Week 4: Complex Case Study Presentation

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PRAC 6675: PMHNP Care Across the Lifespan II

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

Objectives:

1. Understand the symptoms shared across various mental health disorders.
2. Synthesize data to create and prioritize a differential diagnosis list.
3. Apply a stepwise approach to adjust medication treatment plans.

Subjective

CC (chief complaint): "I feel depressed, and my medication no longer works."

HPI: TK is a 22-year-old white single female college dropout who presents with her mom for an initial evaluation referred by her therapist, citing a poor rapport with her last provider. She was diagnosed with depression, anxiety, and unspecified bipolar disorder by her previous provider, who prescribed Fluoxetine, then Sertraline, and Lamotrigine.

She reports feeling depressed and anxious since age 10, states her mood fluctuates daily, and rates her depression at 3/10 and anxiety at 8/10. When she is happy, she has bursts of energy, talkativeness, grandiosity, excessive spending, road rage, racing thoughts, poor focus and concentration, poor time concept, poor sleep, and reckless sexual behaviors. When depressed, she has stomachaches, headaches, low motivation, anhedonia, irritability, low frustration tolerance, temper outbursts with property destruction, crying spells, hopelessness, helplessness, self-harm activities (cutting her wrists, stomach, and hips), passive suicidal ideations (SI). At school, she frequently lost things, used to steal, had attention-seeking behaviors, got into fights, and had problems with authorities. The patient cannot keep meaningful relationships, is

opinionated, likes to control situations, and feels lonely even around people. She states her symptoms are triggered when things do not go her way. The patient was sexually abused at ages 7, 17, and 18 and witnessed her dad verbally and emotionally abuse her mom and other family members. She reports nightmares and vivid dreams about these traumatic events.

TK was raised by her parents, who divorced when she was nine, leading to a chaotic and confusing childhood for her and her younger sister, who is 20. She stays with her mom and sister and sees her dad weekly. Her mom had postpartum depression and undiagnosed ADHD, her dad has undiagnosed anger issues and an alcohol use disorder, and her sister has hypochondriasis. Her parents are employed, and help meet her financial needs. The patient graduated from high school and attended college for three years but dropped out in 2022, taking a medical leave of absence. She recently started working at Starbucks and says she cannot hold a job for long because she hates working and staying in one place for too long. Her hobbies are theater, singing, piano, ballet, painting, reading, and crocheting.

PPH: TK entered therapy at age nine due to her parent's divorce and at the age of 13 after losing a friend to suicide. She took Fluoxetine for two years to manage her depression and anxiety symptoms but pooped out in the summer of 2022 and switched to Sertraline. During that time, she suffered heartbreak from her boyfriend and required hospitalization for SI with a plan to jump in front of a train. Upon hospital discharge, she was diagnosed with bipolar and prescribed Lamotrigine, which she continues to take. She reports improved symptoms but still feels depressed with daily mood fluctuations

and passive SIs. She continues weekly therapy and states the trauma emotions she had suppressed since childhood are emerging.

Substance Current Use: She denies alcohol or drug use, vaping, or nicotine use but has coffee daily and smokes cannabis with her friends 2-3 times weekly.

Medical History: She denies medical health problems but reports frequent headaches and stomachaches related to her depressive and anxiety episodes.

- **Current Medications**:
  - Lamotrigine 100 mg daily (mood stability) – taken for a year.
  - Sertraline 100 mg daily (anxiety/depressive/PTSD symptoms) – taken for a year.
- **Allergies**: She is allergic to pollen but denies food or drug allergies.
- **Reproductive Hx**: She is heterosexual, sexually active, and practices protected vaginal sex. She has an IUD for contraception; her last menstrual period was a week ago. She denies past pregnancies, abortions, or sexually transmitted infections.

ROS

- GENERAL: She denies weight loss, fever, chills, weakness, or fatigue.
- HEENT: She denies head trauma, visual loss, blurred vision, or double vision. She denies hearing loss, ear pain, drainage, nasal congestion, sneezing, rhinitis, or sore throat.
- SKIN: No rash, itching, or lesions.

