Aisef Ahmed
Rotation 5 – Psychiatry rotation
H&P 2
06/23/2026

Location: Elmhurst Hospital
Religion: Islam
Source of Information: patient and Family: sister
History obtained from: Patient, Chart review, and collateral (sister)
Mode of transport: Brought in by EMS & NYPD
Race: Albanian
Marital status: single
Patient hearing: is not hard of hearing, deaf, or mute.
Patient preferred to speak English for this assessment

Chief complaint: “My cousin is physically abusing me, and I need X-rays to prove that I'm being attacked”

History of presenting illness:

I.E is a 32 y.o. Albanian, English-speaking male with no known Past medical history or past Psychiatric history, no prior psychiatric admissions, not currently connected to any outpatient psychiatrist. The patient's sister activated 9-1-1 and was brought in by EMS and NYPD for increased paranoia. During the course of the CPEP, the patient was hostile towards the nursing staff by banging his hands against the plexiglass and yelling at them. In addition, the patient had attempted to elope from CPEP multiple times during the course of the visit, and he was placed in 4-point restraints and was medicated for increased agitation.

During the CEPEP Hospitalization, additional information was obtained from the sister. She stated that 3 years ago, the patient began to present with a new onset of Paranoia towards people within his community. She stated that he had one prior admission to Mount Sinai Hospital for 1 week on the medicine floor to rule out any medical cause for delirium. However, he was discharged and never given a formal diagnosis. She reports that during the patient's admission, the patient was given 1 dosage of Risperdal, which seemed to help with his paranoia however, he continued to not sleep patient was not followed up with any providers, and has been paranoid since then, but not as intense as the beginning of the onset of paranoia. She states that over the course of the last month the patient has been paranoid towards their cousin, who lives with them, accusing him of physically abusing them in his sleep. She states that the patient got X-rays at Mount Sinai last week, but states that he did not believe the results and that the doctors lied to him. She reports that his Urine Toxicology was negative, and he does not drink. She called 911 yesterday because the patient stated that if there continue to be issues with his cousin, he will defend himself if necessary. She states that the patient has not been able to hold his job as a waiter because of paranoia and states he has not been sleeping well. She states that the patient has never been paranoid towards family. The patient was voluntarily admitted to the inpatient psychiatric unit at Elmhurst Hospital Center.

Patient was found on the inpatient psychiatric unit, casually groomed, making fair eye contact, appearing calm, superficially cooperative, and with the writer. Although cooperative with the interview, he was guarded. He reported that he was brought to the hospital on account of his sister calling 911, where he was brought here involuntarily. He acknowledged his sister was concerned about him, described her as "exaggerated" when asked to elaborate, and he said she told him he should seek help from a psychiatrist, but he disagrees with his sister. He previously worked with his cousin as a server in a restaurant; he reported that he quit (timing unclear) after his cousin attempted to "control" him. He reported his cousin, who has been living with him and the patient's sister, has been "toxic" and "controlling" towards him for the past three years. Patient denies any specific incident prior to this. He reports that his cousin has been beating him in the middle of the night. Reports of being hit in his genital area, kidneys, and other multiple body parts. Denies ever noticing any bruises but reports he knows this is happening because he wakes up out of sleep due to this pain. Patient does not recall what his cousin is allegedly using to hit him, although he does mention seeing him run out of his room sometimes. Patient reports attempting to lock his door to avoid this, but states that his sister stopped him. He also mentioned he believes his sister did this because she is on his cousin's side. He additionally mentioned an incident about three years ago during which he experienced seeing a shadow, but adds he believes he may have been drugged, and was unable to recall any details regarding this incident. Patient also reported he left Albania when he was 24 years old due to political issues (unclear if he was officially seeking political asylum). He alluded to knowing sensitive/important information that put him in danger from the Albanian government/authorities. Endorsed feeling like he is being monitored out in the community, did not mention anyone specific other than his cousin. When asked how he learned this information? Or whether he worked in government patient responded: "I have good intuition, I know these things." He also mentioned his mother, with whom he grew up in Albania, had a fall. He reported he believes there may have been foul play by those "persecuting" him in Albania that led to her fall.

Patient described sleep, appetite, and energy levels as okay. Patient denies any auditory hallucinations, visual hallucinations, homicidal ideations, suicidal ideations/plan/intent. Patient denies depressed mood. Patient denies past history of self-harm or self-injurious behavior. He denies any rapid speech, racing thoughts, or overactivity. Endorsed paranoid ideations, denied thought insertion or withdrawal. Denied substance use, however acknowledged smoking 2 packs of cigarettes previously for a few years and now smokes 1 pack of cigarettes per day for the past year. Drinks alcohol socially, denies ever drinking excessively, no hx of withdrawal or hospital admissions due to alcohol use or withdrawal. Reported feeling safe in the unit. Vaguely endorsed some physical pain and requested multiple X-rays of his kidneys, back, chest, and genitals. Patient was not observed to be in acute physical distress at this time.

