Psychiatry Patient Write-up #2

CC: Follow-up: "I'm doing better."

HPI: Ms. X, a 56 YOWF with a history of Paranoid Schizophrenia and Major Depressive Disorder, presents to the clinic for f/u. She is currently prescribed the following psychotropic medications: Abilify 15 mg, 1 tab po q day, Fluoxetine Hydrochloride 20 mg, 1 tab po q day, and Klonopin 1 mg, 1 tab po qhs and ½ tab po prn for increased anxiety (possible panic attack).

The patient is doing quite well now, exhibiting much improvement over the last few months. She continues to be able to carry on a conversation without spontaneously bringing up psychotic delusions or hallucinations. Her main delusion in the past was believing she birthed children whom she has never known, by her ex-husband, and that he gave them away. Her delusions also included believing that young women and girls around her neighborhood are these unknown children and believing that people were following her. She also had paranoia about coworkers talking about her and teasing her, with one man in particular singling her out. Past hallucinations included a young girl in the woods behind her apartment crying out to her, a voice resembling her daughter's voice crying out for help, two voices – one of a man beating a woman and the other of the woman crying, the voice of a black woman talking to her, and a specific voice telling her she owed a debt of $739.57. In this interview, the patient did not bring up these topics or any other psychotic symptoms at all until specifically asked. When asked does she hear anything, she claims she occasionally hears sounds in the woods and sometimes thinks she hears someone walking and crying outside her door. She seems to understand neither of these things are real and lets them go after only mentioning once. A persistent delusion is the thought that there is someone around her apartment that looks like her daughter, but this person will not allow her to get close enough to let the patient see who she is. The patient relates this to her thinking she has had unknown children. She rationalizes that this may not be real and states that she is able to not think about this all the time.

Her focus at work is much improved. Her relationship with her two actual daughters is much improved. Her daughters tell her not to discuss any of her psychotic symptoms around them, and she admits that this sometimes leaves her lonely and unsupported. For the most part, however, they provide a good, stable support system. She has established a working relationship with her youngest son-in-law, about which she was previously quite worried.

She complains consistently about weight gain due to increased appetite since being on Abilify, but continues to focus on maintaining her weight and possibly losing weight by exercising during her lunch breaks, by walking after work, and by eating healthy. These measures also improve her mood, sleep, and occupational functioning. Her depression was a 3/10 at the last visit and improving. She says her mood is stable as long as she keeps busy. She denies any suicidal or homicidal ideation.

Past Psych History: Per her oldest daughter, age 35 YO, she has had paranoid symptoms, including believing someone at work was attempting to kill her by poisoning her food or coffee, since at least 30 years ago. The patient would have been around 25 YO then. She has experienced persistent delusions and hallucinations for some time, with worsening psychotic symptoms following major life stressors, including after her divorce in 1991, after being robbed at a convenience store in 1993, and after her youngest daughter, age 25 YO now, got married and

moved out from home. These symptoms acutely increased around December 2007, and she was not seen in this clinic until August 2008.

She sought psychiatric help in 1991 following her divorce and after experiencing conflicts with her daughters over the divorce. She was treated for depression at that time. In 1993, following her being robbed, she overdosed on Valium, taking 13 pills, and was hospitalized. This may have been a possible suicide attempt, but the true nature of this episode is unclear. She also has a past history of at least one violent episode, in which she beat one of her daughters with a telephone.

Past psychotropic medications include Lexapro for depression, Klonopin for anxiety, and Seroquel for psychosis.

Past Medical History: Current conditions include DM adult onset, hypertension, bilateral lumbar radiculopathy, back pain, bilateral knee pain, BPPV, stress incontinence, and constipation. Medical management includes aspirin 325 mg, 1 po q day, diphenhydramine hydrochloride 25 mg, 1 po prn allergies, Enablex 7.5 mg, 1 po q day, Lisinopril-HCTZ 20 mg – 25 mg, 1 po q day, Lortab 5/500, 1 po q 6 hours prn pain, magnesium citrate 8.85%, 300 ml times 1, metformin hydrochloride 500 mg, 1 po bid, Miralax, 1 packet po q day, omeprazole 20 mg, 1 po q day, vitamin B12 2000 mcg, 1 po q day, vitamin B6, 1 po q day, and vitamin D 400 IU, 2 po q day. Allergies are present to penicillin and sulfa. Health maintenance history includes mammogram, Pap smear, physical exam, and urinalysis all on 6/11/08.