- CARDIOVASCULAR: No chest pain, palpitations, or edema.
- RESPIRATORY: No dyspnea, cough, or sputum.
- GASTROINTESTINAL: She reports frequent stomachaches but no anorexia, nausea, vomiting, diarrhea, constipation, or bloody stools.
- GENITOURINARY: She denies dysuria, urgency, hesitancy, foul odor, or color.
- NEUROLOGICAL: She reports frequent headaches but no dizziness, syncope, ataxia, paralysis, numbness, or tingling of extremities—no change in bowel or bladder control.
- MUSCULOSKELETAL: No muscle, back, or joint pain or stiffness.
- HEMATOLOGIC: Denies anemia, excessive bruising, or bleeding.
- LYMPHATICS: No history of splenectomy or enlarged lymph nodes.
- ENDOCRINOLOGIC: Denies sweating, cold or heat intolerance, polyuria, or polydipsia.

Objective:

Weight: 112 lbs. Height: 5' 2". BMI: 20.5 (healthy).

Diagnostic results:

- PHQ-9 score = 18/27 (moderately severe depression).
- GAD-7 score = 4/21 (minimal anxiety).
- PCL-5 score = 40/80 (positive PTSD).

Assessment

Mental Status Examination:

TK is a 22-year-old white single female college dropout who appears younger than her stated age. She is cooperative with the provider. She is clean, well-groomed, and appropriately dressed for the weather. She wears a tattoo on her left arm and a few necklaces around her neck. She sits with her hands clutched around her purse and maintains eye contact. There is no evidence of abnormal body movements. She is talkative with clear, coherent speech of average rate and tone. Her thought process is linear and logical, with appropriate content. There is no evidence of racing thoughts, flight of ideas, or looseness of associations. She presents with a depressed and anxious mood with a congruent full-range affect. She goes from being talkative, happy, and smiling to crying by the end of the interview. She denies auditory or visual hallucinations. She denies delusions, current suicidal or homicidal ideations, plans, or intent. She is alert and oriented to person, place, time, and situation with intact recent and remote memory. Her concentration is good, with good insight and judgment.

Diagnostic Impression:

1. **Unspecified mood disorder (F39)**

   The patient reports depressive symptoms of low motivation, anhedonia, irritability, low frustration tolerance, temper outbursts with property destruction, crying spells, hopelessness, helplessness, self-harm activities (cutting her wrists, stomach, and hips), and passive suicidal ideations (SI) associated with frequent stomachaches and headaches. She also has mania symptoms that qualify her

for bipolar disorder, such as bursts of energy, talkativeness, grandiosity, excessive spending, road rage, racing thoughts, poor sleep, and reckless sexual behaviors. Still, her mood fluctuates daily, and symptoms do not meet the DSM-V-TR criteria for a specific mood disorder, despite a PHQ-9 score confirming moderately severe depression. These symptoms affect her social, occupational, and academic functionality and are the most distressing, making this her primary diagnosis (American Psychiatric Association, 2022).

2. **Attention-deficit hyperactive disorder (ADHD), combined presentation (F90.2)**

   The patient reports as a child, she frequently lost things, used to steal, had poor concentration, and dropped out of college. She reports attention-seeking behaviors, flawed time concepts, impulsivity, talkativeness, temper outbursts, and low frustration tolerance. She has a genetic ADHD predisposition from her mom, which poses a risk for SI in patients with a comorbid mood disorder. Her symptoms match the DSM-V-TR criteria for ADHD, ruling it in as a diagnosis (American Psychiatric Association, 2022).

3. **Posttraumatic stress disorder (PTSD) (F43.10)**

   The patient has experienced repeated sexual trauma, emotional abuse from her dad, and trauma from her parent's divorce and reports nightmares and vivid dreams about these traumatic events. Her symptoms align with the DSM-V- TR criteria for PTSD, and her PCL-5 score was positive for PTSD, ruling it in as a diagnosis (American Psychiatric Association, 2022).

Reflections:

I agree with my preceptor's assessment and diagnostic impression because the patient's most distressing symptoms support an unspecified mood disorder and align with the DSM-V-TR criteria. Lamotrigine is a second-generation mood stabilizer recommended to treat brief recurrent depressive episodes and rapid cycling manic episodes with comorbid anxiety experienced by this patient (Rybakowski, 2023). Given the patient's suboptimal efficacy from Lamotrigine, I learned that it is wise to keep her on the same drug and titrate up by 25 mg increments, up to a maximum dose of 200 mg daily, before switching to another drug (Stahl, 2021). The patient will continue the same dose of Sertraline as the provider makes one change at a time based on the most prominent symptoms and to monitor patient tolerance better. Once the patient's mood stabilizes, the provider can adjust the Sertraline dose if needed.