Past medical history

- None reported

Past psychiatric history

- None reported

Current medications

- None reported

Current facility- administered medications

- haloperidol (HALDOL) tablet 5 mg orally Q6H PRN
- LORazepam (ATIVAN) tablet 2 mg orally Q6H PRN
- nicotine (NICODERM CQ) 14 mg/24 hr patch, Daily PRN
- nicotine (NICORETTE) gum 2 mg Q4H PRN
- risperiDONE (RisperDAL M-TAB) disintegrating tablet 1 mg orally twice a day
- Trazodone (DESYREL) tablet 50 mg Q12H PRN

Allergies

- Denies any allergies

Family history

The patient is a poor historian regarding his family psychiatric and medical history. He reports that he is unaware of any diagnosed psychiatric illnesses, substance use disorders, suicide attempts, or psychiatric hospitalizations among family members. When questioned further, the patient was unable to provide additional details and stated that mental health issues were not commonly discussed within his family. The patient's sister was unsure if the family had any known history. No known family history of major medical illnesses was reported.

Social History:

- Domiciled, living with his sister and cousin in a private residence.
- Currently unemployed; previously worked as a waiter but reports difficulty maintaining employment due to interpersonal conflicts and increasing suspiciousness toward others.
- Education: Completed high school in Albania; no additional educational history reported.
- Immigration history: Emigrated from Albania to the United States at approximately 24 years of age, leaving due to political concerns, though details remain unclear.
- Relationship history: Single and has never been married. Denies having children.
- Reports limited social support outside of immediate family and has become increasingly socially isolated over the past several years.
- Legal history: Denies current legal involvement, arrests, incarceration, or pending legal charges.
- Access to firearms: Denies access to firearms or other weapons.
- Religion/Cultural background: Muslim; identifies strongly with his Albanian cultural background.
- Activities of daily living: Independent with basic activities of daily living, though family reports increasing functional impairment related to paranoia and poor sleep over the past several years.

Review of Systems (ROS):

General – Denies fever, chills, weight loss, night sweats, fatigue, or malaise.

Head – Denies headache, dizziness, lightheadedness, recent head trauma, or loss of consciousness.

Neck – Denies neck pain, stiffness, or localized masses.

Pulmonary System – Denies shortness of breath, cough, wheezing, chest tightness, or hemoptysis.

Cardiovascular System – Denies chest pain, palpitations, syncope, orthopnea, or lower extremity edema.

Gastrointestinal System – Denies abdominal pain, nausea, vomiting, diarrhea, constipation, melena, hematochezia, or changes in bowel habits.

Genitourinary System – Denies dysuria, urinary frequency, urgency, hematuria, or incontinence.

Neurological System – Denies weakness, numbness, paresthesias, tremors, seizures, headaches, or focal neurological deficits.

Musculoskeletal System – Denies muscle pain, joint pain, joint swelling, stiffness, or gait disturbances.

Dermatological System – Denies rashes, pruritus, skin lesions, bruising, or changes in skin, hair, or nails.

Endocrine System – Denies heat or cold intolerance, excessive thirst, excessive hunger, or polyuria.

Hematologic/Lymphatic System – Denies easy bruising, easy bleeding, or lymph node enlargement.

Psychiatric System – Endorses persistent paranoid ideation and persecutory delusions involving his cousin and individuals from Albania. Reports feeling monitored and targeted by others. Demonstrates suspiciousness, guarded behavior, and poor insight into his condition. Denies suicidal ideation, homicidal ideation, auditory hallucinations, visual hallucinations, tactile hallucinations, depressive symptoms, manic symptoms, self-injurious behavior, and prior suicide attempts. Reports recent sleep disturbance associated with ongoing paranoid beliefs.

Physical examination

Vital Signs: BP 128/76 mmHg, Pulse 82 bpm, Temperature 98.4 F (oral), Respiratory Rate 16 breaths/min, Height 1.803 m (5 ft 11 in), Weight 192 lbs, SpO2 99% on room air, BMI 26.8.

General: Well-appearing male in no acute distress. Alert, awake, and cooperative with examination.

HEENT: Normocephalic, atraumatic. Pupils equal, round, and reactive to light. Extraocular movements intact. Mucous membranes moist.