Social History: Ms. X lives in Tuscaloosa, Alabama, in an apartment by herself. She has a limited social life but enjoys reading. She works full-time as a CAD engineer at the Department of Transportation and has done so for 27 years. She is 3 years short of qualifying for retirement. She graduated from the 12th grade and has an associate's degree from a technical institute. She met all developmental milestones growing up.

She is married once and divorced as of 1991. She has two daughters, age 35 YO and 25 YO, who are both married. It distressed her much when her youngest daughter got married and moved out on her own in August 2007. They have had their difficulties in the past, over Ms. X feeling the children blamed her for their father leaving and over tense emotions surrounding her possible suicide attempt, but seem to be a good support system for Ms. X currently.

She smoked cigarettes socially for several years in the past but quit when she first became pregnant 35 years ago. She has recently begun smoking again, up to 1 pack per day, to deal with her psychotic symptoms. She claims this is back down to only about 3 cigarettes per day. She drinks alcohol occasionally in moderation. She denies any current or past illicit drug use. She consumes caffeine in the form of approximately 3 cups of coffee per day.

In regard to sexual history, Ms. X was sexually abused by her uncle around the age of 3 or 4 YO. After this occurrence, her mother took her to church to be cleansed in the baptismal water.

Spiritual History: From the above statement, it seems that religion and particularly the concept of "washing away evil," possibly associated with seeking forgiveness from God, were a part of Ms. X's upbringing. However, she currently states that she attends church only every now and then, not making organized religion seem to be a cornerstone of her life now.

Family Psych History: Her father had a history of paranoid behavior, constantly worried about the house being robbed and "rigging" doors to catch burglars. Her mother had a history of depression, intractable to treatment. Her two daughters have both been treated for anxiety, supposedly mainly over the stress of the patient's condition. No other family history is identified, and no other family members have ever been hospitalized for psychiatric illness.

Family Medical History: This is positive for DM – type II.

Mental Status Exam:
Orientation – oriented to person, place, and time
Appearance – appeared stated age, well groomed, eye contact good
Behavior – calm, concerned
Attitude – calm, cooperative
Rapport – candid and easy to establish
Speech and Language – clear, normal rate, rhythm, and volume
Mood – mildly depressed
Affect – congruent with mood
Thought Processes/Associations – logical and goal directed
Thought Content – noted delusional thinking, relating everyday noises to other issues per HPI
Suicidal/Homicidal Ideation – no suicidal or homicidal ideation
Cognitive – not formally tested but grossly within normal limits
Concentration – within normal limits
Abstraction – good
Serial Sevens – no errors
Memory – within normal limits
MMSE – 30/30
Insight – fair
Judgment – good

PE:
VS: BP 122/90, P 84, R 16, T 97.6, Weight 209.8 lbs.

Labs: Previous CT neuroimaging shows mild cerebral atrophy. Other recent abnormal results:

4/30/09			
CK-Total/Creatine Kinase,Total,Serum	367 U/L	24-173	**H**
3/5/09			
Vitamin D, 25-Hydroxy/Vitamin D, 25-Hydr	22.7 ng/mL	32.0-100.0	**L**

DDx:
Psychiatric:
1. Schizophrenia, Paranoid Type: This patient has a history of delusions and hallucinations present for greater than 6 months. To support the paranoid type, she has some degree of paranoid delusions with definite frequent auditory hallucinations on initial presentation, and her affect is not prominently flat.
2. Major Depressive Episode: She seems to have met at least 5 of the 9 symptoms at some point in her course.

