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# ALCOHOL-INDUCED PSYCHOTIC DISORDER: A CASE STUDY

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**Abstract**
Alcohol-induced psychotic disorder (AIPD) is a severe psychiatric condition associated with chronic alcohol consumption, characterized by hallucinations, delusions, aggression, and behavioral disturbances. We report the case of a 40-year-old male with a 25-year history of escalating alcohol use who presented with tremors, weakness, aggressive behavior, sleep disturbances, self-talk, and self-laughing over a four-day period. Laboratory investigations and abdominal ultrasonography were within normal limits. The patient was diagnosed with alcohol-induced psychotic disorder with mixed psychotic symptoms and was managed with thiamine, benzodiazepines, antipsychotics, and supportive care. Clinical pharmacist interventions and patient counseling played an integral role in optimizing therapy and promoting recovery. This case highlights the importance of early recognition, multidisciplinary management, and comprehensive patient education in the treatment of alcohol-induced psychosis.

***Keywords:*** *Alcohol-induced psychotic disorder, chronic alcohol consumption, hallucinations, psychosis, thiamine, benzodiazepines, antipsychotics.*



## INTRODUCTION

Alcohol-induced psychotic disorder (AIPD) is an uncommon but serious complication of long-term alcohol abuse, typically presenting with hallucinations, delusions, agitation, and sleep disturbances. The condition often develops in individuals with prolonged, heavy alcohol use, and may be precipitated by acute intoxication or withdrawal [1]. The underlying pathophysiology involves dysregulation of dopaminergic and GABAergic neurotransmission, thiamine deficiency, and disruption of cognitive processes. Prompt recognition and management are critical to prevent long-term cognitive deficits, severe psychiatric complications, and relapse. This report details the clinical course, management, and pharmacist-led interventions in a patient with chronic alcohol use who developed AIPD [2].

## CASE STUDY

A 40-year-old male presented with complaints of weakness and hand tremors for four days. According to the informant, the patient had a 25-year history of alcohol consumption, with gradual escalation over time. He initially consumed 90 ml of alcohol occasionally in 2000, which increased to 180 ml by 2005, 360–540 ml daily by 2010, and eventually exceeded 720 ml daily from 2020 onward. Four days prior to admission, he exhibited aggressive behavior, decreased sleep and appetite, self-talk, and self-laughing. He had no prior psychiatric history or suicidal attempts, and family history was negative for psychiatric disorders. On mental status examination, the patient appeared well-kempt, cooperative, and appropriate for his age. Tremors and increased psychomotor activity were noted. Speech and language were normal, mood was reported as normal despite psychotic features, and although the patient denied hallucinations, self-talk and self-laughing were observed. He was disoriented to time and place but could perform simple calculations and communicate verbally. Vital signs recorded over four days remained largely stable, with minor fluctuations in blood pressure and pulse rate. Laboratory investigations, including abdominal ultrasonography, liver function tests, and pancreatic enzymes, were all within normal limits. Based on these findings, the patient was diagnosed with alcohol-induced psychotic disorder with mixed psychotic symptoms.

## MANAGEMENT

The patient received pharmacological therapy including pantoprazole 40 mg orally twice daily, thiamine 200 mg intravenously twice daily, lorazepam 2 mg intravenously twice daily, olanzapine 10 mg orally twice daily, baclofen 10 mg orally twice daily, and propranolol 20 mg orally once daily. Lorazepam was transitioned to oral form for four days. At discharge, medications were adjusted to pantoprazole 40 mg OD, olanzapine 10 mg

OD, lorazepam 2 mg BD, and thiamine 100 mg OD, with a follow-up review scheduled after seven days.

Clinical pharmacist interventions included reviewing the medication regimen to ensure correct dosing, monitoring for adverse effects such as sedation, orthostatic hypotension, and extrapyramidal symptoms, and assessing potential drug interactions between lorazepam, olanzapine, and propranolol. Patient education emphasized adherence to therapy, the importance of alcohol abstinence, and monitoring for side effects. Thiamine supplementation was highlighted to prevent Wernicke-Korsakoff syndrome.

Patient counseling focused on promoting complete abstinence from alcohol, adherence to medications, and gradual tapering of benzodiazepines. Strategies for stress management and sleep hygiene were provided, and family members were instructed to monitor for hallucinations, aggressive behavior, or suicidal tendencies. The patient was encouraged to follow up with psychiatric and de-addiction services for ongoing support.

## DISCUSSION

Alcohol-induced psychotic disorder is commonly seen in individuals with long-standing alcohol dependence, particularly in middle-aged males. Clinical manifestations include hallucinations, delusions, aggression, tremors, sleep disturbances, and cognitive impairment [3]. This case is consistent with literature describing the gradual escalation of alcohol intake leading to acute psychotic episodes, even in the absence of significant hepatic or pancreatic dysfunction [4]. Management requires a multifaceted approach, including abstinence from alcohol, thiamine supplementation to prevent neurological complications, benzodiazepines for withdrawal and agitation, and antipsychotics to control psychotic symptoms [5]. Clinical pharmacist interventions enhance treatment safety and efficacy by optimizing medication selection, monitoring adverse effects, and providing patient education, thereby reducing the risk of relapse and improving outcomes. Multidisciplinary care and patient counseling remain pivotal components of recovery in alcohol-induced psychotic disorder [6].

## CONCLUSION

This case highlights the critical role of early recognition, multidisciplinary management, and patient-centered interventions in alcohol-induced psychotic disorder. Effective pharmacological therapy, combined with clinical pharmacist involvement and comprehensive patient counseling, led to stabilization of psychotic symptoms, reduced relapse risk, and improved prognosis. Continued follow-up and support for abstinence are essential to prevent recurrence and long-term complications.

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