Neck: No lymphadenopathy or masses appreciated.

Pulmonary: Breathing comfortably on room air.

Extremities: Full range of motion in all joints. No edema, cyanosis, or deformities noted.

Neurological: Alert and oriented x3. Gait intact. Spontaneous movement of all extremities. No focal neurological deficits appreciated.

Skin: Warm, dry, and intact. No rashes, lesions, or ecchymosis noted.

Mental Status Examination

General

1. Appearance: I.E is a 32-year-old Albanian male who appears his stated age. He was casually groomed and appropriately dressed in hospital attire. Hygiene was adequate. No obvious scars, deformities, or signs of acute physical injury were noted.

2. Behavior and Psychomotor Activity: I.E was calm throughout the interview with no evidence of psychomotor agitation or retardation. No abnormal movements, tremors, or tics were observed. Although cooperative, he remained guarded when discussing his beliefs regarding his cousin and alleged persecution.

3. Attitude Towards Examiner: I.E was superficially cooperative with the examiner and established rapport with some difficulty due to suspiciousness and guardedness. He answered most questions but was occasionally evasive when challenged regarding his beliefs.

Sensorium and Cognition

1. Alertness and Consciousness: I. E was alert and fully conscious throughout the interview.

2. Orientation: I.E was oriented to person, place, time, and situation.

3. Concentration and Attention: Attention and concentration were grossly intact. He maintained focus during the interview and provided relevant responses to questions.

4. Capacity to Read and Write: Not formally assessed during this encounter. No deficits were apparent during conversation.

5. Abstract Thinking: Abstract reasoning appeared limited. The patient demonstrated a tendency toward concrete interpretations and exhibited fixed, illogical beliefs regarding persecution and physical abuse despite a lack of objective evidence.

6. Memory: Recent and remote memory appeared grossly intact based on historical recall and interview responses. Formal memory testing was not performed.

7. Fund of Information and Knowledge: Intellectual functioning appeared average and consistent with his educational and occupational background.

Mood and Affect

1. Mood: I.E described his mood as "fine" but expressed significant concern regarding alleged abuse by his cousin and ongoing persecution.

2. Affect: Affect was constricted but appropriate to the topics discussed.

3. Appropriateness: Mood and affect were generally congruent with interview content. No emotional lability, inappropriate laughter, or excessive emotional outbursts were observed.

Motor

1. Speech: Speech was normal in rate, rhythm, volume, and tone. Speech was coherent and goal-directed.

2. Eye Contact: I.E maintained fair eye contact throughout the interview.

3. Body Movements: No tremors, tics, abnormal involuntary movements, or gait abnormalities were observed. Psychomotor activity was within normal limits.

Reasoning and Control

1. Impulse Control: Impulse control was impaired as evidenced by recent episodes of agitation, attempts to elope from CPEP, and behavior requiring four-point restraints. During the interview, however, he remained behaviorally controlled. He denied suicidal or homicidal ideation.

2. Judgment: Judgment was impaired. The patient demonstrated persistent persecutory delusions involving his cousin and individuals from Albania and continued to seek medical testing despite repeated reassurance and negative findings.

3. Insight: Insight was poor. Patient I.E did not believe he was experiencing psychiatric symptoms and attributed his hospitalization entirely to his sister's overreaction and external persecution. He demonstrated little understanding of the possibility that his beliefs may be related to an underlying psychiatric illness.

Assessment

I.E is a 32-year-old Albanian male with no known prior psychiatric history who presents via EMS and NYPD after his sister had activated 911 due to escalating paranoia, persecutory delusions, and behavioral dysregulation. Collateral from his sister describes an approximately three-year history of progressively worsening paranoid ideation involving his cousin and broader beliefs of being targeted and monitored, associated with functional decline, including job loss, poor sleep, and increasing social impairment. In CPEP, the patient demonstrated significant agitation with attempts to elope, requiring four-point restraints and PRN medication administration. On evaluation, he exhibits fixed persecutory delusions that his cousin is physically assaulting him at night despite a lack of objective evidence, along with additional paranoid beliefs involving surveillance and external persecution. He requests unnecessary medical testing, demonstrates poor insight, and attributes his symptoms entirely to external causes. He denies auditory or visual hallucinations, suicidal ideation, homicidal ideation, and mood symptoms, and his thought process remains largely coherent without overt formal thought disorder.