3. Schizoaffective Disorder, Depressed Type: This may best explain all of her symptomatology as a whole.
4. Major Depressive Disorder, Severe with Psychotic Features: This seems possible, though her psychosis and paranoia seem to be pervasive regardless of mood status.
5. Bipolar II Disorder, Severe with Psychotic Features: She has never been fully manic, but she has been depressed more than once. This again seems possible but the psychoses and paranoia are pervasive despite mood.
6. Delusional Disorder: This seems quite possible, owing to the fact that most of her delusions center on a specific theme, however, she has hallucinations along with the delusions. Also, her delusions are unrealistic and somewhat extend into other arenas of life beside the primary theme of unknown children.
7. Substance-Induced Psychotic Disorder or Substance Abuse: This does not seem likely.
8. Psychotic Disorder Due to a General Medical Condition: It seems that these symptoms have been present through most of life and have not developed along with any one specific medical condition.
9. Psychotic Disorder, NOS
10. Schizophreniform Disorder: She has definitely had symptoms for greater than 6 months, so this is in essence ruled out.

– Any of the Cluster A Personality Disorders seems possible, though her traits are not intense or pervasive enough to truly diagnose any specific one.
– She cannot likely be diagnosed with Major Depressive Disorder or Bipolar II Disorder in addition to any Schizoaffective or Schizophrenia diagnoses, since both criteria for the former two disorders include the statement that the symptoms are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia.
– Any medical causes of these symptoms, such as hypercalcemia, hypoglycemia, hypothyroidism, paraneoplastic syndromes, or nutritional deficiencies, seem to be ruled out by evaluation and labs.

<u>Axial Diagnoses</u>:

Axis I:	Schizophrenia, Paranoid Type Major Depressive Episode
Axis II:	Paranoid, Schizoid, and Schizotypal Traits
Axis III:	Per PMH
Axis IV:	-Some past conflicts and underlying issues with primary support group consisting of her daughters -Distress of living alone, especially since youngest daughter moved out -Some occupational conflicts with coworkers, though these may be misperceived by the patient due to mental illness
Axis V:	GAF = 55

<u>Cultural Formulation</u>:
<u>Cultural Identity</u>: Ms. X is a middle-class white female in her 50's. She has a post-secondary education, speaks fluently, and prefers English as her language of choice.
<u>Cultural Explanations of Illness</u>: Most people around Ms. X may simply think she is a little "crazy" or that she is a "strange bird." They may simply explain her illness away by seeing her

as someone who just does not quite fit into mainstream life, or by viewing her as someone extremely affected by life events, such as her divorce.

Her daughters, however, have probably always known, even when their father was there with their mother, that something was just not quite right. They have likely felt that she always needed some help from somewhere. It seems, too, though, that at some point, they also viewed their mother as a bad, lesser, or impaired person for "driving" their father away. They may have at some point just thought their mother had a paranoid personality and was "hard to get along with", something they would never like to emulate. It seems that they now have some insight into the fact their mother has an illness and most likely needs some type of psychiatric care for the rest of her life.

Ms. X may likely see herself as a fairly normal person, who does not like people invading her space and who does not trust others, but who leads the life she wants to lead. She may also view her significant life events as things that caused her to develop more significant illness.

Cultural Elements of the Clinician Relationship: It will be fairly easy for the clinician to establish and maintain rapport with the patient. They are of the same race and from fairly similar socioeconomic backgrounds. Also, the clinician is of a close age to one of the patient's daughters. The only difficulties may be gender and age differences.