The patient smokes cannabis with her friends weekly, and there is evidence showing that the risks of lifetime cannabis use outweigh the benefits as it leads to mood, anxiety, personality, substance use, and gambling disorders and is often comorbid with ADHD (Kameg & Kameg, 2021). Providers are legally obligated to educate patients on the risks of mixing medications with cannabis to help them make informed decisions. Shared decision-making (SDM) is an ethical imperative for providers to promote patient involvement, patient-centered care, and treatment compliance, as it encourages patient autonomy in making decisions that best suit their needs (Slade, 2017). This patient can also benefit from family therapy to foster positive

relationships and enhance health and well-being (Office of Disease Prevention and Health Promotion, n.d.).

Case Formulation and Treatment Plan

Plan Medications

-Increase Lamotrigine to 125 mg daily (mood stability).

-Continue Sertraline 100 mg daily (anxiety/depressive/PTSD symptoms).

Education

-Risks and benefits of treatment discussed with the patient, including refusal.

- Educate the patient about the risk of developing Steven Johnson's syndrome while taking Lamotrigine and advise her to seek immediate medical attention to prevent health complications (Stahl, 2021).

-Educated the patient on the risks of mixing medication with drugs, alcohol, or cannabis.

- Instructed patient to inform the provider before stopping medications to prevent withdrawal symptoms (Stahl, 2021).

-Continue weekly therapy to learn healthy coping skills to manage emotions.

-Advised patient on sleep hygiene, self-care, and exercise to promote sleep and improve mood.

-F/u with PCP for unrelieved headaches and stomachaches and health maintenance.

-Advised to call 911, 988, or go to the nearest ER if she becomes suicidal or homicidal.

-Time was allowed for questions and answers, and supportive and empathic listening was provided.

-The patient appeared to understand the discussion and was agreeable to the plan as discussed.

-Treatment consent was obtained from the patient.

-RTC in 2 weeks or sooner if needed. Continued treatment is medically necessary to address chronic symptoms, improve functioning, and prevent needing a higher level of care.

Discussion Prompts:

1. How would you handle this case differently?
2. Do you agree with the pharmacological and non-pharmacological interventions proposed in this case?
3. What will be your plan for the next visit?

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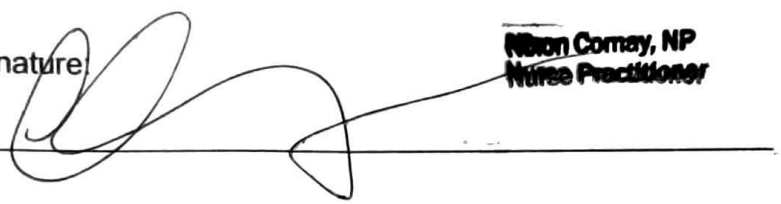
PRECEPTOR VERIFICATION:

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's course of learning.

Preceptor signature: 

Nilon Comay, NP
Nurse Practitioner

Date: June 20th, 2023

References

American Psychiatric Association. (2022). *Numerical listing of DSM-5 diagnoses and codes (ICD-10-CM)* In *Diagnostic and statistical manual of mental disorders*Links to an external site. (5th ed., text rev.). https://go.openathens.net/redirector/waldenu.edu?url=https://dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425787

Kameg, B., & Kameg, K. (2021). Medical marijuana: Liability issues for mental health providers. *Journal of Addictions Nursing, 32*, 73-76. https://doi.org/10.1097/JAN.0000000000000390

Office of Disease Prevention and Health Promotion. (n.d.). Social Determinates of Health.Links to an external site. *Healthy People 2030*. U.S. Department of Health and Human Services. https://health.gov/healthypeople/priority-areas/social-determinants-health

Rybakowski J. K. (2023). Mood stabilizers of first and second generation. *Brain Sciences, 13*(5), 741. https://doi.org/10.3390/brainsci13050741

Slade, M. (2017). Implementing shared decision making in routine mental health care. *World Psychiatry, 16(*2), 146-153. https://doi.org/10.1002/wps.20412

Stahl, S.M. (2021). *Stahl's essential psychopharmacology: Prescriber's guide* (7th ed.). Cambridge University Press.