Overall, the presentation is most consistent with a primary psychotic disorder within the schizophrenia spectrum, given the chronic progressive course, functional deterioration, and persistent fixed delusional system with impaired reality testing and insight. Delusional disorder, persecutory type, remains an important alternative diagnosis given relatively preserved cognitive organization and absence of prominent hallucinations; however, the severity, duration, behavioral escalation, and need for restraints favor a schizophrenia spectrum illness. Substance-induced psychotic disorder is considered less likely given the multi-year course and lack of clear substance correlation, though toxicology screening and collateral verification remain important. The patient currently demonstrates impaired judgment and limited insight, with recent behavioral instability placing him at elevated risk for further decompensation, necessitating continued inpatient psychiatric hospitalization for stabilization, diagnostic clarification, and initiation/optimization of antipsychotic treatment.

Differential diagnosis

1. Schizophrenia Spectrum Disorder :
The most likely diagnosis is a schizophrenia spectrum disorder, most consistent with paranoid schizophrenia, given the chronic, progressive course of illness over approximately three years with clear functional decline. The patient demonstrates persistent persecutory delusions involving his cousin physically abusing him despite a lack of objective evidence, as well as broader paranoid ideation involving government surveillance and persecution. He shows poor insight into his condition and attributes all concerns to external causes rather than recognizing a psychiatric etiology. The severity of symptoms has led to significant occupational impairment, social dysfunction, and behavioral dysregulation requiring restraints during admission, supporting a primary psychotic disorder rather than a transient or isolated process.

2. Delusional Disorder, Persecutory Type:
Delusional disorder, persecutory type, is also strongly considered given the presence of a well-systematized, fixed delusional belief system primarily centered on being targeted and harmed by his cousin. Outside of this delusional framework, the patient appears relatively organized, with largely coherent speech, intact cognition, and no clear evidence of pervasive disorganization or negative symptoms. He does not endorse hallucinations and maintains some degree of interpersonal functioning despite increasing paranoia. This presentation may reflect a more circumscribed psychotic disorder; however, the escalating severity, behavioral dysregulation, and functional decline suggest progression beyond classic delusional disorder.

3. Substance/Medication-Induced Psychotic Disorder:
A substance- or medication-induced psychotic disorder is less likely but remains an important differential to consider. Psychosis can be precipitated or exacerbated by substances such as cannabis, stimulants, or withdrawal states; however, there is no clear evidence of ongoing substance use or intoxication contributing to his symptoms. Additionally, the chronicity of symptoms over several years with persistent paranoia and functional decline despite no reported substance correlation makes a primary substance-induced etiology unlikely. While toxicologic screening and collateral history are important to fully exclude this possibility, the current presentation is more consistent with a primary psychotic disorder.

Plan

Diagnostic / Medical Workup

Obtain baseline labs to rule out medical contributors to psychosis:

- CBC, CMP (electrolytes, renal/hepatic function)
- TSH with reflex T4
- Vitamin B12/folate
- Urine toxicology screen to rule out substance-induced psychosis
- Blood alcohol level
- Neurologic workup only if new focal findings or atypical progression occur

Pharmacologic Management

- Start patient on Risperidone 1 mg PO BID, with gradual titration based on response and tolerance

  PRN medications:

- Haloperidol 5 mg PO/IM PRN for severe agitation or acute psychosis
- Lorazepam 2 mg PO PRN for anxiety/agitation
- Trazodone 50 mg PRN for insomnia
- Consider a long-acting injectable antipsychotic if nonadherence or recurrent decompensation becomes evident

Safety / Behavioral Management

- Continue inpatient psychiatric hospitalization for stabilization and safety
- Maintain Q15-minute observation due to: Recent agitation and elopement attempts, Persistent persecutory delusions, Impaired judgment and insight
- Monitor for escalation of paranoia or potential aggression toward the perceived persecutor
- Maintain a structured, low-stimulation milieu to reduce behavioral dysregulation

Substance Use Considerations

- Confirm abstinence with urine toxicology
- Continue nicotine replacement therapy (patch + gum PRN)
- Provide brief counseling regarding tobacco use and possible impact on anxiety/paranoia
- Monitor for any signs of substance-related withdrawal or intoxication contributing to symptoms

Psychosocial / Therapeutic Interventions & Collateral

- Establish therapeutic alliance using a supportive, non-confrontational approach (avoid direct challenge of delusions)
- Provide psychoeducation framed around symptom management and stress-related perceptual changes

- Engage the patient in structured inpatient milieu activities to improve organization and reduce preoccupation with delusional content

Disposition: Continue inpatient admission until:

- Reduction in persecutory delusions
- Improved behavioral control and decreased agitation
- Stabilization on antipsychotic regimen