Biopsychosocial Formulation: Ms. X is a 56 YOWF, who presents for f/u of previous diagnoses of Paranoid Schizophrenia and Major Depressive Disorder. There appears to be a familial and possibly genetic link for both of these disorders, her father displaying eccentric, paranoid behaviors and her mother experiencing longstanding depression. Though schizophrenia often majorly impairs a person's life, she seems to have functioned reasonably well for the majority of her life, holding a marriage together for at least some time until 1991, having a successful job for 27 years, and raising two well-developed children. The history is unclear, but it is possible that worsening psychoses caused the end of her marriage and caused her daughters to resent her for "driving" their father away. The guilt and distress of this breakup definitely contribute to her depression. It seems that the sometimes tenuous relationship with her daughters also contributes to her depression. She even notes a "falling out" with her oldest daughter after her Valium overdose in 1993. As well, she likely let her youngest daughter become her only true companion after the divorce, and as such, when this daughter moved out, it caused enough distress to increase her psychoses and contribute to developing depression. Also, her desire for companionship and support from her daughters may even influence the content of her delusions and hallucinations. This may also include some aspect of guilt that she was not always there for them. It would seem that her illness, with its prominent delusions and hallucinations along with paranoia, has changed her life course, more so than her direct choices have altered her path. For example, while she has been able to hold down a job, even now, she has no meaningful relationships with her coworkers due to her prevailing distrust of them. Her general medical conditions also pose added stresses to her life and may contribute to her psychiatric illness. Regardless, she has continued to function at a reasonable level and even gets out into the community some through exercise and Tae Kwon Do.

Treatment Plan:

1. Schizophrenia, Paranoid Type: Continue on 15 mg q day of Abilify. Abilify, among other atypical antipsychotics, is beneficial for treatment of delusions and hallucinations and has some mood stabilizing properties. This is only half of the maximum therapeutic dose, but doses above

15 mg are rarely more effective in Schizophrenia. The exact disease-altering MOA is unknown – it is known, however, that this atypical antipsychotic is a partial agonist at the D2 dopamine receptor and at the 5HT1A serotonin receptor and an antagonist at the 5HT2A serotonin receptor. Development of metabolic syndrome is a possible side effect of this medication, and since Ms. X already has DM, type 2, this will need to be monitored closely by labs and primary care follow-up. She also complains of weight gain and has been advised and seems to be compliant in actively exercising and eating healthy. Another common side effect is orthostatic hypotension. She has not complained of this. Rare but serious adverse reactions to this medicine include neuroleptic malignant syndrome and extrapyramidal symptoms.

2. Major Depressive Episode: Continue on Prozac 20 mg q day. This is an SSRI with antidepressant properties. She may need to stay on this medication for at least one year to keep her mood stable and keep her out of depression. She may be on this medication indefinitely for that same purpose. Common side effects include nausea, headache, insomnia or sedation, restlessness, and sexual dysfunction. She has not complained of any of these.

3. Continue Klonopin 1 mg qhs for sleep, decreased anxiety associated with depression, and decreased agitation associated with psychotic symptoms. Benzodiazepines function via agonist activity at the CNS GABA receptors. Primary side effects include sedation or grogginess. This medicine can also have mild respiratory depressant properties.

4. Consider diagnosis of Schizoaffective Disorder, Depressed Type. With this, consider mood stabilizer therapy with lithium. This medicine alters at least two intracellular second messenger systems, and as such affects norepinephrine and serotonin in the CNS. It also alters GABA metabolism and can directly alter ion channel function. Its exact disease-altering MOA is unknown. Possible benefits here are mood stabilization and prevention of depression. Lithium, however, has many side effects and requires good renal function for excretion, becoming toxic even at prescribed doses if a quick decline in renal function occurs. These risks may outweigh the benefits here, but a mood stabilizer may need to be considered if Ms. X does not remain stable.

5. Refer her and her daughters to family therapy. This may improve their relationships and augment Ms. X's support system. This may also give her daughters improved insight into their mother's illness and help them to understand her and to aid her.

6. Consider individual psychotherapy for the patient, as it may also keep her out of depression.

7. Encourage patient to engage in social activities and make meaningful interpersonal relationships.

<u>Prognosis</u>: Ms. X has a good prognosis, if her psychoses are controlled and stabilized and severe depression with possible suicidality is avoided. Her past history of possible suicide attempt is a worry but does not seem to forecast a probable reoccurrence. Also, the improvement of her support system, mainly through her daughters, will be important to her continued health. Her general medical conditions need to be closely monitored and stabilized in order to further improve her prognosis. Her life expectancy should be similar to that of her peers.