts. The patient states having these symptoms for years. S.R meets the criteria for post-traumatic stress disorder according to the DSM5-TR (American Psychiatric Association., 2022).

Major depressive disorder recurrent moderate without psychotic features: S.R has experienced 7 symptoms of Major depressive disorder. He has both a depressed mood and a loss of interest. S.R reported a depressed mood most of the day, rating depression 7/10. He states having insomnia and only getting 4 hours of sleep. He reported having a low appetite and losing weight. He reported worthless and guilt. He voiced having passive suicidal thoughts and no plan or intent during the assessment. He reports having poor concentration and fatigue (American Psychiatric Association., 2022). These clinical manifestations that S.R. presents are sufficient to diagnose S.R with major depressive disorder recurrent moderate without psychotic features. The patient does not present with any hallucinations or psychotic symptoms.

Bipolar 2 disorder: S.R has many symptoms of bipolar 2 disorder, including current or most recent episodes depressed. The patient has decreased need for sleep, only sleeping 4 hours. He reports a flight of ideas. He is easily distracted. The patient has 3 of the symptoms of a hypomanic episode. The patient stated having these symptoms most of the time, indicating that the symptoms do not come and go. Major depressive symptoms that the patient experience may also occur for a bipolar patient, which is why these diagnoses may be easily confused (Miola et al., 2023). According to the DSM5-TR the patient does not meet the criteria for a hypomanic episode, therefore not qualifying for bipolar 2 disorder (American Psychiatric Association, 2022). The diagnosis of bipolar 2 disorder is ruled out for this patient.

Reflection

I agree with my preceptor's diagnostic impression of the patient, that being PTSD and Major depressive disorder. The patient exhibits all the clinical manifestations of these diagnoses. I enjoyed how my preceptor was able to help me navigate through the assessment with the patient to differentiate the adequate symptoms to diagnose these disorders. I learned how veterans are prone to be diagnosed with PTSD but need to assess appropriately to see if there are other diagnoses. I could do things differently would ask more questions about the patient's PTSD. I would advice the patient to follow up with a therapist for psychotherapy due to a history of trauma. S.R reported medications were affordable, just not effective.

Case Formulation and Treatment Plan

Risks and benefits of medications are discussed including non- treatment. Potential side effects of medications discussed (be detailed in what side effects discussed). Informed client not to stop medication abruptly without discussing with providers. Instructed to call and report any adverse reactions. Discussed risk of medication with pregnancy/fetus, encouraged birth control, discussed if does become pregnant to inform provider as soon as possible. Discussed how some medications might decreased birth control pill, would need back up method (exclude for males).

Discussed risks of mixing medications with OTC drugs, herbal, alcohol/illegal drugs. Instructed to avoid this practice. Encouraged abstinence. Discussed how drugs/alcohol affect mental health, physical health, sleep architecture.

Initiation of: Sertraline 25mg PO QAM for depression
Start Trazodone 50mg PO QHS for sleep.

Referred patient to therapist services to learn ways to communicate and talk about trauma related to deployments.

I educated the patient that in my assessment the patient needs to continue/initiate prescribed medications, the possible consequences of not following recommended treatment including most serious ones, among others, risk of danger to self and others, risk of re-hospitalization, risk of suffering legal problems, and the risk of further deterioration of health that may lead to increased disability and death.

Patient was advised and acknowledged that in the event of any emergency, PATIENT OR A LOVED ONE would call 9-1-1and/or ENGLISH: 1-800-LIFENET (800-543-3638), OR ESPANOL LIFENET: 1-877-AYUDESE (877-293-3373).

Time allowed for questions and answers provided. Provided supportive listening. Client appeared to understand discussion. Client is amenable with this plan and agrees to follow treatment regimen as discussed.

Return to clinic:
Continued treatment is medically necessary to address chronic symptoms, improve functioning, and prevent the need for a higher level of care.

Follow up in 1 month.

References

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